STUDENT INFORMATION
2023-2024

WEST PLAINS PUBLIC SCHOOLS

PLEASE PRINT
STUDENT'S LEGAL NAME:

Enrollment Date:_____

Last:_____ First:_____ Middle:_____ Preferred Name:_____

Gender: ☐Female ☐Male Date of Birth:_____/_____/_____ Grade:_____ Student Cell Phone:_____

Who has legal custody? ☐ Both Parents ☐Father ☐Mother ☐Other _____

Are there legal documents concerning custody, educational decision making, etc. associated with this student? ☐Yes ☐No

If yes, please provide a copy of the legal documents to the school. Legal Documents Provided: ☐Yes ☐No ☐NA

Is this student currently in Foster Care? ☐Yes ☐ No

RACE/ETHNICITY/HOME LANGUAGE

Is the student Hispanic/Latino? ☐ Yes ☐ No

Please check all that apply:

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White

High School ONLY- What school district do you live in?

☐Fairview ☐Glenwood ☐Howell Valley ☐Junction Hill ☐ Richards ☐West Plains

PREVIOUS EDUCATIONAL INFORMATION

Last Date in School: _____ Last School Attended/Address:_____

Has the student ever attended the West Plains School District before? ☐Yes ☐No

Has the student ever attended a Missouri school before? ☐Yes ☐No

If yes, please provide the last Missouri school attended._____

Has the student been retained? ☐Yes ☐No If yes, what grade?_____

Has the student been enrolled in a gifted program? ☐Yes ☐No

Has the student been enrolled in Special Education classes? ☐Yes ☐No

Does the student have a current 504 Plan? ☐Yes ☐No

Behavior/Discipline

Is the student currently under suspension or expulsion from another school district? ☐Yes ☐No

If yes, please answer the following:

Has the student ever at any time been involved with juvenile/law enforcement authorities? ☐Yes ☐No

If yes, please explain: _____

1. Reason for suspension/expulsion _____
2. Date of suspension/expulsion _____
3. Name of School _____
4. School's Address: City_____ State _____ Zip _____

High School ONLY - Have you been enrolled in the Missouri A+ program? ☐Yes ☐No

By my signature below, I certify the information I provided on and in connection with this form is true, accurate and complete.

Parent/Guardian Signature_____ **Date**_____

LANGUAGE USE SURVEY

In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads, and writes in English. Please provide information about your child's language

Student's Name: _____ Birthdate: _____

Parent Name: _____ Phone Number: _____

School: _____ Grade: _____

Relationship of person completing this survey: _____ Date: _____

Tier I: Language Background

1. What was your child's first language? English: ___ Other: _____
2. Which language(s) does your child use (speak) at home and with others? English: ___ Other: _____
3. Which language(s) does your child hear at home and understand? English: ___ Other: _____

If any of these answers indicate a language other than English, please complete the rest of the survey.

Tier II: Expand language background

4. Does the student understand when someone speaks with him/her in a language beside English? Yes No
5. Does the student read in a language other than English? Yes No
6. Does the student write in a language other than English? Yes No
7. Does the student interpret for you or anyone else in a language other than English? Yes No

Tier III: Educational History

8. How many years did the student attend school where the native language was used for instruction? _____
9. What was the most recent month and year the student attended school? _____
10. Do you believe that your child has learning difficulties that affects his/her ability to understand? _____
    If yes, please explain: _____
11. Has your child been referred to be evaluated for special education? _____
    If yes, please explain: _____

The school is required to assess the English language proficiency of all students who indicate or are suspected of having a first language other than English. If the results of the assessment show a student needs language support, you will be notified in writing and the school district will provide language support as deemed appropriate by district staff.

NOTICE TO SCHOOL STAFF: This form must be given to all new and enrolling students. Any student that indicates use of a language other than English must be assessed to determine the student's English language proficiency. Please notify district staff responsible for the next steps immediately and when ready, keep his form in the student's permanent records.

WEST PLAINS R-7 SCHOOL MEDICATION FORM

Name_____Birthdate_____ M____F____Grade_____

Parent/Guardian_____Home Phone_____Work Phone_____

Emergency Contact_____Home Phone_____Work Phone_____

Additional Phone Numbers_____

The West Plains R-7 School District has my permission to administer the following Over-the-Counter medications checked:

_____ Acetaminophen for temperatures, general discomfort- (not to exceed one dose per day)- (160 mg tablets) Grades Pre-K-4 (1-2 tablets), (325mg) Grades 5-8 one tablet, grades 9-12 two tablets

_____ Ibuprofen 200mg 1-2 tabs once daily as needed for Pain **(7-12 Grade Only)**

_____ Antacid regular strength for upset stomach/heartburn (not to exceed one dose per day)

_____ Chloroseptic spray for sore throat, Canker sores, minor irritations gums/mouth (3) Sprays for PK-8 (5) for 9-12 (may repeat every two hours)

_____ Anbesol for toothache pain, cold sores (may repeat every two hours as needed)

_____ CamphoPhenique for insect bites/chapped lips (not to exceed twice daily)

_____ Sting kill swabs for insect bites/bee stings

_____ Calamine Lotion for irritated/itching skin (not to exceed twice daily)

_____ Clean abrasions/wounds with soap and water/Hydrogen Peroxide- Apply Antibiotic Ointment

_____ Benadryl 12.5 mg **FOR ALLERGIC REACTIONS ONLY!**

_____ Cough Drop (**<u>one given per day</u>**)

Parent/Guardian Signature_____ Date_____

West Plains R-7 District has my permission to administer the following medication:

Medication _____ Amount to give _____

Doctor Prescribing_____ Time to give_____

Reason taking medication_____

Parent/Guardian Signature_____ Date_____

For medications to be given you must follow the medication protocol outlined in the Handbook and attached to his note, or they WILL NOT be given. *

Vanessa Doss, RN	Taylor Reavis LPN	Amy Green, RN	Jennifer Tidwell, RN	Stacy Kerley, LPN
High School	Elementary	Elementary	Middle School	South Fork
256-6150 ext. 2030	256-6150 ext. 7031	256-6150 ext. 7030	256-6150 ext. 4030	256-2836 ext. 6030

WEST PLAINS R-7 SCHOOL DISTRICT

MEDICATION AND HEALTH HISTORY FORM

Name_____Birthdate_____M____F____Grade____

Parent/Guardian_____Home Phone_____Work Phone_____

Medications and Allergies

Please list ALL current medications (include dosage) _____

_____

Please list ALL allergies (include medications, foods, insects, and all other; ALSO list type of allergic reaction experienced by each) _____

_____

_____

Medical and Health History

Has student ever been diagnosed with or treated for any of the following? Please list name and date of diagnosis.

Diabetes: Type 1_____ Yes[ ] No[ ]

Type 2_____ Yes[ ] No[ ]

Thyroid disease (hypothyroid, hyperthyroid, Graves disease) _____ Yes[ ] No[ ]

Cancer (list type and year of diagnosis and remission if applicable) _____ Yes [ ] No[ ]

Heart Problems_____ Yes[ ]No[ ]

Asthma_____ Yes[ ] No[ ]

Stomach Disorders (acid reflux, heartburn, ulcers) _____ Yes[ ] No[ ]

Intestinal Disorders (chronic constipation, chronic diarrhea, IBS, bowel incontinence)_____ Yes[ ] No[ ]

Migraines or severe chronic headaches_____ Yes[ ] No[ ]

Seizures (list type and date of last seizure)_____ Yes[ ] No[ ]

Depression_____ Yes[ ] No[ ]

Anxiety, panic attacks, or Bipolar Disorder_____ Yes[ ] No[ ]

ADHD_____ Yes[ ] No[ ]

Autism, Asperger, Down Syndrome, Ext._____ Yes[ ] No[ ]

Any Genetic/Chromosome Disorder_____ Yes[ ] No[ ]

Requires Glasses or Hearing Aids _____ Yes[ ] No[ ]

Any other Medical Concerns not listed_____ Yes[ ] No[ ]

School Medication Policy

Student's medication should be given at home if at all possible. This decreases the chance of errors such as missed or forgotten doses. **Medication will only be given during school hours by complying with these guidelines.**

1. Medication consent form must be completed and signed.
2. Prescription medication must be in the original bottle for use. Medications given on a regular basis (inhalers, Ritalin…etc.) must have the newest refill and send no more than a month's supply at a time. **Medication will only be given during school time if prescription states: at noon, every four hours or every six hours. Three times a day will not be given during school hours.**
3. Over-the-counter medication (other than those listed on the Medication Consent Form) must come in the original container and a medication consent form signed by parent or guardian turned into the school nurse.
4. All medications must be turned in at the School Nurse's Office along with a dated note giving permission for the nurse to administer the medication. **Medications are NOT to be sent on the bus. Incidents regarding the transportation of controlled substances on the bus will be referred to law enforcement officials.**
5. Medication bottles will be sent home when medication course is completed or expired.

Please send cough drops for your child to keep in the teacher's classroom

Questions concerning this policy may be directed to your School Nurse.

For medications to be given you must follow protocol outlined herein and in the hand book.

Student Legal Name:Last_____ First_____Nickname_____

Family Doctor: _____

Insurance Provider: _____

Parent/Guardian Signature: _____Date: _____