Family Information Form

St. Paul Lutheran School
(913) 682-5553
admissions1@splcs.org
320 N. 7th Street
Leavenworth, Kansas 66048

Office Use Only
_____/_____
Date Amount Received
_____/_____
Check # Receipt #

Home Information Family's Religion: _____ Church:_____

Parent/ Guardian is: ☐Active Military ☐National Guard / Military Reserve ☐Retired Military ☐Not Military

Parental Status: ☐Married ☐Separated ☐Remarried ☐Single ☐Widowed ☐Other

Please fill in the address of the person(s) with whom the student(s) live:

Address_____ City _____State _____Zip _____

May we list your family in the St. Paul School Directory? ☐Yes ☐No Your address? ☐Yes ☐No

Home Phone: _____ May we list this number in the St. Paul School Directory? ☐Yes ☐No

Email address: _____ (For St. Paul use ONLY. This information WILL NOT be published.)

Name you would like on mailing labels:_____

Information on Father:

Name:_____

Father's Religion:_____

Cell Phone:_____

Occupation:_____

Employer:_____

CGSC ☐Yes ☐No

Work Phone:_____

Email:_____

Father's spouse (if not Mother):_____

Information on Mother:

Name:_____

Mother's Religion:_____

Cell Phone:_____

Occupation:_____

Employer:_____

CGSC ☐Yes ☐No

Work Phone:_____

Email:_____

Mother's spouse (if not Father):_____

Emergency Contacts:

Please list 2 additional persons who can be contacted in case of an emergency if the Parent/Guardian is not available. Both contacts must be local:

Name:_____

Phone #_____

Name:_____

Phone #_____

Authorized to contact 911? ☐Yes ☐No

Medical Contacts:

Preferred Hospital: (Please circle choice)

Cushing Memorial St. John's Hospital

Munson Army Hospital Other: _____

Doctor:_____ Phone #_____

Dentist:_____ Phone #_____

Health Insurance: _____

Authorized to contact doctor? ☐Yes ☐No

Custody Information: Please complete if student does not live with both parents.

Mail information only to custodial home? ☐Yes ☐No If no, please list name and address of second mailing:

Name:_____ Address:_____

City/State/Zip_____ Home Phone #_____

Official court custody documents must be submitted to the school office if a ruling has been ordered. ☐ Received

Custody of Students_____ Conditions of Custody_____

(PLEASE COMPLETE REVERSE SIDE ALSO)

Authorized to Pick Up: List anyone, other than parents, who is authorized to pick up your child(ren): _____ _____ _____	**Additional Information:** Please list other individuals or siblings living in the home: _____ _____ _____

We as parents agree to cooperate with the school in its program and policies for Christian education of our children. We have insurance, which covers accidents or injury, which may occur at school or during school functions.

_____

Parent or Guardian Signature Date

Did someone refer our school to you? If so, we'd like to thank them. Please give their name and address. Thank you!

_____

_____

_____

Student Application for Enrollment

St. Paul Lutheran School 320 N. 7th Street Leavenworth, Kansas 66048 913-682-5553 admissions1@splcs.org

Personal Information:

Student's Name: _____
First MI Last

Preferred First Name: _____ ☐ Male ☐ Female Date of Birth: _____

City & State of Birth_____ Religion: _____

Lives With: □Both Parents □Mother □Father □Mother/Stepfather □Father/Stepmother □Grandparents □Other

Is the child adopted? ☐Yes ☐No If yes, does the child know of the adoption? ☐Yes ☐No

Is the child a foster child? ☐Yes ☐No Is the child a ward of the court? ☐Yes ☐No

Race and Ethnicity: Federal and State regulations require us to record the Race/Ethnicity of every child. You must answer the following questions and then indicate your race. Hispanic is considered an ethnicity and not a racial group. If you are of Hispanic ethnicity, you must also select a racial group.

Are you Hispanic/Latino or of Spanish origin? ☐Yes ☐No

☐American Indian/Alaskan Native ☐Asian ☐Black/African American ☐Native Hawaiian/Pacific Islander ☐White

Enrolling in Grade: (Please circle appropriate level)

Pre 2½ Pre 3 Pre 4

K (All Day) 1 2 3 4 5 6 7 8

Medical/Educational Information:

Special Concerns? _____
_____

Any difficulties in school? _____
_____

Has the student ever been suspended from school? ☐Yes ☐No Expelled? ☐Yes ☐No

Physical/Academic/Behavioral or Emotional Concerns? _____
_____
_____

Is there an IEP ☐Yes ☐No or 504 plan ☐Yes ☐No in place?

Any health problems and/or medication? _____
_____
_____

School Information:

What public school would your child attend if not at St. Paul? _____

What school/daycare did your child last attend?_____

Address _____ City/State/Zip _____Phone #_____

Church Information:

Where will your child attend church and Sunday School Regularly? _____

Has the child been Baptized? □Yes □No If yes when? _____

Has the child been Dedicated? □Yes □No If yes when? _____

Has the child been Confirmed? □Yes □No If yes when? _____

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Rev. 5/2020

Kansas Department of Health and Environment
Bureau of Family Health Facilities
Child Care Licensing Program
1000 SW Jackson, Suite 200
Topeka, KS 66612-1274
Phone (785) 296-1270 Fax (785) 559-4244
Website: www.kdheks.gov/kidsnet

Kansas Department of Health and Environment

MEDICAL RECORD FOR ALL CHILDREN IN CHILD CARE FACILITIES, INCLUDING PROVIDER'S OWN CHILDREN

Parents are to complete the Medical Record and the History of Immunizations for each child in licensed child care facilities. The Medical Record, History of Immunizations, and Child Health Assessment are transferable when the child moves to another licensed child care facility.

Child's First Day in Child Care_____ Name of Child Care Facility_____

Child's Name_____ Date of Birth_____ Gender_____
First Last MM/DD/YYYY M/F

Parent/Guardian Information

Name_____

Home Address_____
Street City Zip Code

Home Phone Number_____

Employer_____

Work Phone Number_____

Cell Phone Number_____

E-mail Address_____

Best way to contact_____

Parent/Guardian Information

Name_____

Home Address_____
Street City Zip Code

Home Phone Number_____

Employer_____

Work Phone Number_____

Cell Phone Number_____

E-mail Address_____

Best way to contact_____

Persons authorized to pick up the child or to notify in case of emergency (other than the parents):

Name_____ Name_____
Address_____ Address_____
Phone Number_____ Phone Number_____

Child's Physician_____ Phone Number_____

Child's Dentist_____ Phone Number_____

Hospital Preference (for emergencies)_____

Has your physician approved the use of any non-prescription medications for your child such as acetaminophen, cough syrup, or ointments that can be given by the child care provider? ___No ___Yes, as follows: _____

_____

_____

Any known allergies or medical conditions of child:

_____

_____

Any major changes at home that might affect your child in care:

_____

_____

Please provide additional information or special instructions that will help the person caring for your child:

_____

_____

Parent/Guardian Signature:_____ **Date:**_____

History of Immunizations

Required for all children in child care facilities, including the provider's own children. A Kansas Certificate of Immunizations (KCI) may be substituted for this form and attached to the completed Medical Record.

Child's Name:_____ **Date of Birth:** _____
First Last MM/DD/YYYY

Section I. For a recommended schedule of immunizations, refer to the current schedule published by the Advisory Committee on Immunization Practices (ACIP).

Vaccine	Record the Month. Day and Year that each Dose of Vaccine was Received					
	1st	2nd	3rd	4th	5th	6th
Diphtheria, Tetanus, Pertussis (DTaP)						
Poliomyelitis (IPV/OPV)						
Measles, Mumps, Rubella (MMR)						
Hepatitis B (HepB)						
Varicella (VAR)			Hx of Disease: Physician Signature		Date of Illness:	
Hemophilus Influenzae Type B (Hib)						
Pneumococcal Conjugate (PCV)						
Hepatitis A (HepA)						
Rotavirus **Recommended <8 mo of age; not required						
**Influenza(Flu) ** ** Recommended annually >6 mo of age; not required						

Section II.
Complete this section only if your child is exempted from the law requiring immunizations [K.S.A. 65-508(g)].

The following two options are the **ONLY** exemptions allowed by law. **Please check either (A) or (B) below and complete as required:**

☐ **(A) Certification from licensed physician stating that immunization would endanger child's life:**
Exempt from following immunizations:

_____DTaP/DT_____Tdap/TD____Pertussis Only_____Polio_____MMR_____HepA_____HepB_____Hib
_____PCV_____Varicella____Other

Physician's Signature (required):_____ **Date:**_____

☐ **(B) My child is exempt under the law from immunizations. As the Parent or Legal Guardian, I state that I am an adherent of a religious denomination whose teachings are opposed to immunizations.**

Section III.

Parent/Guardian Signature:_____ **Date:**_____

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Rev. 05/2020

Child Health Assessment

The Child Health Assessment form is to be completed and signed by a nurse approved by KDHE to perform Child Health Assessments or a Licensed Physician. If a Physician Assistant (PA) completes the Child Health Assessment, the signature of the Licensed Physician authorizing the PA is to be included at the bottom of this form.

A Child Health Assessment, recorded on a KDHE Form or other acceptable Forms mentioned below, is required for all children including children of the provider or staff in Licensed Day Care Homes, Group Day Care Homes, Child Care Centers and Preschools. A Kan-Be-Healthy Assessment Form is a KDHE Form and is acceptable, a Physician Health Assessment Form is acceptable, and a School Health Assessment Form is acceptable for school-age children or youth. The Health Assessment Form used should be attached to the KDHE Medical Record Form (CCL. 029).

Child's Name_____ **Date of Birth**_____
First Last

Health history and medical information pertinent to routine child care and emergencies (describe, if any): ☐ None	Do you see this child for regular health supervision: ☐ Yes ☐ No
Allergies to food or medicine (describe, if any): ☐ None	
List current medications (if any): ☐ None	

Length/Height:_____IN/CM %ILE_____		**Weight:_____LB/KG %ILE_____**
Physical Examination	**✓ If Normal**	**If Abnormal - Comments**
Head/Ears/Eyes/Nose/Throat		
Teeth		
Cardio/Respiratory		
Abdomen/GI		
Genitalia/Breasts		
Extremities/Joints/Back/Chest		
Skin/Lymph Nodes		
Neurologic & Developmental		
Screening Tests	**Screening Date**	**Note Here if Results are Pending or Abnormal**
Lead		
Anemia (HGB/HCT)		
Urinalysis (UA)		
Hearing		
Vision		

Health Problems or Special Needs, Recommended Treatment/Medications/Special Care (Attach additional sheets if necessary) ☐ None	
Signature of Licensed Physician or Nurse approved for Child Health Assessments	Date
Print the Name of the Individual Signing Above	Phone Number
Address City	Zip Code