NOTE TO NEW PRE-K/ECC PARENTS:

Here are a few things to remember when turning in your Pre-K registration paperwork;

1) Make sure student's social security number is on the completed registration packet. If information changes at any time, be sure to call the school and update your information as soon as possible. $100 Deposit is due to hold your spot for the fall. (ECC is exempt)
2) Turn in a copy of the student's certified birth certificate from the courthouse (NOT the one from the Hospital) with the completed registration form.
3) Be sure that you have your three proofs of residency turned in at the same time you turn in your registration form if at all possible. Even though this is not required for our tuition based Pre-K Program, it is mandatory for our Early Childhood Center Students. Since our Pre-K students will need these forms for kindergarten, it is easier if they are just turned in when they first come to our school as it will expedite Kindergarten Registration the following year. Proofs of residency usually consist of an Occupancy Permit, Lease or Mortgage statement, and a utility bill or parent driver's license. All submitted documents must have a parent name and current address on them. If you need to call the office for a list of alternate documents, please call 476-7100 Ext. 1021
4) Please have the student's physical exam form completed and turned in by the first day of school. (The nurse may have a packet ready for you or you may just receive the form that needs to be completed.) If for any reason you cannot get it in by the deadline, please call the nurse's office and let her know when your child's physical appointment is scheduled.
5) Contact your child's teacher for any questions regarding their specific classroom/ program.

NOTE: Please keep in mind that this is just the first step to the registration process so we can get your child started in the classroom and get them entered into our computer system and the administration process started. Here is a heads up on what is to come....

-Appointments will be made at the end of the current school year to come in for a Pre-K screening to let the teachers know where your child is developmentally. If your student was accepted into the ECC program in the middle of the school year, this has already been done.

-You will still have to complete the online registration at the end of the summer or shortly after your start date if you began in the middle of the school year in order to cover more information and permissions before school starts in the fall. You will be contacted by MCS when the online registration is ready for our students starting the first day of school in the fall. When you complete this final part of your registration online, please keep in mind that I will already have all your student's information in the computer so you will need to check that your student ins an EXISTING STUDENT, not a new one.

If you have any questions, please contact the school office at 476-7100 Ext. 1021

Due to COVID, please turn in all paperwork and documentation electronically through fax or email. Photos are acceptable. Documentation can be sent to jseidlitz@mccsd160.com. If you need to pick up or turn in paperwork to the school, please call the above number to make an appointment.

MILLSTADT PRIMARY CENTER

NEW STUDENT INFORMATION

GRADE/HR: _____ SCHOOL YEAR: _____

(Please print)

LAST NAME: _____

FIRST NAME: _____

MIDDLE NAME:: _____ Birth Place:

SS#: | | | | DATE OF BIRTH: | | | |

RACE: _____ GENDER: M: _____ F: _____

Birth Certificate _____

School ID# _____

SID# _____

Illinois Transfer Form _____

Trans Code: _____ *AM* | *PM*

Office Use Only

ADDRESS: _____

(street) (city) (zip)

HOME PHONE #: ( ) _____

CELL PHONE #: Mother: _____ Father: _____

Email Address: _____

Name of Mother or Legal Guardian: _____ Maiden Name: _____

Address: _____

Occupation: _____ Federally Employed: Yes _____ No _____

Employer: _____ Phone #: ( ) _____

Name of Father or Legal Guardian: _____

Address: _____

Occupation: _____ Federally Employed: Yes _____ No _____

Employer: _____ Phone #: ( ) _____

Parent (s) are a member of a branch of the Armed Forces? If so, (please list)
Future deployment date Indicated:

Status of Parents or Legal Guardians: Married: _____ Separated: _____ Divorced: _____

Child Living with: Parents: _____ Mother: _____ Father: _____ Legal Guardian: _____ Other: _____

EMERGENCY CONTACT: If student should get ill, in the event parents cannot be reached, call the following:

Name	Relationship to Student	Emergency Phone Number

If a language other than English is spoken in the home, what is the language: _____

Does the student speak a language other than English? Yes: _____ No: _____

If Yes, what is the language? _____

Please list names and birth dates of **all** other children living in your home:

_____

The State of Illinois furnishes, on a loan basis, some of the textbooks used in the various classrooms. (Public Act 79-961 OF 1975) Do we have your permission to let your child use these textbooks? YES NO

My child has permission to go on Field Trips with the students and teachers of Millstadt Grade School District #160, as designated by the School. (Parents will be notified of such designated Field Trips) YES NO

If student is going to a sitter or address other than home - please list:

Name: _____

Address: _____

Phone Number _____

SIGNATURE OF PARENT OR GUARDIAN: _____

FAMILIES ENROLLING IN THE MILLSTADT PRIMARY CENTER

Please present the following items at time of registration:

1. Proof of Parent or Guardian Relationship

   - Driver's License or Other Acceptable Photo ID of parent/guardian.
   - Copy of certified birth certificate of student (the certificate you received from the hospital is not sufficient). A copy can be obtained from the county clerk where the child was born.
   - Proof of guardianship (if applicable).
   - Court Order Agreement, Judgment or Divorce Decree that awards custody of the child to any person (if one exists).

2. Social Security number of student.

3. **Three proofs of residency**. (Follow the guidelines for either **Section A, B, or C** on reverse side):

   A. District residents occupying homes or rental units **before** occupancy permits were required must meet the following criteria.

      1. Provide at least **two** of the following:
         - Current Real Estate Tax Bill
         - Home Ownership Title or Deed
         - Lease showing landlord name and phone number
         - One Current Utility Bill (gas, sewer, water, or electric)
         - Homeowner or Renter Insurance Bill

      2. Plus at least **one** of the following:
         - Driver's License with Address in District
         - Current Paycheck Stub or proof of income with Address in District
         - Documentation of TANF or Approval Letter from Nutrition Program and Support Services
         - Utility Bill (If did not use it as proof of residency in number A1 above.)

   B. District residents occupying homes or rental units **after** occupancy permits were required must meet the following criteria:

      1. **Occupancy Permit** – You will need an occupancy permit from either St. Clair County or the Village of Millstadt if the Parent/Guardian moved into the dwelling according to the following guidelines:

Unincorporated St. Clair County	Village of Millstadt
Renters since January 1, 1998	Renters since November 1, 2007
Homeowner since January 1, 1999	Homeowners since November 1, 2007

      2. Provide at least **one** of the following:
         - Current Real Estate Tax Bill
         - Home Ownership Title or Deed
         - Lease showing landlord name and phone number
         - One Current Utility Bill (gas, sewer, water, or electric)
         - Homeowner or Renter Insurance Bill

      3. Plus at least **one** of the following:
         - Driver's License with Address in District
         - Current Paycheck Stub or proof of income with Address in District
         - Documentation of TANF or Approval Letter from Nutrition Program and Support Services
         - Utility Bill (If did not use it as proof of residency in number B2 above.) (OVER)

C. Requirements of you are living with a District resident:

1. **Affidavit of Residency Requirements**:
   - District Homeowner/renter and the Parent/Guardian must both sign an Affidavit of Residency.

AND

Follow the requirements for **Section A or B** on the front side depending need of an occupancy permit.

- Homeowner/renter must follow Section A1 **or** B1 and B2
- Parent/Guardian must follow Section A2 **or** B3

Any person who knowingly or willfully presents to the district any false information regarding the residency of a student for the purpose of enrolling that student to attend school in the district, or who knowingly enrolls a student who is not a resident of the district, shall be guilty of a Class C misdemeanor, punishable by up to 30 days incarceration in the St. Clair Jail ILCS 5/5-8-3 and/or a fine up to $1500.00 730 ILCS 5/5-9-1. In addition, any nonresident student will be charged tuition for each day of enrollment in accordance with Section 10-20.12a, of the Illinois School Code.

Appeal Procedures: In the event the district denies enrollment, the parent/legal guardian may appeal the decision to the Principal. If the parent/legal guardian is not satisfied with the Principal's decision, he/she may appeal to the Superintendent's decision, he/she may appeal at the next regularly scheduled board meeting. While this decision is being decided, the student may not enroll in the school. As part of the investigation process, the district may require the parent/legal guardian of the student to produce additional proofs of legal residence. If the decision by the Board of Education is that the student does not reside within the district, admission is denied.

State of Illinois
Certificate of Child Health Examination

Student's Name Last First Middle	Birth Date Month/Day/Year	Sex	Race/Ethnicity	School /Grade Level/ID#
Address Street City Zip Code	Parent/Guardian	Telephone # Home		Work

IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for *every* dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.

REQUIRED Vaccine / Dose	DOSE 1 MO DA YR	DOSE 2 MO DA YR	DOSE 3 MO DA YR	DOSE4 MO DA YR	DOSE 5 MO DA YR	DOSE 6 MO DA YR
DTP or DTaP						
Tdap; Td or Pediatric DT (Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles Mumps. Rubella						
Varicella (Chickenpox)						
Meningococcal conjugate (MCV4)						
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

Comments:

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.
If adding dates to the above immunization history section, put your initials by date(s) and sign here.

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.
***MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.
Date of Disease **Signature** **Title**

3. Laboratory Evidence of Immunity (check one) ☐Measles* ☐Mumps ☐Rubella ☐Varicella Attach copy of lab result.**

*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.
**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____
Physician Statements of Immunity MUST be submitted to IDPH for review.

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and *Maintained* by the School Authority.

Last	First	Middle	Birth Date (Month/Day/Year)	Sex	School	Grade Level/ ID

HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)	Yes / No	List:		**MEDICATION** (Prescribed or taken on a regular basis.)	Yes / No	List:	
Diagnosis of asthma?	Yes No			Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No		
Child wakes during night coughing?	Yes No						
Birth defects?	Yes No			Hospitalizations? When? What for?	Yes No		
Developmental delay?	Yes No						
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No			Surgery? (List all.) When? What for?	Yes No		
Diabetes?	Yes No			Serious injury or illness?	Yes No		
Head injury/Concussion/Passed out?	Yes No			TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.	
Seizures? What are they like?	Yes No			TB disease (past or present)?	Yes* No		
Heart problem/Shortness of breath?	Yes No			Tobacco use (type, frequency)?	Yes No		
Heart murmur/High blood pressure?	Yes No			Alcohol/Drug use?	Yes No		
Dizziness or chest pain with exercise?	Yes No			Family history of sudden death before age 50? (Cause?)	Yes No		
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Dental ☐ Braces ☐ Bridge ☐ Plate Other			
Ear/Hearing problems?	Yes No			Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature**		**Date**	
Bone/Joint problem/injury/scoliosis?	Yes No						

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**
HEAD CIRCUMFERENCE if < 2-3 years old **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐ **Ethnic Minority** Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE: Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** **Result**

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

No test needed ☐ **Test performed** ☐ **Skin Test: Date Read** / / **Result: Positive** ☐ **Negative** ☐ **mm**_____
Blood Test: Date Reported / / **Result: Positive** ☐ **Negative** ☐ **Value**

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	**Normal**	**Comments/Follow-up/Needs**		**Normal**	**Comments/Follow-up/Needs**
Skin			**Endocrine**		
Ears		Screening Result:	**Gastrointestinal**		
Eyes		Screening Result:	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		
NEEDS/MODIFICATIONS required in the school setting			**DIETARY** Needs/Restrictions		

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ☐ No ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)
PHYSICAL EDUCATION Yes ☐ No ☐ Modified ☐ **INTERSCHOLASTIC SPORTS** Yes ☐ No ☐ Modified ☐

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**