Welcome New Students and Parents,

Rockville Elementary School welcomes you and your child to the 2011-2012 school year. Please take a few minutes to read this letter and complete the enrollment forms. If you still have questions the office will be available to answer them after August 1, 2011 at 837-1970.

- Walk in enrollment is Tuesday, August 9, 2011 from 8:00 a.m. to 8:00 p.m. Please note that teachers will not be in the building that day.
- **First day of school for 1st and 2nd graders will be Wednesday, August 17th**.
- **First day of school for Kindergarten will be Thursday, August 18th.**
- The school day begins at 8:10 a.m. and dismissal is at 3:20 p.m. The doors are open to students at 7:40 a.m.
- We do offer breakfast to students for a fee. (see fee sheet for prices)
- Office staff are available for tours of the building by appointment only.
- PTO is a very strong organization in our school and a way for new parents to meet people in the community.
- New Kindergarten students will be required to have a physical within the past six months, shot records and birth certificate.
- Student records for new first and second graders will be requested from the school they are coming from.

Louisburg – USD 416 Enrollment Form

Mark Building>	Preschool:	Rockville:	Broadmoor :	Louisburg Middle:	Louisburg High :

Perm Number:	Grade:	Gender - Male:	Female:

Student Full Legal Name:

Last Name, First Name Middle Name

Street Address:

Mailing Address:	State:	Zip Code:
City:	Cell Phone:	Unlisted-Yes No
Home Phone:	Birth Place:	

Birthdate:

Language Spoken at Home:

CUSTODIAL PARENT/Guardian Information (Student Living With)

Relationship: Last Name: First Name:

Home Street Address:

Home Mailing Address:	State:	Zip Code:
City:	Cell Phone:	Unlisted-Yes No:
Home Phone: Unlisted-Yes No	Work Phone:	Unlisted-Yes No:

Employer:

Email Address:

Would you like announcements sent to this email address? YES NO:

Relationship: Last Name: First Name:

Home Street Address:

Home Mailing Address:	State:	Zip Code:
City:	Cell Phone:	Unlisted-Yes No
Home Phone: Unlisted-Yes No	Work Phone:	Unlisted-Yes No

Employer:

Email Address:

Would you like announcements sent to this email address? YES NO:

Non-CUSTODIAL PARENT/Guardian Information

Relationship: Last Name: First Name:

Home Street Address:

Home Mailing Address:	State:	Zip Code:
City:	Cell Phone:	Unlisted-Yes No:
Home Phone: Unlisted-Yes: No	Work Phone:	Unlisted-Yes No:

Employer:

Email Address:

Would you like announcements sent to this email address? YES NO:

EMERGENCY NUMBERS

In case of emergency, we will attempt to contact parent/guardian first. In the event we cannot do this, please provide the name of a relative or close friend that we may contact:

Name:

Relationship to student:	Work Phone:	Cell Phone:

Home Phone:

SIBLING INFORMATION (attending USD 416)

Name:	**Building**	RES:		BES:		LMS:		LHS:	
Name:	**Building**	RES:		BES:		LMS:		LHS:	
Name:	**Building**	RES:		BES:		LMS:		LHS:	

I understand that Louisburg USD 416 does NOT provide insurance for students while they are attending school or participating in school activities.

_____

Signature

This form can be copied, filled out and then mailed in with payment. IF paying online, attach copy of online receipt with this form.

Student Name:	School:	Grade:

Dear Parent or Guardian:

Each year, every school district in Kansas is required to report student data by race and ethnicity categories set by the federal government to the Kansas State Department of Education (KSDE). Though KSDE does not report individual student data to the federal government, the total number of students in various categories of each school is reported. These reports help keep track of changes in student enrollment and ensure that all students receive the educational programs and services to which they are entitled.

Recently, the federal government adjusted the student data reporting categories. With the new reporting categories, you will need to update your child's data. Starting with the 2009-10 school year, all schools in Kansas will report student data to the Kansas State Department of Education using the new categories.

Please update your child's student data, by completing the enclosed form and returning it to your child's school by September 20. If we do not receive a response from you, an employee of the district will be required to provide this information based on observation. (Note that federal regulations do not permit districts to leave the space blank.) Please contact your child's school principal if you would like to check the student data currently on file for your child.

For more information about the data reporting categories, please visit the Race/Ethnicity Regulations page at the KSDE website under News/Publications. The URL address is as follows: http:www.ksde.org/Default.aspx?tabid=3370.

Sincerely,

Dr. Sharon Zoellner
Superintendent of Schools

Race and Ethnicity: (Note: Both Part A and Part B of the question must be answered.

Part A:	Is this student Hispanic/Latino? (Choose only one) ☐ No, not Hispanic/Latino ☐ Yes, Hispanic/Latino (A person of Cuban, Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race.)

The above part of the question is about ethnicity, not race. No matter what you selected above, **please continue to answer the following** by marking one or more boxes to indicate what you consider your student's race to be.

Part B:	**What is the student's race?** *(Choose one or more)* ☐ **American Indian or Alaska Native** (A person having origins in any of the original peoples of North and South American (including Central America), and who maintains tribal affiliation or community attachment.) ☐ **Asian** (A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.) ☐ **Black or African American** (A person having origins in any of the black racial groups of Africa.) ☐ **Native Hawaiian or Other Pacific Islander** (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.) ☐ **White** (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

I attest that the information contained herein is correct to the best of my knowledge.

(Legal Parent/Guardian Signature) (Date)

This form can be copied, filled out and then mailed in with payment. IF paying online, attach copy of online receipt with this form.

ROCKVILLE ELEMENTARY SCHOOL

Registration Fees

STUDENT_____TEACHER_____

Please mark the grade level for 2011-12 school year: ☐K ☐1 ☐ 2

Payment for registration fees can be mailed to Rockville Elementary School at P.O. Box 219, Louisburg, KS 66053 or brought in on Open Enrollment Day, August 9, 2011. Please attach this form to your payment. Online payments may be made using Rev Trak located on our website www.usd416.org.

REQUIRED FEES

Materials Fee (maximum $110.00 per family).....$45.00
Writing Journal – Kindergarten …….$ 6.00
Agenda Book – 1st and 2nd Grades ……...$ 6.00
Art Fee ……...$ 5.00

Transportation Fee (maximum $225.00 per family) $150.00
Applies only to outside-of-district students and students who live less than 2.5 miles from the school

All Day Kindergarten Fee (per month) ……..$150.00

FOOD SERVICE

Lunch	$ 1.95
Breakfast	$ 1.25
Extra Milk	$ .40

Yearbook (optional) $25.00

FEES PAID:

Materials Fee $_____ Kindergarten $_____

Journal/Agenda Book $_____6.00__ Student Meals $_____

Art Fee $_____5.00__ Yearbook $_____

Transportation $_____ **TOTAL PAID $_____**

……..……

(Please retain for your records)

Paid by: Check #_____ Money Order _____ Rev Trak Order ID _____

DO NOT MAIL CASH! *Total Amount Paid $* _____

DURHAM SCHOOL SERVICES

BUS RIDER INFORMATION

(Please complete a card for each student)

Check Here if You Have Child Care Information on Reverse ☐

STUDENT'S NAME: _____

PARENT'S NAME: _____

HOME ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____

DOES YOUR CHILD HAVE A MEDICAL CONDITION? _____

IF YES, PLEASE EXPLAIN _____

WHAT GRADE IS YOUR STUDENT IN? _____

CHILD CARE INFORMATION

(Please Print)

CHILD CARE PROVIDER: _____

CHILD CARE ADDRESS: _____

CHILD CARE PHONE: _____

WILL YOUR CHILD BE PICKED UP AT CHILD CARE? _____

WILL YOU R CHILD BE DROPPED OFF AT CHILD CARE? _____

WHAT DAYS OF THE WEEK WILL CHILD CARE BE PROVIDED?

MON ☐ TUES ☐ WED ☐ THURS ☐ FR ☐

OTHER INSTRUCTIONS: _____

_____

Louisburg 416
Over-the-Counter Medications

Name _____
Sex: ☐ Male ☐ Female Date of Birth _____ Grade _____

School _____ Are you new to our district? ☐ Yes ☐ No

Medication allergies/sensitivities _____

List all medication your child receives _____
_____

Please check all medications that are kept in the nurse's office that you wish to be made available to your child. Generic equivalents may be used in place of more expensive brand name items.

☐ Acetaminophen (like Tylenol)

☐ Ibuprofen (like Advil)

☐ Throat lozenges

☐ Antacids (Like Tums)

☐ Sunscreen

☐ Anti-itching lotion (like caladryl)

☐ Antibiotic ointment for cuts (like Neosporin)

☐ Diphenhydramine (like Benadryl for allergic reactions) Parents will be called first.

☐ Hydrocortisone cream (for insect bites)

☐ Sting-Kill (topical anesthetic for stings)

☐ I do **not** want any of the above medication given to my child.

☐ I understand that any school employee who administers these medications according to proper dosages shall not be liable for damages as a result of an adverse reaction to the medication administered. I hereby give permission for my child to receive any medication checked on this form as deemed necessary by the school nurse.

Signature of parent/ guardian _____ Date _____

Revised 01/09

Elementary Student Health Info

Please fill out completely every year

Student Name: **Grade:**

Does your student have:	Yes:	PLEASE EXPLAIN IFANSWERED YES
ADD/ADHD	☐	Medication:
Autism Spectrum Disorder	☐	Medication:
Allergies: food- insects- medication If exposed/ingested, does your child need: **Benadryl/epi-pen or both**	☐	List of allergic food(s) Type of reaction:
Asthma/Reactive Airway Disease?	☐	
Behavioral issues?	☐	
Bladder Infections?	☐	
Blood Disorder or Cancer?	☐	
Bone or Joint Problems?	☐	
Congenital (birth) defects?	☐	
Diabetes/blood sugar issues?	☐	
Difficulty controlling bladder or bowel movements?	☐	Parents will be called to school to change child.
Emotional difficulties?	☐	
Recent surgery?	☐	
Hearing difficulties/hearing aids/tubes	☐	
Heart disease or defect?	☐	
Migraines or Headaches?	☐	Medication:
Seizures? Type:	☐	Medication: Date of last seizure: Precautions/restrictions?
Skin problems/rashes?	☐	
Stomachaches?	☐	Medication:
Vision difficulties?	☐	Glasses/contacts?
Other not mentioned/Special Health services needed	☐	
Does your child have health insurance? Yes/No Medicaid, HealthWave,Unicare -Would you like info sent to you about insurance? yes/no	☐	Name of insurance provider:

In the event of an ILLNESS, ACCIDENT, or other EMERGENCY and we are unable to reach you or any person under emergency numbers; I authorize the school to call the physician listed below and follow his/her instructions. If it is impossible to contact your child's physician, the school may make whatever arrangements deemed necessary. I give consent for my child's immunization information to be released to the Kansas Immunization Program for the purpose of assessment and reporting.

Physician's Name _____ Phone: _____

Dentist's Name _____ Phone: _____

Hospital Preference: _____

Parent/guardian signature: _____ Date: _____

If your child needs medication or a procedure at school, please contact the school nurse. This information will be shared with appropriate school personnel. 05/11

Immunization Requirements for the 2011 - 2012 School Year

K.A.R. 28-1-20 defines immunizations required for any individual who attends school or a childcare program operated by a school. There are changes in requirements for immunizations for the upcoming school year. Please carefully review the requirements below. The usual number of doses required are listed; however there are exceptional circumstances that could alter the number of doses a child needs. If you have questions about your child's immunization status, contact your child's primary care provider or local health department.

Proof of receiving the immunizations must be provided to the school prior to attending the first day of school.

Early Childhood Program Operated by a School Ages 4 years and Under	
Vaccine	**Requirement**
DTaP/DT (diptheria, tetanus, pertussis)	4 doses
IPV (polio)	3 doses
MMR (measles, mumps, rubella)	1 dose
Varicella (chickenpox)	1 dose*
Hepatitis A	2 doses
Hepatitis B	3 doses
Hib (haemophilus influenza type B)	3 doses
Prevnar (pneumococcal conjugate)	4 doses

Kindergarten - Grade 2	
Vaccine	**Requirement**
DTaP/DT (diptheria, tetanus, pertussis)	5 doses
IPV (polio)	4 doses
MMR (measles, mumps, rubella)	2 doses
Varicella (chickenpox)	2 doses*
Hepatitis B	3 doses

Grades 3 - 6	
Vaccine	**Requirement**
DTaP/DT (diptheria, tetanus, pertussis)	5 doses
IPV (polio)	4 doses
MMR (measles, mumps, rubella)	2 doses
Varicella (chickenpox)	1 dose**
Hepatitis B	3 doses

Grade 7	
Vaccine	**Requirement**
Tdap	1 dose***
IPV (polio)	4 doses
MMR (measles, mumps, rubella)	2 doses
Varicella (chickenpox)	2 doses*
Hepatitis B	3 doses

Grades 8 - 9	
Vaccine	**Requirement**
Tdap	1 dose***
IPV (polio)	4 doses
MMR (measles, mumps, rubella)	2 doses
Varicella (chickenpox)	1 dose**
Hepatitis B	3 doses

Grades 10 - 11	
Vaccine	**Requirement**
Tdap	1 dose****
IPV (polio)	4 doses
MMR (measles, mumps, rubella)	2 doses
Varicella (chickenpox)	1 dose**
Hepatitis B	3 doses

Grade 12	
Vaccine	**Requirement**
Tdap	1 dose****
IPV	4 doses
MMR (measles, mumps, rubella)	2 doses

Additional ACIP Recommended Vaccines NOT REQUIRED for School Entry
• *Influenza (flu) vaccine yearly for everyone 6 mos and older*
• *Meningitis Vaccine at age 11 yrs, and booster at age 16 yrs*
• *HPV Vaccine (a three dose series) at age 11 yrs*

School Entry Physicals
Any new early childhood program or kindergarten student will need a school entry physical completed by a Kansas physician within 12 months prior to the first day of school. New students under the age of 9 years who are attending a Kansas school for the first time, also require a physical as described above. ***Documentation of the physical must be provided to the school prior to attending.***

* Varicella (chickenpox) vaccine is not required if child has had chickenpox disease ***and*** disease is documented by a physician signature. Without physician signature, vaccine is required even if you believe your child has had chickenpox disease.

** Although 1 dose of varicella is required for school attendance, 2 doses are recommended by the ACIP (Advisory Committee on Immunization Practices).

*** All 7th - 9th graders are required to have one dose of Tdap regardless of the interval since the last dose of Td (tetanus/ diptheria). This is to improve pertussis (whooping cough) immunity due to increasing outbreaks.

**** All 10th - 12th graders are required to have one dose of Tdap if more than 10 years since previous DTaP (pertussis containing vaccine). This is to improve pertussis (whooping cough) immunity due to increasing outbreaks.

Health Information Kindergarten Screening 11-12

Date: _____

Child's name: _____

First Middle Last

Date of Birth: _____ Sex: ☐ Male ☐ Female

Has your child attended Pre-K in Louisburg before? ☐ Yes ☐ No

* *

- Any complications during: ☐ Pregnancy ☐ Labor ☐ Delivery
  Explain _____
- Birth weight: _____ Premature: ☐ Yes ☐ No
- Any problems at birth with ☐ Heart ☐ Breathing ☐ Jaundice
  ☐ Genetic/congenital problems?
  Explain _____
- Did your child sit, walk, talk, and develop at expected age? ☐ Yes ☐ No
  Explain: _____

Self care skills- ** must be able to master before entering kindergarten!!!

- Is your child potty trained? ☐ Yes ☐ No
- Does your child have frequent potty accidents? ☐ Yes ☐ No
- Does your child have frequent soiling accidents? ☐ Yes ☐ No
  Can your child? Wipe (toilet) themselves ☐ Yes ☐ No Tie shoes ☐ Yes ☐ No
  Use zipper ☐ Yes ☐ No Button pants ☐ Yes ☐ No Fasten belt ☐ Yes ☐ No

Have there been any experiences that may affect your child?

☐ Divorce ☐ New Marriage ☐ Illness ☐ Death ☐ Recent move ☐ Other

Explain: _____

Health

- Illnesses: ☐ **Meningitis** ☐ **Seizures** ☐ **Diabetes** ☐ **Hypoglycemia**
  Explain: _____
- Does your child have **Asthma:** ☐ Yes ☐ No
  Asthma Medication: _____
- **Surgery**: ☐ Yes ☐ No Explain _____
- **Childhood accidents**: _____
- **Daily Medication**: ☐ Yes ☐ No _____
- **ADD/ ADHD**: ☐ Yes ☐ No Medication: _____
- **Allergies** ☐ food ☐ medication ☐ seasonal
  List: _____
  If yes, does your child take ☐ Benadryl OR ☐ Use an **Epi-Pen**

Vision/ Hearing

- History of ☐ frequent ear infections ☐ tubes _____
- History of ☐ Hearing loss ☐ hearing aids? _____
- History of ☐ vision problems ☐ glasses? _____
- Has your child had vision/ hearing checked by a doctor? ☐ Yes ☐ No
  If yes why? _____

(more on back page)

Behavioral/ Emotional Readiness

This information will help us ensure your child's school year begins well and is successful.

Is/does your child: (check appropriate box)	Yes	No	Sometimes
Excessively fearful, anxious, or worried?	☐	☐	☐
Afraid to try new things?	☐	☐	☐
Picky or irregular eater?	☐	☐	☐
Have difficulty waiting his/her turn?	☐	☐	☐
Have problems getting along with others (friends, siblings, parents)?	☐	☐	☐
Have problems in group activities, games, or team play?	☐	☐	☐
Have difficulty calming self?	☐	☐	☐
Loses temper frequently?	☐	☐	☐
Disobeys or refuses to follow adult's request or rules?	☐	☐	☐
Touchy or easily annoyed by others?	☐	☐	☐
Have tics or nervous twitches (such as repeated eye blinking, head jerking, or throat clearing)	☐	☐	☐
Have prolonged temper tantrums (greater that 20-30 minutes)?	☐	☐	☐

Louisburg Physical Assessment Pre-K/Kindergarten

Rockville Elementary School • 977 N. Rockville Road • PO Box 219• Louisburg, KS 66053

•Telephone 913/837-1970 •Fax 913/837-1978

Child's Name _____ Date of Birth _____ Sex ____
Physician _____ Telephone Number _____

Health History

♦Allergies _____
If yes, is Benadryl required: YES/NO Is EpiPen required: YES/NO
Food Substitution required: YES/NO
♦Current Medications _____
♦Nutritional Status _____

Physical Examination

HEIGHT _____ WEIGHT _____ BLOOD PRESSURE _____

HEAD_____ ABDOMEN _____
EENT _____ GU _____
TEETH _____ GYN _____
HEART _____ SKELETAL_____
LUNGS_____ NEUROLOGICAL _____

Diagnosis:

Recommendations:

Full participation in all activities? Yes/No

Restrictions:_____
_____

- Has child had varicella **disease?** Yes/No If yes…. Date: _____
  Mo/year

_____ _____
Signature of Licensed Physician Date