RETURNING REGISTRATION SY 2024/2025

Dear Parents/Guardians:

Welcome and thank you for applying to KCS. Please attach all required documents to the registration form and submit as one completed packet per student.

For information please contact: Josephine Naranjo, jmontoya@khapoeducation.org, (505) 614-4812 or Danielle Martinez, dmartinez@khapoeducation.org (505) 901-7898

All NEW students must complete all the forms in this packet and provide the following documents to the front office:

- Signed Media Release Form
- Emergency Form Contact Form
- School Health Forms
- Updated Copy of Physical Exam
- Proof of Food Allergy (if applicable)
- Updated Copy of Immunization Records
- Field Trip Form

**Please keep in mind RETURNING students are not officially registered until all documents are received and an official acceptance letter has been provided.**
Media Release Form
School Year 2024/2025

● I do hereby grant Kha’p’o Community School (KCS) the unlimited right to use and/or reproduce photographs, likenesses or the voice of my child in any legal manner and for the internal or external promotional and informational activities of the school.

● I agree to allow my child to be interviewed and/or photographed by representatives of the external news media in relation to any and all coverage of KCS in which they are involved.

● I agree to allow my child's work and/or photograph to be published on the KCS Web Pages and/or publications or KCS’ social media pages.

● I understand that by signing this release, I waive any and all present, or future compensation rights to the use of the above stated material(s).

Student's Name:_________________________________________________________ Grade:________________

Parent/Guardian Signature:_________________________________________ Date:________________

Parent/Guardian Name (please print):_________________________________________
EMERGENCY CONTACT FORM SCHOOL YEAR 2024/2025

STUDENT’S NAME:_____________________________________________________________ GRADE:_______ DOB:__________________

Will Student Ride Bus: (CIRCLE) YES NO Will Student Ride Bus: (CIRCLE) AM PM or BOTH
IF Yes, PHYSICAL ADDRESS OF PICKUP:__________________________________________

PARENT(s) NAMES: (required)
1____________________________________________________ Phone No.________________________
EMAIL ADDRESS:_____________________________________________________________

2____________________________________________________ Phone No.________________________
EMAIL ADDRESS:_____________________________________________________________

LEGAL GUARDIAN(s) NAMES: (required)
1____________________________________________________ Phone No.________________________
EMAIL ADDRESS:_____________________________________________________________

2____________________________________________________ Phone No.________________________
EMAIL ADDRESS:_____________________________________________________________

EMERGENCY CONTACTS (REQUIRED)
1 Name:________________________________________ Phone No.________________________ Relationship:__________________________

2 Name:________________________________________ Phone No.________________________ Relationship:__________________________

3 Name:________________________________________ Phone No.________________________ Relationship:__________________________

WHO MAY CHECK OUT YOUR CHILD? *(PERSON(S) NOT ON CHECK OUT LIST WILL NOT BE ALLOWED TO CHECK OUT STUDENT - NO EXCEPTIONS)
1________________________________________ 2________________________________________

3________________________________________ 4________________________________________

**COURT ORDER IS REQUIRED FOR WHO IS NOT ALLOWED TO CHECK OUT YOUR CHILD (Legal documentation is required)
1________________________________________ 2________________________________________

PARENT/GUARDIAN SIGNATURE:_____________________________________________________ DATE:________________________
Dear Parents/Guardians,

At Kha’p’o Community School, students are fortunate to have a School Health Office that provides them care when they get sick, injured, or for any other health issue. To ensure that the students are provided the best care here at KCS, we do require the School Health Packet to be completed by the parent(s) or legal guardian(s).

Immunization requirements need to be met for your child to begin their first day of school. KCS requires students receive the following immunizations:

- **DTP/DTap/TD (tetanus, diphtheria, pertussis) vaccine**
  The new rule states that a booster dose of tetanus, diphtheria, pertussis (Tdap) is required for all students attending school. One dose is required on or after their 4th birthday. 4 doses sufficient if the last dose given on or after 4th birthday. This change was made to help reduce the incidence of whooping cough (pertussis) among children. In recent years, New Mexico, as well as the rest of the United States, has seen an increase in the number of whooping cough cases. By giving your children a booster of Tdap, they will receive protection against this deadly disease for the years to come. So, if it has been five years since your child received a tetanus-containing vaccine, he/she will need a dose of Tdap.

- **Varicella Vaccine**
  K-2nd grade, Proof of Immunization receipt of vaccine, titer, or laboratory-confirmed diagnosis of prior disease. For all newly diagnosed Varicella cases, laboratory confirmation of disease is required. 2 doses of varicella vaccine required for all students K-10th, and recommended for all students grades 11th-12th.

- **Polio (OPV/IPV) Vaccine**
  3 doses are sufficient if the last dose was given on or after 4th birthday. Hepatitis B vaccine Two doses Adult Recombivax HB is also valid if administered at ages 11-15 years and if 2nd dose received no sooner than 16 weeks after 1st dose.

- **Hepatitis B Vaccine**
  Two doses Adult Recombivax HB is also valid if administered at ages 11-15 years and if the 2nd dose is received no sooner than 16 weeks after the 1st dose.

As you are completing the forms, please make sure you:

- Sign and date each form
- Check front and back of each form
- Submit copy of immunization (Required to be submitted at the beginning of each school year)
- Doctor's note must be submitted for ALL allergies: food, insects, medication, etc (Required to be submitted at the beginning of each school year)
- Note: Doctor's Dietary Documentation is required for Food Allergies for the Kitchen Staff to order special milk or food.
- If applicable, submit medical history (allergy, medication, restrictions, etc.) (Required to be submitted at the beginning of each school year)
Kha’p’o Community School-School Health Department

Child’s Name: ____________________________ DOB: ________________ Grade: __________
Mailing Address: ____________________________________________
Clinic Chart No.: ____________________________________________
Doctor/Pediatrician: ____________________________ Phone No. ________________
Mailing Address: ____________________________________________
Medical Insurance: ____________________________________________
Who is the child living with?: ____________________________ Relationship: ____________________________
Name of other children attending KCS: ____________________________________________
Is child’s immunization up to date? Yes No (Immunization Record is required to be submitted to KCS every school year)
Mother’s Name: ____________________________ Phone No. ________________
Work Phone No. ____________________________ Email Address: ____________________________
Father’s Name: ____________________________ Phone No. ________________
Work Phone No. ____________________________ Email Address: ____________________________
Legal Guardian’s Name: ____________________________ Phone No. ________________
Work Phone No. ____________________________ Email Address: ____________________________
Legal Guardian’s Name: ____________________________ Phone No. ________________
Work Phone No. ____________________________ Email Address: ____________________________

EMERGENCY CONTACTS
(IF WE CANNOT REACH YOU)
Name: ____________________________ Phone No. ________________
Work No. ____________________________
Name: ____________________________ Phone No. ________________
Work No. ____________________________
Name: ____________________________ Phone No. ________________
Work No. ____________________________

In case of EMERGENCIES which require medical attention during school hours, I give permission for my child to be transported for the rendering of such Medical Services as deemed necessary in the opinion of School Health Personnel.

Parent/Guardian Name (Please Print) ____________________________________________
Signature: ____________________________ Date: ____________________________
HEALTH CONDITIONS (Check any your child has had and put approx. date)

<table>
<thead>
<tr>
<th>Yes</th>
<th>Date</th>
<th>No</th>
<th>Condition</th>
<th>Yes</th>
<th>Date</th>
<th>No</th>
<th>Condition</th>
</tr>
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<td>Anemia</td>
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<td>Hepatitis</td>
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<td>Asthma</td>
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<td>Kidney Disease</td>
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<td>Chicken Pox</td>
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<td>Diabetes</td>
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<td>Mumps</td>
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<td>Ear Infection</td>
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<td>Seizures</td>
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<td>Tubes in Ears</td>
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<td>Tuberculosis</td>
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<td>Hearing Problems</td>
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<td>Vision Problems</td>
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<td>Heart Condition</td>
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<td>Glasses</td>
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<td></td>
<td>Other</td>
<td></td>
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<td></td>
<td>Other</td>
</tr>
</tbody>
</table>

ALLERGIES: Is your child allergic to any of the following?
Medication?Drugs: Yes____ No____ Which One(s)?______________________________
Bee/Wasp Stings Yes_____ No_____ EpiPen Prescribed: Yes_____ No_____
Lactose Intolerant: Yes_____ No____ If yes, medical documentation from the doctor must be provided each school year.
Food/Plants: Yes_____ No_____ Which One(s)?________________________________
Epipen Prescribed: Yes_____ No_____ (Doctor’s note must be provided to KCS indicating specific type of food each school year)

Medications:
Is your child taking any medication? Yes_____ No_____ If yes, explain why:___________________________________________________________
What medication does your child take?
Epipen Prescribed: Yes_____ No_____ If yes, an Epipen must be provided to the school by or before the 1st day of school. (No expired medication will be accepted)
Inhaler: Yes_____ No_____ If yes, what type of inhaler:___________________________________________________________ Inhalers must be provided to the school by or before the 1st day of school. (No expired medication will be accepted)
Date of last eye exam:____________________ Where:__________________________
Does your child wear glasses?: Yes_____ No_____ Date of eyeglass prescription:________________________________________
Is your child’s eye glass prescription current?: Yes_____ No_____

All over the counter (OTC) and prescription medication sent to school must be in the same prescription/OTC container as put up by the pharmacist/store and must have the patient’s NAME, NAME OF MEDICATION, DOSAGE, AND DIRECTIONS on the label. A 2024/2025 parent authorization to receive OTC/RX medication at school must be completed and signed. Medication will be sent to the School Health Office.
I give permission for my child to receive **OVER THE-COUNTER** medicine I checked below for relief of discomfort due to minor accident(s) or illness. Please check all that apply for your child.

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Medicine</th>
<th>Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen (Tylenol)</td>
<td>Sudafed</td>
<td>Hydrocortisone 1%</td>
</tr>
<tr>
<td>Ibuprofen/Motrin</td>
<td>Head Lice Treatment</td>
<td>Bacitracin Ointment</td>
</tr>
<tr>
<td>Cold Medicine</td>
<td>Pepto-Bismol</td>
<td>Cough Medicine</td>
</tr>
<tr>
<td>Benadryl</td>
<td>First Aid Cream</td>
<td>Burn Gel/Spray</td>
</tr>
<tr>
<td>Calamine Lotion</td>
<td>Eye Drops</td>
<td></td>
</tr>
</tbody>
</table>

Parent/Guardian Name (Please Print): ________________________________________________

Signature: _______________________________________________________________________

Relationship to Student: ___________________________ Date: _____________________
2024/2025 Parent Authorization to Receive Over The Counter/Prescription Medication at School

Child’s Name: ___________________________________________ DOB: __________ Grade: ________

Name of Medication(s): __________________________________________
____________________________________________________________________
____________________________________________________________________

Doctor/NP/PA: __________________________________________
Office/Clinic Name: ________________________________ Phone No. __________

What time should medicine be given? ________________________________
Any special instructions? ____________________________________________

**Medicine needs to be in the original bottle with the over the counter or pharmacy label or original packaging. The school Health Office will document all medication administered. They will NOT give medicine that is expired, or out of its original bottle. They will not give medication without this consent.

Parent/Guardian Consent: I request the School Health Office to administer my child’s medication as described above. I release Kha’p'o Community School and its staff members from liability regarding administration of this medication.

Parent/Guardian Name (Please Print): ________________________________

Signature: __________________________________________

Relationship to Student: _____________________________ Date: __________
Field Trip Form School Year 2024/2025

The Kha’p’o Community School requires written permission by the student’s parents or legal guardian in order for the student to leave school for any reason. The permission slip below must be completed and signed in order for your child to attend field trips during the school year.

- Parent(s)/legal guardian will be notified about field trips specifics as each trip is planned by your child’s classroom teacher and or designee.
- It is the parent/legal guardian’s responsibility to inform Kha’p’o Community School if there are any updates or changes to any information.
- **This signed form will cover all field trips made throughout the school year.**

Student’s Name:_________________________________________ Grade:________

Doctor’s name and phone number:________________________________________

Hospital preferred:____________________________________________________

Name of Insurance Company:____________________________________________

Policy Number:________________________________________________________

Parent/Guardian (Please Print):_________________________________________ Date:____________

Parent/Guardian Signature:_____________________________________________