Student's Name:________________________

Red River Early Childhood Network Student Enrollment

All forms from section A must be checked off before a parent may receive a preschool eligibility/registration form.

Section A

___ Birth Certificate

___ Social Security Card

___ Immunization Record (current)

___ Proof of Income for each adult in the household

Adult's Name:__________________ Proof of Income:______________

Adult's Name:__________________ Proof of Income:______________

Adult's Name:__________________ Proof of Income:______________

Or Statement of No Income/Student

___ Proof Of Residence

___ Photo ID

All information from Section A must be completely filled out before Section B may be completed.

Section B

___ Preschool Eligibility/Registration Form Completed

___ Enrollment Forms Completed

___ Health Information Completed Health Staff Initial ___

Date & Time Completed:__________________________

Checked by:__________________________________

Red River Parish School System Preschool and Head Start

Child's First Name: ______________________ Middle Name: ____________________

Child's Last Name: ________________________ Birthday: _______________

Sex: ____ Race: ________ Social Security #: ________ Home Phone: ____________________

Mailing Address: ____________________________________

911 Physical Address: ___________________________ City: _______________________

State __________ Zip code: ________

The Father's and Mother's Name must be the same as shown on birth certificate. If child lives with someone different, the person the child lives with should be shown under Guardian. Custody papers or notarized papers will need to be on file.

Child Lives with: ______________________________

Mother's Name: ____________________________________

Highest Level of Education: ________________

Home #: _______________________ Cell #: ________________________

Name of Employer: ______________________________ Work#: ______________________________

Father's Full Name: ____________________________________

Highest level of Education: ________________________________

Home #: _______________________ Cell #: ________________________

Name of Employer: ______________________________ Work#: ______________________________

Guardian: __________________________ Relation to child: ______________ Cell #: ________________
Work Place: ______________________ Work Phone: ______________________

List All Members of the Household and birthdate for each

Example: Joe Doe (father) 11/11/1990 Jack Doe (child) 05/21/2016

Red River Parish School System Preschool and Head Start

Emergency & Third Party Release Information/Contacts

The following are authorized to pick up my child:(besides parents)

Name	Relationship	Phone Number

Child's Doctor: ______________________ Dr. Phone: ______________

Child's Dentist: ______________________ Dr. Phone: ______________

Does your child have any allergies? Yes or no if so please list:

____

____

Please list any chronic illness, special needs, dietary needs, food restrictions or allergies:

____

____

Has your child had screenings or evaluations for any special services? ______________

Does your child receive any special services or therapy?______________________

Will your child need Transportation?__________

Morning: Bus or Car Rider

Afternoon: Bus or Car Rider

Directions to your Home:

Parent's Signature__________________________ Date:______________

Staff Signature__________________________ Date:__________

Revised Dec. 2019

Red River Parish School System Preschool and Head Start

Photo Release

Provider's name: **Red River Parish School System Preschool and Head Start**

Child's full name: ____________________________

Photographs and videos are taken on some occasions such as birthdays, holidays, outings and special occasions. We use these pictures/videos for teaching, arts & crafts, albums, newspapers, bulletin boards, website, and various other things.

Please mark the appropriate box:

▫I give permission for photos to be taken ▫I do not give permission

Please mark the appropriate box:

▫I give permission for videos to be taken ▫I do not give permission

I understand that these photographs and/or videos will not be sold without my written permission.

Date:____________

Parent Signature:______________________________

Red River Parish School System Preschool and Head Start

Emergency Release

Consent to Emergency First Aid & Transportation:

I hereby give permission for my child, ______________________________, may be given emergency treatment by a staff member of Red River Head Start or Red River Elementary School. I also give permission for my child to be transported by car or ambulance, to an emergency center for treatment, and agree to hold The Red River Parish School Board, Red River Head Start, Red River Elementary School, and its employees harmless.

Parent's Signature ____________________________ Date: ___________________________

Consent to Medical Care and Treatment:

In the event that I cannot be contacted immediately, medical or surgical treatment can be administered to my child in the case of an accident or emergency, as prescribed by a treating physician, and hold Red River Parish School Board, Red River Head Start, Red River Elementary School, and its employees harmless.

Parent's Signature ____________________________ Date ___________________________

Red River Early Childhood Network Eligibility/Registration Form

Student Information

Child's First Name:______________________ Last Name:______________________

Date of Birth:________________

Physical Address:________________________________

Mailing Address:________________________________

Person Child Resides with:__________________ Relationship to Child:________________

Family Income Information:

Number of adults in home: ☐ Number of Children ☐ Total number in Household ☐

Number of Adults Contributing to Income ☐

Adult Name	Employer Name	Total Income
	Total Family Income	

Please list any siblings applying to programs: ____________________________

I, the undersigned, understand that sharing the information I have provided in this application across early childhood programs in my community will facilitate matching my child to a seat, and I hereby give permission for the information provided to be shared with the programs in the Red River Early Childhood Network.

Print Name of Parent/Guardian filling out forms:____________________________

Parent/Guardian Signature:______________________________ Date:______________

FINAL 11/06

STATE OF LOUISIANA

SSN:____________________

HEALTH INFORMATION

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN EACH SCHOOL YEAR

PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE. Parent/Legal Guardian is encouraged to participate in the development of an Individual Health Care Plan if needed. Use additional sheets, if necessary, for further explanation.

Name of School:			Grade:	
Student's Name: Last		First		M.I.
Student's Date of Birth:		Sex: M F	State or Country of Birth:	
Student's Mailing Address:		City:	State:	Zip Code:
Student's Physical Address:		City:	State:	Zip Code:
Name of Mother or Legal Guardian:	Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	Employer:
Name of Father or Legal Guardian:	Home Phone: ( )	Work Phone: ( )	Cell Phone: ( )	Employer:
Name of child's pediatrician or primary care provider:		Names of medical specialists or special clinics caring for your child:		

____

Parent or Legal Guardian Signature Date

Please check the type of health insurance your child has: Private Medicaid/LaCHIP None

If your child does not have health insurance, would you like information on no cost health insurance? Yes No

In case of emergency—if parent or legal guardian cannot be reached—contact the following:

Name Complete Phone Number ( )

My child has a medical, mental, or behavioral condition that may affect his/her school day: No Yes (If yes, please complete Part 2.)

PART 2: COMPLETE ALL BOXES THAT APPLY TO YOUR CHILD. Parent/Legal Guardian is responsible for providing the school with any medication and may be responsible for providing the school with any special food or equipment that the student will require during the school day. Check with the school nurse to obtain correct medication and procedure forms.

❑ **ALLERGIES**

Allergy Type:

Food (list food(s)) ______________________________

Insect sting (list insect(s)) ______________________________

Medication (list medication(s)) ______________________________

Other (list) ______________________________

Reactions: (Date of last occurrence if yes.)

Coughing (Date:) Hives (Date:) Rash (Date:)

Difficulty breathing (Date:) Local swelling (Date:) Wheezing (Date:)

Generalized swelling (Date:) Nausea (Date:) Other ________ (Date:

Currently prescribed medications and treatments:

Oral antihistamine(Benadryl, etc.) Epi-pen Other ____________

❑ **ASTHMA**

Triggers: Environmental (i.e., tobacco, dust, pets, pollen, etc.) (list) ____________ Other (list) ____________

Does your child experience asthma symptoms with exercise? No Yes

Symptoms:

Chest tightness, discomfort, or pain Difficulty breathing Coughing Wheezing Other ____________

Currently prescribed medications and treatments: ______________________________

____

Date of last hospitalization related to asthma ____________ Date of last emergency room visit related to asthma ________

Does your child have a written asthma management plan? No Yes

Is peak flow monitoring used? No Yes

EMERGENCY TRANSPORT PLAN

RED RIVER PARISH SCHOOLS

Student's Name ______________________________ *Date* ____________

Student's Birthdate ______________ *School: Red River Elementary/Jr. High/High*

Name of medical facility where student is to be taken ______________ *Phone#* ________

Name of physician to be notified ______________________ *Phone#* ________

Name of family member to be notified ______________________________

Emergency phone# ______________________ *Relationship* ______________

Name of alternate family member to be notified ______________________

Emergency phone# ______________________ *Relationship* ______________

I am aware that if my child has an emergency at school, the school principal or designee will have my child transported to a medical facility immediately. I will be responsible for payment of emergency care.

LOCATION OF EMERGENCY MEDICINE AT THE SCHOOL ______________________

STUDENT'S ALLERGIES ____

STUDENT SPECIFIC EMERGENCIES

IN THE EVENT OF	DO THIS
Accident/Injury or Illness	Call parent – Transport to ER

IF AN EMERGENCY OCCURS:

1. If the emergency is life-threatening, immediately call 9-1-1.
2. Stay with the student or designate another adult to do so.
3. Call or designate someone to call the principal and/or school nurse.
   a. State who you are
   b. State the problem

The following staff members are trained to handle an emergency and to initiate the appropriate procedures.

Erikka Caldwell, HCA (signature) ______________ Vanessa Lloyd (signature) ______________ ______________

Erikka Caldwell **Vanessa Lloyd**

______________________ ______________________

Parent/Guardian Signature Date

Fletter Taylor, RN (signature) ______________________

Fletter Taylor, School Nurse Date

NOTE: THIS TRANSPORT PERMISSION FORM IS APPLICABLE UNLESS CANCELED BY THE PARENT/GUARDIAN

Red River Parish Public Schools

Initial Notice and Consent

Regarding Medicaid Reimbursement

NOTICE

The Louisiana Department of Health and Hospitals (DHH) Medicaid program allows school districts to request reimbursements for costs associated with provision of certain services. These services include occupational and physical therapy, speech pathology, behavioral health services, nursing services and special transportation. Schools are required to provide notice and to obtain consent form a parent before accessing a child's Medicaid benefits.

Red River School System seeks your consent to disclose personally identifiable information about your child to Louisiana Medicaid to access reimbursement for the Medicaid covered health services that are provided a school order to submit claims for Medicaid covered health services that are provide at school. In order to submit claims for Medicaid covered services, the following types of records may be required: child's full name, address, date of birth, Medicaid ID, disabilities, types of services, disabilities, type of services, an dates of reimbursement for the school district hall not result in any decrease in availability lifetime Medicaid coverage, benefit of insurance or create any risk of loss of your child's eligibility for home and community-based waivers based total health-related expenditures.

You may withdraw this consent in writing at any time. If you refuse consent to allow access to the Medicaid benefits, it will not relieve the school system of its responsibility to ensure that all required services are provided at no cost to your child.

CONSENT

I hereby authorize Red River School system to disclose necessary information to Louisiana Medicaid in order to seek reimbursement for the Medicaid-covered health services provided to my child.

Name of Student: ______________________________ Date: ______________________________

____ Relationship to Student: ________________

Parent(s)/Guardian(s) Signature

Red River Parish Public Schools

Annual Notice Regarding Medicaid Reimbursement

Student's Name: ________________________________ Date: _______________

You have authorized **Red River School System** to share personally identifiable information about your child with Louisiana Medicaid to seek reimbursement for the Medicaid covered health services that are provided at school.

This disclosure of personally identifiable information to Louisiana Medicaid and access to Medicaid reimbursement for the school district shall not result in any decrease in available lifetime coverage, shall not result in any cost to you or your family, shall not increase any premiums or lead to the discontinuation of your child's benefits or insurance, and shall not create any risk of loss of your child' eligibility.

You may withdraw this consent in writing at any time. If you refuse consent or withdraw consent to allow access to the Medicaid Benefits it will not relieve the school system of its responsibility to ensure that all required services are provided at no cost to your child.

For assistance in this area, please contact Red River Parish Nursing Department at (318) 271-3163.