LA CENTER MIDDLE SCHOOL
PO BOX 1750
La Center, WA. 98629
(360)263-2136
FAX (360)263-5936

Form Sent ________________
date

Records Sent ________________
date

REQUEST FOR SENDING PERSONALLY IDENTIFIABLE RECORDS

STUDENT ______________________________ DATE ____________

BIRTHDATE ______________________________

I request an exchange of records:

- [ ] Permanent Records
- [ ] Health Records
- [ ] Special Education Records (including speech and language records)

  Special Education Coordinator ________________________
- [ ] Discipline

This information is to be exchanged

"new" school (name/address below)	"old" school (name/address below)
La Center Middle School P.O. Box 1750 La Center, WA 98629	

Following reason:
As provided under the Family Rights and Privacy Act of 1974, I understand that I may obtain a copy of child's personally identifiable records. I am aware that I may challenge the content of these records. I also understand the school will treat these records confidentially. Finally, no one will send these records to a non-public school agency without my written consent.

____
(Signature)

____
(Relationship)

____
(Address)

____
(Phone)

White: Receiving School District
Yellow: Sending School District

LA CENTER SCHOOL DISTRICT NO. 101
P.O. BOX 1840/725 HIGHLAND ROAD
La Center, WA 98629

MIDDLE SCHOOL REGISTRATION

Date: ______________________

School Entry Date: ____________ Returning Student? Yes: __ No: __ Date last attended: __________

Student Last Name: ___________________ First: __________________ Middle: _____________

Student's Legal Last Name: ________________ Legal First Name: ____________ Grade Level: ______

Sex: ______ Parent/Guardian Home Phone: ________________ (unlisted __ message __)

Ethnicity (Optional): (1) American Indian (2) Asian/Pacific Islander (3) Black (4) Hispanic
(Circle one) (5) White (6) Native Hawaiian/Other Pacific Islander (7) Multi-racial

Immigrant: ___Yes ___ No Birth Date: ____________

Student lives with: **(Circle one)** (1) Both parents (2) Mother only (3) Father only (4) Self (5) Agency (6) Guardian (7) Mother/Stepfather (8) Father/Stepmother (9) Stepfather/Stepmother (10) Grandparent

(Primary Household) Parent/Guardian #1
Last Name: ____________________ First Name: ______________________

Work phone #: ________________ Work Ext. # ______ Pager/Cell phone #______________
(Primary Household) Parent /Guardian #2
Last Name: ____________________ First Name: ______________________

Work phone #: ________________ Work Ext. #_____ Pager/Cell phone #: _____________

Mailing Address: ____________________ City: ______________ Zip Code: ____________

Street Address: ______________________ City: ______________ Zip Code: ____________

Primary Household E-Mail ____

(Alternate Household) Parent/Guardian #1 Send Mailings? YES / NO
Last Name: ____________________ First Name: ______________________

Work phone #: ________________ Work Ext. # ______ Pager/Cell phone #______________
(Alternate Household) Parent/Guardian #2
Last Name: ____________________ First Name: ______________________

Work phone #: ________________ Work Ext. # ______ Pager/Cell phone #______________

Mailing Address: ____________________ City: ______________ Zip Code: ____________

Alternate Household E-Mail ____ -over-

Emergency Contact Person #1: ______________________ Phone #: ____________ Relationship: __________
(Other than parents)
Emergency Contact Person #2: ______________________ Phone #: ____________ Relationship: __________

Emergency Contact Person #3: ______________________ Phone#: ____________ Relationship: __________

Other siblings you are enrolling in La Center School District:
Name Grade

____

____

____

____

For the past five (5) years, the student has attended the following schools:
Date entered Name of School City, State Date withdrawn

____

____

____

____

____

Has anyone in the family moved across school district lines/boundaries to obtain seasonal or temporary work in any agriculture or fishing activity within the last 36 months?
Yes: __ No: __

____

Has student ever been enrolled in a special program? Yes: __ No: __
If yes, please indicate which program:
Gifted/TAG: __ Remedial: ___ Special Ed. ___ IEP ___ Section 504 ___ ESL: ___

Does the student have past, current or pending, disciplinary action? YES / NO

Is student currently suspended or expelled from the previous school district? YES / NO

History of violent behavior: YES / NO. If yes, please explain ______________________________

____

Unpaid fines or fees imposed by other schools: YES / NO

<u>I certify that the above information is correct</u>

Parent/Guardian Signature ______________________________ Relationship to Child __________

LA CENTER SCHOOL DISTRICT

Student's Name ______________________________

HAS STUDENT BEEN ENROLLED IN SPECIAL CLASSES?

Please circle

Yes - No Special Education
If yes, in what area(s) was student served.

Yes - No Tutorial Reading
If yes, in what area(s) was student served

Yes - No Resource Room
If yes, in what area(s) was student served

Yes - No Speech Therapy
If yes, in what area(s) was student served

Signature ______________________________ Date __________

Relationship to student ______________________________

La Center Middle School
PO 1750 • 700 E Fourth Street
La Center, WA 98629
Tel 360.263.2136 • Fax 360.263.5936

FAMILY EMERGENCY PLAN

Should an emergency closure of school be necessary, each family needs to have prepared a plan for supervision of your child(ren). Please discuss with your child(ren) to whom they should report if you are not home when they arrive. It is especially helpful to children to have at least two alternatives for safe supervision. Also, in an emergency they are more assured if the family has actually practiced the routine of what to do if parents are not home to meet them. Emergency closures of school are extremely rare. However, we need to prepare our children for a safe experience should the need arise. If we do not have an alternative plan, we will send your child home according to their regular routine.

Please specify below any specific instructions for the school staff in the event of an unannounced early dismissal.

<u>PHONE CALLS FROM SCHOOL CANNOT BE A PART OF THIS PLAN.</u>

Student's Name: ____

Grade: ____________________ Teacher: ____________________

Other brothers and sisters, grade level:

____

____

____

Special instructions. Please include any alternate <u>bus numbers</u>.

Parent Signature ______________________________

Date ______________ Phone ____________________

La Center School District
Student Health History 2015-16

To be completed by parent/guardian

Student Name: ______________________ Date of Birth: ________ Grade: ____ ☐ Male ☐ Female

Parent Name: ____________________ Phone #: ______________ Teacher: ________ Bus# ____

INDICATE IF STUDENT HAS BEEN DIAGNOSED BY A LICENSED HEALTHCARE PROVIDER WITH ANY OF THE FOLLOWING:

If your child has a life-threatening condition, state law requires a medication and/or treatment orders from a Licensed Health Professional and an Emergency plan must be in place before your child can attend school. See office for forms. Please check appropriate boxes below and explain if needed

Health Condition	Yes	No	Explanation if "Yes" checked
Food Allergies	☐	☐	Food(S): ☐ peanut ☐ tree nut ☐ dairy ☐ eggs ☐ other________ Rate the reaction: ☐ mild ☐ moderate ☐ life-threatening Does your child require an EpiPen? ☐ yes ☐ no
Allergy to Bee Stings	☐	☐	Rate the reaction: ☐ mild ☐ moderate ☐ life-threatening Does your child require an EpiPen? ☐ yes ☐ no
Medication Allergies	☐	☐	List:
Allergies (other)	☐	☐	List:
Asthma	☐	☐	Rate the severity: ☐ mild ☐moderate ☐ life-threatening Asthma medication taken at home: Medication required at school:
Diabetes	☐	☐	☐Type 1 (insulin Dependent) ☐Type 2 Diabetes medications(s) taken at home:
Seizure Disorder	☐	☐	Type of seizure: Medications:
Heart Condition	☐	☐	Specify:
Cancer	☐	☐	Specify:
Blood Disorder	☐	☐	Specify: Treatment:
ADD/ADHD	☐	☐	Medication for ADD/ADHD:
Mental Health / Behavioral Issues	☐	☐	Specify: Treatment/Medication:
Orthopedic Condition	☐	☐	Specify:
Wears glasses	☐	☐	☐ For Distance ☐ For Reading
Hearing Loss	☐	☐	Hearing Loss ☐ Right Ear ☐ Left Ear ☐ Hearing Aids

Does your child have any other condition that would affect his/her classroom performance or P.E. activities?

☐ No ☐ Yes if yes, explain: ______________________________________

Daily Medication

State law requires written permission from a Licensed Health Professional and parent before any medication (prescription or over-the-counter) can be given at school. A form is available from the school office.

☐ No ☐ Yes Medication needed at school- specify: ______________________

☐ No ☐ Yes Medication needed at home- specify: ______________________

This information is considered confidential. It will be shared with school staff and emergency responders as needed during the time your child is enrolled in LaCenter School District in order to ensure the health and safety of your child, unless otherwise requested by you in writing.

Parent/guardian signature: ________________________ Date: ____________

LaCenter School District

P.O. Box 1840, 725 Highland Rd. LaCenter, Wa. 98629

Authorization For Administration Of Medication

(Oral medications, Inhalers, Epi-pens, Insulin, Eye, Ear, and Topical Medications)

For Questions contact the school nurse at:

Phone 360-263-2134 ext.218, Fax 360-263-2133

Student Name:________________________________ Birth Date:_______________ Sex: M / F

School: ________________ Teacher: ________________ Grade:

HEALTH CARE PROVIDER completes this section: (please print)

I have determined that the medication named below is necessary during the school day.

Diagnosis or reason for medication ______________________________

Name of medication ______________________________ Dose:______________

☐ Tablet/Capsule ☐ Liquid ☐ Inhaler ☐ Nebulizer ☐ Other______________

If medicine is given DAILY, at what time? ______________________________

If medicine is to be given WHEN NEEDED, describe indications ______________________________

____

How soon can it be repeated? ______________________________

Is child allowed to carry and self-administer rescue inhaler ? ☐ *Yes* ☐ *No*

I have trained this student in the purpose and appropriate method and frequency of use. *Yes* ☐ *No* ☐

Medication authorization are only valid for current school year.

Significant side effects ______________________________

Date ______________ Health Care Provider Signature:______________________________

Phone # ______________ Print Name:______________________________

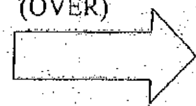
Fax # ______________ Address:______________________________

PARENT/GUARDIAN completes this section:

I request that my child be allowed to take the medication as described above.
I request that authorized school staff assist my child in taking the medication(s) described above.
I understand that school staff will attempt to administer medication in a timely manner.
I will provide the medication in the original, properly labeled container.
I give my permission for the exchange of information regarding this medication between the school staff and health care provider. I authorize my student to self-carry inhaler/medication. Yes______ No______.

(Date) ______ (Parent/Guardian Signature) ______ (Daytime Phone) ______ (Emergency Phone)

(OVER)



SCHOOL MEDICATION POLICY

Whenever possible we encourage medication doses to be scheduled during non-school hours.

For those students who need medication at school, the following is required by Washington State Law (RCW 28A.210.260 and 270) and must be completed and on file **BEFORE** any medication may be given.

OVER-THE-COUNTER and NON-PRESCRIPTION MEDICATIONS/PRODUCTS

- Authorization for Administration of Medications Form **completed by both parent/guardian AND a licensed health care professional with prescriptive authority.**
- MUST be in original container labeled with the student's name.

PRESCRIBED MEDICATION

- Authorization for Administration of Medications Form **completed by both parent/guardian AND a licensed health care professional with prescriptive authority.**
- Medication must be in a properly labeled container from the dispensing pharmacy. A pharmacy can provide a labeled container for school upon request.
  - Student's name
  - Name, Strength and Dose of Medication
  - Time and Mode of Administration
- Provide no more than a 20 day supply.

PLEASE NOTE:

- Requests for the administration of oral medication are valid only for the medication listed and the dates indicated. Requests for medication administration must be re-authorized each school year.
- **All medications will be kept in the school office unless otherwise directed by the Health Care Provider. Medications stored in this area may not be available to the student during non-school hours.**
- **It is the responsibility of the parents/guardians to assure that necessary emergency (rescue) medications are available to their students after school hours and while traveling to/from and during after school events.**

Thank you for your cooperation.

La Center School District
Student Housing Questionnaire 2015-2016

For distribution to all families/students annually

School Name____

Student Name____ ☐ Male
First Middle Last ☐ Female

Birth Date ____ /____ /____ Age_____
Mo Day Year

This form is intended to address requirements of the McKinney-Vento Act, Title X, Part C of the No Child Left Behind Act. Your answers to these questions will help staff with school enrollment and may enable the student to receive additional services.

1. Is your current residence a temporary living arrangement? ☐ Yes ☐ No
2. Is your living arrangement due to loss of housing or economic hardship? ☐ Yes ☐ No
3. Is your current residence inadequate for meeting physical and psychological needs? ☐ Yes ☐ No

If you answered YES to <u>any</u> of the questions, please complete the remainder of this form.
If you answered NO to <u>all</u> of the questions, you may stop here.

Where does the student stay at night? (*Please check one box*)

☐ In a motel/hotel
☐ In a shelter
☐ With more than one family in a house, mobile home, or apartment (doubled-up)
☐ In a car, park, campsite, or location not usually used for sleeping accommodations (unsheltered)

Address____ Phone______________
Street City Zip

Parent/Legal Guardian Name____

I declare under penalty of perjury under the laws of the State of Washington that the information provided here is true and correct.

Parent/Guardian Signature_______________________________________ **Date**__________

OR

Unaccompanied Youth Signature__________________________________ **Date**__________

For School Personnel Use Only

If student is missing enrollment records, please contact the student's previous school for records.
Following records are still missing:

☐ Birth certificate ☐ Immunizations ☐ Medical records ☐ Prior academic records

Building Liaison Signature_______________________________________ **Date**__________

I hereby certify that the above named student qualifies for rights and services under the McKinney-Vento Act.

McKinney-Vento Liaison Signature__________________________________ **Date**__________

McKinney-Vento District Liaison, La Center School District (360) 263-2136.

LA CENTER SCHOOL DISTRICT - Ethnicity & Race Data Collection Form

Student's Name ______________________ School ______________ Grade ____

Please fill out both question 1 and question 2

QUESTION 1. Is your student of Hispanic or Latino origin? (check all that apply)

- [ ] NOT HISPANIC/LATINO
- [ ] CUBAN
- [ ] DOMINICAN
- [ ] SPANIARD
- [ ] PUERTO RICAN
- [ ] MEXICAN/MEXICAN AMERICAN/CHICANO
- [ ] CENTRAL AMERICAN
- [ ] SOUTH AMERICAN
- [ ] LATINI AMERICAN
- [ ] OTHER HISPANIC/LATINO

QUESTION 2. What race(s) do you consider your student? (Check all that apply)

- [ ] AFRICAN AMERICAN / BLACK

- [ ] WHITE

- [ ] ASIAN / INDIAN
- [ ] CAMBODIAN
- [ ] CHINESE
- [ ] FILLIPINO
- [ ] HMONG
- [ ] INDONESIAN
- [ ] JAPANESE
- [ ] KOREAN
- [ ] LAOTIAN
- [ ] MALAYSIN
- [ ] PAKISTANI
- [ ] SINGAPOREAN
- [ ] TAWIANESE
- [ ] THAI
- [ ] VIETNAMESE
- [ ] OTHER ASIAN

- [ ] NATIVE HAWAIIAN
- [ ] FIJIAN
- [ ] GUAMANIAN OR CHAMORRO
- [ ] MARIANA ISLANDER
- [ ] MELANESIAN
- [ ] MICRONESIAN
- [ ] SAMOAN
- [ ] TONGAN
- [ ] OTHER PACIFIC ISLANDER

- [ ] ALASKA NATIVE
- [ ] CHEHALIS
- [ ] COLVILLE
- [ ] COWLITZ
- [ ] HOH
- [ ] JAMESTOWN
- [ ] KALILSPELL
- [ ] LOWER ELWHA
- [ ] LUMMI
- [ ] MAKAH
- [ ] MUCKLESHOOT
- [ ] NISQUALLY
- [ ] NOOKSACK
- [ ] PORT GAMBLE KLALLAM
- [ ] PUYALLUP
- [ ] QUILLEUTE
- [ ] QUINAULT
- [ ] SAMISH
- [ ] SAUK-SUIATTLE
- [ ] SHOALWATER
- [ ] SKOKOMISH
- [ ] SNOQUALMIE
- [ ] SPOKANE
- [ ] SQUAXIN ISLAND
- [ ] STILLAGUAMISH
- [ ] SUQUAMISH
- [ ] SWINOMISH
- [ ] TULAUP
- [ ] YAKIMA
- [ ] OTHER WASHINGTON INDIAN
- [ ] OTHER AMERICAN INDIAN / ALASKA NATIVE

English

Office of Superintendent of Public Instruction (OSPI)
Washington State Transitional Bilingual Instructional Program
Home Language Survey

Student Name:				**Date:**
Birth Date:	**Gender:**	**Grade:**	**SSID:**	

Form Completed by:

Parent/Guardian Name ____________________ Relationship to Student ____________

Parent/Guardian Signature ______________________________

If available, in what language would you prefer to receive communication from the school?

____

Did your child receive English language development support through the Transitional Bilingual Instruction Program in the last school your child attended? Yes__ No__ Don't Know__

1. In what country was your child born?	____________
2. **What language did your child first learn to speak?***	____________
3. **What language does <u>YOUR CHILD</u> use the most at home?***	____________
4. What language(s) do <u>parent/guardians</u> use the most when you speak to your child?	____________ ____________
5. Has your child ever attended a school outside of the United States? _____Yes _____No	If yes, in what language(s) was instruction given? ____________ For how many months? ____
6. Has your child attended school in the United States before enrolling in this district? (Kindergarten – 12th grade) _____Yes _____No	For how many months? ________ months *One (1) school year =10 months*
7. Do grandparent(s) or parent(s) have a tribal affiliation? _____Yes _____No	

****WAC 392-160-005:*** *"Primary language" means the language most often used by a student (not necessarily by parents, guardians, or others) for communication in the student's place of residence.*

April 2013

Military Parent or Guardian Affiliation
(Please mark all that apply)

Parent/Guardian(s) Name(s):	Student Name(s):

	N- No parent or guardian of the above children is currently serving as a member of the active duty U.S. Armed Forces, Reserves of the U.S. Armed Forces or Washington National Guard
	A- A parent or guardian of the children above is a current member of the active duty U.S. Armed Forces
	R- A parent or guardian of the children above is a current member of the reserves of the U.S. Armed Forces
	G- A parent or guardian of the children above is a current member of the Washington National Guard
	Z- No response/Refused to State

Please return completed forms to the school office.