Des Moines Adventist School

Immunization Record

Student's Name: _____

Iowa state law requires that all students receive the minimum number of immunizations required for polio, measles, mumps, rubella, diphtheria, tetanus, pertussis, and Hepatitis B.

Students are required to be adequately immunized prior to the first day of school for the current academic school year.

Des Moines Adventist School is required to maintain an immunization record for each student enrolled in/attending school. Parents are required to provide updated records of current immunizations on all students attending Des Moines Adventist School.

Please present this form to your student's health care professional (doctor, nurse practitioner, physician's assistant, nurse) and have this Immunization Record signed by that health care professional. Then, please supply the signed Immunization Record to Des Moines Adventist School during the registration process. A copy of an immunization card is not sufficient.

I have reviewed the health record for the above-noted patient. Our records indicate that the patient is up-to-date on the following required immunizations:

Polio – date of immunization: _____
Measles – date of immunization: _____
Mumps – date of immunization: _____
Rubella – date of immunization: _____
Diphtheria – date of immunization: _____
Tetanus – date of immunization: _____
Pertussis – date of immunization: _____
Hepatitis B – date of immunization: _____

_____
Printed Name

_____ _____
Signature of Health Care Professional Date

_____
Name and Address of Physician's Practice

Des Moines Adventist School

2022-2023 Health Care and Over-The-Counter Medication Consent Form

(For OTC products provided by school)

Students Name: _____

Des Moines Adventist School, with parent/guardian written consent, will provide the basic treatments for minor illnesses and injury while at school.

Anti-itch	**Oral / Dental**	**Miscellaneous**
Benadryl Cream	**Vaseline for chapped lips**	**Isopropyl alcohol**
Caladryl/Calamine lotion	**Salt for Gargle**	**Hydrogen Peroxide**
Hydrocortisone Cream	**Cough drops**	**Baking Soda**
0.5% and 1%	**Dental Floss**	**Antacids / Tums**
		Tylenol
Eye Care	**Wound Care**	**Ibuprofen**
Solution/lubricating drops	**Bactine/Wound Care**	
Saline eye solution	**Wash**	
Wash/irrigation	**Triple Antibiotic**	
Visine eye drops	**Ointment**	

I, _____ (parent name) give Des Moines Adventist School permission to treat my child to include the above-referenced over-the-counter medication(s) as needed, but not to exceed manufacturer's recommendations.

This signed consent form shall remain valid for the current school year. Note: If a child demonstrates habitual usage of the over-the-counter medications, a doctor's order may be requested to verify that ongoing symptoms have been evaluated and the parent may be required to provide the medication.

Parent Signature: _____ Date:_____

Des Moines Adventist School

Media Release Form

This is to certify that I _____,
give permission to Des Moines Adventist School to photograph and / or videotape my child, _____, for use on their website and in various school productions and printed media. In addition, I also give permission for work samples and or artwork to be used in various school productions, printed media and events that happen live at Des Moines Seventh-day Adventist Church.

I understand that all rights, title, and interest in the digital media for said media outlets belong to Des Moines Adventist School and that I will receive no financial compensation for the use of these pictures and/ or videotape. I further understand that Des Moines Adventist School may edit, copy, alter, or revise the digital media and/or videotape.

I have read this form and understand its meaning.

_____ _____

Parent / Legal Guardian Signature **Date**

_____ _____

Parent / Legal Guardian Signature **Date**

Des Moines Adventist School

Consent to Treat

(separate form required for each student)

Authorization to Release Information

We, the undersigned parent(s) or guardian(s) of_____, a minor, do hereby consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital service that may be rendered to said minor under the general or special instruction of the doctor listed below, or any physician the school or treating organization may call, whether such diagnosis or treatment is rendered at the office of said physician or at a licensed hospital. It is understood that reasonable effort will be made to contact the parents, guardian, or alternate emergency contacts prior to any medical intervention, and reasonable effort will be made to contact the physician listed below before any other physician is called by the school or other organization. If a dentist is needed, the one listed below will be called.

Physician's Name:_____ Phone Number _____
Dentist's Name: _____ Phone Number _____

It is further understood that this consent is given in advance of any specific diagnosis or treatment which might be required and is given to authorize Des Moines Adventist School or the physician to exercise their best judgment as to the requirements of such diagnosis or treatment. This consent shall remain in continuous effect until revoked in writing and delivered to the physician named above and to the school or organization entrusted with the custody of said minor.

If Des Moines Adventist School desires financial help from the General Conference Insurance Service for school related injuries or illnesses, we hereby authorize any hospital, physician, or other person who has attended or examined the minor to furnish the General Conference Insurance Service or its representative, any and all information, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records related to that injury or illness.

A photo static copy of this authorization shall be considered as effective and valid as the original.

Student Allergies (please list)	Life Threatening?	Other Medical Conditions (please list)	Life Threatening?
	Yes No		Yes No
	Yes No		Yes No
Treatment for Allergies:		Treatment for Medical Conditions:	

Medical Insurance Company Name _____ **Policy No.**_____

Student Name:		Birth Date:	
Student Address:	City:	State:	Zip:
Student Home Phone:			
Mother Cell:	Mother Work:	Father Cell:	Father Work:

If our student requires prescription medication, we consent to administration of that medication by Des Moines Adventist School.

Emergency Contact *(Person to contact when parent/guardian is NOT available):*

Name:		Relation:
Cell Phone:	Work Phone:	Home Phone:
Name:		Relation:
Cell Phone:	Work Phone:	Home Phone:

Parent Signature:	Date:

(this form to be kept in teacher's emergency binder)

Des Moines Adventist School

Administration of Medication

Student's Name_____ DOB_____ Grade_____

I certify that I am the student's parent, legal guardian, or other person in legal control of the student and authorize Des Moines Adventist School to administer the below medication to my student. I acknowledge that a non-medical person may administer the medication.

Mother's Name: _____ Father's Name: _____

_____ _____

Signature Date

Over-the-counter Medication:

Medicine Available: **Tylenol** **Ibuprofen** (*Circle preferred medications)*

Dosage & Frequency: As directed on medication for age

Prescription Medication:

Prescription medication must be in original container, and the physician/dentist dosing instructions must be present. The parent/guardian must add medication information to this form any time a new medication must be administered during school hours.

Name of Medication___

_____ Dosage_____ Time to be given_____

Name of Medication___

_____ Dosage_____ Time to be given_____

Name of Medication___

_____ Dosage_____ Time to be given_____

Name of Medication___

_____ Dosage_____ Time to be given_____

Des Moines Adventist School

Records Release Form

My student last attended…

Name of School:_____

Address of School:_____

Phone/Fax No.: _____

Dear Registrar:

Parental permission is no longer required when records are requested by authorized school personnel. (Family Educational Rights and Privacy Act, Final Rule on Educational Records, Federal Register, June 17, 1976, Vol. 41, No. 118, Page 14673). Therefore, please furnish us with the following information in order to provide the proper placement of the below student(s).

A. **All subjects and grades for the current school year plus withdrawal grades. We are also requesting final grades for previous school years in addition to an explanation of your grading system.**
B. **Standardized test records and scores.**
C. **Immunization and Health records.**
D. **Psychological/Physiological reports.**
E. **Any other data pertinent to understanding the student's individual needs.**

Student: _____ **Grade:** _____

(First Name) ***(Last Name)***

Student: _____ **Grade:** _____

(First Name) ***(Last Name)***

Student: _____ **Grade:** _____

(First Name) ***(Last Name)***

Please send the records indicated for the above-listed student(s) to:

Des Moines Adventist School
2317 Watrous Ave.
Des Moines, IA 50321
515.285.7729
Thank you for your prompt reply.

Des Moines Adventist School

Asthma Action Plan

If your student has asthma, we ask that this completed form be brought to school in a Ziploc bag with "controller" medicines in addition to "rescue" medicines. This labeled Ziploc bag will be kept in your student's classroom and will be brought on any field trips.

Student's Name_____ **DOB**_____ **Grade**____

Does student have asthma?

Yes

No ***(do not complete the rest of the form)***

Doctor's Name_____ **Phone Number**_____

Emergency Contact_____ **Emergency Phone**_____

Asthma Triggers	
Pollen	**Medicine**_____ **How much?**_____ **When?**_____
Exercise	**Medicine**_____ **How much?**_____ **When?**_____
Mold	**Medicine**_____ **How much?**_____ **When?**_____
Cold/Flu	**Medicine**_____ **How much?**_____ **When?**_____
Dust mites	**Medicine**_____ **How much?**_____ **When?**_____
Weather	**Medicine**_____ **How much?**_____ **When?**_____
Animals	**Medicine**_____ **How much?**_____ **When?**_____
Air Pollution	**Medicine**_____ **How much?**_____ **When?**_____
Smoke	**Medicine**_____ **How much?**_____ **When?**_____
Food	**Medicine**_____ **How much?**_____ **When?**_____
Other	**Medicine**_____ **How much?**_____ **When?**_____

Asthma Analysis:

SAFETY ZONE			
Symptoms	**Use "Controller" medicines as listed:**		
Breathing is easy **No cough or wheeze** **Can do usual activities**	**Medicine**	**How much**	**How often/when**

CAUTION ZONE			
Symptoms	**Continue with "Controller" medicines listed above and ADD these "Rescue" medications:**		
Some shortness of breath **Cough, wheeze, or chest tightness** **Some difficulty doing usual activities** **Symptoms of a cold or flu**	**Medicine**	**How much**	**How often/when**

DANGER ZONE			
Symptoms	**Take this medicine and call the doctor NOW!**		
Severe breathing Problems **Cannot do usual activities** **Difficulty walking and talking** **Medicine is not helping**	**Medicine**	**How much**	**How often/when**

Revised 3-1-17 **(one copy -- in Ziploc bag containing emergency medication; one copy – in teacher's emergency binder)**

Des Moines Adventist School

Allergy Action Plan

(Complete one Form for each separate category of allergy)

If your student has an allergy serious enough to require either epinephrine or a prescribed antihistamine at school, we ask that this completed form (with physician's signature) be brought to school in a Ziploc bag with the required treatment (epinephrine and/or antihistamine). This labeled Ziploc bag will be kept in your student's classroom and will be brought on any field trips.

Parents of children with food allergies are expected to provide a quantity of safe classroom snacks (to be kept by the teacher) which can be given to the student when questionable foods are brought into the classroom for all of the students to enjoy.

Student's Name_____ DOB_____ Grade___

Does student have allergies?

Yes

No *(do not complete the rest of the form)*

Allergic to_____

Allergic reactions to the following: Smell Physical contact Ingestion

****STEP 1: TREATMENT****

Symptoms:		**Give Checked Medication:**	
If an allergen has been ingested, and **any of the following symptoms occur**:			
Mouth	Itching, tingling, or swelling of lips, tongue, mouth	Epinephrine	Antihistamine
Skin	Hives, itchy rash, swelling of the face or extremities	Epinephrine	Antihistamine
Abdomen	Nausea, abdominal cramps, vomiting, diarrhea	Epinephrine	Antihistamine
Throat	Tightening of throat, hoarseness, hacking cough	Epinephrine	Antihistamine
Lung	Shortness of breath, repetitive coughing, wheezing	Epinephrine	Antihistamine
Heart	Weak or thready pulse, low blood pressure, fainting, pale, blueness	Epinephrine	Antihistamine
Other	_____	Epinephrine	Antihistamine
If reaction is progressing (several of the above areas affected), give:		Epinephrine	Antihistamine

DOSAGE:

Epinephrine: inject intramuscularly (circle one) EpiPen EpiPen Jr. Twinject 0.3 mg Twinject 0.15 mg

Antihistamine: give_____

medication/dose/route

Other: give _____

medication/dose/route

****STEP 2: EMERGENCY CALLS****

Call 911 and state that "*An allergic reaction has been treated, and additional epinephrine may be needed.*"

Dr. _____ Phone Number:_____

Parent _____ Phone Number:_____

Emergency contacts: Phone Numbers:

a. _____ 1) _____ 2)_____

b. _____ 1) _____ 2)_____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, PLEASE MEDICATE AND TAKE CHILD TO MEDICAL FACILITY!

I have completed this form and am responsible for the description of medical treatment for my student.

Parent/Guardian's Signature _____ Date _____

EpiPen and EpiPen Jr. Directions	**Twinject 0.3 mg/Twinject 0.15 mg Directions**
Pull off gray activation cap. **Hold black tip near outer thigh (always apply to thigh).** **Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place for 10 seconds. Remove the EpiPen unit and massage the injection area for 10 seconds.** **<u>SECOND DOSE ADMINISTRATION</u>:** **If symptoms don't improve after 10 minutes, administer second dose.**	**Remove caps labeled "1" and "2."** **Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.** **<u>SECOND DOSE ADMINISTRATION</u>:** **If symptoms don't improve after 10 minutes, administer second dose:** **Unscrew rounded tip. Pull syringes from barrel by holding blue collar at needle base.** **Slide yellow collar off plunger.** **Put needle into thigh through skin, push plunger down all the way and remove.**

Once EpiPen or Twinject is used, call 911. <u>Take the used unit with you to the Emergency Room</u>. Plan to stay for observation at the Emergency Room for at least 4 hours.

Revised 3-1-17 **(one copy -- in Ziploc bag containing emergency medication; one copy – in teacher's emergency binder)**

Des Moines Adventist School

Field Trip Permission, Consent to Treat, and Insurance Information

I, the undersigned parents or guardians of _____, a minor, do hereby give my consent for him/her to attend all field trips taken by DAS students during the 2022-2023 school year. This consent negates the need for separate permission forms for each activity, and will remain in effect until the end of the school year. I understand that I have the right to deny permission for an individual activity, in writing, if I so choose. I am aware that by my child a need for emergency medical treatment may occur as a result of an accident or illness.

In the event emergency medical treatment becomes necessary for my child, I grant to Des Moines Adventist Personel the authority to obtain such emergency medical assistance.

I also consent to my child being transported by private car driven by Des Moines Adventist School Personel or any other representative of DAS School to the various destinations.

I further grant permission to the medical care provider authority to administer emergency treatment to my child.

I understand that I must send a booster seat for my child if they are over four years of age, but less than eight years of age, who also weighs between 40 and 80 pounds and is less than 4'9" tall.

THE ABOVE MENTIONED STUDENT IS [ ] IS NOT [ ] COVERED BY INSURANCE.

Medical Insurance Company Name _____ Policy No._____

Parents Name:		**Students Birth Date:**	
Address:	**City:**	**State:**	**Zip:**
Student Home Phone:			
Mother Cell:	**Mother Work:**	**Father Cell:**	**Father Work:**

If our student requires prescription medication, we consent to administration of that medication by Des Moines Adventist School.

Emergency Contact *(Person to contact when parent/guardian is NOT available):*

Name:		**Relation:**
Cell Phone:	**Work Phone:**	**Home Phone:**
Name:		**Relation:**
Cell Phone:	**Work Phone:**	**Home Phone:**

PARENT SIGNATURE _____ **fDATE** _____

Des Moines Adventist School

Textbook Policy and Contract

(one form per student)

All hardback school textbooks will be assigned a "condition" before being issued to students. Conditions will be set at:

- Excellent (brand new)
- Very Good (slightly used)
- Good (used, but in "OK" condition)
- Fair (not falling apart…yet)
- Poor (starting to fall apart, but still usable)

Books should be returned in no more than one condition below the issued condition. For example, a book given out as "Excellent" should be returned in at least "Very Good" condition. Books that are returned in far worse condition than given or books that are lost will require the student to make up the difference. Assessing the books will be managed by the Treasurer and the Principal.

Books will be labeled for student identification.

I understand that is my responsibility to keep my books in good condition during the school year. Any books damaged or lost could result in my helping to replace them.

_____

Student's Signature

I understand that it is my student's responsibility to keep his/her books in good condition during the school year. Any books damaged or lost could result in my student being charged a book replacement fee.

_____

Parent's Signature

Des Moines Adventist School

Parental and Student Acknowledgement

Acknowledgment must be signed before a student will be admitted to the Des Moines Adventist School

I agree to join my child's teachers as a partner. This means I will do my best to support and encourage his/her teachers, maintain cordial two-way communication, attend school functions and participate in parent/teacher conferences.

I understand the objectives and regulations of the school as outlined in the DAS Handbook and pledge my full support. I understand that one of DAS's goals is to help students grow spiritually. I will do all I can to make this possible.

I will receive notification prior to all DAS field trips. I will abide by the Iowa child safety seat requirements and will provide a booster seat complying with the law (see the IA child safety seat requirements) if a booster seat is required by law.

I understand that there is a strict **NO GUM Policy** at DAS.

Per Iowa State law, I agree to keep immunization records (or an "Immunization Waiver") for my child(ren) up-to-date and on file at DAS.

I, the student, and I/we, the parent(s), recognize that attending Des Moines Adventist School is a privilege, not a right. We recognize that the values, curriculum, teaching staff, and carefully-crafted environment all contribute to a special environment, meant to compliment the teachings and values within a Christian home.

I, the student, agree that I will uphold the standards outlined within this handbook. I understand that my decision to ignore certain or all of the school's standards will result in discipline, which may include my expulsion. I choose to be a student at a school where my moral and spiritual health are just as important to my teachers and family as is my academic success.

I/we, the parent(s), state that we will uphold the rules of the Des Moines Adventist School. In the event that we take issue with a rule or application of a rule to our child's behavior, we will not oppose the school's standards in front of our child. We seek a cooperative working arrangement with our child's/children's teacher(s), one which does not disregard the school's standards. Accordingly, we will seek to partner with the school in an effort to enhance the Christian values that we uphold in our home. In keeping with our commitment to partner with the school, we will volunteer our services at Des Moines Adventist School.

_____ _____

Signature of student/students Date

_____ _____

Signature of parent(s) Date

Des Moines Adventist School

Application for Financial Aid

2022-2023 School Year

Parents or Responsible Party
Name: _____
Address :_____
_____
Phone: _____
Email: _____

Registration Fee ($210 per Student) Student (In Same Family)	Grade: PK- 8th	Tuition	Amount
1st Student _____	_____	$300	$_____
2nd Student _____	_____	$270	$_____
3rd Student _____	_____	$240	$_____
4th Student _____	_____	$210	$_____

Parents or Responsible Party will contribute monthly: $_____

Refugee Assistance Fund $ _____

Financial Aid Needed Monthly $_____

Total Per Month $_____

I (We) agree to pay this amount when billed each month.
Tuition will be billed in 10 payments (August through May)

_____ _____
Parent/Guardian Signature Date

**** **Every student NEEDS a copy of their birth certificate to apply.**