ENROLLMENT FORM 2022-2023

❑ New Student ❑ Returning Student

Please Return To: *Kato Public Charter School, Attn: Business Office*
110 North 6th Street, Mankato, MN 56001
Phone: 507-387-5524 Fax: 507-387-5680

Did someone refer you to KPCS? [ ] Yes [ ] No If yes, who: _____

How did you hear about KPCS? [ ] KPCS Student [ ] Radio [ ] Newspaper [ ] Other:_____

STUDENT INFORMATION:

_____ _____ _____
Student Last Name | Student First Name | Student Middle Name

_____ _____ _____ _____
Male/Female | Student Date of Birth | Grade in Fall 2022 | Previous School and/or District # (Please include city)

_____ _____
Student Home Address | Student Home City/State/Zip

_____ _____ _____ _____
Student Home Phone | Student Cell Phone | Social Security # (Optional) | Student E-mail Address

IS THIS ADDRESS (check one):

[ ] Permanent (you are receiving mail at this address)
[ ] Temporary (you will physically be living at this address for 60 days or less)

RACE/ETHNICITY (please answer both Part A and Part B):

Part A: ***Is this student Hispanic/Latino (choose only one)***
[ ] No, not Hispanic/Latino
[ ] Yes, Hispanic/Latino

Part B: ***What is the student's race? (choose one or more)***
[ ] American Indian or Alaska Native
[ ] Asian
[ ] Black or African American
[ ] Native Hawaiian or Other Pacific Islander
[ ] White

Please use additional piece(s) of paper for answers if needed.

Does the student have a current 504 Plan? _____ (yes or no)

Does the student have a current IEP? _____ (yes or no)

Does the student have English Language Learner Services? _____ (yes or no)

Has the student ever been expelled from school? If yes, please explain.

Has your student had truancy issues at previous school? _____ (yes or no)

Is there any other information about your child that the school needs to know to best meet his/her needs?

*****My signature certifies all information listed above is accurate.*****

_____ _____
Parent or Guardian Signature/Student's Signature if 18 Years Old or Older | Date

PARENT/GUARDIAN CONTACT INFORMATION:

Contact #1: Do you want this person to receive all information regarding this student? [ ] Yes [ ] No
Can this contact to be called to pick up student if necessary due to illness, etc.: [ ] Yes [ ] No

❑ Biological ❑ Step-parent ❑ Other (please describe relationship)_____

Name_____ E-mail Address_____

Home Address (if different from student's)_____

Cell Phone_____ Home Phone _____ Work Phone_____

Contact #2: Do you want this person to receive all information regarding this student? [ ] Yes [ ] No
Can this contact to be called to pick up student if necessary due to illness, etc.: [ ] Yes [ ] No

❑ Biological ❑ Step-parent ❑ Other (please describe relationship)_____

Name_____ E-mail Address_____

Home Address (if different from student's)_____

Cell Phone_____ Home Phone _____ Work Phone_____

Contact #3: Do you want this person to receive all information regarding this student? [ ] Yes [ ] No
Can this contact to be called to pick up student if necessary due to illness, etc.: [ ] Yes [ ] No

❑ Biological ❑ Step-parent ❑ Other (please describe relationship)_____

Name_____ E-mail Address_____

Home Address (if different from student's)_____

Cell Phone_____ Home Phone _____ Work Phone_____

EMERGENCY INFORMATION:

In case of emergency, if KPCS can't contact the parent/guardian, please contact:
(Other than the 3 listed above)

First Choice

Name: _____

Relationship: _____

Best contact #: _____

Second Choice

Name: _____

Relationship: _____

Best contact #: _____

My signature certifies all information listed above is accurate.

_____ _____
Parent or Guardian Signature/Student's Signature if 18 Years Old or Older Date

Immunization Form

Name_____ Birthdate_____

Enter the dates for each vaccine your child has received to date. Specify the month, day, and year of each dose such as 01/01/2010.

Immunizations required for child care, early childhood programs, and school.

Vaccine	Birth to 6 months			12 -24 months		At Kindergarten	At 7th grade	At 12th grade
Hepatitis B								
Diphtheria, Tetanus, Pertussis (DTaP, DT, Td)								
Haemophilus influenzae type b (Hib)								
Pneumococcal (PCV)								
Polio								
Measles, Mumps, Rubella (MMR)								
Chickenpox (varicella)								
Hepatitis A								
Tetanus, Diphtheria, Pertussis (Tdap)								
Meningococcal (MCV4)								

Minnesota law requires children enrolled in child care, early childhood education, or school to be immunized against certain diseases, unless the child is medically or non-medically exempt.

Instructions for parent or guardian:

1. Fill out the dates in chronological order even if your child received a vaccine outside of the age/grade category that the box is in. Depending on the age of your child, they may not have received all vaccines; some boxes will be blank.
   - If you have a copy of your child's immunization history, you can attach a copy of it instead of completing the front of this form.
   - Your doctor or clinic can provide a copy of your child's immunization history. If you are missing or need information about your child's immunization history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-3980 or 800-657-3970.
2. Sign or get the signatures needed for the back of this form.
   - Document medical and/or non-medical exemptions in section 1.
   - Verify history of chickenpox (varicella) disease in section 2.

DEPARTMENT OF HEALTH

Instructions: Complete section 1 to document a medical or non-medical exemption, section 2 to verify history of varicella disease, and section 3 to consent to share immunization information.

Name _____

1. Document a medical and/or non-medical exemption (A and/or B).
Place an X in the box to indicate a medical or non-medical exemption. If there are exemptions to more than one vaccine, mark each vaccine with an X.

Vaccine	Medical Exemption	Non-Medical Exemption
Diphtheria, Tetanus, and Pertussis		
Polio		
Measles, Mumps, Rubella		
Haemophilus influenzae type b		
Chickenpox (varicella)		
Pneumococcal		
Hepatitis A		
Hepatitis B		
Meningococcal		

A. Medical exemption: By my signature below, I confirm that this child should not receive the vaccines marked with an X in the table for medical reasons (contraindications) or because there is laboratory confirmation that they are already immune.

Signature: _____ Date: _____
(of health care practitioner*)

B. Non-medical exemption: A child is not required to have an immunization that is against their parent or guardian's beliefs. However, choosing not to vaccinate may put the health or life of your child or others they come in contact with at risk. Unvaccinated children who are exposed to a vaccine-preventable disease may be required to stay home from child care, school, and other activities in order to protect them and others.

By my signature, I confirm that this child will not receive the vaccines marked with an X in the table because of my beliefs. I am aware that my child may be required to stay home from child care, school, and other activities if exposed.

Signature: _____ Date: _____
(of parent or guardian in presence of notary)

Non-medical exemptions must also be signed and stamped by a notary:

This document was acknowledged before me
on _____ (date)
by _____
(name of parent or guardian)

Notary Signature:

_____

Notary Stamp

STATE OF MINNESOTA, COUNTY OF

_____

2. History of chickenpox (varicella) disease. This child had chickenpox in the month and year _____

My signature below means that I confirm that this child does not need chickenpox vaccine because:

☐ I am a health care practitioner and this child was previously diagnosed with chickenpox or the parent provided a description that indicates this child had chickenpox in the past.

☐ I am the parent or guardian and this child had chickenpox on or before September 1, 2010.

Signature: _____ Date: _____
(of health care practitioner*, representative of a public clinic, or parent/guardian). Parent can sign if chickenpox occurred before September 2010.

*Health care practitioner is defined as a licensed physician, nurse practitioner, or physician assistant.

3. Consent to share immunization information: This school is asking for permission to share your child's immunization record with Minnesota's immunization information system. Giving your permission will:

- Provide easier access for you and your school to check immunization records, such as at school entry each year.
- Support your school in helping to protect students by knowing who may be vulnerable to disease based on their immunization record. This can be important during a disease outbreak.

Under Minnesota law, all the information you provide is private and can only be released to those authorized to receive it. Signing this section of the form is optional. If you choose not to sign, it will not affect the health or educational services your child receives.

I agree to allow my child's school to share my child's immunization documentation with Minnesota's immunization information system:

Signature: _____ Date: _____
(of parent/guardian)

ADDITIONAL STUDENT INFORMATION

At times there are situations in a family's or student's experience that could affect educational progress. In an effort to better serve your student, having additional information may help us to better understand and assist your child in the most beneficial manner. **Please note, any information you provide here is completely optional and will not affect your child's admission to Kato Public Charter School.**

Please complete the following, listing possible factors that may affect your child's educational experience. On the lines below, describe any situations which you would like applicable Kato Public Charter School staff to be aware of. These may include but are not limited to: medical, physical, emotional, or behavioral issues related to your student or a family member, family changes, sickness or death of a loved one, bullying and/or other issues.

Medical_____

Emotional_____

Behavioral_____

Attendance_____

Student changes_____

Bullying_____

Any additional information

_____

_____

_____

_____

Your child's advisor is the first point of contact in discussing the needs of your child. Additionally, Kato Public Charter School has in-school therapy through Counseling Services of Southern MN (CSSM)?

Are you interested in receiving information about counseling or therapy services for your student?
__YES__No

If you would like to discuss your student's specific situation, please contact the school at (507) 387-5524 to make an appointment to talk with your advisor, the director, or to connect you with the school's appointed CSSM therapist.

HOME LANGUAGE QUESTIONAIRE 2022-2023

Dear Parents and Guardians: In order to help your child be most successful, your child's teachers need to know which language your child uses most often. Please complete the information below.

Students Name (Last, First, Middle) _____
Last First Middle

Date of Birth _____

Age _____

Please check the appropriate box.

Which Language did your child learn first?

- ❑ English
- ❑ Other (Specify) _____

Which Language is most often spoken in your home?

- ❑ English
- ❑ Other (Specify) _____

Which Language does your child usually speak?

- ❑ English
- ❑ Other (Specify) _____

Signature - Parent/Guardian _____Date _____

STUDENT VEHICLE REGISTRATION
2022-2023

Driver's Name _____ **Today's Date** _____

Driver's License # _____

Primary Vehicle

Vehicle Make _____ Vehicle Model _____
Vehicle Color _____ License Plate # _____
Vehicle Owner _____ Phone # _____

Secondary Vehicle

Vehicle Make _____ Vehicle Model _____
Vehicle Color _____ License Plate # _____
Vehicle Owner _____ Phone # _____

**** Student driven vehicles MUST park in the school parking lot behind the building. ****
If parked on the street in front of school the vehicle could possibly be towed at owner's expense.

TRANSPORTATION REGISTRATION FORM
SCHOOL YEAR 2022-2023

THIS FORM MUST BE FILLED OUT FOR EACH STUDENT

_____ _____ SEX: M F _____/_____/_____
Student Last Name | Student First Name | Date of Birth

_____ _____ _____ _____
Student Home Street Address **(Do Not Use PO Box)** | City | State | Zip Code

_____ _____ _____
Parent/Guardian Last Name | **First Name** | **Parent Phone Number**

_____ _____ _____
School Currently Attending | **Grade During 2022-23** | **School Will Attend During 2022-23 School Year**

Will your residence change before next year? Yes___No ___If Yes, students who move need to visit the Central Registration Office to change their address and register for a pass to their new address.

What means of transportation will your student use most often to get to/from school? (Mark only one answer)

_____ Walking/Biking _____ Parent/Private Vehicle _____ Parent pays the Bus Company for transportation

_____ District Paid Bus (must be eligible per District Guidelines – see below) one way or round trip

Date of First Bus Ride_____ **How often will student be riding the bus**?_____

_____ Special Education Mini Bus per IEP (no bus pass needed – **must** be set up by Special Education case manager)

Other (please list)

Will your student (**K-5 only**) use a District bus to be transported to/from a Daycare Facility? Yes_____No_____

REMINDER: The Daycare Transportation Form must be completed before a pass will be issued. Forms are available at all elementary school offices, in the Central Registration Office or on the District website at **www.isd77.org**; under District, click Transportation. Please contact 207-4006 with questions regarding completion of the Daycare Transportation Form.

Since the 2006-07 school year, Mankato Area Public Schools has been using the VersaTrans Solutions computer system to collect & record the school bus transportation data for all public & non-public students being transported on a regular bus. Each year all students entering grades K-12 MUST pre-register in the spring for their busing needs the following school year. Obtaining an accurate count of students who will actually ride a school bus is VERY important to the design of efficient low cost routes that will keep our transportation costs at a minimum.

To be eligible for transportation students in grades K-5 must reside at least 1 mile from their school of attendance and students in grades 6-12 must reside at least 2 miles from their school of attendance, and must live within the attendance boundary of the school they attend. Students not eligible for transportation who are interested in paying for busing would need to contact the bus contractor who serves their area to find out if a private contract is an option. **Students who move need to visit the Central Registration Office to change their address and register for a new pass.** Students eligible for transportation who decline bus service at this time may re-establish the service any time during the school year by completing a new Transportation Registration Form at the Central Registration Office or at the school the student attends. **Late and new student registrations need to allow at least 5 business days for processing before accessing bus services.** If you have questions, please contact Tricia Ries in the District Transportation Office at **tries2@isd77.org** or at 507-207-4006.

Passes - All students must be registered at either a public or a non-public school before a bus pass can be issued. Passes will be sent to each school in August and can be picked up at their entrance conference or orientation. **If a student loses his/her pass they must report it to either their bus driver or bus company and replacement passes will be issued by the bus company for a fee of $5.00 each.**

ALL INFORMATION SUBJECT TO CHANGE DUE TO BUDGET

PERMISSION TO GIVE MEDICATION AT SCHOOL 2022-2023

Please note: Whenever possible medication(s) should be given at home.

TO BE COMPLETED BY PARENT OR GUARDIAN:

I request that my child _____ receive the medication(s) listed below***. I will furnish the medication in the original prescription bottle properly labeled by a pharmacist. Non-prescription medication must be in the original bottle (such as Tylenol, Advil, etc.).*** I understand that the school district is providing a service and does not assume any responsibility for this service. I also understand that although the school health aide will supervise the administration of the medication, the school health aide will not necessarily administer the medication. We ask that the medication accompany this form or be delivered by the parent to the office.

Non-prescription medication(s) authorized and provided by parent: _____

_____

Parent or guardian signature: _____ Date: _____

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*TO BE COMPLETED BY PHYSICIAN **OR** INCLUDE A COPY OF THE PRESCRIPTION:*

I request that my patient receive the following medication (prescription and/or over the counter):

Name of Student: _____ Date of Birth: _____

Diagnosis: _____

Name of medication and prescribed dosage: _____

_____

Means of administration: _____

Time to be administered during school hours (8:00 – 3:05): _____

Expected duration of treatment: _____

Possible side effects and adverse reactions: _____

Other recommendations: _____

Date: _____ Signature of Physician: _____

PARENT VOLUNTEERS 2022-2023

We need your help! We need parent volunteers to help with many activities and events throughout the year here at Kato Public Charter School. We are looking for creative and willing parents to join STPC and help KPCS students have a positive and educational experience. If you are interested in helping please fill out the information below. Please watch our web page for upcoming STPC meetings and other activities that you will be needed to help support. Please come join us in making this a great year at KPCS. All are welcome at any time!

Please Print Legibly

Parent(s)/Guardians Name: _____

Student Name: _____

Address: _____

City: _____, MN Zip Code_____

Phone #_____ Alternate Phone: _____ E-mail Address: _____

Please put a check mark by the activities you would be interested in helping with:

- ☐ Prom
- ☐ School Activities and Programs
- ☐ Robotics
- ☐ Graduation
- ☐ Field Trips/Chaperones
- ☐ Fundraising and Donations
- ☐ Student Teacher Parent Committee (STPC/PTO)
- ☐ Other: _____