WELCOME TO GERING PUBLIC SCHOOLS!

1519 10TH STREET
GERING, NEBRASKA 69341
PHONE: 308-436-3125
FAX: 308-436-4301

Gering Public School Early Childhood Program

2017-2018

Dear Parent(s),

Thank you for choosing Gering Public Schools Early Childhood Program!! We look forward to working with you and your student. Included are forms that are required for admittance into the Early Childhood Program. Please fill out forms and return them as soon as possible. This includes a copy of your child's birth certificate and immunization records. Enrollment forms will also be accessible through geringschools.com.

Tuition is based on the free and reduced lunch application. The prices listed below were last year's prices. We anticipate the prices will remain the same. You will be provided this application in August prior to school starting. Tuition is due on the 15th of each month and there will be a $15 late charge applied if tuition is not received by the due date. Below are the tuition prices.

- **$130 – full**
- **$60 – reduced**
- **$45 – based on free approval**

All classes will meet on **Monday, Tuesday, Thursday and Friday**. There will not be classes held on Wednesdays. Class times are:

- **8:00 a.m. – 11:15 a.m.**
- **12:00 p.m. – 3:30 p.m.**

If you have any questions regarding the forms, please contact us at 308-436-2350.

Sincerely,
Julie Cochran
Early Childhood Coordinator

School Health Entrance Requirements

****In order to assist the care of your child while at school it is recommended to give last wellness records to the school nurse.****

_____Student Information Sheet and Student Health Form

- *Complete and sign form*
- *If your student will require medication administration during school hours (inhaler, oral medication) and/or has health conditions that require nursing care, then contact school nurse. See included Medication Administration Policy.*

_____Certified Birth Certificate

- *Bring the official certificate with the raised seal to the office and a copy will be made.*
- *If you need to obtain a legal copy of a Nebraska Birth Certificate:*
  - *Online: www.dhhs.ne.gov/ced/bicert.html or a form is available at the central office.*
  - *If student is born in state other than Nebraska, contact that states health department.*

_____ Immunization Record with state required age appropriate immunizations completed

- *If your student does not receive immunizations due to Medical or Religious reasons, complete refusal form.*
- *If student has had Chicken Pox, then complete the included documentation of disease form.*
- *If student needs updated immunizations, contact your health provider or see included Scottsbluff County Immunization Clinic or CAPWN Clinic information.*
- *Students **entering Kindergarten and 7th grade** will need to receive updated immunizations. In addition, **all students, (K-12) are now required to have two doses of Chicken pox (Varicella),** unless they have had the disease or do not receive immunizations for Medical or Religious reasons.*

_____ Proof of Residence (examples: bill, bank statement, driver's license with current address)

Summary of the School Immunization Rules and Regulations 2017-2018

Student Age Group	Required Vaccines
Ages 2 through 5 years enrolled in a school based program not licensed as a child care provider	4 doses of DTap, DTP, or DT vaccine 3 doses of Polio vaccine 3 doses of Hib vaccine or 1 dose of Hib given at or after 15 months of age 3 doses of pediatric Hepatitis B vaccine 1 dose of MMR or MMRV given on or after 12 months of age 1 dose of varicella (chickenpox) or MMRV given on or after 12 months of age. Written documentation (including year) of varicella disease from parent, guardian, or health care provider will be accepted. 4 doses of pneumococcal or 1 dose of pneumococcal given on or after 15 months of age

Source: Nebraska Immunization Program, Nebraska Department of Health and Human Services. The School Rules & Regulations are available on the internet: http://www.hhs.state.ne.us/reg/t173.htm (Title 173: Control of Communicable Diseases- Chapter 3; revised and implemented 2011)

Scotts Bluff County Health Department 2017 Immunization Clinic Schedule

Adults & Children with Medicaid, Medicare, Insurance, or No Insurance are Welcome! The clinic is at RWMC St. Mary Plaza Located @ 3700 Ave B, Suite 301, Scottsbluff. **By Appointment Only- Call for an Appointment: 308-630-270, Option 1 for appointment**

Parent/Guardian must accompany child less than 19 years old for immunizations or call 630-1126 to make other arrangements.

1st and 3rd Tuesdays; 3:00 p.m. – 7:00 p.m.		2nd Tuesdays; 10:00 a.m. – 12:00 p.m.	
January 3, 2017	January 17, 2017	January 10, 2017	**Questions?**
February 7, 2017	February 21, 2017	February 14, 2017	**Call 308-630-1563**
March 7, 2017	March 21, 2017	March 14, 2017	
April 4, 2017	April 18, 2017	April 11, 2017	
May 2, 2017	May 16, 2017	May 9, 2017	
June 6, 2017	June 20, 2016	June 13, 2017	
July 11, 2017	July 25, 2017	July 18, 2017	
August 1, 2017	August 15, 2017	August 8, 2017	
September 5, 2017	September 19, 2017	September 12, 2017	
October 3, 2017	October 17, 2017	October 10, 2017	
November 7, 2017	November 21, 2017	November 14, 2017	
December 5, 2017	December 19, 2017	December 12, 2017	

http://www.scottsbluffcounty.org/health-department/immunization-clinic.html

Medication Administration Policy

A student who is required to take medication during the regular school day must comply with medication administration policy. The policy has been developed for the safety of the student receiving the medication and for the safety of all the students.

Medication will be administrated by the school nurse, a Medication Aide, or other school staff member meeting the minimum competency standards for the Medication Aide Act.

Requirements:

- A doctor and/or health care provider's authorization
- Written order
- Parent/Guardian authorization
- Parent/Guardian are responsible for bringing medication to school ***(DO NOT SEND MEDICATIONS TO SCHOOL WITH YOUR CHILD)***
- Medication in **ORIGINAL** labeled prescription bottle that includes:
    - Child's name
    - Health care provider's name
    - Drug name
    - Instructions of use (time, dosage, duration)

****Authorization must be renewed on an annual basis and/or if the prescription changes. Loose capsules, tablets, unidentified or non-labeled medication will not be accepted for administration.****

A record of the medication administration is kept on each student receiving medication.

OVER-THE-COUNTER MEDICATION: (i.e. acetaminophen, ibuprofen, tums, cough drops, saline eye drops, hydrocortisone cream, triple antibiotic ointment, insect sting swab, topical cooling gel)

- Must have parent/guardian signed permission recorded on the Student Health Form

ALL MEDICATION:

- Will be kept in a secure area.
- **Students may carry medication only with the approval of parents and building principal with appropriate paperwork completed.**
- Medications must be picked up by an adult on the last day of school, or they will be disposed of.

****Schools are not staffed with a full-time nurse. The student has the responsibility to remember to report to the office at medication administration time.****

Gering Public Schools – Early Childhood Student Information Sheet

Enrolling in school year: _____

Date:_____

Student's Legal Name: _____ Suffix (Jr/Sr/III): _____
(Last) (First) (Middle)

Nickname:_____

Grade:_____ Gender: _____

Birth Date: ___/___/___ Student Cell#_____

Address (City/State/ Zip Code): _____

_____

Ethnicity (Check One)	**Race** (Check One)
☐ Hispanic / Latino	☐ American Indian / Alaska Native
☐ Not Hispanic / Latino	☐ Asian
	☐ Black / African – American
	☐ Native Hawaiian / Pacific Islander
	☐ White or Hispanic

Preschool Attended (if applicable):_____

School Address/City/State/Zip code: _____

PARTICIPATION IN SPECIAL PROGRAMS IF PREVIOUSLY ENROLLED IN SCHOOL

☐ **Special Education / IEP / Resource** – List Verification Area(s): _____

☐ **English as Second Language** ☐ **504 Plan** ☐ **Health Plan**

LANGUAGE

What language did the student first learn to speak? _____

What language is spoken most often by the student? _____

What language does the student most frequently use at home?_____

PLEASE ANSWER THE FOLLOWING QUESTIONS

Is the student a Ward of the Court? ☐ Yes ☐ No Ward of the State? ☐ Yes ☐ No

Has the court ordered any restraining/protection orders on behalf of this student? ☐ Yes ☐ No

Has the student ever been expelled from school? ☐ Yes ☐ No If so, when? _____

Has the student previously been enrolled in Gering Public Schools? ☐ Yes ☐ No If so, when? _____

Revised 7-11-15

Gering Public Schools - Household Information Sheet

Student Name: ______________________________ Birth Date:____/____/____

Child lives with:______________________________

Please check primary parent contact below.

☐ **Father/Guardian**:______________________________ Birth Date:____/____/____
(Last) (First) (Middle)

Address (City/State/Zip)______________________________ Ethnicity: __________

Home# __________ Work# __________ Cell# __________

E-mail: ____________________Employment: ____________________

☐ **Mother/Guardian**: ______________________________ Birth Date:____/____/____
(Last) (First) (Middle)

Address (City/State/Zip)______________________________ Ethnicity: __________

Home# __________ Work# __________ Cell# __________

E-mail: ____________________Employment: ____________________

Sibling: ______________________________ Gender: __________
(Last) (First) (Middle)

Birth Date: ____/____/____ ☐ Lives in household ☐ Hispanic/Latino Race:__________ Enrolled @__________

Sibling: ______________________________ Gender: __________
(Last) (First) (Middle)

Birth Date: ____/____/____ ☐ Lives in household ☐ Hispanic/Latino Race:__________ Enrolled @__________

Sibling: ______________________________ Gender: __________
(Last) (First) (Middle)

Birth Date: ____/____/____ ☐ Lives in household ☐ Hispanic/Latino Race:__________ Enrolled @__________

Sibling: ______________________________ Gender: __________
(Last) (First) (Middle)

Birth Date: ____/____/____ ☐ Lives in household ☐ Hispanic/Latino Race:__________ Enrolled @__________

Sibling: ______________________________ Gender: __________
(Last) (First) (Middle)

Birth Date: ____/____/____ ☐ Lives in household ☐ Hispanic/Latino Race:__________ Enrolled @__________

* If more siblings, please attach on separate sheet.

LOCAL EMERGENCY CONTACTS – (Will be called only if parents **cannot** be reached. Please notify them.)

Name: ______________________________ Birth Date:____/____/____
(Last) (First) (Middle)

Address (City/State/Zip)______________________________ Ethnicity: __________

Home# __________ Work# __________ Cell# __________

E-mail: ____________________Employment: ____________________

Relationship to student:______________________________

Name: ______________________________ Birth Date:____/____/____
(Last) (First) (Middle)

Address (City/State/Zip)______________________________ Ethnicity: __________

Home# __________ Work# __________ Cell# __________

E-mail: ____________________Employment: ____________________

Relationship to student:______________________________

Revised 7-11-15

STUDENT HEALTH

Student Name_____ **Birthdate:** _____ **Age:** _____ **Grade:** _____ **Male**___ **Female**____ □

The following information is requested in order to help us meet your student's health needs at school. The information you provide may be shared with school personnel as needed in order to promote your student's safety and educational success. Contact the school nurse with questions. Return the completed form to the school health office.

Please notify office immediately with phone number changes and/or contact changes.

Family Physician:_____ Date of last exam:_____
Dentist:_____ Date of last exam:_____
Optometrist:_____ Date of last exam:_____

Medication

Does the student take medicine or supplements regularly? □ ***YES*** □ ***NO***
If yes, then please list medication & dosage: _____
If your student needs medication administrated during the school day, then please contact nurse
Has the student had immunizations in last year□ ***YES*** ***NO*** ***If yes, then please provide school an updated record***

Health Information:

Allergies □ ***YES*** □ ***NO*** If yes, list (food, bee stings, environmental, medication):_____
Reaction: _____
If your student requires diet modification and/or has history/risk of anaphylaxis, then contact nurse for Anaphylaxis Action Plan

Asthma □ ***YES*** □ ***NO*** Uses inhaler/nebulizer □ ***YES*** □ ***NO*** List known triggers:_____
If your student has Asthma, an Asthma Action Plan will be sent home for required completion

Diabetes □ ***YES*** □ ***NO*** If yes, please describe:_____
Seizures □ ***YES*** □ ***NO*** If yes, please describe:_____
Heart Problems □ ***YES*** □ ***NO*** If yes, please describe:_____
Mental Health Condition ***Please Circle*** (ADHD, Bipolar, Autism Spectrum, Depression, Anxiety, ODD, Selective Mutism, Tourette's Syndrome*)* If other, please describe:_____
Eczema/Skin Problems □ ***YES*** □ ***NO*** If yes, please describe:_____
Restrictions on Physical Activity □ ***YES*** □ ***NO*** If yes, please describe & provide doctor note:_____
Vision Deficits □ ***YES*** □ ***NO*** If yes, please describe (glasses/contacts):_____
Hearing Deficits □ ***YES*** □ ***NO*** If yes, please describe:_____
History of Surgeries □ ***YES*** □ ***NO*** If yes, please describe:_____
History of Broken Bones □ ***YES*** □ ***NO*** If yes, please describe:_____
Please explain ***any other medical condition*** that your student has: _____
_____

Over-the-Counter Medication

I give my permission for trained school medication administration staff to administer over-the-counter medications such as Tylenol, ibuprofen, tums, cough drops, saline eye drops, hydrocortisone cream, triple antibiotic ointment, insect sting swab, topical cooling gel to my child as needed. I release Gering Public Schools and employees from liability in case of choking, allergic reaction, side effects and/or health risks related to the medication. ***YES*** _____ ***NO*** _____

Parent/Guardian Signature: _____ *Date:*_____

In Case of an Emergency

I hereby authorize any qualified personnel to administer emergency medical first aid and/or any other treatment essential to the health and well being of my child. Also, the consent to transport my child per ambulance in case the parent/guardian **can not** be reached. In the event that surgery is necessary, I hereby authorize any licensed and qualified surgeon, assistants, and anesthetist to perform emergency surgery if deemed necessary. ***YES*** _____ ***NO*** _____

Parent/Guardian Signature: _____ *Date:*_____

Student Asthma/Allergy Action Plan

(This Page To Be Completed By Health Care Provider)

Student Name: _____ **Date Of Birth:** ____/____/____ (MONTH) (DAY) (YEAR)

❑ **Exercise Pre-Treatment:** Administer inhaler **(2 inhalations)** 15-30 minutes prior to exercise. (e.g., PE, recess, etc).

❑ Albuterol HFA inhaler (Proventil, Ventolin, ProAir)
❑ Albuterol DPI (ProAir RespiClick)
❑ Levalbuterol (Xopenex HFA)
❑ Use inhaler with valved holding chamber
❑ Other: _____

Asthma Treatment

Give **quick relief medication** when student has asthma symptoms, such as coughing, wheezing or tight chest.

❑ Albuterol HFA (Proventil, Ventolin, ProAir) 2 inhalations
❑ Albuterol DPI (ProAir RespiClick) 2 inhalations
❑ Levalbuterol (Xopenex HFA) 2 inhalations
❑ Use inhaler with valved holding chamber
❑ Albuterol inhaled **by nebulizer** (Proventil, Ventolin, AccuNeb)
❑ .63 mg/3 mL ❑ 1.25 mg/3 mL ❑ 2.5 mg/3 ml
❑ Levalbuterol inhaled **by nebulizer** (Xopenex)
❑ 0.31 mg/3 mL ❑ 0.63 mg/3 mL ❑ 1.25 mg/3 mL
❑ May carry & self-administer inhaler (MDI)
❑ Other: _____

Closely Watch the Student after Giving Quick Relief Medication

If, after 10 minutes:

- Symptoms are better, student may return to classroom after notifying parent/guardian
- Symptoms are not better, give the treatment again and notify parent/guardian right away
- **If student continues to get worse, CALL 911 and use the Nebraska Schools' Emergency Response to Life-Threatening Asthma or Systemic Allergic Reactions (Anaphylaxis) Protocol**

Anaphylaxis Treatment

Give **epinephrine** when student has allergy symptoms, such as hives, hard to breathe (chest or neck "sucking in"), lips or fingernails turning blue, or trouble talking (shortness of breath).

❑ EpiPen® 0.3 mg
❑ EpiPen® Jr. 0.15 mg
❑ Adrenaclick® 0.3 mg
❑ Adrenaclick® 0.15 mg

❑ May carry & self-administer epinephrine auto-injector
❑ Use epinephrine auto-injector immediately upon exposure to known allergen
❑ If symptoms do not improve or they return, epinephrine can be repeated after 5 minutes or more

Lay person flat on back and raise legs. If vomiting or difficulty breathing, let them lie on their side.

***CALL 911* After Giving Epinephrine & Closely Watch the Student**

- Notify parent/guardian immediately
- ***Even* if student gets better, the student should be watched for more symptoms of anaphylaxis in an emergency room**
- **If student does not get better or continues to get worse, use the Nebraska Schools' Emergency Response to Life-Threatening Asthma or Systemic Allergic Reactions (Anaphylaxis) Protocol**

❑ This student has a medical history of asthma and/or anaphylaxis and the use of the above-listed medication(s) has been reviewed by the HCP. If medications are self-administered, the school staff **must** be notified.

Additional information: *(i.e. asthma triggers, allergens)* _____

Heath Care Provider name: *(please print)*_____ **Phone:** _____

Health Care Provider signature: _____ **Date:** _____

Parent signature: _____ **Date:** _____

Reviewed by school nurse/nurse designee:_____ **Date:** _____

Version: 05/16

Student Asthma/Allergy Action Plan

(This Page To Be Completed By Parent/Guardian)

Student Name: _____ **Age:** _____ **Grade:** _____

School: _____ **Homeroom Teacher:** _____

Parent/Guardian: _____ **Phone( )** _____ **( )** _____

Parent//Guardian: _____ **Phone( )** _____ **( )** _____

Emergency Contact: _____ **Phone( )** _____ **( )** _____

Known Asthma Triggers: Please check the boxes to identify what can cause an asthma episode for your student.

- ❑ Exercise
- ❑ Respiratory/viral infections
- ❑ Odors/fumes/smoke
- ❑ Mold/mildew
- ❑ Pollens
- ❑ Animals/dander
- ❑ Dust/dust mites
- ❑ Grasses/trees
- ❑ Temperature/weather—humidity, cold air, etc.
- ❑ Pesticides
- ❑ Food—please list below
- ❑ Other—please list: _____

Known Allergy/Intolerance: Please check those which apply and describe what happens when your child eats or comes into contact with the allergen..

Peanuts	❑	_____
Tree Nuts	❑	_____
Fish/shellfish	❑	_____
Eggs	❑	_____
Soy	❑	_____
Wheat	❑	_____
Milk	❑	_____
Medication	❑	_____
Latex	❑	_____
Insect stings	❑	_____
Other	❑	_____

Notice: If your child has been prescribed epinephrine (such as an EpiPen®) for an allergy, you must provide epinephrine at school. If your student needs a special diet to limit or avoid foods, your doctor will need to complete the form *"Medical Statement Form to Request Special Meals and/or Accommodations" which can be found on the website—www.airenebraska.org*

Daily Medicines: Please list daily medicines used at home and/or to be given at school.

Medicine Name	Amount/Dose	When does it need to be given

I understand that all medicines to be given at school must be provided by the parent/guardian.

Parent signature: _____ **Date:** _____

Reviewed by school nurse/nurse designee: _____ **Date:** _____

GERING PUBLIC SCHOOLS

SPECIALIZED TRANSPORTATION INFORMATION for 20____ - 20____ School Year

Student Name_____DOB_____BLDG_____Teacher _____

(If Applicable): Nebraska ID #_____ IEP Date_____ IEP Review Date_____ MET Date_____

Parent (Guardian)_____ Phone #_____

Address_____

City, State, ZIP _____

Resides with: ___Parents ___ Mother ___Father ___Grandparent ___Guardian ___ Other_____

Transportation Needs:

__Wheelchair
__Lift
__Car Seat
__Booster Seat
__Seat Belt
__Harness
__Must be Met By Adult
__Other_____

Student Information (include Physical or Sensory Limitations, etc)

__Visual / ___ Hearing Impairment
__ Medications
__Seizures / ___Diabetic
__Allergic Reactions
__Respiratory Problems
__Heart Problems
__Behavioral Considerations
__ Other_____

Special Transportation
(Seating, interventions, BIP, Communication Strategies, etc.) _____

_____
_____
_____
_____

Other considerations that may work_____

_____

___ PEC's for Non Verbal Student

Information for emergencies (medical and/or behavioral)_____

_____

Individual(s) who may pick up student (if different than parent)_____

Pick Up Student ___Home ___Other: Address if different from home_____

Drop Off Student ___Home ___Other Daycare/Preschool_____

Address:_____ Phone_____

Program: ___All Day ___Half Day ___AM ___PM DAYS: __M __T __W __TH __FR

Initial Transportation Start Date_____ ____Ongoing

Parent Signature_____ Date_____

Director of Transportation_____Date_____

SPECIAL EDUCATION TRANSPORTATION REQUESTS must be forwarded to the Director of Special Services for authorization.

Director of Special Services **(if applicable)**_____Date_____