Kansas City International Academy

414 Wallace Ave

Kansas City, MO 64125

Phone: 816-242-4206

Fax: 816-920-6629

Student Name: _____

Thank you for your interest in Kansas City International Academy. For more information or to schedule a tour of the school please contact Jennifer Wilson at 816-242-4206 or jwilson@dellalambkc.org

Please be prepared to submit a copy of the following documents upon enrollment:

- Birth Certificate/I-94 Documents _____
- Immunization report _____
- Residency Verification _____
- Photo ID for adults in household _____

Office Use

Received by _____ ON _____ @ _____

Name *Date* *Time*

Kansas City International Academy Student Enrollment 2017-2018

Student Name: _____ ID #: _____
Last First Middle

Grade: _____ **Nickname:** _____ **Birth Date:** _____ **Gender:** _____

Address: _____
Street City/State/Zip

Contact Phone: _____ **Alternate Phone:** _____

Is the student living with their parent or legal guardian in someone else's house other than your own, living with a friend or family member other than their parent/guardian; living at a shelter, at a hotel or motel, or in a vehicle or campground (unsheltered)? □ No □ Yes Residency Date Check: _____

Student Racial/Ethnic Heritage: (Please complete information.)

Race—please check all that apply: □ American Indian or Alaska Native □ Asian □ Pacific Islander □ White □ Black or African American (Selecting two or more denotes multi-racial)

Is there any language other than English as the primary spoken in your home? □ No □ Yes - Language: _____

Ethnicity—please check one: □ Hispanic/Latino □ Not Hispanic/Latino

Student's country of origin: _____ Parent's country of origin: _____

Date entered United States: _____ Date entered a school in United States: _____

Parents/Guardians:

Parent Name: _____ Parent Name: _____

Relationship to Student: _____ Relationship to student: _____

Address: _____ Address: _____

Place of Employment: _____ Place of Employment: _____

Home Phone: _____ Home Phone: _____

Work Phone: _____ Ext: _____ Work Phone: _____ Ext: _____

Mobile Phone: _____ Mobile Phone: _____

E-Mail: _____ E-Mail: _____

Daytime Emergency Alert Phone: _____

Name Additional Parents: _____ Relationship_____ Phone: _____

Is there a court order that restricts either parent from contact with your student or access to student records? □ No □ Yes

If such a court order exists, it is the parent's/ Guardian's responsibility to provide a copy of this court order to the school. It must be on file in the school's office to act on any restrictions.

Emergency Contact When Parent/Guardian Cannot Be Reached: *(Do not include persons listed as Parents/Guardians.)*

I authorize the district to release any and all identifiable information about my student to the following persons. Initial to authorize this person to pick up your student on your behalf.

		Relationship	Pick Up Student Initial below
1st _____	Phone: _____	_____	_____
2nd _____	Phone: _____	_____	_____
3rd _____	Phone: _____	_____	_____
4th _____	Phone: _____	_____	_____

I understand to change this information I must submit a written request to my school.

School Attendance:

School Last Attended: _____ District: _____

Former School's Address: _____
Street City/State/Zip

Has your student ever been homeschooled? □ No □ Yes Is your student currently being homeschooled? □ No □ Yes

Special Services:

Does your student have an IEP for special education services or a 504 accommodation plan? □ IEP □ 504
Date Identified: _____ School District: _____
Has your student participated in supplementary education programs such as extra help with reading, math and/or language arts?
If yes, which subject(s)? □ Reading □ Math □ Language Arts Please describe: _____
Has your student ever been identified for gifted and talented education? □ No □ Yes
Date Identified: _____ School District: _____

Sibling Information: List brothers, sisters, stepbrothers, and stepsisters younger than 20 years of age who currently reside within Kansas City International Academy. Don't include your student for whom this form is completed.

First/Last Name	Phone	Gender (M/F)	Birth Date	School Grade (if applies)	Same Address?
					□ Yes □ No
					□ Yes □ No
					□ Yes □ No

Employment Information:

Have you moved within the past 3 years to seek or obtain work in the following areas? If so, check the appropriate categories:
□ Feeding poultry, gathering eggs, working in a hatchery □ Planting or harvesting crops
□ Processing meat, poultry, fruit or vegetables, dairy products □ Commercial fishing or working on a fish farm

Early Dismissal: In case of early dismissal, your student is to do the following:

□ Ride the bus home □ Walk Home □ Car Rider □ Day Care _____
□ Stay for after school care.
□ Go to the following relative or baby-sitter: Name: _____ Phone: _____

Missouri Safe Schools Act:

Is your student currently under suspension or expulsion from school? □ No □ Yes _____ Initials
Has your student ever been under suspension or expulsion from school? □ No □ Yes _____ Initials
If you have answered yes to either of the previous questions, state the reason(s) for the suspension/expulsion: _____

It is a crime to give false information regarding any student's disciplinary history.

Media Release: The following information may be released without obtaining parental consent:
Student's name; parent's name; grade level; participation in school-based activities and sports; dates of enrollment; honors and awards Received; artwork or coursework displayed by the district; and photographs, videotapes, digital images, and recorded sound that have been prepared for public consumption and would not be considered harmful or an invasion of privacy. _____ Initials
If you don't want the district to release the information listed above, you must submit a written notice to your school within 10 days of completing this form.

Educational Decisions: (Question can/be left blank)

I authorize the following person(s) to act on my behalf when making educational decisions and to have access to student records to student records regarding my student.

Name: _____ **Relationship to Student:** _____

Verification:

I verify that the information provided on this form is accurate and current. Submitting false statements or information relating to residency is defined as a class A misdemeanor and that district may recover from you tuition payments for any pupil who is enrolled based on false information you provide.

X_____ _____ _____

SIGNATURE indicates you are the Parent, Legal Guardian, or Guardian PRINTED Name of Parent, Legal Guardian, or Guardian Date

I am the legal Parent/Guardian of this student. □ No □ Yes _____ Initials
If you are not the legal Parent/Guardian of this student, state your relationship to this student. _____

Consent for Release of Information

Student's Name: _____

We Request the following information from _____School.

Please fax or mail to the attention of: Jennifer Wilson

C/o Kansas City International Academy

414 Wallace Ave

Kansas City, MO 64116

Fax#:816-920-6629

_____ Cumulative permanent schools records

_____ Psychological Reports

_____ Health Records

_____ Special Education Records including: active IEP and current Evaluation Report

_____ Others: _____

This information is requested for the following reason (s):

_____ Transfer of student to this/another district

_____ New enrollment/ Re-enrollment

_____ Hospitalization

_____ Contractual Placement

_____ Other: _____

_____ _____

(Signature of Parent/Guardian) (Date)

Tile I ESEA
Parent-School Compact
Kansas City International Academy
414 Wallace Ave, Kansas City, MO 64125 Phone: 816-242-4206

Our school envisions the highest level of success for every student. To accomplish this, families, teacher and students need to work together. Please complete and sign the part of this agreement that applies to you.

Staff Section:

We understand the importance of the school experience to every student and our role as educators and role models. Therefore, we agree to carry out the following responsibilities to the best of our ability:

- The staff will provide an environment conducive to learning
- The staff will communicate classwork expectation.
- The staff will communicate with families regarding your child's progress.
- The staff will help each student grow to his/her fullest potential

_____ _____

(Principal's Signature on behalf of staff) (Date)

Student Section:

I realize that my education is important. I know that I am the one responsible for my own success. Therefore, I agree to carry out the following responsibilities to the best of my ability.

- I will come to class on time and will be prepared to work.
- I will ask for help when needed.
- I will respect the rights of others to learn.
- I will show respect and cooperate with all adults in the school.

_____ _____

(Student's Signature) (Date)

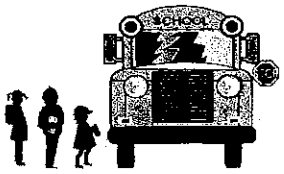
Family/Parent/Guardian Section:

I understand that my participation in my student's education will help his/her achievement and attitude. Therefore, I will continue to carry out the following responsibilities to the best of my ability.

- I will see that my child attends school regularly and on time.
- I will provide a home environment that encourages my child to learn.
- I will make sure my child get adequate sleep and has health diet.
- I will encourage my child to engage in Reading activities daily.
- I will attend all parent-teacher conference.

_____ _____

(Parent/Guardian Signature) (Date)



Kansas City International Academy
414 Wallace Ave
Kansas City, MO 64116
816-242-4206 FAX No. 816-920-6629

Transportion Form 2017-2018 SCHOOL YEAR

A new form must be submitted each school year.

Please complete one form for each child.

____ **New Application**
____ **Change of Address**
____ **Change of Pickup/Drop Off Location**

Student's ID# _____ Student's Name _____

Home Address _____ Apt _____ Zip _____

Pick up if different from home _____

Drop off if different from home _____

Parent's Home Phone _____ Work Phone _____ Extension _____

Emergency Contact: _____ Phone: _____ Extension _____

Emergency Contact: _____ Phone: _____ Extension _____

School Attended 2016-2017 _____

Grade _____ _____ Male _____ Female Student Birth Date _____/ _____/ _____

Print Parent Name _____

Signature of

Date _____ Parent or legal guardian _____

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Bus Route Information **FOR OFFICE USE ONLY**

Provide proof of residence: yes__ No___ (NO CHANGES WILL TAKE EFFECT UNTIL THIS IS PROVIDED)

A.M. Route No. _____ Time _____ Effective _____

Location _____

P.M. Route No. _____ Time _____ Effective _____

Location _____

Staff Signature: _____ **Date:** _____

REQUEST FOR INFORMATION

(Complete one form per family)

Please answer the question below by checking the appropriate box. The following information is request adopted by the General Assembly in 2010 requiring school districts to determine whether or not all children in a family have health insurance.

Dose each child in your family have health care insurance?

☐ YES

☐ NO

MO HealthNet (Medicaid) is considered health care insurance.

If NO is checked the school district will provide a MO HealthNet for kids application for the family.

Completion of this form is not a condition to determining meal eligibility. The Free and Reduced Price Meals Application will be reviewed regardless of response to this Request for Information.

Submit this request with your Free and Reduces Price School Meal Family Application or return to you school/school district.

Student Name(s) _____

Printed name of parent/guardian: _____

Mailing Address: _____

City: _____ State:_____ Zip Code: _____

Della Lamb Charter School Kansas City

Over the Counter (OTC) Medication Policy

Student's Name: _____

(First) (Middle) (Last)

Gender: ☐ Male ☐ Female Grade Level: _____ Date of Birth: ____-____-_____

Over-the-Counter (OTC) medications will be administered sparingly, by the School Registered Nurse or delegated staff person, when indicated to make your child more comfortable and able to remain at school. For example, the medication may be used for dental pain, mild headaches, or orthopedic pain related to a recent injury. You may still be contacted for further care of your child. If your child has a fever (100.0F or higher), he/she will be sent home from school and not allowed to return until fever-free without medication for 24 hours.

The following OTC medications are typically stocked in the nurse's office. The School Registered Nurse must have parental consent in order to administer any of these. If parents send their own OTC medications to be administered at school, they must complete the "Authorization for Medications" Form, which can be obtained from the School Nurse.

The School Registered Nurse, or delegated staff person, will administer the following approved OTC medications listed below as deemed necessary using his/her judgment:

Acetaminophen (like Tylenol)	Ibuprofen (like Motrin or Advil)
Cough Drops/Throat Lozenges	Cough Syrup (like Robitussin)
Antacids (like Tums or Pepto Bismul)	Allergy medicine (like Benadryl)
Eye Drops (like Visine AC)	Lotions, Creams, Ointments (like Calamine, Cortaid, Neosporin, Anti-Fungal)

Please check one of the following:

☐ **YES**, I hereby give permission for my child to receive **ANY** of the medications listed on this form, as deemed necessary by the School Registered Nurse or delegated staff person. I understand that any school employee who administers these medications, according to proper dosages, shall not be held liable for damages as a result of an adverse reaction to the medication administered.

☐ I **DO NOT** want the following medications to be given to my child at school:

1. _____ 2. _____ 3. _____

☐ **NO**, I **DO NOT** want **ANY** medications to be given to my child at school.

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____ Date: _____

Kansas City International Academy

Authorization for Medications Form

Student's Name: _____

(First) (Middle) (Last)

Gender: ☐ Male ☐ Female Grade Level: _____ Date of Birth: ____-____-_____

This section is to be completed for any Over-the-Counter (OTC) medication(s), that are supplied by the student's parent/guardian, to be given at school.

Name of OTC Medication: _____Dose: _____ How often should this be taken? _____

About what time does medication need to be administered: _____a.m. _____ p.m.

Health Condition for which medication is needed: _____

The medication is to be given from: (Start date) _____ to (End date) _____.

Any precautions (side effects) that the School Registered Nurse or delegated staff person need to know?

_____

This section is to be completed for any Prescription (rX) medication(s), that are supplied by the student's parent/guardian, to be given at school. It is our school policy that ALL prescription medication have the pharmacy's original prescription label attached to the medication and be in its original container. A physician's order is also recommended. This policy is for the safety and well-being of your child.

Name of rX Medication: _____Dose: _____ How often should this be taken? _____

What time does medication need to be administered: _____a.m. _____ p.m.

Health Condition for which medication is needed: _____

The medication is to be given from: (Start date) _____ to (End date) _____.

Any precautions (side effects) that the School Registered Nurse or delegated staff person need to know?

_____

By signing this form, I hereby given permission for my child to receive the above listed medications (OTC and/or rX) by the School Registered Nurse or delegated staff person. I understand that any school employee who administers these medications, according to proper dosages, shall not be reliable for damages as a result of an adverse reaction to the medication administered.

Parent/Guardian Name (please print): _____

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

Kansas City International Academy

Student Health Form 2017- 2018

Student's Name: _____

(First) (Middle) (Last)

Gender: ☐ Male ☐ Female **Grade Level:** _____ **Age:** ____ **Date of Birth:** ____-____-____

NEW Students enrolling in Kansas City International Academy, please **ATTACH** a copy of current immunizations from the Physician or Clinic. Students **WILL NOT** be permitted to **ENROLL** without proof of state required immunizations, or show proper documentation of religious exclusion(s). Thank you.

Health Information:

Student's Primary Care Physician (PCP): _____ Phone: _____

Hospital Preference: _____

Please list ALL your child's **FOOD/DRUG/ENVIRONMENT/ANIMAL ALLERGIES** here:

_____

_____

Please list ALL your child's **Diet Restriction(s)** here:

_____

Please circle "Yes" if your child has ever experienced any of these health conditions. If your child has not experienced any of these conditions, please circle "No."

Asthma	Yes	No	Dental Problems	Yes	No
Attention Deficit/Hyperactive Disorder	Yes	No	Diabetes	Yes	No
Behavior Problems	Yes	No	Digestive Problems (reflux,etc.)	Yes	No
Bladder Problems	Yes	No	Frequent Ear Infections	Yes	No
Bleeding Disorders	Yes	No	Head Injury/Concussion	Yes	No
Blood Pressure (high/low) Problems	Yes	No	Headaches/Migraines	Yes	No
Bowel Problems	Yes	No	Hearing Problems	Yes	No
Cancer	Yes	No	Heart Problems/Murmur	Yes	No

Kansas City International Academy

Student Health Form 2017- 2018

HIV/AIDS	Yes	No	Skin Conditions (eczema, etc)	Yes	No
Hospitalizations	Yes	No	Seizure Disorder	Yes	No
Mental/Emotional Problems	Yes	No	Sickle Cell Anemia	Yes	No
Physical Limitations	Yes	No	Speech Problems	Yes	No
Pneumonia	Yes	No	Surgery	Yes	No

For any item(s) above marked "Yes", please provide pertinent information below. For example, any ongoing treatment, symptoms for the nurse and teachers to be aware of, medical diagnosis, ongoing medications, etc.

_____

_____

_____

_____

_____

Does your child wear Glasses or Contacts? ___Yes ___No

Emergency EpiPen Authorization:

I give the School Registered Nurse permission to administer an EpiPen under a standing prescription order by a KCIA advising physician during an emergency medical situation if there is a suspected allergy situation.

___Yes ___No

Parent/Guardian Signature_____ Date:_____

Verification:

In case of illness or injury of my child, I understand the school will attempt to contact parents or guardians first. Then, they will contact other persons I have listed; who are authorized to receive information, make certain medical decisions and have my child released to their custody. If none is available, the school is authorized to make whatever arrangements are deemed necessary to maintain my child's health including, but no limited to, emergency medical treatment.

I am the legal Parent/Guardian: ___Yes ___No Signature: _____

If you are not the legal Parent/Guardian of this child, state your relationship to this child: _____

I verify that the information provided on this form is accurate and current.

Parent/Guardian Name (Please Print): _____

Parent/Guardian Signature: _____ Date: _____

Kansas City International Academy

Annual Hearing and Vision Screening Policy

Every school year, Kansas City International Academy (KCIA) will conduct a school-wide vision and hearing screening. These screenings are free of charge, safe, and are conducted by a trained technician. All parents/guardians will be notified of their child's results. If a student does not pass the screening, the school nurse will recommend an outside referral for further evaluation.

If you agree to having your child screened no further action is required.

If you do NOT want your child screened, please fill out the form below.

Student's Name: _____

(First) (Middle) (Last)

Gender: ☐ Male ☐ Female Grade Level: _____ Date of Birth: ____-____-_____

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