KINDERGARTEN REGISTRATION

Students need to be 5 by Aug 1, 2017 – documented by an official Birth Certificate

Please complete this packet & return it as soon as possible!

This checklist is just for your own use. Please check off as you fill in or gather the following information and include all items with your packet.

PLEASE USE YOUR CHILD'S FULL LEGAL NAME! YOUR CHILD'S EDUCATION RECORD IS A LEGAL DOCUMENT AND WE MUST USE THEIR LEGAL NAME OF OFFICIAL RECORDS. (Of course, your child may use their "nick-name" in the classroom.)

_____ 1. *Birth Certificate* - ***MANDATORY***
_____ 2. Current *Immunization Record* (even if not complete)
_____ 3. Kindergarten *Enrollment Form* (Signature Required)
_____ 4. IN State Dept. of Health's Children's & Hoosier's Immunization Registry Program (CHIRP) (Signature Required)
_____ 5. Race & Ethnicity Form (Signature required)
_____ 6. Residency Form (Signature Required)
_____ 7. Home Language Survey (mandatory from the Federal Dept of Education)
_____ 8. Divorce Decree or Legal Custody Court Papers - copied (if applicable)
(We can copy these in the school office, if necessary)
_____ 9. **Physician & Dental Form (Health Appraisal) – This form *should* be turned in as soon as possible, but it *is REQUIRED no later than the first day of school*.**
_____ 10. IN. Department of Education Work Survey (Required)

Doctor appointment made: Date _____Time_____
Dentist appointment made: Date _____Time_____

We do ask that your child complete a physical and dental checkup before coming to Kindergarten. ***Please make an appointment ASAP with your child's physician and dentist, as those appointments fill up quickly.*** *We'd like the attached physical and dental form returned to the school nurse by the end of the current school year, but* ***NO LATER THAN THE FIRST DAY OF SCHOOL IN AUGUST!***

********Students may not attend school beyond the first day if there is no proof of the required immunizations being administered.***

Thank you for your cooperation!

++

CHECK HERE IF INFORMATION HAS CHANGED SINCE LAST YEAR _____

SUNMAN-DEARBORN COMMUNITY SCHOOLS
STUDENT AND HEALTH INFORMATION

GRADE_____

TEACHER_____

Student: _____ ____ ____ _____
(Last Name) (First Name) (Middle Name) M/F Age Date of birth

Mailing Address: _____
(Street/ PO Box) (City) (Zip Code)

(If you have a P.O. Box, list your 9-1-1 Address) _____

County: _____ Email address: _____

Home Phone: (____) _____ Preferred weather related phone number _____

Preferred number for Emergency/Disaster _____ Preferred Early Dismissal Number _____

Student rides Bus # _____ AM (Circle) From: Home From: Daycare or Sitter

Student rides Bus # _____ PM (Circle) To: Home To: Daycare or Sitter

Race (circle): Asian or Pacific Islander Black White Hispanic American Indian Multiracial

Is parent(s)/guardian(s) currently active military personnel? **YES** _____ **NO**_____

Student Lives With (circle): Mother Stepmother Other (relationship) _____

Name: _____ Employer: _____

Cell Phone (_____) _____ Work Phone: (_____) _____

Student Lives With (circle): Father Stepfather Other (relationship) _____

Name: _____ Employer: _____

Cell Phone (_____) _____ Work Phone: (_____) _____

If student does not live with both parents, are there custodial restrictions on non-custodial parent that the school should be aware of? **YES** _____ **NO** _____

Explain _____

Who has custody? _____ **(Custody papers are required on file)**

Name of Non-Custodial Parent: _____ Phone: (____) _____

If the parent ***WITH*** custody cannot be reached in an emergency, can the school contact the parent ***WITHOUT*** custody?
YES_____ **NO** _____

Can the parent ***WITHOUT*** custody pick-up the student from school? **YES** _____ **NO** _____

List two neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached.

Name: _____ Phone: (____) _____ Cell: (____) _____

Name: _____ Phone: (____) _____ Cell: (____) _____

List siblings enrolled in this school corporation below:

Name: _____ School: _____

Name: _____ School: _____

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

Please Turn Page Over to Complete & Sign Medical Information.

Name_____ Birth Date_____ Teacher_____ Grade_____

Medical History and Consents:
The information on this form can be shared with other corporation personnel as necessary for the well-being of this student. Consents granted on this form are valid for only this school year and a new form is required each year.

*****Parent Signature:** _____ **Date:** _____

PLEASE CIRCLE AND/OR FILL IN THE BLANKS TO ALL THAT APPLY BELOW:

ADD/ADHD Medication: _____ **Dose:** _____ Times Given: _____
***Severe Allergy* requiring an EPIPEN**? ALLERGIC TO WHAT? _____**(MD Orders Required)**
Mild or Moderate Allergy? ALLERGIC TO WHAT? _____
Medication Allergy? ALLERGIC TO WHAT MEDICATION? _____
Seasonal Allergies: ALLERGIC TO WHAT? _____
Severe Asthma: ____ List the Inhaler and/or Nebulizer used _____**(MD orders required for both)**
Diabetes: ___ Needs: (Circle) Insulin Pump AM/PM Snacks at school (MD orders required)
Epilepsy (Seizures): (Circle) Absence Tonic/Clonic Partial
Medications: _____ Last Seizure _____
Hearing Loss: (Circle) Right Left Hearing Aid Needs Preferred Seating_____
Heart Condition: Specify _____ ___P.E. Limitations?_____
Irritable Bowel: Explain _____
Menstrual Problems: Explain _____
Orthopedic Limits: Explain _____
Restricted Physical Activities: _____
Psychological DX: _____
Scoliosis: _____
Urinary Problems: _____
Vision: (Circle) Glasses Contacts Other
Other: _____
***List all prescription medications this student is currently taking*:** _____
_____

Regulations established by the Indiana State Board of Health require that schools have parental permission to administer non-aspirin pain reliever, antacids, sore throat lozenges, Orajel, Aloe and Calamine Lotion for minor discomfort *on an infrequent basis*.

I hereby give permission for _____ ***to receive non-aspirin pain reliever (and the over-the-counter products listed above) during school hours for minor discomfort.***
(Student Name)

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

In case of an accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician below and to follow his instructions and/or call the life squad. **Depending on the emergency the life squad will make the decision of where to transport your child according to their mandates.** If you would like to request a hospital, please circle one of the following:
Margaret Mary Dearborn Co. Franciscan Med Center (Harrison) Cincinnati Children's Hospital

Physician's Name: _____ Phone: _____
(Number must be provided)

Dentist's Name: _____ Phone: _____

PLEASE NOTIFY SCHOOL IF ANY OF THE ABOVE INFORMATION CHANGES

SUNMAN DEARBORN COMMUNITY SCHOOL CORPORATION

I, _____, give Sunman Dearborn School District permission to release
Parent's Name
the following information concerning my child, _____, to the Indiana
Child's Name
State Department of Health's Children and Hoosiers Immunization Registry Program (CHIRP):

*Name
*Address
*Birth Date
*Immunization Data

I understand that the information in the registry may be used to verify that my child has received proper immunizations and to inform me or my child of my child's immunization status or that an immunization is due according to recommended immunization schedules.

I understand that my child's information may be available to the immunization data registry of another state, a healthcare provider or a provider's designee, a local health department, an elementary or secondary school, a child care center, the office of Medicaid policy and planning or a contractor of the office of Medicaid policy and planning, a licensed child placing agency, and a college or university. I also understand that other entities may be added to this list through amendment to I.C.16-38-5-3.

I hereby consent to the release of such information.

_____ _____
Signature **Date**

_____
Printed Name of Parent or Guardian

_____ _____
Address **Telephone Number**

_____ _____
Child's Name **Grade Level**

_____
School

SUNMAN-DEARBORN COMMUNITY SCHOOLS
1 TROJAN RD., SUITE B
ST. LEON, IN 47012

I/We_____,hereby swear and affirm that I/we are actual and legal residents of the Sunman-Dearborn District, having resided at _____since _____, and further state that I/we:
(address) (date)

_____ Are the parent(s), guardians(s), legal custodian of the minor child(ren) Listed below:

_____

_____

_____

_____ Have applied for guardianship of the above-named child(ren. I understand that under these circumstances the child(ren) may be enrolled without cost for a period not to exceed thirty (30) days and that if the guardianship is denied after the thirty (30) day period the child must be withdrawn.

Applicant further states that in enrolling in Sunman-Dearborn School Corp. I/we have provided accurate and truthful information, and that I/we have not knowingly withheld, concealed or misrepresented any information that would have bearing upon the eligibility for enrollment.

If evidence and investigation indicates that the student's lawful guardian does not reside in said school district, legal proof of residence may be required or the student withdrawn.

_____ _____
(Applicant) (Applicant)

_____
(Date)

Race & Ethnicity

(Note: Both Part 1 and Part 2 of the question must be answered)

STUDENT'S NAME_____DATE OF BIRTH_____DATE_____

Part 1: Ethnicity

Is this individual Hispanic/Latino? (Choose only one)

_____No, not Hispanic/Latino

_____Yes, Hispanic/Latino (A person of Cuban, Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race.)

Part 2: Race

What is the individual's race? (Choose one or more)

_____American Indian or Alaska Native: A person having origins in any of the original peoples of North America and maintain cultural identification through tribal affiliation or community recognition.

_____Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

_____Black or African American: A person having origins in any of the black racial groups of Africa.

_____Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

_____White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Parent Signature:_____Date_____

IMAGINING
the possibilities.
MAKING THEM HAPPEN.

Indiana
Department of Education

Glenda Ritz, NBCT
Indiana Superintendent of Public Instruction

Home Language Survey (HLS)

The Civil Rights Act of 1964, Title VI, Language Minority Compliance Procedures, requires school districts and charter schools to determine the language(s) spoken in each student's home in order to identify their specific language needs. This information is essential in order for schools to provide meaningful instruction for all students as outlined Plyler v. Doe, 457 U.S. 202 (1982).

The purpose of this survey is to determine the primary or home language of the student. The HLS must be given to all students enrolled in the school district / charter school. The HLS is administered one time, upon initial enrollment, and remains in the student's cumulative file.

Please note that the answers to the survey below are student-specific. If a language other than English is recorded for ANY of the survey questions below, the LAS Links placement test will be administered to determine whether or not the student will qualify for additional English language development support.

Please answer the following questions regarding the language spoken by the student:

1. What is the native language of the **student?** _____

2. What language(s) is spoken most often by the **student?** _____

3. What language(s) is spoken by the **student** in the home? _____

Student Name: _____ **Grade:** _____

Parent/Guardian Name: _____

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

By signing here, you certify that responses to the three questions above are specific to your student. You understand that if a language other than English has been identified, your student will be tested to determine if they qualify for English language development services, to help them become fluent in English. If entered into the English language development program, your student will be entitled to services as an English learner and will be tested annually to determine their English language proficiency.

For School Use Only:

School personnel who administered and explained the HLS and the placement of a student into an English language development program if a language other than English was indicated:

Name: _____ Date: _____

STUDENTS WHO DO NOT PRESENT PROOF OF IMMUNIZATIONS ON OR BEFORE THE FIRST DAY OF SCHOOL MAY NOT ATTEND BEYOND THE FIRST DAY!

HEALTH APPRAISAL BY PHYSICIAN AND DENTIST

TO BE COMPLETED BY PARENT:

Student's Name (last, first) _____ Date of Birth _____

Address: _____ School: NORTH DEARBORN ELEMENTARY

Parent/Guardian Name: _____ Phone # _____

History: Serious Injuries? _____ Surgeries? _____ Seizures? _____

Severe illnesses? _____ Allergies? _____

Does student take any daily medications? (Please explain) _____

Parent Signature: _____ Date _____

TO BE COMPLETED BY PHYSICIAN/CLINIC:

IMMUNIZATION RECORD

(Provide specific dates – Month/Day/Year)

DTP/DT/DTaP 1)_____ 2)_____ 3)_____ 4)_____ 5)_____
(5 doses of Dtap, DTP, or DT required. 4 doses are acceptable if the fourth dose was administered on or after the 4th birthday.)

Polio 1)_____ 2)_____ 3)_____ 4)_____ 5)_____
(4 doses of any combination of IPV or OPV are required. 3 doses of all OPV or all IPV are acceptable if the third dose was administered on or after the fourth birthday.)

MMR 1)_____ 2)_____ 3)_____
(2 doses of measles (Rubeola) vaccine, 2 doses of Mumps vaccine, and 1 dose of Rubella (German Measles) vaccine all on or after the first birthday are required.)

Hepatitis B 1)_____ 2)_____ 3)_____ 4)_____
(3 doses of Hepatitis B vaccine are required.)

Varicella 1)_____ 2)_____ 3)_____
(2 doses of Varicella vaccine separated by at least 3 months are required.)

Hepatitis A 1)_____ 2)_____ 3)_____
(2 doses of Hepatitis A vaccine are required.)

HIB 1)_____ 2)_____ 3)_____ 4)_____ 5)_____

Others? _____ _____ _____ _____ _____

Date of Child's Last Physical Exam: _____

HEALTH CARE PROVIDER _____ **Date** _____
(Signature)

DENTAL EXAMINATION

STUDENT NAME _____ DATE OF EXAM _____

EXAMINING DENTIST'S SIGNATURE: _____