Kingsman Academy
Public Charter School

Student Enrollment Documentation

In addition to the forms that follow, the following items must be presented in the original (not copies) and in person at the school.

Student Birth Certificate
A student birth certificate (original, not a copy) must be presented in person to the school.

Parent/Guardian Proof of Identity
Proof of identity must be submitted in person, and must be an unexpired, legal form of identification (drivers license, state ID, or passport).

Most Recent Report Card (new students only)
The student's most recent report card must be presented in person to the school.

Proof of Immunization
All students attending school in DC must present proof of appropriately spaced immunizations by the first day of school. A list of immunization requirements is included in this packet.

Proof of Residency
To attend Kingsman Academy, the student must reside in the District of Columbia.

Proof of Residency can only be submitted in person and forms must be originals, not copies, with the name of the parent or legal guardian enrolling the student.

Please submit ONE of the following:

- a pay stub issued within 45 days with your DC address and DC taxes (not MD or VA)
- proof of financial assistance from the DC Government on official letterhead or sent directly from a DC office (such as Housing Assistance, TANF, or Food Stamps)
- Supplemental Security Income (SSI) annual benefits notification
- Military Housing Orders and Verification Letter

Or TWO of the following with the same name and address on both documents:

- unexpired DC drivers license (or other official non-driver identification)
- unexpired DC motor vehicle registration
- unexpired lease or rental agreement with proof of payment or receipt
- a utility bill (only gas, electric and water bills are acceptable) with proof of payment or receipt

If you have questions about enrollment, please email enroll@kingsmanacademy.org or call the school at (202) 547-1028

Kingsman Academy
Public Charter School

2020-2021 School Year

SEAT ACCEPTANCE FORM

Parents/Guardians/Adult Students: Please complete this form to confirm your acceptance of a seat at Kingsman Academy Public Charter School. Acceptance of a seat within two (2) weeks of the offer guarantees enrollment at Kingsman Academy but does not guarantee enrollment in any specific program.

Student Information

You must fill out one form for each student enrolling in grades 6-12 at Kingsman Academy.

First and Last Name:	**Date of Birth (MM/DD/YYYY):**
Current School (2019-20):	**Current Grade (2019-20):**
Enrolling School (2020-21): Kingsman Academy PCS	**Enrolling Grade (2020-21):**

Records Release

Please read and sign the bottom of this form so that the enrolling school can request the student's records.

By signing this form, I authorize the enrolling school to request records from the current school for the student above. I also hereby authorize the enrolling school to request records from any other previous schools that the student above has attended. I understand that the enrolling school will not further transfer or communicate the records to any other party or agency without my express written consent except under authority of the Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99).

Enrollment Confirmation

Please read and sign the bottom of this form to confirm your understanding of each statement and the student's enrollment for the 2020-21 school year.

I understand that I cannot maintain enrollment at more than one school for the 2020-21 school year and I am confirming my enrollment at Kingsman Academy Public Charter School.

I understand that once this form is submitted, I will give up my space at my current school for the 2020-21 school year.

Parent/Guardian/Adult Student Information

This should be the same person completing the form.

Signature: _____ **Print Name:** _____ **Date:** _____

FOR OFFICE USE ONLY **Application Tracking #:** _____

DC HEALTH Universal Health Certificate

Use this form to report your child's physical health to their school/child care facility which is required by DC Official Code §38-602. Have a licensed medical professional complete part 2 - 4.

Part 1: Child Personal Information | To be completed by parent/guardian.

Child Last Name:	**Child First Name:**	**Date of Birth:**
School or Child Care Facility Name:	**Gender:** ❑ Male ❑ Female ❑ Non-Binary	
Home Address:	**Apt:** / **City:** / **State:** / **ZIP:**	
Ethnicity: *(check all that apply)*	❑ Hispanic/Latino ❑ Non-Hispanic/Non-Latino ❑ Other ❑ Prefer not to answer	
Race: *(check all that apply)*	❑ American Indian/ Alaska Native ❑ Asian ❑ Native Hawaiian/ Pacific Islander ❑ Black/African American ❑ White ❑ Prefer not to answer	
Parent First Name:	**Parent Last Name:**	**Parent Phone:**
Emergency Contact Name:	**Emergency Contact Phone:**	
Insurance Type: ❑ Medicaid ❑ Private ❑ None	**Insurance Name/ID #:**	
Has the child seen a dentist/dental provider within the last year? ❑ Yes ❑ No		

I give permission to the signing health examiner/facility to share the health information on this form with my child's school, child care, camp, or appropriate DC Government agency. In addition, I hereby acknowledge and agree that the District, the school, its employees and agents shall be immune from civil liability for acts or omissions under DC Law 17-107, except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct. I understand that this form should be completed and returned to my child's school every year.

Parent/Guardian Signature: _____ **Date:** _____

Part 2: Child's Health History, Exam, and Recommendations | To be completed by licensed health care provider.

Date of Health Exam:	**BP:** ____/____ ❑ NML ❑ ABNL	**Weight:** ❑ LB ❑ KG	**Height:** ❑ IN ❑ CM	**BMI:**	**BMI Percentile:**

Vision Screening: Left eye: 20/_____ Right eye: 20/_____ ❑ Corrected ❑ Uncorrected ❑ Wears glasses ❑ Referred ❑ Not tested

Hearing Screening: *(check all that apply)* ❑ Pass ❑ Fail ❑ Not tested ❑ Uses Device ❑ Referred

Does the child have any of the following health concerns? *(check all that apply and provide details below)*

- ❑ Asthma
- ❑ Autism
- ❑ Behavioral
- ❑ Cancer
- ❑ Cerebral palsy
- ❑ Development
- ❑ Diabetes
- ❑ Failure to thrive
- ❑ Heart failure
- ❑ Kidney Failure
- ❑ Language/Speech
- ❑ Obesity
- ❑ Scoliosis
- ❑ Seizures
- ❑ Sickle Cell
- ❑ Significant food/medication/environmental allergies that may require emergency medical care. *Details provided below.*
- ❑ Long-term medications, over-the-counter-drugs (OTC) or special care requirements. *Details provided below.*
- ❑ Significant health history, condition, communicable illness, or restrictions. *Details provided below.*
- ❑ **Other:**_____

Provide details. If the child has Rx/treatment, please attach a complete Medication/Medical Treatment Plan form; and if the child was referred, please note. _____

_____

TB Assessment | Positive TST should be referred to Primary Care Physician for evaluation. For questions call T.B. Control at 202-698-4040.

What is the child's risk level for TB?

❑ High → *complete skin test and/or Quantiferon test*

❑ Low

Skin Test Date: / **Quantiferon Test Date:**

Skin Test Results: ❑ Negative ❑ Positive, CXR Negative ❑ Positive, CXR Positive ❑ Positive, Treated

Quantiferon Results: ❑ Negative ❑ Positive ❑ Positive, Treated

Additional notes on TB test:

Lead Exposure Risk Screening | All lead levels must be reported to DC Childhood Lead Poisoning Prevention. Call 202-654-6002 or Fax: 202-535-2607

ONLY FOR CHILDREN UNDER AGE 6 YEARS *Every child must have 2 lead tests by age 2*	**1st Test Date:**	**1st Result:** ❑ Normal	❑ Abnormal, **Developmental Screening Date:**	**1st Serum/Finger Stick Lead Level:**
	2nd Test Date:	**2nd Result:** ❑ Normal	❑ Abnormal, **Developmental Screening Date:**	**2nd Serum/Finger Stick Lead Level:**

HGB/HCT Test Date: / **HGB/HCT Result:**

Part 3: Immunization Information | To be completed by licensed health care provider.

Immunizations	Provide in the boxes below the dates of Immunization (MM/DD/YY)						
Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	5		
DT (<7 yrs.)/ Td (>7 yrs.)	1	2	3	4	5		
Tdap Booster	1						
Haemophilus influenza Type b (Hib)	1	2	3	4			
Hepatitis B (HepB)	1	2	3	4			
Polio (IPV, OPV)	1	2	3	4			
Measles, Mumps, Rubella (MMR)	1	2					
Measles	1	2					
Mumps	1	2					
Rubella	1	2					
Varicella	1	2	Child had Chicken Pox (month & year):				
Pneumococcal Conjugate	1	2	3	4			
Hepatitis A (HepA) (Born on or after 01/01/2005)	1	2					
Meningococcal Vaccine	1	2					
Human Papillomavirus (HPV)	1	2	3				
Influenza (Recommended)	1	2	3	4	5	6	7
Rotavirus (Recommended)	1	2	3				

❑ The child is **behind on immunizations** and there is a plan in place to get him/her back on schedule. **Next appointment is:** _____

Medical Exemption (if applicable)
I certify that the above child has a valid medical contraindication(s) to being immunized at the time against:

❑ Diphtheria ❑ Tetanus ❑ Pertussis ❑ Hib ❑ HepB ❑ Polio ❑ Measles
❑ Mumps ❑ Rubella ❑ Varicella ❑ Pneumococcal ❑ HepA ❑ Meningococcal ❑ HPV

Alternative Proof of Immunity (if applicable)
I certify that the above child has laboratory evidence of immunity to the following and I've attached a copy of the titer results.

❑ Diphtheria ❑ Tetanus ❑ Pertussis ❑ Hib ❑ HepB ❑ Polio ❑ Measles
❑ Mumps ❑ Rubella ❑ Varicella ❑ Pneumococcal ❑ HepA ❑ Meningococcal ❑ HPV

Part 4: Licensed Health Practitioner's Certifications | To be completed by licensed health care provider.

This child has been appropriately examined and health history reviewed and recorded in accordance with the items specified on this form. At the time of the exam, this child is **in satisfactory health** to participate in all school, camp, or child care activities except as noted on page one. ❑ No ❑ Yes

This child is cleared for **competitive sports.** Additional clearance(s) needed from: _____ ❑ N/A ❑ No ❑ Yes ❑ Yes, pending additional clearance

I hereby certify that I examined this child and the information recorded here was determined as a result of the examination.

Licensed Health Care Provider Office Stamp	**Provider Name:**
	Provider Phone:
	Provider Signature:
	Date:

Access health insurance programs at https://dchealthlink.com. You may contact the Health Suite Personnel through the main office at your child's school.

OFFICE USE ONLY | Universal Health Certificate received by School Official and Health Suite Personnel.

School Official Name:	**Signature:**	**Date:**
Health Suite Personnel Name:	**Signature:**	**Date:**

DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

Oral Health Assessment Form

For all students aged 3 years and older, use this form to report their oral health status to their school/child care facility.

Instructions

- Complete Part 1 below. Take this form to the student's dental provider. The dental provider should complete Part 2.
- Return fully completed and signed form to the student's school/child care facility.

Part 1: Student Information (To be completed by parent/guardian)

First Name _____ Last Name _____ Middle Initial _____

School or Child Care Facility Name _____

Date of Birth (*MMDDYYYY*) ☐☐☐☐☐☐☐☐

Home Zip Code ☐☐☐☐☐

School Grade

Day-care	Pre-K3	Pre-K4	1	2	3	4	5	6	7	8	9	10	11	12	Adult Ed.
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Part 2: Student's Oral Health Status (To be completed by the dental provider)

	Yes	No
Q1 Does the patient have at least one tooth with **apparent cavitation** (untreated caries)? This does NOT include stained pit or fissure that has no apparent breakdown of enamel structure or non-cavitated demineralized lesions (i.e. white spots).	☐	☐
Q2 Does the patient have at least one **treated carious tooth**? This includes any tooth with amalgam, composite, temporary restorations, or crowns as a result of dental caries treatment.	☐	☐
Q3 Does the patient have at least one permanent molar tooth with a **partially or fully retained sealant**?	☐	☐
Q4 Does the patient have untreated caries or other oral health problems requiring **care before his/her routine check-up**? **(Early care need)**	☐	☐
Q5 Does the patient have **pain, abscess, or swelling? (Urgent care need)**	☐	☐

Q6 How many of **primary teeth** in the patient's mouth are affected by caries that are either **untreated or treated with fillings/crowns**?

Total Number ☐☐

Q7 How many of **permanent teeth** in the patient's mouth are affected by caries that are either **untreated, treated with fillings/crowns, or extracted due to caries**?

Total Number ☐☐

Q8 What type of dental insurance does the patient have?

Medicaid ☐ Private Insurance ☐ Other ☐ None ☐

Dental Provider Name _____

Dental Provider Signature _____

Dental Examination Date _____

Dental Office Stamp

This form replaces the previous version of the DC Oral Health Assessment Form used for entry into DC Schools, all Head Start programs, and child care centers. This form is approved by the DC Health and is a confidential document. Confidentiality is adherent to the Health Insurance Portability and Accountability Act of 1996 (HIPPA) for the health providers and the Family Education Right and Privacy Act (FERPA) for the DC Schools and other providers.

DC | HEALTH

Medication and Medical Procedure Treatment Plan

Use this form to detail your student's medication and/or medical procedure plan to be administered at their school and return it to the Health Suite Personnel. The Health Suite Personnel will contact you to arrange medication/medical supply drop-off. For multiple needs, complete multiple sheets.

Part 1: Student and Parent/Caretaker Information | To be completed by student's parent/caretaker.

Student First Name:	**Student Last Name:**	**Grade:**
School Facility Name:		**Student DOB:**
Parent First Name:	**Parent Last Name:**	
Parent Email:		**Parent Phone:**

I hereby request and authorize Health Suite Personnel to administer prescribed medication/treatment as directed by the licensed health care providers to the student named in Part I. I understand that:

- I am responsible for bringing the necessary medications/medical supplies to school for the Health Suite Personnel.
- All medication/medical supplies will be stored in a secured area of the school. Health Suite Personnel will not assume any responsibility for possible loss of student medication/medical supplies.
- Within one week of the expiration of the medication/medical supplies and/or within one week of the end of the school year, I must collect what is unused or it will be destroyed.
- The School or Health Suite Personnel will not assume any responsibility for unauthorized medication/treatments that the student gives to himself/herself.
- If any changes occur in my student's health or treatment plan, I will immediately notify the school and health suite personnel annually as required by DC Official Code § 38-651.03.
- Treatment plans and medication plans must be updated annually and when there is any change in the student's health or treatment requirements.
- I hereby acknowledge that the District, and its schools, employees, and agents shall be immune from civil liability for acts of omissions under DC Law 17-107 except for criminal acts, intentional wrongdoing, gross negligence, or willful misconduct.

Parent/Caretaker Signature: _____ **Date:** _____

Part 2a: Student's Medication Plan | To be completed by licensed health care provider.

Diagnosis:	**End date for school administration of this medication:**

This medication is: ❑ New; the first dose was given at home on date and time: _____ ❑ Renewal ❑ Change

Is this a standing order?
- ❑ Yes, epinephrine auto injector 0.15 mg: *refer to anaphylaxis plan*
- ❑ Yes, epinephrine auto injector 0.3 mg: *refer to anaphylaxis plan*
- ❑ Yes, albuterol sulfate 90 mcg/inh: *refer to asthma action plan*
- ❑ Yes, other: _____
- ❑ No

Name and strength of medication:	**Dose/route:**

Time and Frequency at School *(e.g. 10am and 2pm every day; as needed if standing order)*

If a reaction can be expected, please describe:

Additional instructions or emergency procedures:

Part 2b: Student's Medical Procedure Treatment Plan | To be completed by licensed health care provider.

Diagnosis:	**This procedure is:** ❑ New ❑ Renewal ❑ Change

Treatment:

When should treatment be administered at school? *(e.g. 10am and 2pm every day)*

End date for school administration of this treatment:

Additional instructions or emergency procedures:

Has the student's Universal Health Certificate form been updated to reflect new health concerns? ❑ Yes ❑ No

Licensed Health Care Provider Office Stamp

Provider Name:	
Provider Phone:	
Provider Signature:	**Date:**

OFFICE USE ONLY | Medication and/or treatment plan received by Health Suite Personnel.

Name:	**Signature:**	**Date:**

Office of the
State Superintendent of Education

OSSE Home Language Survey (HLS) Form

Complete this Home Language Survey at the Student's initial enrollment in a District of Columbia School.

This form must be signed and dated by the Parent or Guardian. This form must be kept in the student's file.

School: _____ **Student ID #:** _____

Student's Last Name: _____ **Student's First Name** _____

English

1. **Is a language other than English spoken in your home?**
   ☐ No ☐ Yes _____ **(specify language)**
2. **Does your child communicate in a language other than English?**
   ☐ No ☐ Yes _____ **(specify language)**
3. **What is your relationship to the child?**
   ☐ Father ☐ Mother ☐ Guardian ☐ Other (specify)_____

If the answer to question 1 or 2 is Yes, the law requires your child's English language proficiency to be assessed.

REGISTRAR PROCESS:

- If a parent/guardian does not speak English and your school does not have staff that speaks the parent/guardian's language, please use the Language Line for communication (1-800-752-6096).
- If the HLS indicates a language other than English is spoken in the home, then further assessment must be conducted to determine the student's English-language proficiency level.

Español (Spanish)

1. **¿Se habla otro idioma que no sea el inglés en su casa?**
   ☐ No ☐ Sí _____(idioma)
2. **¿Habla el estudiante un idioma que no sea el inglés?**
   ☐ No ☐ Sí _____(idioma)
3. **¿Cuál es su relación con el estudiante?**
   ☐ Padre ☐ Madre ☐ Guardián ☐ Otro (especifique)_____

Si la respuesta a la pregunta 1 ó 2 es "Sí", la ley requiere que se evalúe la fluidez de su hijo/a en el idioma inglés.

Français (French)

1. **Parlez-vous une langue autre que l'anglais à la maison ?**
   ☐ Non ☐ Oui _____ **(spécifiez la langue)**
2. **Votre enfant communique-t-il dans une langue autre que l'anglais ?**
   ☐ Non ☐ Oui _____ **(spécifiez la langue)**
3. **Quel est votre relation avec l'enfant ?**
   ☐ Père ☐ Mère ☐ Tuteur ☐ Autre (spécifiez) _____

Si la réponse à la question 1 ou 2 est Oui, la loi exige que les compétences de votre enfant en anglais soit évaluées.

中文 (Chinese)

1. 您家庭中是否使用不是英语的另外一种语言?
   ☐ 否 ☐ 是 _____ (请指明语言)
2. 您的孩子会使用不是英语的另一种语言交流吗?
   ☐ 不会 ☐ 会 _____ (请指明语言)
3. 您和孩子的关系是什么?
   ☐ 父亲 ☐ 母亲 ☐ 监护人 ☐ 其它(请指明) _____

如果第一或第二项问题的答案为"是"，法律要求评估您孩子的英语熟练能力（English language proficiency）。

Tiếng Việt (Vietnamese)

1 **Có ngôn ngữ nào khác ngoài tiếng Anh được nói ở nhà quý vị không?**
   ☐ Không ☐ Có _____ **(xin ghi rõ ngôn ngữ nào)**
2 **Con em quý vị có nói một ngôn ngữ nào khác ngoài tiếng Anh không?**
   ☐ Không ☐ Có _____ **(xin ghi rõ ngôn ngữ nào)**
3. **Xin cho biết liên hệ của quý vị với con em?**
   ☐ Cha ☐ Mẹ ☐ Giám hộ ☐ Liên hệ khác (xin ghi rõ)

_____

Nếu trả lời của câu hỏi 1 hoặc 2 là Có, luật lệ đòi hỏi con em quý vị phải được thẩm định trình độ thông thạo Anh ngữ.

አማርኛ (Amharic)

1. በቤትዎ ውስጥ ከእንግሊዘኛ ሌላ የሚነገር ቋንቋ አለ ?
   ☐ የለም ☐ አዎን _____ (ቋንቋውን ይጥቀሱ)
2. ልጅዎ ከእንግሊዘኛ ሌላ የሚነጋገርበት ሌላ ቋንቋ አለ?
   ☐ የለም ☐ አዎን _____ (ቋንቋውን ይጥቀሱ)
3. ለልጁ ያለዎት ዝምድና ምንድን ነው?
   ☐ አባት ☐ እናት ☐ አሳዳጊ ☐ ሌላ_____ (ይገለጽ)

ለጥያቄ 1 ወይም 2 መልስዎ አዎን ከሆነ፣ የልጅዎ የእንግሊዘኛ ቋንቋ ቅልጥፍና ችሎታው ደረጃ እንዲገመገም ህጉ ያዛል።

School Official's Comments:

_____ _____

Signature of School Official **Date** **Signature of Parent/Guardian** **Date**

Kingsman Academy
Public Charter School

Releases, Consents, & Authorizations

School Year 2019–20

Student & Parent/Guardian Information

Student's First Name: _____ Parent's First Name: _____

Student's Last Name: _____ Parent's Last Name: _____

Student's Date of Birth: _____

❑ Check this box if the student is an adult enrolling himself or herself in school.

Records Release

By signing below I authorize Kingsman Academy Public Charter School to request records from all schools the student above has attended. I understand that Kingsman Academy will not further transfer or communicate the records to any other party or agency without my express written consent except under the authority of the Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99).

Parent/Guardian/Adult Student Signature: _____ Date: _____

Field Trip Authorization (Optional)

I understand that the student above may have the opportunity to participate in field trips that will take him or her away from campus. I understand that these trips will be under the direct supervision of a Kingsman Academy Public Charter School faculty member and that the student above will be transported either by public transportation, a Kingsman Academy vehicle, or a for-hire vehicle.

I request that the student above be allowed to attend such field trips.

I authorize any medical treatment in case of emergency and agree that I am responsible for the cost of such treatment.

I agree to release, hold harmless and indemnify Kingsman Academy Public Charter School, its agents, representatives, and employees from all claims, damages, or other liabilities for injuries to the student above that are not the result of gross negligence, intentional neglect or willful or wanton conduct by the school or its agents, representatives, or employees.

I understand that any trips that take my student out of the District of Columbia metropolitan area or that require an overnight stay will require a separate permission form that will be provided to me by Kingsman Academy.

Parent/Guardian/Adult Student Signature: _____ Date: _____

Media Release (Optional)

By signing below, I hereby grant Kingsman Academy Public Charter School and its employees, agents, successors, and assignees the right to: (1) record the image and voice of the student above; (2) edit such recordings at their discretion; and (3) use such recordings, along with the artwork and written work of the student on videotape, in photographs, in digital media, and in any other form of electronic or print media. I understand that this release does not grant Kingsman Academy the right to disclose any biographical or other identifying information regarding the student above and that I may revoke this consent at any time by contacting the school.

I hereby release Kingsman Academy, its successors, its assignees, and anyone using image, voice, artwork, and/or written work of the student above pursuant to this release from any and all claims, damages, liabilities, costs, and expenses which I or the student above now have or may hereafter have by reason of any use thereof.

I understand that the provisions of this release are legally binding. This consent is valid through the end of the school year and can be revoked at any time.

❑ I consent. ❑ I do not consent.

Parent/Guardian/Adult Student Signature: _____ Date: _____

Release of Information to Military Recruiters (Optional)

Federal laws require Kingsman Academy Public Charter School to provide military recruiters, upon request, with the name, address, and telephone number ("information") of all sixth through twelfth-grade students unless the parent/guardian or adult student has opted out of such disclosure by signing below. This opt-out is valid throughout the student's time enrolled at Kingsman Academy Public Charter School and can be revoked at any time.

❑ I request that Kingsman Academy not release the information of the student above to military recruiters.

Parent/Guardian/Adult Student Signature: _____ Date: _____

Consent to Social and Emotional Health Services (Optional)

Kingsman Academy Public Charter School has highly qualified professionals to help students experiencing stress, sadness, anger, or other emotions that can affect their lives. By signing below, you authorize Kingsman Academy professionals to begin working with the student above. You will be notified and included in any plan for services, consistent with best practices. The student's information will be reviewed by the school's mental health and behavioral support professionals and will be handled confidentially. This consent is valid through the end of the school year and can be revoked at any time.

If you consent, please check which of the following your student has or is experiencing:

❑ Parental divorce/separation ❑ Homelessness ❑ Foster care ❑ Incarcerated parent

❑ Death of close family ❑ Incarceration ❑ Other trauma: _____

Would you like to be contacted to discuss further? ❑ Yes ❑ No

Parent/Guardian/Adult Student Signature: _____ Date: _____

Google Apps Consent (Optional)

Kingsman Academy Public School uses G Suite for Education, and we are seeking your permission to provide and manage a G Suite for Education account for the student above. G Suite for Education is a set of education productivity tools from Google including Gmail, Calendar, Docs, Classroom, and more used by tens of millions of students and teachers around the world. Kingsman Academy students use their G Suite accounts to complete assignments, communicate with their teachers, sign into Chromebooks, and learn 21st-century digital citizenship skills.

Kingsman Academy has a notice that provides answers to common questions about what Google can and can't do with the personal information of the student above, including:

- What personal information does Google collect?
- How does Google use this information?
- Will Google disclose the student's personal information?
- Does Google use student personal information for users in K-12 schools to target advertising?
- Can the student share information with others using the G Suite for Education account?

The notice is posted on the school website and available in print by request. Please read it carefully, let us know of any questions, and then sign below to indicate that you've read the notice and give your consent. If you don't provide your consent, we will not create a G Suite for Education account for the student above. Students who cannot use Google services may need to use other software to complete assignments or collaborate with peers.

By signing below, I give permission for Kingsman Academy to create/maintain a G Suite for Education account for the student above and for Google to collect, use, and disclose information about the student above only for the purposes described in the notice described above.

Parent/Guardian/Adult Student Signature: _____ Date: _____

Kingsman Academy
Public Charter School

STUDENT HANDBOOK ACKNOWLEDGMENT FORM

Student's First Name	Student's Last Name

Each year, Kingsman Academy Public Charter School publishes the Student and Family Handbook, which contains the most current information about school policies and procedures. The 2019-20 Student and Family Handbook can be downloaded from the school website on the Resources page beginning on August 1, 2019. Hard copies of the handbook are available upon request. Please note policies and expectations may have changed from the previous year.

If you have questions about any of the school policies, please contact the main office at (202) 547-1028.
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Please complete the following form, acknowledging that you have reviewed the 2019-20 Student and Family Handbook. Forms must be submitted no later than September 13, 2019.

Student's Signature	Date

Parent/Guardian's Signature	Date

DC HEALTH Immunization Requirements for School Year 2019-2020

All students attending school in DC must present proof of appropriately spaced immunizations by the first day of school. Provide this sheet to your child's licensed health professional to ensure proper immunization.

On the first day of school my student is:	By the start of SY19-20, my student should have received:[i]
2-3 years old	4 doses of Diphtheria/Tetanus/Pertussis (DTaP) 3 doses of Polio 1 dose of Varicella if no history of chickenpox [ii] 1 dose of Measles/Mumps/Rubella (MMR) 3 doses of Hepatitis B 2 doses of Hepatitis A 3 or 4 doses *depending on the brand* of Hib (Haemophilus Influenza Type B) 4 doses of PCV (Pneumococcal)
4 years old	5 doses of Diphtheria/Tetanus/Pertussis (DTaP) 4 doses of Polio 2 doses of Varicella if no history of chickenpox[ii] 2 doses of Measles/Mumps/Rubella (MMR) 3 doses Hepatitis B 2 doses Hepatitis A 3 or 4 doses *depending on the brand* of Hib (Haemophilus Influenza Type B) 4 doses of PCV (Pneumococcal)
5-10 years old	5 doses of Diphtheria/Tetanus/Pertussis (DTaP) 4 doses of Polio 2 doses of Varicella if no history of chickenpox[ii] 2 doses of Measles/Mumps/Rubella (MMR) 3 doses of Hepatitis B 2 doses of Hepatitis A
11+ years old	5 doses of Diphtheria/Tetanus/Pertussis (DTaP)/Td 1 dose of Tdap 4 doses of Polio 2 doses of Varicella if no history of chickenpox[ii] 2 doses of Measles/Mumps/Rubella (MMR) 3 doses of Hepatitis B 2 doses of Hepatitis A[iii] 1 dose of Meningococcal (Men ACWY)[iv] 2 or 3 doses of Human Papillomavirus Vaccine (HPV)[v]

[i] The number of doses required varies by a child's age and how long ago they were vaccinated. Please check with your child's health suite personnel or health care provider for details.

[ii] All Varicella/chickenpox histories MUST be verified by a health care provider and documented with month and year of disease.

[iii] If born on or after 01/01/05.

[iv] Dose #1 at 11-12 years of age is required. A booster dose is recommended at 16 years of age.

[v] Two doses if student receives first dose between ages 9 -14 (doses 6-12 months apart); 3 doses if student starts series on or after age 15.