

INITIAL DATA FORM: KANSAS SCHOOL FOR THE DEAF

450 E. Park, Olathe, KS 66061; 913-210-8149
FAX 913-324-0601

Has your child attended KSD before? Yes No Dates: _____ Number _____

Date Received _____ Date Enrolled _____ Date Entered _____ Official Exit Date _____

IMPORTANT: This will become part of the permanent record of your child if he/she attends KSD. Please answer all questions carefully and accurately. **Write clearly** with **black** ink. Please return this form promptly.

A. Student Information:

Name: First Middle Last Birthdate M / F Sex

Nickname Age USD # Grade Social Security # Birth City Birth State

Parental Status of biological parents: Married Divorced Separated Single

Student lives with: Mother / Step-Mother / Foster Mother Father / Step -Father / Foster Father Guardian
(Circle all that apply)

Parent Home Information:

Mother's Full Name
Deaf or Hard of Hearing? Yes No

Father's Full Name
Deaf or Hard of Hearing? Yes No

Street

Street

City

City

State Zip Code County

State Zip Code County

Daytime Phone Landline Cell Videophone

Daytime Phone Landline Cell Videophone

Evening Phone Landline Cell Videophone

Evening Phone Landline Cell Videophone

Cell Provider

Cell Provider

E-Mail

E-Mail

Parent Work Information:

Mother's Occupation

Father's Occupation

Employer

Employer

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Street _____

Street _____

City _____ State _____ Zip _____

City _____ State _____ Zip _____

Work Phone Landline Cell Videophone

Work Phone Landline Cell Videophone

E-Mail _____

E-Mail _____

Guardian Information: Is there legal documentation to support this guardianship? Yes No

Guardian's Full Name _____
Deaf or Hard of Hearing? Yes No

Guardian's Occupation _____

Street _____

Employer _____

City _____

Street _____

State _____ Zip Code _____ County _____

City _____ State _____ Zip _____

Daytime Phone Landline Cell Videophone

Work Phone Landline Cell Videophone

Evening Phone Landline Cell Videophone

E-Mail _____

Cell Provider _____

Case Manager Name & Contact Info _____

E-Mail _____

B. Vision Does your child wear glasses/contacts? Yes No Family history of vision concerns? Yes No

Has your child ever had eye surgery? Yes No

Has your child ever been seen by an ophthalmologist or optometrist? Yes No

Other vision information about your child _____

The Kansas School for the Deaf is committed to a policy of non-discrimination on the basis of race, sex, national origin, handicap or other non-merit reasons, in admissions, education programs or activities, and employment, all as required by applicable laws and regulations. Inquiries may be addressed to: Affirmative Action Director, Kansas School for the Deaf, 450 East Park, Olathe, KS 66061.

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C. Hearing Loss Was the child born deaf? Yes No

Number of children in family? _____ At what age did you first suspect the child was deaf? _____

What was the cause of the hearing loss? _____

Name of the other Deaf/Hard of Hearing children in the family? _____

Does your child have a cochlear implant? Yes No Is the CI in: Both Ears? Right Ear Left Ear

When did your child get the implant? RE _____ LE _____

Who does your child see for CI mapping? _____

Does your child have a hearing aid? Yes No Both ears Right only Left only

If yes, who made the aid recommendation? _____

When did your child begin using an aid? _____ How old is the aid? _____

Does the child have sign language skills? Yes No
Does the child have speech which can be understood by members of the family? Yes No
Does the child have speech which can be understood by strangers? Yes No

D. Habits

Can the child wash and dress himself? Yes No Can the child go to the toilet without help? Yes No

What other information can you provide about your child which the dorm or classroom teachers should know about your child's personal habits, i.e. bed-wetting, allergies, eating habits, etc.?

Please list all people, agencies, clinics, etc., you have consulted about your child's hearing loss (most recent first).

Date	Name & Address	What were you told?

Education: Please list all schools (including pre-school) your child has attended (most recent first).

Dates Attended	School	Address

Date _____ Signature of Person Completing the Form _____

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Authorization for the Release of Information

Student _____ Date of Birth _____

I hereby authorize: _____

To release the following information from any records maintained on my child:

- All educational records, including those listed below
- Audiological records
- School Transcripts
- Current IEP/Three Year Evaluation/Re-evaluation
- Testing/evaluation/consent for placement in Special Education Programs
- Guidance and Counseling records
- Health records including immunization
- Notice and consent for related services (speech therapy, OT, PT, etc.)
- Vision Records
- Other: (specify) _____

To be sent to: **Kansas School for the Deaf**
Attention: Admissions
450 E. Park
Olathe, KS 66061
(913) 210-8149 / (913) 324-0601 fax
ksdoutreach@kssdb.org

I understand that I have the right to revoke this authorization at any time, except when actions have already been taken on the basis of this authorization. To revoke this authorization, I must provide written notice to the Kansas School for the Deaf by registered mail; return receipt requested.

Signature Date

Relationship to Student