

Damar Enhancement Preschool

2023 – 2024

# CHECKLIST

- School Physical (First Time Students)
- Social Security Card
- Birth Certificate
- Immunization Record
- Set up bus transportation (if needed)
- Enrollment Forms

USD #269 – PALCO Jr./Sr. HIGH SCHOOL  
Enrollment Information 2023 – 2024

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Soc. Sec #: \_\_\_\_\_

M \_\_\_\_\_ F \_\_\_\_\_ Are you Hispanic/Latino or of Spanish origin? YES or NO

Select one or more races from the following racial groups:

- a. American Indian or Alaska Native
- b. Asian
- c. Black or African American
- d. Native Hawaiian or Other Pacific Islander
- e. White

Parent's/Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address (if Different): \_\_\_\_\_

Phone: \_\_\_\_\_ Cell #'s \_\_\_\_\_  
(Mother) (Father)

Email Address \_\_\_\_\_ Ride Bus: YES or NO (Circle one)

Does your child have any health problems or physical limitations that the school staff should be aware of?

If so please explain: \_\_\_\_\_

Does your child have any allergies? \_\_\_\_\_ If yes, what are they? \_\_\_\_\_

Emergency Contact Information

Contact Father/Guardian at \_\_\_\_\_  
(Employment) (Phone)

Contact Mother/Guardian at \_\_\_\_\_  
(Employment) (Phone)

\*\*\*Alternate Contact Person \_\_\_\_\_  
(Name) (Phone)

\_\_\_\_\_  
(Name) (Phone)

If your family doctor is not from Plainville and you cannot be reached, may the school take your child to the Plainville hospital or doctor's office for emergency treatment? Yes \_\_\_\_\_ No \_\_\_\_\_

If your answer is NO to the above question, please explain how you want to provide emergency medical care for your child. \_\_\_\_\_

Transportation Permission Form

Permission has been granted for \_\_\_\_\_ to ride with his/her parents/guardian from a school activity. Parents must notify the coach/sponsor in person (& sign student out) before leaving activity with their child. (Students can only be released to parents/guardian.)

Parent/Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

**Preschool  
Parent Information Form**

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Address \_\_\_\_\_ PO Box \_\_\_\_\_  
\_\_\_\_\_

Mother's Name \_\_\_\_\_

Address \_\_\_\_\_

Father's Name \_\_\_\_\_

Address \_\_\_\_\_

**Statistical Information**

Education: Please check the parent's level of education

Mother:

Father:

High School Diploma

High School Diploma

GED

GED

Associate Degree

Associate Degree

College Degree

College Degree

Other \_\_\_\_\_

Other \_\_\_\_\_

Please check one that applies to child's family:

Single

Married

Foster Parent

Relative

Other \_\_\_\_\_

Were you or your spouse a teen parent (19 or younger)? Y N

Child's Primary Language: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

# INTERNET PHOTO & NAME RELEASE

To enhance our website and our facebook page, we would like to include photos with names of our students participating in various school activities. In order to include photos with names, we need a signed Internet Photo Release Form from each parent.

## INTERNET PHOTO/NAME RELEASE

Please check your following preference.

Include photo  
without name

Include photo  
with name

No photo on  
page

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Child's Name

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Parent/Guardian Signature

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Date

## DISTRICT STUDENT INSURANCE

### 1. STUDENT INSURANCE

Covers all students PK – 12 during extra curricular events and during school hours. This policy covers up to \$25,000.00 per jury. If student has personal insurance coverage, your policy will be requested to pay first. Student Insurance will cover the remaining portion up to the maximum benefit if all forms are filed correctly.

Claim form must be filed with Student Insurance within 30 days following the injury.

### 2. REGULAR KSHSAA INSURANCE

This policy provides coverage for students/athletes (grades 7-12) injured while participating in, practicing for or traveling (as defined in the policy) to/from activities/interscholastic athletics under the jurisdiction of KSHSAA. Mutual of Omaha provides this coverage to KSHSAA.

- 1) Lifetime excess medical, dental, and rehabilitative expense benefit pays reasonable and customary covered expense, up to \$5,000,000 (scheduled benefits for certain services/treatment) with a lifetime benefit period. There is a \$25,000 deductible with a 3 year loss establishment period.
- 2) \$10,000 accidental death and dismemberment benefit.
- 3) \$10,000 heart or circulatory malfunction loss of life benefit.
- 4) \$500,000 catastrophic cash benefit, for coma or paralysis resulting from a covered accident.

### 3. OPTIONAL EXTENDED CATASTROPHIC INSURANCE

This coverage extends to all (K-12) students (non-KSHSAA) participating in school activities excluding gym class, field trips, and intramurals. Also certain classroom accidents (not involving classroom negligence) are covered from \$10,000 to \$2,000,000 in medical benefits.

All claims must be filed within 30 days from the date of injury.

I hereby state that I have read the forgoing statement regarding school insurance coverage.

\_\_\_\_\_  
Parent/Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student's Name

\_\_\_\_\_  
Grade

### Health Screenings - Grades PK-12

During the school year, the health nurse will schedule health screenings. Those screenings include: vision, hearing and a dental screening.

Please place an (X) by the screenings in which you do not want your child to participate.

\_\_\_\_\_ Hearing Screening

Dental screening completed by First Care.

\_\_\_\_\_ Vision Screening

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### Human Sexuality Education - Grades 4-6

As part of your child's education, we offer information on puberty and human sexuality. At the 4<sup>th</sup> grade level, this information will be provided to the female students by the health nurse. She will meet with the students as a group in her office.

At the 5<sup>th</sup> & 6<sup>th</sup> grade level, this information will be provided to the female students as a group and the male students as a group. The health nurse will provide the instruction to the two separate groups.

If your preference is for your child to "opt-out" of the puberty and human sexuality education, please indicate your preference below. By so doing, your child will attend study hall and will not attend class sessions which are identified as addressing puberty and human sexuality.

\_\_\_\_\_ I do not grant permission for my child to participate in the puberty and human sexuality education.

\_\_\_\_\_ I do grant permission for my child to participate in the puberty and human sexuality education.

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\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

## Permission for Self-Administration of Medication

Name of Student \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Teacher \_\_\_\_\_

Medication \_\_\_\_\_ Dosage \_\_\_\_\_

Date Started \_\_\_\_\_

Conditions under which the medication is to be given:

\_\_\_\_\_

Any additional circumstances under which the medication is to be given:

\_\_\_\_\_

Length of time medication is to be administered:

\_\_\_\_\_

I hereby give my permission for \_\_\_\_\_ to administer the above  
(Name of student)

medication at school as ordered. I understand that it is my responsibility to furnish this medication. I acknowledge that the school incurs no liability for any injury resulting from the self-administration of medication and agree to indemnify and hold the school, and its employees and agents, harmless against any claims relating to the self-administration of such medication.

**My child has been instructed on self-administration of the  
medication and is authorized to do so in school.**

\_\_\_\_\_  
(Signature of Parent or Guardian) Date \_\_\_\_\_

\_\_\_\_\_  
(Signature of Health Care Provider) Date \_\_\_\_\_

Approved:

District Office Use Only:

\_\_\_\_\_  
(Signature of Parent or Guardian for Proof of Acknowledgment)