ELDON R-I SCHOOLS ENROLLMENT INFORMATION

Date_____ Grade_____

Student's Name: _____ **Birthdate:**_____ **Age:**_____

Address: _____ **City**_____ **ZipCode**_____

IF PO BOX is used, please list actual street address above: PO BOX #_____

Home Phone #: _____ **Cell:** _____ **E-mail address:**_____

Grade _____ **Social Security #:** _____ **Male**___**Female**____

RACE: (please check) White___Black___Hispanic___Indian___Asian___Other_____

Parent/Guardian (in home) or whom you are living with: **Are you a registered voter? YES NO**

Parent One Name: _____ **Marital Status: M W D S**

Relationship to Student:_____ **Cell #:** _____

Parent/guardian E-mail Address:_____

Employer: _____ **Work #:** _____

Parent/Guardian 2 information_____ **Marital Status: M W D S**

Relationship to Student:_____ **Cell #:** _____

Parent/guardian E-mail Address:_____

Employer: _____ **Work #:** _____

Please list all siblings in Eldon Schools and their ages:_____

Are there currently any court orders dealing with custody or visitation? YES NO

IF YES, please provide the school with a copy. We CANNOT honor without documentation.

Emergency Contacts:

1.Name_____ **Relation:**_____ **Phone #:** _____ **Cell:** _____

2.Name_____ **Relation:** _____ **Phone #:** _____ **Cell:** _____

3.Name_____ **Relation:** _____ **Phone #:** _____ **Cell:** _____

4.Name_____ **Relation:** _____ **Phone #:** _____ **Cell:** _____

Name of Parent out of the home (if applicable):_____ **Relationship:** _____

Address: _____

Cell#: _____ Employer: _____ Work #: _____

Spouse: _____ Cell #: _____

Would this parent like a grade card sent to them? YES NO

Continued on back.....

Previous school attended (name of school in what State):_____

Previous school address:_____ Phone #:_____

Circle the county in which you live: MILLER MORGAN MONITEAU

Circle the district in which you live: ELDON R-I HIGH POINT OTHER

Does the student use a language other than English? YES NO If YES, what language?_____

Is a language other than English used in the home? YES NO If YES, what language?_____

Are you or an immediate family member in the Military? (circle one) Active Duty National Guard or Reserve Unknown

Are you currently living in a temporary residence due to loss of permanent housing (e.g. motel, hotel, car, shelter)? YES NO

Has your family moved within the past 3 years to seek or obtain temporary or seasonal agricultural or food processing work? YES NO

Is child involved in (check all that apply):

Special Ed. classes_____ Speech_____ Title I Reading_____ Gifted_____ 504 Plan_____

I VERIFY THAT ALL ENROLLMENT INFORMATION IS CORRECT.

Parent Signature_____

Eldon R-1 School District – Health Services
Student Health Information 2023-2024

Student Name _____ **Grade** _____

Regular or Emergency Medications Your Child Is Taking

(at home) _____

(at school) _____

I request that you give over the counter medication to my child during the school year in accordance with the Board Policy. I authorize the school nurse or designee to give my child medication. I will not hold the school staff responsible for any undesired reaction that may occur from the medication. (Examples of non-prescription medication to be given with parent permission are: non-aspirin pain relievers including Acetaminophen, Ibuprofen, Tylenol, sore throat spray, antacid, antibiotic ointment, hydrocortisone cream, calamine lotion, throat lozenges, topical anti-sting treatments and generic substitutes.

Please initial below for over the counter medications:

_____ Yes

_____ No

I hereby give my permission for the Eldon Schools to obtain or send my students immunization record to Physician of choice.

Please initial below:

_____ Yes

_____ No

Please mark below if your child has any of the following:

___ **Asthma**	___ **ADHD**	___ **Other Medical Condition EXPLAIN**
___ **Diabetes**	___ **ADD**	_____
___ **Seizures**	___ **Hearing problem**	_____
___ **Severe Allergies**	___ **Vision problem**	_____
___ **Heart Condition**	___ **Seasonal Allergies**	_____

List **All** Child's **Medication Allergies** _____

List **All** Child's **Food Allergies and provide Doctors note:**

_____

Students Physician _____

1. Any medication that is sent to school with a student must be in the original container with the student's name on it.
2. Medication sent to school with a student must be accompanied by a signed and dated note from the parent/guardian requesting the medication to be given.
3. It is recommended that a small container of medication be sent to school.
4. All medications must be given to the school nurse as soon as the student arrives at school.
5. Please make sure the medication is age appropriate.

It is my understanding that my signature allows all of the above information and treatment as well as yearly vision, hearing, height and weight screenings to be administered to my student.

Parent Cell Phone _____

Parent Signature _____ **Date** _____

Title One Home-School Compact

Upper Elementary School is a school-wide Title 1 building; therefore, all students have the opportunity for additional assistance in learning.

Students of Upper Elementary School are encouraged to be responsible for their own success. To aid in this success they can make the following commitments:

1. Attending school on time every day.
2. Doing their best in class and completing homework on time.
3. Respecting others and themselves, making good choices and being a cooperative learner.
4. Keeping parents informed about progress in school and asking for help when needed.
5. Using time wisely at home and at school.

Parents are encouraged to be involved in their child's education in an effort to help with his/her achievement, attitude and behavior. To aid in this effort parents can make the following commitments:

1. Sending child to school every day, well rested and ready for the day.
2. Providing appropriate learning supplies and a place and time for learning.
3. Letting child know how much they care about their learning.
4. Checking child's homework and their graded schoolwork.
5. Making sure communication flows two ways, both from school to home and from home to school.

As educators at Upper Elementary School, we understand the importance of the educational experience for every student and our role as the teacher and role model. Therefore, in order to insure learning that takes place for every student we are committed to the following:

1. Maintain high expectations for every child to learn and achieve.
2. Provide a safe, positive and respectful learning environment.
3. Recognize and adapt for each students' needs and encourage individual talents.
4. Communicate with parents and students on a regular basis concerning student progress.
5. Help parents to support learning and positive behavior and encourage interaction at school.

By signing this compact, I acknowledge that I have access to a printed and online version of the Student/Parent Handbook and understand the terms and conditions. Together, students, parents, and educators become partners to enable the child to know success and a lifelong love of learning.

_____

Parent Signature

_____

Student Signature

For NEW Parent Portal Users ONLY

***Please only fill out if you are a new portal user or your email address has changed.**

Through this web-based system, Parent Portal, parents will be able to view their child's attendance history, schedule, grades based on three week progress reports, and lunch account balances.

Information for your child is available only with a password. All passwords are distributed through email. It will be your responsibility to keep this password private. We cannot issue any passwords via phone conversation. Passwords will not be issued to the student. You must have an email address to view your child's records in PARENT LINK.

Please provide the email address that you would like used for student information notifications. You may use only one email address, for example, home or work, but email cannot be sent to both. Please fill in the correct email address on the line provided. This form must be submitted each school year for you to have access.

____ I would like to be able to access my student's information over the Internet by using a password.

____ I do not want access to my student's information available over the Internet.

PLEASE PRINT BELOW

Student Name _____

_____ _____

Parent Name Email Address

_____ _____

Parent Name Email Address

I understand that it is my responsibility to protect my PARENT LINK password. I should not share my password with my children. I understand that the PARENT LINK system may not be available 24 hours a day due to maintenance on the school network, weather related interruptions, etc.

Date: _____

Parent Signature Parent Printed Name

Media Permission

Dear Parents/Guardians,

On certain occasions, media will be taking pictures of students in the classroom or participating in special events on and off campus. We believe this is a wonderful opportunity for the community to see what great students and staff we have. It provides an outlet for the community to see and hear about the wonderful things we have going on at Upper Elementary.

Student Name_____ Teacher_____

☐ Yes, I give permission for my student's picture to be published.

☐ No, I **DO NOT** give permission for my student's picture to be published.

_____ _____

Parent/Guardian Date

Thanks for all you do! When families and schools work together, great things can happen.

ELDON SCHOOL DISTRICT

Home of the Mustangs

Access to Devices/Internet

Please provide as much information as possible

Student Name: _____ Grade: _____

Teacher Name: _____

Please check all that apply:

- Does your student have internet access? Yes ____ No____
- Does your student have access to a computer during school hours? Yes____ No____

Please check all that apply:

- My student has access to the following devices during school hours:
- Computer/Chromebook _____
- Tablet/I-Pad _____
- Phone _____
- My student does not have access to any of the devices listed above. _____

What internet provider do you have access to? _____

Email address to best reach you: _____

Thank you ☺

BUS TRANSPORTATION REQUEST FORM

1. All requests must be completed and given to the student's Building Official for review prior to their approval. ***THREE SCHOOL DAYS NOTICE IS REQUIRED BEFORE A REQUEST MAY BE GRANTED.***
2. Final approval of request must be made by the Transportation Department prior to student being placed on a transfer bus to insure that all parties involved (parent/guardian, teacher, building official, Transportation Department and bus driver) are informed and the student's safe transportation is assured.
3. Transfer students must present a bus pass to the driver, given to them by the Principal's Office, to ride their new bus to their new location. The transfer stop should be written on the bus pass given to the new driver.

REASON FOR REQUEST: **New Student** ____ **Address Change** _____ **Child Care** ____
Parental Custody ____ **Other** _____

South School _____ **Upper Elementary** _____ **Middle School** _____ **High School** _____

Student Name: _____ Grade & Teacher: _____

Parent/Guardian Name: _____ Phone #: _____

Current Bus # of student: _____ Current Bus Stop: _____

Note other siblings in district grades/buildings: _____

_____ **Parent/Guardian signature:** _____

****

Date Parent/Guardian request transportation/transfer to START ____/____/____
(Must be 3 days from date of request)

Frequency of Transfer: *(Please circle all that apply)*

(Days of Week) (Time of Day)

M T W TH F AM NO LEAP DAYS **My child does NOT require bus trans.**

M T W TH F PM NO LEAP DAYS

AM Requested Bus Stop: _____

PM Requested Bus Stop: _____

If request is for childcare provider, please supply information below:

Name of childcare provider: _____ **Phone #:** _____

****

OFFICE USE ONLY:

Requested Approval: YES ___ NO ___ Bldg. Approval _____

Transportation Department Notified: YES ___ Transportation Official _____ Date ___/___/___

Building notified: Homeroom Teacher _____ Parent/Guardian _____ Date ___/___/___

Transportation Notified: Bus Driver(s) _____ Building Secretaries _____ Date ___/___/___

Date Request Will Take Effect: ____/____/____ New AM bus stop: _____

New PM bus stop: _____

New AM bus #: _____ AM P/U Time: _____ *Time is approximant*

New PM bus #: _____ PM D/O Time: _____ *Time is approximant*

Revised 4/27/20

INCOMPLETE FORMS WILL BE RETURNED

School Safety Alert: District's Bus Transfer Requests Policies and Procedures

BUS TRANSFER REQUESTS

The Eldon School District continuously strives to maintain and improve its operation as a Safe School District for all students and staff. One area that the District needs continued parent cooperation is in following the District's procedures and policies for requesting bus transfers for students because of childcare and related reasons. When moving please provide an updated proof of residency.

On the reverse side of this sheet is a copy of the District's Bus Transportation Request Form. **Please note that all bus transfer requests are to be in writing on this form and they are to be made in advance, at least three (3) school days prior to the requested transfer start date.** The time is necessary to insure that the transfer is consistent with Board policy and that all parties (Building Official, Homeroom Teacher, Bus Driver, and Transportation Office) are informed in a timely manner.

BUS STOP POLICIES AND PROCEDURES

By state law, all bus drivers must carry with them a roster of all students riding their bus. Please fill out the information on the backside of this form so that your student(s) will be included on the roster the first day of school.
It is the Parent/Guardian's responsibility to have your child at the designated bus stop at least 5 minutes before the morning pick-up time and drop-off time in the afternoon. This allows extra time for a safe pick-up and drop-off in case of unforeseen circumstances, road conditions, inclement weather, substitute drivers, or mechanical problems.

Students will only be allowed to ride one bus to one destination, either home or to an alternate site. This is important because drivers and other school personnel cannot keep up with the high volume of daily changes in home destinations and some buses are filled to near capacity.
Students will not be allowed to ride a different bus except in emergency situations. It is the parent's responsibility to make other arrangements.

All students riding a bus to and from school or any school activity are subject to rules of the Eldon R-I School Board, Department of Elementary and Secondary Education and the laws of the State of Missouri. Any misbehavior, which distracts the driver, is a very serious hazard to the safety of all passengers and other motorists on the road.

Please read the following Eldon R-I School Assertive Discipline Plan for buses. Talk with your child concerning the contents of the plan and the consequences of misconduct. Your support and cooperation are needed and appreciated.

Discipline Guidelines for Buses

1. Obey the driver promptly
2. Stay seated until the bus comes to a complete stop
3. Keep hands, feet and items to yourself at all times and no throwing objects
4. No offensive language or disruptive behavior
5. No food, candy, gum, or beverages on the bus
6. No large equipment, animals, skateboards or other harmful objects on the bus

Consequences

1. Verbal warning issued.
2. Assigned seat given by the driver.
3. Contact parent/guardian and the building principal
4. Sent to the principal with a recommendation for suspension of bus privileges.

Severe Clause

Visit the principal with a minimum three-day (3) suspension of bus privileges recommended.

Contact your children(s) building principal if you have any questions or need assistance with the above bus procedures and policies.

Parent/Guardian signature: Date:

Pick-Up/Walker Dismissal Authorization

Students who are picked up from Eldon Upper Elementary on a regular basis must have this authorization form on file. The safety of your student is very important to us! Therefore, we would like to know who has permission to pick your student up from school. Authorized individuals must have photo identification such as a driver's license available if requested.

Student:_____

Grade:_____ Teacher: _____

Please list the names of all individuals that will be allowed to pick up your student both regularly and occasionally, such as yourself, other parents, step-parents, grandparents, aunts, uncles, older brothers/sisters, church and sports organizations, Girl Scout leaders, etc.. Please print.

Name	Phone Number
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____
6._____	_____
7._____	_____

*Please write the names of any other individuals you wish to include on the back of this sheet.

_____My student will be a walker or a bike rider. Please list the house number and street address:

_____

Please mark the days you child will be picked up, walk or ride a bike on a regular basis.

_____Monday _____Tuesday _____Wednesday _____Thursday _____Friday

Parent/Guardian Signature:_____Date:_____

CENTRAL OZARKS MEDICAL CENTER

COMC

ELDON SCHOOL CLINIC

Child's Name: _____

Dear Parent/Guardian:

Central Ozarks Medical Centers (COMC) is excited to announce, we have partnered with the Eldon School District to provide Medical, Dental and Behavioral Health services during the 2022-23 school year! This partnership will allow COMC to expand access to convenient care, ensuring your child stays healthy throughout the school year. COMC is a local, non-profit organization that has worked to meet the healthcare needs of your community and surrounding areas since 1979.

Open all year, even during the summer and school breaks, COMC's School-Based Clinic offers school and sports physicals, care for colds, flu, immunizations, rapid labs, treatment for health problems like asthma, diabetes, and many other health concerns.

COMC welcomes Dr. Susan Currey to our Eldon Dental Clinic (located across from the Medical Clinic). Dr. Currey has a passion for dentistry and education. She will be a great addition to our Eldon School Based Team. Access will be provided to the students, staff, faculty, and the Eldon community for all dental needs.

In addition to Medical and Dental services, our Behavioral Health staff can work with your child to provide access to counseling services for issues such as depression, body image, peer pressure and any other challenges that your child may be experiencing. Students served by our school-based therapists have direct access in a convenient and confidential setting while they are at school. This limits absences from the classroom, ensures appointments are kept and creates a less intimidating environment for the student.

COMC's School-Based Services are available to any child who completes registration information and makes financial arrangements. COMC accepts Medicaid, private medical and dental insurance. We also offer a Sliding Fee Scale based on household size and income. We have dedicated staff to assist in eligibility for our Slide Scale and to identify if your student is eligible for the Missouri Medicaid program. If your child is insured, please attach a copy of the front and back of their insurance card to the completed packet.

We look forward to working with you to provide the best healthcare experience for your child. If you have questions or concerns, please contact our toll-free number: (877) 406-2662. Or send us an email: info@centralozarks.org.

If you would like for your child to be seen by COMC, please complete the attached registration packet and return it to school at your earliest convenience.

Indicate below, which services you would like for us to provide your child:

□ Medical □ Dental □ Behavioral Health

Sincerely,

Kelly Miller, CEO

Your Health... Our Mission

MEDICIAL INSURANCE INFORMATION

Insurance Carrier: _____

Full billing address on back of card: _____

Group Number: _____ Plan Number: _____

Participant's ID Number: _____

Subscriber Name (if different than patient): _____

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Step-Parent

Subscriber's Birthdate: _____ Subscriber's Social Security Number: _____

Subscriber's Phone #: _____ Subscriber's Address: _____

DENTAL INSURANCE INFORMATION

Insurance Carrier: _____

Full billing address on back of card: _____

Group Number: _____ Plan Number: _____

Participant's ID Number: _____

Subscriber Name (if different than patient): _____

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Step-Parent

Subscriber's Birthdate: _____ Subscriber's Social Security Number: _____

Subscriber's Phone #: _____ Subscriber's Address: _____

By participating in certain federal programs we are required to request the following information

Race

Please check all that apply

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

Primary Language:

- ☐ English
- ☐ Spanish
- ☐ Russian
- ☐ Ukrainian
- ☐ Other: _____

Gender Identify (18+ years)

- ☐ Male ☐ Female ☐ Decline to Specify
- ☐ Transgender Male ☐ Transgender Female
- ☐ Gender Neutral

Highest Level of Education

- ☐ 1-Not yet in school
- ☐ 2-Pre-School/Kindergarten
- ☐ 3-Grade School
- ☐ 4-Middle School
- ☐ 5-High School (Currently)
- ☐ 6-High School Grad/GED
- ☐ 7-Did Not Complete High School
- ☐ 8-Technical/Trade School
- ☐ 9-Some College
- ☐ 99-College Graduate

Ethnicity

- ☐ Latino or Hispanic
- ☐ Not Hispanic

Sexual Orientation (18+ years)

- ☐ Straight or heterosexual
- ☐ Lesbian, gay or homosexual
- ☐ Bi Sexual
- ☐ Something else
- ☐ Don't know
- ☐ Decline to Specify

Public Housing:

Do you currently live in public (income-based) housing?:

☐ YES ☐ NO

Patient Self Determination Act:

Please check **ALL** that apply

- ☐ None
- ☐ DNR
- ☐ Living Will
- ☐ Durable Power of Attorney
- ☐ HC Proxy

Estimated Annual Household Income

- ☐ $10,000 or below
- ☐ $10,001 - $20,000
- ☐ $20,001 - $30,000
- ☐ $30,001 - $40,000
- ☐ $40,001 - $50,000
- ☐ $50,001 - $60,000
- ☐ $60,001 - $70,000
- ☐ $70,001 - $80,000
- ☐ $80,001 - $90,000
- ☐ $90,001 - $100,000

Number of Persons in Household:

_____

CENTRAL OZARKS MEDICAL CENTER
COMC
EDEN SCHOOL CLINIC

Patient Name: _____ **DOB:** _____

Central Ozarks Medical Centers Policies and Consents

Consent to Treat:

I, _____, consent for the treatment of _____.
(Printed Name of Parent/Guardian) **(Printed Name of Minor)**

I attest that I have legal responsibility for this patient and the legal right to direct the medical treatment of this patient. I give permission for Central Ozarks Medical Centers (COMC) to provide healthcare services to my child - WITHOUT a parent or legal guardian present.However, Medical Services will be PROVIDED ONLY AFTER attempting to reach a parent/guardian. COMC's Behavioral Health Services WILL NOT begin until an intake is completed with a parent/guardian. This consent allows for treatment today and all future appointments. I understand this record may be given to other providers within COMC to treat this minor as needed. I understand that I will be contacted for treatment plans or any changes in treatment. I understand that the information in my child's health record is confidential and will not be released to any unauthorized person or agency without my consent. I authorize COMC to only disclose any portion of my child's health record to school personnel only as it relates to my child's academic success, including scheduling treatment and confirmation that my child is receiving services. I authorize COMC to have access to my child's school records only to assist in providing necessary care to my child.

Consent for Services:

I agree to my child receiving the below School Based Services while at school. Initial all that apply:

_____ **Medical Services**
(Initial)

_____ **Dental Services**
(Initial)

_____ **Behavioral Health Services**
(Initial)

_____ **Telehealth Services**
(Initial)

Finance Policy/Release of Billing Information/Assignment of Benefits:

COMC serves all patients whether they are covered by insurance or not. When you use our services, you are responsible for the cost of those services. If you have insurance: You are responsible for understanding the limitations of your insurance coverage and are responsible for any co-pays, cost shares, and deductibles, or non-covered services at the time service is provided. As a courtesy, we will bill your insurance for you. If requested, payment plans are available. If you do not have insurance: We offer a sliding fee scale based on household size and income. You may apply for a discount at the front desk. We can also assist you with obtaining insurance c overage. I authorize COMC and its representatives to release any information they obtain, including medical information to my insurance company or their representatives to process claims for payment. As applicable, I authorize my insurance provider to pay COMC for services rendered.

Notice of Health Information Exchange Participation:

COMC may participate in one or more health information exchanges (HIEs) and may electronically share your medical information for treatment, payment, healthcare operations, and other authorized purposes, to the extent permitted by law, with other participants in the HIEs. HIEs allow your health care providers, health plan, and other authorized recipients to efficiently access medical information necessary for your treatment, payment for your care, and other lawful purposes. The types of medical information that may be shared through HIEs, includes, but is not limited to: diagnoses, medications, allergies, lab test results, radiology reports, health plan enrollment and eligibility. Such information may also include health information that may be considered particularly sensitive to you, including: mental health information; HIV/AIDs information, genetic information, STD treatment, test results, and family planning information. The inclusion of your medical information in an HIE is voluntary and subject to your right to opt-out. If you do not opt-out, we may provide your medical information in accordance with applicable law to the HIEs in which we participate. More information on any HIE in which we participate and how you can exercise your right to opt-out can be found at: www.mhc-hie.org or you may call us at (877) 406-2662. If you choose to opt-out of data-sharing through HIEs, your information will no longer be shared through an HIE, including in a medical emergency; however, your opt-out will not modify how your information is otherwise accessed and released to authorized individuals in accordance with the law, including being transmitted through other secure mechanisms (i.e., by fax or an equivalent technology).