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 DISTRICT

MEDICATION CONSENT & HEALTH HISTORY FORM

Student Name _____ DOB _____ Male ___ Female ___ Grade _____

PARENT / GUARDIAN INFORMATION

Parent/Guardian #1 Name_____ Phone #_____

Parent/Guardian #2 Name_____ Phone #_____

Emergency Contacts: Name_____ Relationship_____ Phone #_____

Name_____ Relationship_____ Phone #_____

MEDICATIONS

The West Plains R-VII School District has my permission to administer the following over-the-counter medications. Medications will be administered according to package directions for age/weight.

Acetaminophen (Tylenol) Liquid or chewable (160mg); Tablet (325mg) 1-2 tablets; for fever and general discomfort; (one dose per day)	YES	NO
Ibuprofen (Advil or Motrin) Tablet (200mg) 1-2 tablets for pain; **7-12 Grade Only;** (one dose per day)	YES	NO
Antacid (Tums) Chewable Tablet (500mg) 1-2 tablets for upset stomach and heartburn (one dose per day)	YES	NO
Anbesol for toothache, gum pain & canker sores	YES	NO
Campho-Phenique for insect bites, minor burns, cuts, scrapes & irritation	YES	NO
Sting Kill swabs for insect bites and stings	YES	NO
Calamine Lotion for irritated or itching skin	YES	NO
Hydrogen Peroxide to clean cuts and abrasions	YES	NO
Antibiotic Ointment apply to wounds, cuts and abrasions	YES	NO
Diphenhydramine (Benadryl) Liquid or capsule (12.5 - 25 mg) **FOR ALLERGIC REACTIONS ONLY!**	YES	NO
***Cough Drop* - one given/day** **Please send cough drops for your child to keep in the teacher's classroom**	YES	NO

CURRENT MEDICATIONS

MEDICATION	REASON FOR TAKING	DOSAGE	HOW OFTEN

Parent/Guardian Signature_____ Date_____

Please continue to pages 2 and 3

Nurses Phone Numbers:

Elementary School 256-6150 ext. 7030 & 7031

Middle School 256-6150 ext. 4030

High School 256-6150 ext. 2030

South Fork 256-2836 ext. 6030

WEST PLAINS R-7 SCHOOL DISTRICT
MEDICATION CONSENT & HEALTH HISTORY FORM

Student Name _____ DOB _____

MEDICAL HISTORY

Has your child ever been diagnosed or treated for any of the following?			If Yes, please explain. Is this a current issue? Does your child see a doctor for this condition?
Diabetes Type 1__ Type 2__	YES	NO	
Thyroid Disease	YES	NO	
Asthma	YES	NO	Actively uses inhaler: Yes__ No__ As Needed__
Heart or Cardiovascular Conditions	YES	NO	
Stomach Disorders	YES	NO	Acid reflux___ Heart burn___ Ulcers___ Other_____
Intestinal Disorders	YES	NO	Chronic constipation___ IBS___Other_____
Headaches	YES	NO	
Migraines	YES	NO	
Seizures	YES	NO	Type:_____ Date of last seizure:_____ Currently under Doctor's care due to seizures: Yes___ No___
Kidney Disease	YES	NO	
Depression	YES	NO	
Anxiety and/or Panic attacks	YES	NO	
Mental Health Diagnosis	YES	NO	
ADD/ADHD	YES	NO	
Autism	YES	NO	
Vision problem/condition	YES	NO	Wears glasses___ Wears contacts___
Hearing problem/condition	YES	NO	Wears hearing aid___ Cochlear implant___
Neuromuscular Disorder	YES	NO	
Cancer	YES	NO	
Genetic Disorder	YES	NO	
Other medical condition(s):	YES	NO	

ALLERGIES

___ YES (provide details below) ___ No Known Allergies

Allergen	Specify Name/Type	Reaction	Treatment
Food			
Medication			
Stinging Insect			
Environmental			
Animal			

Please continue to page 3

Nurses Phone Numbers:

Elementary School	Middle School	High School	South Fork
256-6150 ext. 7030 & 7031	256-6150 ext. 4030	256-6150 ext. 2030	256-2836 ext. 6030

WEST PLAINS R-7 SCHOOL DISTRICT
MEDICATION CONSENT & HEALTH HISTORY FORM

Student Name _____ DOB _____

CURRENT MEDICATIONS

MEDICATION	REASON FOR TAKING	DOSAGE	HOW OFTEN

SCHOOL MEDICATION POLICY

Student medications should be given at home if possible. This decreases the chance of errors such as missed or forgotten doses. Medications will only be given during school hours by complying with these guidelines:

1. Medication consent and health history form is completed and signed.
2. Parents/Guardians must sign-in prescription medication and over-the-counter (OTC) medication (other than those listed on Medication Consent Form), at the nurses office. Students are not allowed to bring medications with them to school.
3. Medications will only be given during school time if prescription states: at noon, every four hours or every six hours. Three times a day medication will not be given during school hours.
4. Prescription medications must be in the original container with the label intact and legible. Ask your pharmacist for a bottle for school use. Medications given on a regular basis (Inhaler, Ritalin, etc.) must have the newest refill. No more than a month's supply of medication at a time will be provided to the school, unless under the discretion of the school nurse.
5. The district prohibits students from possessing or self-administering medications unless the student is allowed by law to do so and has been given permission in accordance with this section.
6. Students with health conditions such as diabetes, asthma, anaphylaxis and/or other chronic health conditions who may need to self-carry/administer medications must have a signed authorization form and be in compliance with district policy to carry such medication.
7. The school district student-occupied buildings are equipped with prefilled epinephrine auto syringes, asthma-related rescue medications and naloxone. In the event of an emergency, the school nurse or district employee may administer these medications when they believe, based on training, that a student is having a serious or life-threatening reaction or episode. If a parent or guardian wishes for their child not to receive these medications in an emergency situation written documentation must be provided to the school.
8. It is the responsibility of the parent/guardian to pick up medication when the course is complete or expires. At the end of the school year, unclaimed medication will be disposed of appropriately.
9. Parents/Guardians are responsible for updating school nurses regarding any change in health conditions or medications.

Questions concerning this policy may be directed to your school nurse.

Student Last Name_____ First Name_____

Family Doctor_____

Does your child have health insurance? Yes___ No___

Parent/Guardian Signature_____ Date_____

Nurses Phone Numbers:

Elementary School	Middle School	High School	South Fork
256-6150 ext. 7030 & 7031	256-6150 ext. 4030	256-6150 ext. 2030	256-2836 ext. 6030