WESTERN HILLS ACADEMY

524 Thunderbird El Paso, TX 79912 / 915-584-6642

ENROLLMENT INFORMATION

Please Print

Facility Name: **Western Hills Academy**		Director's Name: ***Patricia Aguirre***	Rev June 2015
Child's Name:		Date of Birth:	
Child's Address:		Child's Home Phone:	
Date of Admission:	Days Enrolled- (circle) M T W TH F - Grade level ELC, Pre-k, Kinder, 1, 2, 3, 4, 5		
Persons legally responsible: TX DL # SS #		Address **(if different from child's)** E-mail Address	

	Mother's Phone #	Father's Phone #	Guardian's Phone #
List telephone numbers where parents/guardian may be reached while child is in care: Permission to Text: (Y) (N) Mobile Carrier:	Home: Work: Cell:	Home: Work: Cell:	Home: Work: Cell:
List a person to call in case of an emergency if parent or guardian cannot be reached: *(This person may have access to my child's health information.)*	**1** Name: *Phone:* *Address:* *Relationship*	**2** Name: *Phone:* *Address:* *Relationship*	**3** Name: *Phone:* *Address:* *Relationship*
In addition to the above; I hereby authorize the day care facility to allow my child to leave the facility with the following persons:	Name: Phone:	Name: Phone:	Name: Phone:

I hereby ____ GIVE ____ do not give - my consent for my child to participate in field trips with advance notice. (N/A for Toddlers or Twos)

I hereby ____ GIVE ____ do not give - my consent for my child to be photographed for T.V., newspapers, Facebook, and school website

Photos for Assessment Circle (Y) (N) Photo Yearbooks Circle (Y) (N)

Allowed to apply if needed: Neosporin? (Y) (N) Hand Sanitizer? (Y) (N) Sun Screen? (Y) (N)

Insect Repellant containing DEET? (Y) (N)

List any special needs or problems your child may have, including known allergies, existing illnesses, previous serious illness and injuries, any disabilities, any hospitalizations during the past 12 months, and any medication prescribed for long-term use and any other information which staff should be aware of:

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION: In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the facility director or person in charge to take my child to:

Physician	Address	Phone
Dental Emergency	Address	Phone
Hospital	Address	Phone

I give my consent for this facility to secure any and all necessary emergency medical care for my child. It is understood that the school or its representatives do not assume any financial responsibility for any expenses that might be incurred for said emergency treatment. It is further understood that school authorities will notify us as soon as possible following the emergency, but in no way is treatment to be delayed until we have been notified. ***My health insurance information copied on the back of this form.***

I have received a copy of the Family Handbook. I agree to abide by all such policies and procedures as defined within.

All above is accurate and agreed upon.

Signature - Parent or Legal Guardian _____ Director_____

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No

PLACE PICTURE HERE

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG — Short of breath, wheezing, repetitive cough

HEART — Pale, blue, faint, weak pulse, dizzy

THROAT — Tight, hoarse, trouble breathing/ swallowing

MOUTH — Significant swelling of the tongue and/or lips

SKIN — Many hives over body, widespread redness

GUT — Repetitive vomiting, severe diarrhea

OTHER — Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. ***INJECT EPINEPHRINE IMMEDIATELY.***
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE — Itchy/runny nose, sneezing

MOUTH — Itchy mouth

SKIN — A few hives, mild itch

GUT — Mild nausea/ discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 7/2016

TB Questionnaire

Name of Child_____Date of Birth _____

Child Care Home/Center_____ Date_____

Tuberculosis (TB) is a disease caused by TB germs and is usually transmitted by an adult person with active TB lung disease. It is spread to another person by coughing or sneezing TB germs into the air. These germs may be breathed in by the child.

Adults who have active TB disease usually have many of the following symptoms: cough for more that two weeks duration, loss of appetite, weight loss of ten or more pounds over a short period of time, fever, chills and night sweats.

A person can have TB germs in his or her body but not have active TB disease (this is called latent TB infection or LTBI).

Tuberculosis is preventable and treatable. TB skin testing (often called the PPD or Mantoux test) is used to see if your child has been infected with TB germs. No vaccine is recommended for use in the United States to prevent tuberculosis. The skin test is not a vaccination against TB.

We need your help to find out if your child has been exposed to tuberculosis.

Place a mark in the appropriate box:	Yes	No	Don't Know
TB can cause fever of long duration, unexplained weight loss, a bad cough (lasting over two weeks), or coughing up blood. As far as you know: has your child been around anyone with any of these symptoms or problems? or has your child had any of these symptoms or problems? or has your child been around anyone sick with TB?			
Was your child born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia?			
Has your child traveled in the past year to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia for longer than 3 weeks? If so, specify which country/countries?_____			
To your knowledge, has your child spent time (longer than 3 weeks) with anyone who is/has been an intravenous (IV) drug user, HIV-infected, in jail or prison or recently came to the United States from another country?			

Has your child been tested for TB? Yes___ (if yes, specify date ____/____) No___
Has your child ever had a positive TB skin test? Yes___ (if yes, specify date ____/____) No___

****

Parent _____
Signature/date

If positive, referral to healthcare provider Yes___ No___

If yes, name of provider _____

Adapted for El Paso CCL

TEXAS Department of State Health Services

INCOME DETERMINATION FORM

This form uses free and reduced-price meal income levels as the threshold to determine eligibility.

Family Address: _____

Age or grade levels of children living in your household and attending: Western Hills Academy.

A. Locate your household size and the minimum allowable income earned each month. If your monthly income is equal to or less than this amount, please check here: ☐

Family size	Income earned each month*	
	Qualifies for Free Meals	Qualifies for Reduced Meals
1	$1,383	$1,968
2	$1,868	$2,658
3	$2,353	$3,349
4	$2,839	$4,040
5	$3,324	$4,730
6	$3,809	$5,421
7	$4,295	$6,112
8	$4,780	$6,802
For each additional family member, add:	$486	$691

The 2020-2021 income guidelines for future school years can be found at: http://www.squaremeals.org/Publications/IncomeEligibilityGuidelines.aspx#CACFP.

B. Is your family qualified for food stamps? ☐ Yes ☐ No

C. Are you receiving Temporary Assistance to Needy Families (TANF) (Formerly Aid to Families with Dependent Children or Public Assistance)? ☐ Yes ☐ No

Please return this form to: Patricia Aguirre, Director at Western Hills Academy.

An adult household member must sign the application.

I certify (promise) that all information on this application is true and that all income is reported. I understand that the school will get Federal funds based on the information I give. I understand that school officials may verify (check) the information. I understand that if I purposely give false information I may be prosecuted.

Signature of adult household member	Printed name of adult household member	Date
Street Address	City, State, Zip Code	Phone Number

Completed forms to be filed and maintained in the Private Non-Profit School Office for auditing purposes.

Revised 06/04/2020

OForma de Determinación de Ingresos

EPISD
EL PASO INDEPENDENT SCHOOL DISTRICT | AM EPISD

ELL Compliance

EL PASO INDEPENDENT SCHOOL DISTRICT HOME LANGUAGE SURVEY

19 TAC Chapter 89, Subchapter BB, §89.1215

(Home Language Survey applicable ONLY if administered for students enrolling in pre-kindergarten through grade 12)

TO BE COMPLETED BY PARENT OR GUARDIAN FOR STUDENTS ENROLLING IN PREKINDERGARTEN THROUGH GRADE 8 (OR BY STUDENT IN GRADES 9-12): The state of Texas requires that the following information be completed for each student who enrolls in a Texas public school for the first time. It is the responsibility of the parent or guardian, not the school, to provide the language information requested by the questions below.

Dear Parent or Guardian:

To determine if your child would benefit from Bilingual and/or English as a Second Language program services, please answer the two questions below.

If either of your responses indicates the use of a language other than English, then the school district must conduct an assessment to determine how well your child communicates in English. This assessment information will be used to determine if Bilingual and/or English as a Second Language program services are appropriate and to inform instructional and program placement recommendations. If you have questions about the purpose and use of the Home Language Survey, or you would like assistance in completing the form, please contact your school/district personnel.

For more information on the process that must be followed, please visit the following website:
https://projects.esc20.net/upload/page/0081/docs/JuneUpdates/EnglishLearnerIdentification-ReclassificationFlowchart.pdf

This survey shall be kept in each student's permanent record folder.

NAME OF STUDENT: _____ **STUDENT ID#:** _____

ADDRESS: _____ **TELEPHONE #:** _____

CAMPUS: _____

NOTE: PLEASE INDICATE ONLY ONE LANGUAGE PER RESPONSE.

1. What language is spoken in the child's home **most of the time**? _____
2. What language does the child speak **most of the time**? _____

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Student if Grades 9-12 Date

NOTE: If you believe you made an error when completing this Home Language Survey, you may request a correction, in writing, only if: 1) your child has not yet been assessed for English proficiency; and 2) your written correction request is made within two calendar weeks of your child's enrollment date

Western Hills Academy

524 Thunderbird Dr.
El Paso, TX. 79912
Tel: (915) 584-6642

(Form to be completed by child's physician and returned to school with enrollment packet)

Physician's Statement

I have examined _____ and see no physical or emotional reason to restrict participation in activities at school.

I have noted the following, if applicable:

Restrictions of activity:

Special attention or care needed:

Date_____ Signed _____
(Physician)

***Please attach a copy of the child's immunization record to this form**

Revised June 2015