Lee A. Tolbert Community Academy
3400 Paseo Boulevard, Kansas City, MO 64109

NEW SCHOLAR CHECKLIST

School Year Applying For (Example: 24-25) _____

Scholar's Name: _____ Gender: _____

The following items are to be completed for every scholar attending Lee A. Tolbert Community Academy (LATCA). A checkmark indicates the item has been completed.

Provided by LATCA			
Required	**Item**	**Enclosed** *(Parent Check)*	**Enclosed** *(LATCA Check)*
✓	New Scholar Application		
✓	Authorization to Release Records		
✓	Immigrant Form		
✓	Media Release Authorization		
✓	Medication Authorization		
✓	Parent Assurances		
✓	Parent Portal Access Agreement		
✓	Safe Schools Assurance		
✓	Transportation Request		
*	Two-Party Affidavit *(Required only if you and your scholar in the home of a district patron. Residency verification of a current utility bill, lease, or mortgage is required.)*		
✓	DESE Parent Questionnaire		
✓	DESE Parent Survey Form Protocol		
✓	McKinney Vento Services		
Provided by Parent			
✓	Birth Certificate or Copy Of		
✓	Immunization Records		
✓	Proof of Residency *(Current Utility Bill, Lease, or Mortgage*		

How did you hear about LATCA?

O Friend O Radio O Television O Newspaper O Relative O Church O Other: _____

Screening Date: _____ **Screening Time:** _____

Telephone: 816.561.0114 • Fax: 816.561.1015 • enrollment@tolbertacademy.org

Scholar's Name: _____ Gender: _____

NEW SCHOLAR CHECKLIST - CONTINUE

Provided by LATCA			
Required	**Item**	**Enclosed** *(Parent Check)*	**Enclosed** *(LATCA Check)*
✓	Health Information Form		
✓	Food Allergy & Anaphylaxis Emergency Care Plan		
✓	Food & Nutrition Service Instruction 783-2		
✓	Asthma History		
✓	Asthma Action Plan		
✓	Diabetes Action Plan (2 Pages)		
✓	Medical Statement for Student Requiring Special Meals		
	CONTINUE IF 7TH OR 8TH GRADE		
✓	Permission to Self-Carry Medications		
Provided by Parent			

Lee A. Tolbert Community Academy
3400 Paseo Boulevard, Kansas City, MO 64109

NEW SCHOLAR APPLICATION

Demographic Information

Scholar's First Name	Scholar's Last Name	Scholar's Middle Name		
Scholar's Gender O Male O Female	Scholar's Date of Birth	Grade Applying For	Does Student have IEP?	If Yes, Docs Attached?
Scholar's Previous School		Previous School's City, State		

Scholar's Race / Ethnic Origin (check all that apply):
O Black O White O Hispanic O Asian O Indian O Pacific Islander O Multi-Racial

Is a language other than English spoken in your home? O Yes O No	Language:

Home Information

Scholar's Home Address	Scholar's Zip Code	Scholar's Home Number

Scholar Lives With (check all that apply):
O Both Parents O Father O Mother O Grandparents O Guardian O Uncle O Brother O Sister O Other

Name of Person Scholar Lives With, If *Other Than* the Parent:

Are you sharing the home of another person due to O Economic Hardship O Loss of Housing O Other
If Other, please explain.

Are the scholar and family residing in a shelter? O Yes O No
Due to economic hardship, does the scholar and family have a temporary housing arrangement or reside in a hotel, motel, car, or at a campsite? O Yes O No

Parents / Guardian Information

Mother's First Name	Mother's Last Name	Mother's Cell Number
Mother's Employer / Employer's City, State		Mother's Work Number
Father's First Name	Father's Last Name	Father's Cell Number
Father's Employer / Employer's City, State		Father's Work Number

Military Affiliation (Either Parent /Guardian) O Yes O No	Branch / Affiliation:

Additional Scholars

Name	Age	Relationship	Current Grade Level	Grade Applying For

Emergency Contact

Name	Relationship	Address	Home Number	Cell Number

Parental / Guardian Consent

Parent's / Guardian's Signature	Date

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AUTHORIZATION TO RELEASE RECORDS

Please do not withdraw the scholar until notified by the registrar.

Scholar Information

Scholar's Name: _____

Address / City / State / Zip: _____

Date of Birth: _____ Gender: _____

Scholar's Name: _____

Address / City / State / Zip: _____

Date of Birth: _____ Gender: _____

Former School Information

School Name: _____

Address / City / State / Zip: _____

School's Telephone / Fax: _____

RECORDS REQUESTED	
Cumulative Education	Psychological
Assessment Scores	Social
Attendance	Special Education/IEP/Section 504 Plan
Discipline	Outside Agency
Immunization	

ENROLLMENT / ADMISSION/ READMISSION

ln compliance with the Missouri Safe School Act, prior to enrolling or readmitting a scholar who has been suspended for more than 10 consecutive days, including expulsion. for an act of school violence. a conference must be held to review the conduct which resulted in the suspension/ expulsion regardless of whether or not the conduct occurred at a public, charter, or private school.

AFFIDAVIT

Prior to enrolling, Lee A. Tolbert Community Academy (LATCA) requires a parent/guardian to execute a sworn affidavit including whether the scholar has been expelled from any public, charter, or private school for violations of weapons, drug, or alcohol policy, and/or for the willful infliction of injury to another. Executing a false affidavit is a Class B misdemeanor. By law, LATCA cannot enroll or readmit a scholar who has been charged with, convicted of, or had petition(s) filed in court, or who has had a petition sustained that alleges any of the "acts of violence" listed above.

I authorize the release of the records as indicated above.

_____ _____

Parent's / Guardian's Signature *Date*

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IMMIGRANT / SEASONAL WORKER

Child(ren)'s Information

1. Child's Name: _____ Grade: _____
2. Child's Name: _____ Grade: _____

Please assist us in ensuring that your applicant receives all the educational benefits provided by the Lee A. Tolbert Community Academy (LATCA) staff by answering the following questions:

1. Is there another language(s), other than English spoken in your home? ☐ Yes ☐ No
   Primary Language: _____ Secondary Language: _____

2. If you have moved from one school district to another within the last three years, your applicant may be eligible for a special program of supplemental services. Please answer the following questions:
   - ☐ Yes ☐ No Before the move was either parent / guardian child or child's spouse employed in temporary or seasonal agricultural or agricultural-related work sch as: planting or harvesting crops, vegetables, fruits, cotton, etc.): transporting farm products to market; feeding poultry; gathering eggs; working in hatcheries; processing poultry, beef, hogs, fruits, vegetables, etc; working in dairy or catfish farm; cutting firewood or logs to sell?
   - ☐ Yes ☐ No Was the move from one school district to another made for the purpose of looking for or obtaining any of the above jobs?
   - ☐ Yes ☐ No Is either parent / guardian, child, or the child's spouse now employed in any of the above kinds of work?
   - ☐ Yes ☐ No During the summer months only, have you moved away with your child or has the child moved away to engage in crop harvesting or other seasonal agricultural work?
   - ☐ Yes ☐ No Has the child ever been suspended from school for more than 10 days?
   - ☐ Yes ☐ No Are you homeless? If yes, are you living in a: ☐ Shelter ☐ Other
     Please Explain: _____

3. Is the applicant currently expelled from the last school he / she attended? ☐ Yes ☐ No
   Please Explain: _____
4. Is the applicant currently serving a suspension of more than 10 school days? ☐ Yes ☐ No
   Please Explain: _____

IMMIGRANT STUDENT SURVEY

1. The applicant wasn't born in any state and was been attending school in one or more states for less than three complete school years.
2. The applicant fits the definition of "immigrant" under the Immigrations and Nationality Act. As amended. Immigrant children: will include the children of lawful permanent resident aliens, refugees, asylees, parolees, persons of other immigrant status, and immigrant residents in the United States without proper documentation.
3. They will exclude children from foreign diplomats. United States citizens, children who were born abroad, and children of foreign residents temporarily in the United States for business or pleasure.
   - ☐ In the United States Less than One (1) Year ☐ In the United States One (1) to Two (2) Years
   - ☐ In the United States Two (2) to Three (3) Years ☐ Does Not Apply

_____ _____

Parent's / Guardian's Printed Name *Parent's / Guardian's Signature*

_____

Parent's / Guardian's Telephone Number

Telephone: 816.561.0114 • Fax: 816.561.1015 • enrollment@tolbertacademy.org

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MEDIA RELEASE AUTHORIZATION

Scholar's Information

1. Scholar's Name: _____ Grade: _____
2. Scholar's Name: _____ Grade: _____
3. Scholar's Name: _____ Grade: _____
4. Scholar's Name: _____ Grade: _____
5. Scholar's Name: _____ Grade: _____

In consideration of my scholar being allowed to participate in any way at Lee A. Tolbert Community Academy (LATCA), in any official event and/or activity, the undersigned agrees that LATCA is hereby granted the unrestricted and exclusive right and permission, free from approval or review to copyright and/or use my scholar's likeness in all media now or hereafter known, including but not limited to, pictures and videos of my child when he/she may be included intact or in part for promotion or other commercial or organizational use.

☐ **YES** – I want my scholar's name and photograph included in the school directory, yearbook, social media, and all other print material.

☐ **NO** – I do ***not*** want my scholar's name and photograph included in the school directory, yearbook, social media, and all other printed material.

I authorize the release of the information as indicated above.

_____ _____

Parent's / Guardian's Signature *Date*

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MEDICATION AUTHORIZATION

Scholar Information

Scholar's Name: _____ Grade: _____

Date of Birth: _____ Gender: _____

Allergies: _____

Physician's Name: _____

Physician's Telephone Number: ___ _____

I authorize that my scholar be administered the following over-the counter medications by the Lee A. Tolbert Community Academy (LATCA) nursing staff who are qualified to administer medication.

Over-the-Counter Medication *(Check all that apply)*

- ☐ Children's Tylenol *(Dose: 1 to 2 pills)*
- ☐ Ibuprofen *(Dose: 1 to 2 pills)*
- ☐ Hydrocortisone Cream *(Relieves itching)*
- ☐ Neosporin Ointment *(Soothes cuts and scrapes)*

Prescription Medication

Name of Medication: _____

Prescription Number: _____ Time: _____

Method of Dispense (Pills / Drops / Liquid): _____

Dose: _____ Start Date: _____

Reason for Medication: _____

AUTHORIZATION TO RELEASE MEDIAL INFORMATION

The undersigned parent/guardian/legal representative of the above named Lee A. Tolbert Community Academy (LATCA) scholar hereby authorizes the exchange of health/medical information and records between LATCA and the above named physician. Use and disclosure shall be for the planning and implementation of any health-related care that is provided during school hours and at school-related activities.

I further authorize the LATCA nursing staff to share records and/or information that is pertinent to my scholar's academic progress with school personnel and/or other health care providers too which my child may be referred. By signing this authorization. I am certifying to the LATCA nursing staff and the above named physician that I have the lawful right to make this request and that I consent to the release of health/medical information. I understand and agree that unless previously revoked, this authorization will expire one year from the date written below.

_____ _____

Parent's / Guardian's Signature *Date*

Lee A. Tolbert Community Academy
3400 Paseo Boulevard, Kansas City, MO 64109

PARENT ASSURANCES

Scholar's Information

1. Scholar's Name: _____ Grade: _____
2. Scholar's Name: _____ Grade: _____
3. Scholar's Name: _____ Grade: _____
4. Scholar's Name: _____ Grade: _____
5. Scholar's Name: _____ Grade: _____

I understand that Lee A.Tolbert Community Academy (LATCA) is a public charter school and that the following efforts will be part of my responsibilities as a parent/guardian of a LATCA scholar. Therefore, I agree to the following assurances so that my scholar will be eligible to enroll:

1. I agree to participate and abide by the rules set forth in the Parent/Scholar Handbook.
2. I agree to purchase the uniform, which is required.
3. I will:
    a. Help my scholar establish regular attendance and punctuality. (Scholars with irregular attendance and excessive tardiness will not be guaranteed a spot for the following school year.)
    b. Attend school activities, meetings, parent-teacher conferences, mandatory Parent meetings, and all pertinent school functions.
    c. Pay donations and classroom fees within the designated timeframe.
    d. Follow through and see that my scholar does his/her homework assignments.
    e. Participate and assist with Parent Board projects and functions.
4. I will monitor my scholar's academic performance and agree to:
    a. Instructors will identify scholars not meeting the requirements for promotion by the end of first quarter.
    b. A conference will be held with the administrator, teacher(s), and parent(s) to discuss academic concerns.
    c. A collaborative plan will be devised for the scholar, with the understanding that I will work with LATCA to bring the scholar's performance to a satisfactory level.
    d. Methods to assist the scholar may include tutoring, mentoring, peer tutoring, Saturday School, and/or alternate methods of evaluation.
    e. If Saturday School is needed for my scholar's success, I will ensure that he/she attends.
5. Fundraisers:
    a. In an effort to offset expenses for activities and supplies, I agree to support any fundraising activities. I agree to participate and sell $200.00, profit per family for the combined fall and spring fundraisers.
    b. I understand that in lieu of selling or participating in the fundraisers, I may donate $200.00 to the school. The donation must be paid the first day of second quarter or my family will be expected to participate in the fundraisers.
6. In conjunction with the school, I agree to support community outreach events.
7. With a minimum of 20 volunteer hours per school year, I agree to participate in LATCA's Parent Work Service Program.

I understand that failure to meet the above expectations will cause my family to forfeit pre-enrollment opportunities.

_____ _____

Parent's / Guardian's Signature *Date*

Lee A. Tolbert Community Academy
3400 Paseo Boulevard, Kansas City, MO 64109

PARENT PORTAL ACCESS AGREEMENT

STUDENT INFORMATION SYSTEM

I understand that in order for me to have access to my scholar(s) electronic records. I must have a signed and dated parent portal access agreement on file with the Lee A. Tolbert Academy (LATCA) network administrator. Also, I understand that complete Student Information System Parent Portal, username and password instructions will be sent to me via email. Therefore, I am giving LATCA permission to send instructions to the following email that I have provided. Furthermore, this email address will grant me access to my scholar(s) electronic records.

Scholar's Information

1. Scholar's Name: _____ Grade: _____
2. Scholar's Name: _____ Grade: _____
3. Scholar's Name: _____ Grade: _____
4. Scholar's Name: _____ Grade: _____
5. Scholar's Name: _____ Grade: _____

Parental Consent:

Primary Parent's / Guardian's Name (Printed):_____

Primary Parent's / Guardian's Email Address:_____

Secondary Parent's / Guardian's Name (Printed):_____

Secondary Parent's / Guardian's Email Address:_____

_____ _____

Parent's / Guardian's Signature *Date*

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Lee A. Tolbert Community Academy
3400 Paseo Boulevard, Kansas City, MO 64109

SAFE SCHOOLS ASSURANCE

Name: _____ Date of Birth: _____

Social Security Number: _____ Current Grade: _____

Please complete the following questions by checking yes or no. If you answer yes to any question, an explanation ***must*** be provided.

1. Has the applicant ever been charged or convicted of a felony? ☐ Yes ☐ No

   Please explain: _____

2. Has the student ever been adjudicated (appeared before a judge) to have committed an act, which if committed by an adult would be one of the following:

✓ First Degree Arson	✓ Felonious Restraint	✓ Property Damage
✓ First Degree Assault	✓ Possession of a Weapon	✓ Rape or Sodomy
✓ Burglary	✓ Kidnapping	✓ First Degree Robbery
✓ Child Molestation	✓ Manslaughter	✓ Sexual Abuse
✓ Distribution of Drugs to a Minor	✓ First or Second Degree Murder	✓ Sexual Assault
		✓ Sexual Misconduct

   Please explain: _____

3. Is the applicant currently serving a suspension of more than 10 days? ☐ Yes ☐ No

   Please explain: _____

4. Is the applicant currently serving a suspension of more than 10 days? ☐ Yes ☐ No

   Please explain: _____

5. Is the applicant currently serving a suspension of more than 10 days? ☐ Yes ☐ No

   Please explain: _____

SAFE SCHOOLS ACT, HOUSE BILL 1301

Prior to admission to any public school, a school board may require the parent, guardian or other person having control or charge of a child of school age to provide, upon enrollment, a sworn state or affirmation indicating whether the student has been expelled from school attendance at any school in this state or in any other state for an offense in violation of school board policies relating to weapons, alcohol or drugs, or for the willful infliction of injury to another person. Any person making a materially false statement or affirmation shall be guilty upon conviction of a misdemeanor. The registration document shall be maintained as a party of the student's scholastic records.

I understand this statement will be maintained as part of the applicant's scholastic record.

_____ _____

Parent's / Guardian's Signature *Date*

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Lee A. Tolbert Community Academy
3400 Paseo Boulevard, Kansas City, MO 64109

TRANSPORTATION REQUEST

Scholar Information	
Scholar's Name	Scholar's Grade
Scholar's Name	Scholar's Grade
Scholar's Name	Scholar's Grade
Scholar's Name	Scholar's Grade
Scholar's Name	Scholar's Grade

Home Address		
Scholar's Home Address	Scholar's Zip Code	Scholar's Home Number

Transportation Needs

AM – On most days, my scholar(s) will:
☐ Parent Drop Off ☐ Ride the Bus ☐ Walk ☐ LINC ☐ Other (*Please explain*)_____

PM – On most days, my scholar(s) will:
☐ Parent Drop Off ☐ Ride the Bus ☐ Walk ☐ LINC ☐ Other (*Please explain*)_____

Transportation Address *(If different from Home Address)*		
Scholar's Transportation Address	Trans. Zip Code	Trans Phone Number

Parents / Guardian Information		
Mother's Name	Mother's Cell Number	Mother's Work Number
Father's Name	Father's Cell Number	Father's Work Number

Emergency Contact *(In the event a parent cannot be reached)*			
Emergency Contact	Relationship	Home Number	Cell Number

Parental / Guardian Consent	
Parent's / Guardian Signature	Date

Transportation Department Use Only			
Approved ☐ Yes ☐ No	Reason Approved or Denied	Start Date	
Pick Up Time	AM Bus Stop	AM Route Number	AM Route In SISK12 ☐ Yes ☐ No
Drop Off Time	PM Bus Stop	PM Route Number	PM Route In SISK12 ☐ Yes ☐ No
Transportation Director's Signature		Date	

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Lee A. Tolbert Community Academy
3400 Paseo Boulevard, Kansas City, MO 64109

☐ New Scholar ☐ Reprove

TWO-PARTY AFFIDAVIT OF RESIDENCE

For scholar / family living with a district homeowner / lease holder

☐ I understand that the following information will be fully investigated by Lee A. Tolbert Community Academy (LATCA).

I/we, _____ , am/are residing at
Parent / Legal Guardian Name(s)

_____ with _____
Address / City / State / Zip *Homeowner / Lease Holder's Printed Name*

In the LATCA school district. I have been residing there since _____. I
Date

have no other residence.

List previous address(es) within the past year:

The scholar for whom I am applying for admission to LATCA is/are as follows:

Scholar's Name(s)	Grade	School

I/we have provided accurate and truthful information to the best of my/our knowledge and belief. I/we have not knowingly withheld, concealed, or misrepresented any information that would have material hearing upon the eligibility of the above scholar(s) to attend the LATCA school district.

Further, I/we understand that persons making a false "Affidavit of Residence" are committing a Class A misdemeanor. Violators may be charged with such, and, upon conviction, may be jailed and/or fined. In the event, LATCA will recover costs of school attendance of pupil(s) who attend under a false affidavit. Therefore, I/we understand we will be obligated to pay any tuition monies then due and the scholar(s) will be removed from the district.

_____ _____
Parent / Guardian's Printed Name *Homeowner / Lease Holder's Printed Name*

_____ _____
Parent / Guardian's Signature *Homeowner / Lease Holder's Signature*

_____ _____
Parent / Guardian's Telephone Number *Homeowner / Lease Holder's Telephone Number*

In addition to a signed affidavit, a current utility bill (in the homeowner's / lease holder's name) is required as proof of residency. A current utility bill is within the last 30 days. A Two-Party Affidavit is valid for one school year only.

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MCKINNEY VENTO SERVICES

Student Name: _____ Grade:_____

PLEASE NOTE:

The McKinney Vento Services are for Students/Families who are Homeless/In-Transition. Please select the services that you need assistance with:

- ☐ Uniforms: Please Include the Size _____
- ☐ Transportation
- ☐ Field Trip Fee Assistance
- ☐ Field Trip T-Shirt
- ☐ Mattresses
- ☐ Referral to Dental, Medical, Mental Health or Other Service
- ☐ If you have already provided your information to office staff please select this box

Please proceed to the next page to fill out Eligibility Questionnaire

MCKINNEY-VENTO ELIGIBILITY QUESTIONNAIRE

All information is confidential

This questionnaire is intended to address the McKinney-Vento Act, 42 U.S.C. 11435. The answers to these questions will help determine services a student may be eligible to receive.

Is your current address a temporary living arrangement? Yes ____ No ____
Is your temporary address due to loss of housing or economic hardship? Yes ___ No ___

If you answered "NO" to either of the questions above you may stop here.

Responses to the rest of this page are also voluntary and will tell us that you are interested in possible services under McKinney-Vento. If you answered "yes" to the questions above, please complete the remainder of this form. You may fill out one form for all children.

Name of Student: _____ Date of Birth:_____
Age: ____ Gender: ___ Grade: ____ School most recently attended: _____
Name of Parent(s) Legal Guardian(s) _____
Temporary/Physical Address: _____
Length of time at Address: _____
Phone Number: _____

1. Where is the student presently living? (Check on box)
   - ☐ Doubled up: Temporarily living with family or friends due to lack of adequate housing or financials.
   - ☐ In a transitional housing program
   - ☐ In a motel: Living in hotels/motels for lack of other suitable housing – Please list name and address of hotel/motel: _____
   - ☐ In a place not considered traditional "housing": Living on the streets, abandoned buildings, in cars, trailers, campgrounds, public places, housing not fit for habitation—Please provide information regarding area in which student is living: _____
   - ☐ In a shelter: Please provide name of shelter: _____ Address: _____
   - ☐ Moving from place to place
   - ☐ Abandoned at hospital
2. Do you also have pre-school children at home? Yes ____ No ____

CONTINUE ON NEXT PAGE

MCKINNEY-VENTO ELIGIBILITY QUESTIONNAIRE CONTINUED

All information is confidential

3. Are you a high school student who is currently living on your own due to hardship? Yes ____ No ____

   Unaccompanied youth also qualify for services under this law

4. Are there any pressing needs that could prevent your child from being successful in school? Yes ____ No ____

   Yes….Please Explain: _____
   _____
   _____

Lee A. Tolbert Community Academy
3400 Paseo Boulevard, Kansas City, MO 64109

Health Information Form

Student: Grade: Gender: ☐ M ☐ F Date of Birth:

Health Information

Physician's Name:

Dentist's Name:

Name of health insurance provider: ☐ No Insurance

Does your child take medications? ☐ No ☐ Yes Diagnosis/Reason:

Medication: Dose: Times:

Medication: Dose: Times:

Medication: Dose: Times:

Will medication be given at school? ☐ No ☐ Yes

Allergies (as diagnosed by a physician)

☐ Food: ☐ Medication: ☐ Insect:

☐ Environmental: ☐ Other:

Reaction: ☐ Hives/rash ☐ Breathing difficulty ☐ Swelling of lips, tongue, throat ☐ Other:

Treatment of allergic reaction:

If your child has an allergy which may cause difficulty breathing, you MUST provide an EpiPen and an Emergency Action Plan from your health care provider.

Medical History

Have you ever been told by a physician or health care professional that your child has:

Asthma **(Must complete back of form)**	☐ No/Yes ☐	Heart condition (specify)	☐ No/Yes ☐
ADD/ADHD (circle specific condition)	☐ No/Yes ☐	Migraine headaches	☐ No/Yes ☐
Bladder incontinence	☐ No/Yes ☐	Neurological concerns	☐ No/Yes ☐
Bowel incontinence	☐ No/Yes ☐	Orthopedic problems	☐ No/Yes ☐
Constipation	☐ No/Yes ☐	Physical limitations (specify)	☐ No/Yes ☐
Dental concerns	☐ No/Yes ☐	Seizure disorder	☐ No/Yes ☐
Diabetes (circle one) Type I or Type II	☐ No/Yes ☐	Speech concerns	☐ No/Yes ☐
Gastrointestinal (circle one) Crohn's, UC, IBS	☐ No/Yes ☐	Vision concerns	☐ No/Yes ☐
Head injury/concussion : Date of injury:	☐ No/Yes ☐	Wears glasses/contacts	☐ No/Yes ☐
Hearing problems	☐ No/Yes ☐		

Mental health concerns (circle condition) Anxiety, Autism, Bipolar, depression, OCD, ODD, PTSD, **Sickle Cell** ☐ No/Yes ☐

Other (please specify):

Please explain YES answers here:

AUTHORIZATION FOR CARE AND EMERGENCY MEDICAL TREATMENT

I understand the information given above may be shared with appropriate school staff to provide for the health and safety of my child, according to the Family Educational Rights and Privacy Act. If you prefer information not be shared, please contact your school nurse. If either I or an authorized emergency contact person cannot be reached at the time of a medical emergency, I authorize and direct school staff to send my child to the most easily accessible hospital or physician. I understand I will assume full responsibility for payment of any transport or emergency medical services rendered. I verify the information provided on this form is accurate and current.

X Signature of Parent/Guardian/Other: PRINTED Name of Parent/Guardian/Other: X

PLEASE SEE THE FOLLOWING PAGE FOR IMPORTANT INFORMATION

Lee A. Tolbert Community Academy
3400 Paseo Boulevard, Kansas City, MO 64109

FARE FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: [ ] Yes (higher risk for a severe reaction) [ ] No

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following foods: _____

THEREFORE:

[ ] If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

[ ] If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

FOR ANY OF THE FOLLOWING: SEVERE SYMPTOMS

LUNG
Short of breath, wheezing, repetitive cough

HEART
Pale, blue, faint, weak pulse, dizzy

THROAT
Tight, hoarse, trouble breathing/ swallowing

MOUTH
Significant swelling of the tongue and/or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell them the child is having anaphylaxis and may need epinephrine when they arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport them to ER even if symptoms resolve. Person should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy/runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea/ discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand: _____

Epinephrine Dose: [ ] 0.15 mg IM [ ] 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

Telephone: 816.561.0114 • Fax: 816.561.1015 • enrollment@tolbertacademy.org

United States Department of Agriculture

Food and Nutrition Service Instruction 783-2

7 CFR PART 15b

"Handicapped person" means any person who has a physical or mental impairment which substantially limits one or more major life activities, has record of such an impairment, or is regarded as having such an impairment.

"Physical or mental impairment" means (1) any physiological disorder or condition, cosmetic disfiguration, or anatomical loss affecting one or more of the following body systems:

Neurological, musculoskeletal, special sense organs, respiratory, including speech organs, cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic skin, and endocrine or (2) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities. The term "physical or mental impairment" includes, but is not limited to, such diseases and conditions as orthopedic, visual, speech, and hearing impairments; cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, drug addiction, and alcoholism.

"Major life activities" means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

Lee A. Tolbert Community Academy
3400 Paseo Boulevard, Kansas City, MO 64109

Asthma History

Student:

Please answer each question ONLY if your child has been diagnosed with ASTHMA.

Is a daily medication used to control asthma?	☐No/Yes☐
If yes, what medication:	
Has he/she required emergency care due to asthma in the last 3 years?	☐No/Yes☐
Has he/she been hospitalized for asthma problems in the last 3 years?	☐No/Yes☐
Does he/she have symptoms more than 2 days per week?	☐No/Yes☐
Does he/she use a rescue inhaler more than 2 days per week?	☐No/Yes☐
Will you be providing a rescue inhaler to keep at school?	☐No/Yes☐

If you will be providing an inhaler to keep in the health room,
you MUST provide a current Asthma Action Plan completed by your health care provider.

If your child is to self-carry the inhaler, TWO self-administration forms must be completed:
One completed by your health care provider
One completed by a parent

Forms are available from the school nurse and are on the district website.
Completed forms will be kept on file in the health room.
All inhalers must have a prescription label.

NOTE: Health Rooms do NOT have over the counter medications available for students.
This includes Tylenol, ibuprofen, and antacids.
Parents must provide any medications and have a signed Medication Administration form.
Medications will only be administered according to package directions or
as directed by a health care provider prescription.
Medications in plastic bags, envelopes, etc. will NOT be accepted.
Medications must be brought to school by a parent/guardian.
Students may not bring medications to school.

Reviewed by Nurse:

Date:

Telephone: 816.561.0114 • Fax: 816.561.1015 • enrollment@tolbertacademy.org

Asthma Action Plan

AMERICAN LUNG ASSOCIATION.

General Information:

- Name _____
- Emergency contact _____ Phone numbers _____
- Physician/healthcare provider _____ Phone numbers _____
- Physician signature _____ Date _____

Severity Classification

- ○ Intermittent ○ Moderate Persistent
- ○ Mild Persistent ○ Severe Persistent

Triggers

- ○ Colds ○ Smoke ○ Weather
- ○ Exercise ○ Dust ○ Air Pollution
- ○ Animals ○ Food
- ○ Other _____

Exercise

1. Premedication (how much and when) _____
2. Exercise modifications _____

Green Zone: Doing Well

Peak Flow Meter Personal Best =

Symptoms

- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeps well at night

Control Medications:

Medicine	How Much to Take	When to Take It

Peak Flow Meter

More than 80% of personal best or _____

Yellow Zone: Getting Worse

Contact physician if using quick relief more than 2 times per week.

Symptoms

- Some problems breathing
- Cough, wheeze, or chest tight
- Problems working or playing
- Wake at night

Continue control medicines and add:

Medicine	How Much to Take	When to Take It

Peak Flow Meter

Between 50% and 80% of personal best or _____ to _____

IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick-relief treatment, THEN

- ○ Take quick-relief medication every 4 hours for 1 to 2 days.
- ○ Change your long-term control medicine by _____
- ○ Contact your physician for follow-up care.

IF your symptoms (and peak flow, if used) DO NOT return to Green Zone after one hour of the quick-relief treatment, THEN

- ○ Take quick-relief treatment again.
- ○ Change your long-term control medicine by _____
- ○ Call your physician/Healthcare provider within ____ hour(s) of modifying your medication routine.

Red Zone: Medical Alert

Ambulance/Emergency Phone Number:

Symptoms

- Lots of problems breathing
- Cannot work or play
- Getting worse instead of better
- Medicine is not helping

Continue control medicines and add:

Medicine	How Much to Take	When to Take It

Peak Flow Meter

Less than 50% of personal best or _____ to _____

Go to the hospital or call for an ambulance if:

- ○ Still in the red zone after 15 minutes.
- ○ You have not been able to reach your physician/healthcare provider for help.
- ○ _____

Call an ambulance immediately if the following danger signs are present:

- ○ Trouble walking/talking due to shortness of breath.
- ○ Lips or fingernails are blue.

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Diabetes Action Plan

Name of Student: _____ DOB: _____ Grade/Teacher: _____

Bus #: _____ Bus Driver: AM: _____ PM: _____

Date of Diagnosis _____ Type 1 ☐ Type 2 ☐ Date of Plan _____

Needs assistance: ☐ None With: _____

Notify parents in the following situations: _____

Location of student's diabetes supplies: _____

Blood Glucose Monitoring

Target range for blood glucose is: _____ Usual times to check blood glucose are: ☐ Before meals ☐

Before afternoon snack ☐ If student feels "low" or ill ☐ Before exercise ☐ After exercise ☐ Other _____

- For BG below _____ before exercise, give 15 grams carbohydrate snack without insulin.
- For BG below _____ give 15 grams fast acting carbohydrate and recheck blood glucose in 15 minutes.
- If BG is still below _____ treat again and call parent/guardian.
- If student has BG over_____ with urine ketones, notify parent/guardian.

Medications

☐ Oral Diabetes Medication: _____ When Taken: _____

Insulin to be given only with food unless otherwise directed by parent.

Types of insulin: ☐ Humalog ☐ Novolog ☐ Other _____ ☐ Insulin Pen

Usual dose for carbohydrates coverage: _____ units for every _____ grams of carbohydrate.

Insulin for blood glucose correction: Formula: (BG minus _____) divided by _____ equals number of units to give.

Other correction: _____

☐ Student has an insulin pump Type of Pump: _____

Type of insulin in pump: ☐ Humalog ☐ Novolog ☐ Other _____

Insulin to carbohydrate ratio and high blood sugar correction programmed into meter per students needs.

Other pump instructions: _____

☐ If pump failure occurs or if student has blood sugar more than _____ with urine ketones, give insulin per injection to cover high blood sugar and notify parent/guardian.

Diet: ☐ Regular ☐ Other: _____

☐ **Changes and updates to student's diabetes medication and care may be communicated to the school by the parent/guardian in writing. Parent/guardian is responsible for communicating the level of supervision for their child that is required by school personnel for blood glucose monitoring and insulin administration.**

GLUCAGON: For severe hypoglycemic (low blood sugar) reaction (loss of consciousness, seizure), give:

☐ 1.0 mg IM ☐ 0.5 mg IM

Turn on side and observe for vomiting. When alert, may treat low blood sugar with 15 grams carbohydrate. **If GLUCAGON IS REQUIRED, ADMINISTER IT PROMPTLY AND CALL 911 AND THE PARENT/GUARDIAN.**

Physician's Signature _____ **Date:** _____

Print/Stamp physician name, address and phone number:

Diabetes Action Plan (con't)

Name of Student: _____ DOB: _____

School: _____ Grade/Teacher: _____

All medication for use at school will be furnished by parent or guardian in a container properly labeled by a pharmacist with identifying information (e.g., name of child, medication dispensed, dosage prescribed, and the time it is to be given or taken).

Parent Permission

I hereby give my permission for my child to receive medication during school hours. This medication has been prescribed by a licensed physician. I hereby release the School Board and their agents and employees from all liability that may result from my child taking the prescribed medication. This consent is good for one year, unless revoked.
I give permission to the school nurse and other designated staff members of Tolbert Academy to perform and carry out the tasks as outlined by this Diabetes Action Plan. I also consent to the release of the information contained in this Diabetes Action Plan to all staff members and other adults who have custodial care of my child and who need to know this information in order to maintain my child's health and safety.

EMERGENCY CONTACTS: Name/Relation

1._____a) home_____ b) work _____ c) cell_____

2._____a) home_____ b) work _____ c) cell_____

3._____a) home_____ b) work _____ c) cell_____

EMERGENCY PLAN

1. Recognize when the student is having a **low blood sugar** reaction. Some children with low blood sugar may experience:
Hungerappears paleirritability, cryingsweatingtrembling dizziness inability to concentrate, confusion
Steps to take when a low blood sugar is suspected:

- **NEVER LEAVE THE STUDENT ALONE OR ALLOW HIM/HER TO LEAVE THE CLASSROOM ALONE.**
- Check the blood sugar, if possible.
- When in doubt, treat for low blood sugar.
- Observe level of consciousness, **if unconscious administer glucagon if ordered by the physician, and call 911 for emergency assistance.**
- If conscious, give a "fast sugar" such as: 2 teaspoons sugar; regular soft drink; fruit juice with sugar (1/2 to 2/3 cup); small tube of cake frosting.
- After 15 minutes, recheck the blood sugar. If improved, give protein snack (cheese, peanut butter crackers, milk). Fast sugar may be repeated if blood sugar does not improve within 15 minutes.
- Always notify parent/guardian of the low blood sugar episode.
- Additional information: _____

2. Recognize when the student is having a high blood sugar reaction. Some children with high blood sugar may experience:
Thirstfrequent urinationfatigue/sleepinessincreased hunger
Blurred visionstomach painslack of concentrationsweet fruity breath
Steps to take when a high blood sugar is suspected:

- Check blood sugar, ketones and give insulin as indicated
- Allow free use of the bathroom
- Encourage student to drink water
- Exercise

Acknowledged and received by:

Parent/Guardian _____ Date _____

Parent Email address _____ Parent Phone Numbers _____

School Nurse's Signature _____ Date _____

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Medical Statement for Student Requiring Special Meals

Name of Student:	School District:
Birth Date:	School Attended:
Parent Name:	Telephone:
Telephone:	

For Physician's Use

Identify and describe disability, or medical condition, including allergies that requires the student to have a special diet. Describe the major life activities affected by the student's disability (see back of form).

_____

_____

_____

Diet Prescription (check all that apply):

☐ Diabetic (include calorie level or attach meal plan) ☐ Modified Texture and/or Liquids
☐ Reduced Calorie ☐ Food Allergy (describe): _____
☐ Increased Calorie ☐ Other (describe): _____

Food Omitted and Substitutions:

Use space to list specific food(s) to be omitted and food(s) that may be substituted. You may attach an additional sheet if necessary.

OMITTED FOODS	SUBSTITUTIONS

Indicate Texture:

☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

Indicate thickness of liquids:

☐ Regular ☐ Nectar ☐ Honey ☐ Pudding

☐ **Special Feeding Equipment** _____

Additional comments: _____

I certify that the above named student needs special school meals as described above, due to the student's disability or chronic medical condition.

Physician's Signature	**Telephone Number**	**Date**
Signature of Preparer or Other Contact	**Telephone Number**	**Date**

I hereby give my permission for the school staff to follow the above stated nutrition plan.

Parent/Guardian	**Date**

Lee A. Tolbert Community Academy
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FOR 7TH & 8TH GRADE ONLY

Permission to Self-Carry Medications

I, _____, the parent/guardian of _____, a student Lee A Tolbert Community Academy, give my permission for the student to retain in his/her possession the following medications:

_____.

This permission shall be effective for the 20___ - 20___ school year and must be renewed annually. This medication will be carried to and from school by the student and maintained in the student's backpack or special carrying device during school hours.

I have provided the District with the following:

- A written medical history of the Student's condition for which the medication is required on the Health Information Form or other documentation.
- An Action Plan for addressing an emergency situation that could reasonably occur as a result the condition.

I understand that the District and its employees or agents may disclose information provided to administrators, school nurses, teachers and other school employees as may be necessary to protect the health of the Student and to establish that the Student has been authorized to self-carry the medication and shall incur no liability for the disclosure of such information.

I understand that the District and its employees or agents shall incur no liability as a result of any injury arising from the self-administration of medications by the Student, absent any negligence by the District, its employees or its agents. I shall indemnify and hold harmless the District and its employees or agents against any claims arising out of the self-administrations of medication by the Student.

_____ _____

Signature of Parent/Guardian Date

_____

I certify that I am a licensed physician authorized by law to prescribe medication. I have prescribed the following medication, _____ for my patient, _____ to treat or manage the following condition, _____.

I further certify that I have instructed the student in the correct and responsible use of this medication, attached a treatment plan for managing the student's condition and that the student is capable of self-administering the medication in accordance with the treatment plan. The student has demonstrated to me or my designee the skill level necessary to self-administer the medication.

_____ _____ _____

Printed Name of Physician Signature of Physician Date