Wellington-Napoleon High School

800 Hwy 131, Wellington, MO 64097
Fax(816)934-8649 Phone(816)240-2621

Consent for Release of Information

Date_____ Grade _____

Student Full Name _____ Date of Birth _____

Previous School Attended _____ Date Withdrawn _____

Street _____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

Previous Home Address _____

When this form is used to release information to Wellington-Napoleon School District, it will be used in compliance with Family Educational Rights and Privacy Act (FERPA), which allows documents to become part of the student's confidential records and be subject to inspection. In addition, the information may be copied.

I hereby authorized the release of the information for the student listed above:

Legal Custodial Parent/Guardian Signature _____ Date _____

Previous School: Please send the complete school records for the student listed above, including the following:

_____Academic Records (including US and MO constitution Test with dates passed

_____Withdrawal Grades

_____Disciplinary Records

_____Test Scores (State/District, MAP, EOC, ACT, etc.)

_____Health Records

_____Attendance Records

_____Student Identification Records

_____Special Education Records (IEP, 504, Evaluation Reports)

SEND STUDENT RECORDS TO:

Wellington-Napoleon High School
800 N. Hwy 131
Wellington, MO 64097
Fax (816) 934-8649

Wellington-Napoleon R-IX Enrollment Packet
Student Enrollment Checklist

Enrollment Date _____ Requested Start Date _____

Student Full Name _____ Grade _____

Legal Custodial Parent/Guardian _____ Phone _____

1. DOCUMENTATION NEEDED PRIOR TO ENROLLMENT:

___Consent for Release of Information
___Wellington-Napoleon R-IX Enrollment Form
___Basis for Admission of Student
___Proof of Residency within the R-IX School District Boundaries
___Safe Schools Act Statement
___Medical History Forms
___Current Immunization Records
___Proof of age- Official document that states student's legal name, date of birth, and name of parent(s) (If the student is not living with at least one of the parents listed on the official document, you will need to provide proof of court appointed guardianship)

Residency can be proven by submitting one of the documents described below:

A. A current, original utility bill (only electricity, gas, water, or water statement or account) that means the following:
B. Rental/Lease agreement including:
C. A contract to build to purchase a home in the district reflecting a possession or closing date within 90 calendar days of the first day of attendance.

_____ Interested in Sports Activities Y _____ N _____

_____ Interested in a Free/Reduce Lunch Form Y_____ N _____

Office Use Only:

_____ Academic Records (const. test records)	Date Received _____	Counselor: _____
_____ Withdrawal Grades	Date Received _____	Secretary: _____
_____ Disciplinary Records	Date Received _____	Secretary: _____
_____ Test Scores	Date Received _____	Special Programs: _____
_____ Health Records	Date Received _____	Nurse: _____
_____ Attendance Records	Date Received _____	Secretary: _____
_____ Student Identification Records	Date Received _____	Secretary: _____
_____ Special Education Records	Date Received _____	Special Programs: _____

_____ Completed Enrollment Packet---Principal

Wellington-Napoleon R-IX 800 N. Hwy 131 Wellington, MO 64097

Wellington-Napoleon R-IX Enrollment Form

Date _____ Grade Level _____ Start Date _____

Student Full Name _____ MOSIS #(assigned by school)_____

Date of Birth _____ Age _____ Race _____ Sex _____

"911" Address _____ P.O. Box _____

City, State, Zip _____

Phone number _____ Cell Phone Number _____

Does student receive any Special Education Services? Y _____ N _____
What is primary language spoken in the home? _____
Were you enrolled in ELL (English Language Learners) at previous school? Y _____ N _____

LEGAL CUSTODIAL PARENT/GUARDIAN

Father/Step _____ Mother/Step _____
Date of Birth _____ Date of Birth _____
Employment _____ Employment _____
Work Phone _____ Work Phone _____
Cell Phone _____ Cell Phone _____
E-Mail _____ E-Mail _____

NON-CUSTODIAL PARENT (The custody of a child is presumed to be held by the child's parents unless a court order states otherwise. Even in divorce situations, it is presumed that both parents will have joint custody of the child. That is, they will share equally in all important decisions such as medical and educational. If one parent informs the school district that the other parent has been denied custody or visitation, that parent must provide a copy of the court document as proof.)

Father/Step _____ Mother/Step _____
Address _____ Address _____
Employment _____ Employment _____
Work Phone _____ Work Phone _____
Cell Phone _____ Cell Phone _____
E-Mail _____ E-Mail _____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Family Doctor _____ Phone _____

Previous School _____

Has student ever been enrolled in the Wellington-Napoleon R-IX Schools? Y ___, grade _____ N_____

Other Siblings currently attending Wellington-Napoleon R-IX Schools _____

Legal Custodial Parent/Guardian Signature _____ Date _____

WAIVER INFORMATION

Waiver requested by:

_____ Parent

_____ Legal Guardian

_____ Student (at least 18 years of age)

_____ Other (Complete information below.)

a. Name of person/relative student resides with _____

b. Relationship _____

c. Address _____

d. City/State/Zip _____

e. Address Verification _____

f. Reason why student is living with person/relative _____

_____

Other reasons showing hardship or good cause _____

_____

Hearing Date (must be within 45 days of request) _____

_____ Student admitted pending decision on waiver request

Date student admitted _____

_____ Waiver granted. Date _____

_____ Waiver denied. Date _____

Wellington-Napoleon R-IX School District
Basis for Admission of Student

ADDRESS VERIFICATION (Parent/Legal Guardian) (Attach copy of document)

_____ Rental contract
_____ Real Estate Contract signed by all parties
_____ Utilities Bill/Deposit Receipt
_____ Other, such as payroll check, driver's license, W-4, employment documents

BASIS for ADMISSION OF STUDENT (Section 167.020 RSMo)

_____ Resides with parent in the School District

_____ Resides with legal guardian in the School District (Copy of court ordered guardianship must be attached. A guardian may be appointed for the sole and specific purpose of school registration (SB944).)

_____ Resides with a military guardian in the School District (SB944)

_____ Homeless child (person less than 21 years of age who lacks a fixed, regular and adequate nighttime residence), including a child who is:

a. _____ living on the street, in a car, abandoned building or other form of shelter not designated as a permanent home
b. _____ living in a community shelter facility
c. _____ living in transitional housing for less than one year
Give address or directions _____

_____ Special circumstances (Section 167.151, RSMo)

a. _____ an orphan
b. _____ one parent living
c. _____ Parents do not contribute to the student's support
d. _____ agriculture (all four of the following conditions must be met: owns real estate of which 80 acres or more are used for agricultural purposes, parent's residence is on the real estate, at least 35% of the real estate is in the District, parent notified District on or before June 30 that student would be attending)

_____ Parent is a teacher under contract with the District (Board policy required-Section 167.151, 168.151, RSMo)

_____ Parent is a regular employee with the District (Board policy required-Section 163.011, RSMo)

OTHER EXEMPTIONS TO THE RESIDENCY REQUIREMENTS (Section 167.020.6, RSMo)

_____ Attending school not in the pupil's district of residence as a participant in an interdistrict transfer program established under a court-ordered desegregation program

_____ A ward of the state and has been placed in a residential care facility by state officials*

_____ Has been placed in a residential care facility due to a mental illness or developmental disability*

_____ Has been placed in a residential facility by a juvenile court*

_____ Has a disability identified under state eligibility criteria if the student is in the District for reason other than accessing the District's educational program

_____ Has Wellington-Napoleon R-IX approved admission waiver

_____
Signature-----states that the above statements are true.

Wellington-Napoleon R-IX High School
Safe Schools Act Statement

Student Full Name _____ Sex _____ DOB _____ Grade _____

The Safe Schools Act of 1996 allows school districts to obtain information from a parent, legal guardian, or caretaker of the student regarding whether the student has been suspended or expelled from school attendance in this state or another state for weapons, alcohol, drugs, or willful infliction of injury to another person (Section 167.023 RSMo)

I, _____, affirm the _____
(Legal custodial parent/guardian) (Student full name)

<u>has not been</u> suspended or expelled from school attendance at a private or public school in Missouri or another state for offense in violation of any of the above mentioned offenses.

I, _____, affirm the _____
(Legal custodial parent/guardian) (Student full name)

<u>has been</u> suspended or expelled from school attendance at a private or public school in Missouri or another state for an offense in violation of any of the above mentioned offenses.
Explanation

_____
_____
_____

Has the student been charged or convicted of a felony? Yes _____ No _____
Explanation

_____
_____
_____

Legal Custodial Parent /Guardian Signature _____ Date _____

Student Signature _____ Date _____

WELLINGTON-NAPOLEON R-IX SCHOOLS
HEALTH SERVICES

Parental Authorization for Medication Administration

Student Name:_____ Grade:_____ Date of Birth:_____

Allergies (medication or others):_____

The following is a list of over the counter medications that can be administered during school. Please initial on the line in front of the medication name that you wish for your child to receive while at school. Your child **will not** be given any of these medications without signed consent. Parents will be notified in writing when medication(s) are administered.

_____ Acetaminophen (generic Tylenol) as directed on label for pain or fever.

_____ Ibuprofen (generic Motrin/Advil) as directed on label for pain or fever.

_____ Equate Antacid tablets (generic Tums) as directed on label for heartburn, sour stomach or upset stomach.

_____ Pepto-Bismol as directed on label for upset stomach or diarrhea.

_____ Diphenhydramine HCL (generic Benadryl) as directed on label for allergic reaction or allergies.

_____ Equate Oral Anesthetic as directed on label for toothache or canker sores.

_____ Chloraseptic Spray as directed on label for minor throat irritation.

I give permission for the School Nurse or her designated substitute to administer the above initialed medications to my child as needed.

The School Nurse or her designated substitute will evaluate each request from the above listed medications and will administer only when appropriate. Any frequent request for a continuing condition will be discussed with the parents. Any inappropriate requests will be reported to the building principal and the parents immediately.

This permission may be terminated at any time by WRITTEN notification to the School Nurse.

Parent/Guardian Signature:_____ Date:_____

The following is a list of products that are used as first aid treatments:

Hydrogen peroxide	Rubbing alcohol	Hydrocortisone cream 1%
Triple antibiotic ointment	Soothing eye drops	Saline solution
Muscle rub	Menthol cough drops	

WELLINGTON-NAPOLEON R-IX SCHOOLS
HEALTH SERVICES

Parental Authorization for Medication Administration

FOR GIRLS ONLY

Student
Name:_____Grade_____Birthdate_____

The following is a medication that can be administered during school for girl's menstrual cramps. Your child **will not** be given this medication without parental consent. Any frequent requests for this medication will be discussed with the parents. Any inappropriate requests will be reported to the building principal and the parents immediately.
The first dose of this medication or any other medication will not be given at school.

_____Midol –as directed on label for menstrual cramps.

I give permission for the School Nurse or designated substitute to administer the above initialed medication.

This permission may be terminated at any time by WRITTEN notification to the School Nurse.

Parent/Guardian
Signature_____Date_____

Wellington-Napoleon R-IX Health Services
Health History

Your child's learning depends upon good health. To assist in providing health services at school, please complete the following and return to the School Nurse.

Student Name_____M __F___ Birthday_____

INSURANCE
Is your child covered by Health Insurance? YES NO HMO/Managed Care YES NO
Is your child enrolled in the Medicaid Program? YES NO UNSURE

ALLERGIES: (medication, foods, insects, pollen, etc.)

1._____ 2._____

3._____ 4._____

REACTION: (to each allergen)
1. _____ 2._____

3. _____ 4._____

EMERGENCY ACTION OR MEDICATION NEEDED FOR EACH ABOVE ALLERGY:
1._____ 2._____

3._____ 4._____

DOCTOR'S NAME_____PHONE_____
Has your child been seen by a physician for a comprehensive physical exam in the last 2 years?
YES OR NO

MEDICATION:
Does your child take ***daily*** medication at home? YES OR NO

Please list the name of each medication, reason for taking, dose and time(s) taken at home.

1._____ 2._____

3._____ 4._____

Will your child need to take daily medication at ***SCHOOL***? Reason for taking, dose and time?
1._____ 2._____

TURN PAGE OVER

BIRTH:	Was pregnancy not full term?	YES	NO
	Any complications during pregnancy or delivery?	YES	NO
	Were forceps used during delivery?	YES	NO
GENERAL:	Any physical limitations or disabilities?	YES	NO
	Any mental limitations or disabilities?	YES	NO
	Has your child had a high temperature that required seeing a Dr.? How high?	YES	NO
	Has your child had a lack of oxygen that required hospitalization?	YES	NO
	Any concern with (circle) appetite, excess thirst, sleep, energy level or nervous habit?	YES	NO
SKIN:	Any (circle) rashes, bruises, lumps, or abnormal spots?	YES	NO
EARS:	Past history of chronic ear infections?	YES	NO
	Has child ever had trouble hearing?	YES	NO
NOSE:	Has child had tubes in one or both ears?	YES	NO
THROAT:	Has child had more than 4 bad colds per year?	YES	NO
LUNGS:	Does child frequently have severe coughing with colds?	YES	NO
	Has child ever had (circle) pneumonia, RSV, bronchitis or asthma?	YES	NO
BOWEL:	Does child frequently complain of stomachaches?	YES	NO
BLADDER:	Has child had (circle) diarrhea, constipation or vomiting, that last for several days?	YES	NO
	Has child had a problem with (circle) pain or difficulty urinating or having a bowel movement or frequent accidents?	YES	NO
NERVOUS SYSTEM:	Does child appear clumsy or awkward?	YES	NO
	Has child had a serious injury that required going to the hospital?	YES	NO
	Has child had a head injury that required going to the hospital?	YES	NO
	Has child had convulsions or seizures?	YES	NO
	Does child ever have staring spells?	YES	NO
	Does child have any weakness in any part of body?	YES	NO
LEAD EXPOSURE:	Does child eat non-food items (pencils, paint, and woodwork)?	YES	NO
	Is child cranky more than 4 or 6 hours per day?	YES	NO
	Does child live in a house built before 1950?	YES	NO
	Has child been tested for lead levels? Result?	YES	NO
BEHAVIOR:	Any concerns with behavior?	YES	NO
	Any concerns with attention span?	YES	NO

PLEASE EXPLAIN ANY **YES** ANSWERS:

FAMILY DENTIST _____ PHONE _____
Has your child seen a dentist in the past year? YES NO

OPTOMETRIST _____ PHONE _____
Date of last eye exam? _____ Result of exam? _____

DIABETIC YES NO Date diagnosed _____
Problems with hypoglycemia (Low blood sugars) YES NO
Doctor's name _____ PHONE _____

SEIZURES YES NO
Diagnosis or disease process _____
Doctor's name? _____ PHONE _____
Date of last seizure? _____ Describe seizure. _____
Name(s) of seizure medication(s), dose and time? _____

ASTHMA YES NO Date diagnosed? _____ Last attach? _____
Doctor's name _____ PHONE _____
Triggered by? _____
Treatments/Medications (name, dose & time) _____
_____

HEART CONDITION YES NO Date diagnosed? _____
Doctor's Name _____ PHONE _____
Diagnosis? _____
Physical restrictions? _____
Medications (name, dose & time) _____
_____

BONE/JOINT PROBLEMS YES NO Date diagnosed? _____
Doctor's Name _____ PHONE _____
Diagnosis? _____
Physical restrictions? _____
Medications (name, dose & time) _____

ADD/ADHD YES NO Date diagnosed? _____
Doctor's name? _____ PHONE _____
Medications (name, dose & time) _____

TURN PAGE OVER

The information on this Health History is **strictly confidential** and will be used only in providing your child with appropriate health care to enable him/her to participate fully in the educational process. We encourage your assistance and will in turn, keep you informed of any health related concerns that may affect your child's participation in the classroom.

SIGNATURE OF PARENT/LEGAL GAURDIAN_____

Date_____

FOR OFFICE USE ONLY

Date received_____

Reviewed by_____