North Elementary School
805 N. Cherokee
Taylorville, IL 62568
Phone 217-824-3315
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Principal,
Karen Kuntzman
kkuntzman@tcusd3.org

Website
www.tcusd3.org

February 15, 2023

Dear Parents of the 23-24 Kindergarten Class,

We are excited to have your child as a future North School kindergarten student in the fall!

A child's birth date determines whether or not they will attend kindergarten in the fall. If your child turns 5 **on or before** September 1, they are allowed to register for kindergarten for the 2023-24 school year. There are times a parent chooses to keep their child in preschool. Per ISBE, if a child turns 5 on or before September 1, 2023, we are not permitted to enroll them in our *public preschool program (PREP)*. Therefore the student would either attend a private preschool or register for kindergarten.

At the beginning of the school year, we will complete several benchmark assessments to determine all students' ability levels. By using the information from assessments, our kindergarten staff is prepared to meet students where they are in all areas of development in order to best meet every child's individual needs.

All students must have a physical, proof of vaccinations, a dental exam, and a vision exam prior to entering kindergarten. It would be helpful if you schedule those appointments as soon as possible, as the clinics get overwhelmed in the summer. We also need a certified copy of each student's birth certificate and two proofs of residency. If possible, please return those with your pre-registration information.

This is a pre-registration process in order to get your student entered into our Skyward system prior to the district's online registration this summer. We will mail your username and password for Skyward so that you can access online registration because there will still be some registration steps to complete in the summer. Please keep the folder at home for reference to forms regarding physicals, immunizations, dental and eye exams.

We will host an open house on Wednesday, March 8 from 5:00-6:00 in our cafeteria. If you are able to attend, please bring the registration forms that night. If you cannot attend the open house, please return your registration forms to your preschool or to the North School office between the hours of 8:30 and 3:30 Monday through Friday.

If you have any questions, please feel free to email me (kkuntzman@tcusd3.org) or call the school office at 217-824-3315. I look forward to creating a partnership with all of you!

Once again, welcome to North Elementary!

Sincerely,

Karen Kuntzman, principal

You're on your way to K!

The transition to kindergarten is respected as a major milestone not only for the child, but for his or her family as well. The attitude towards school and learning that the child carries with them for life is often determined by this very first experience with school. A smooth transition to kindergarten can help make sure your child is successful in school.

The information provided below is designed to help you prepare your children for their school experience.

You bet, I'm ready for K!

Personal Needs Without help, can they...
____ Put on and take off coat
____ Tie their own shoes
____ Wash their hands
____ Snap, button, zip, and buckle

Social Skills Can they ...
____ Listen to an adult & follow simple instructions
____ Cooperate with other children
____ Sit for short periods of time
____ Follow simple two-step directions

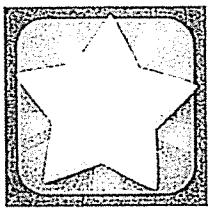
Intellectual Skills Do your children...
____ Sit and listen to a story
____ Hold a book upright and turn the pages
____ Know their first and last name
____ Tell and retell familiar stories
____ Know colors, shapes and sizes
____ Counts 0-10

Intellectual Skills {continued}
____ Saying the ABC's
____ Holds scissors & pencil appropriately
____ Recognizes and writes first name (remember-use capital letter for the first letter in a name.) M-a-t-t, not M-A-T-T
____ Recognizes the letters within their name

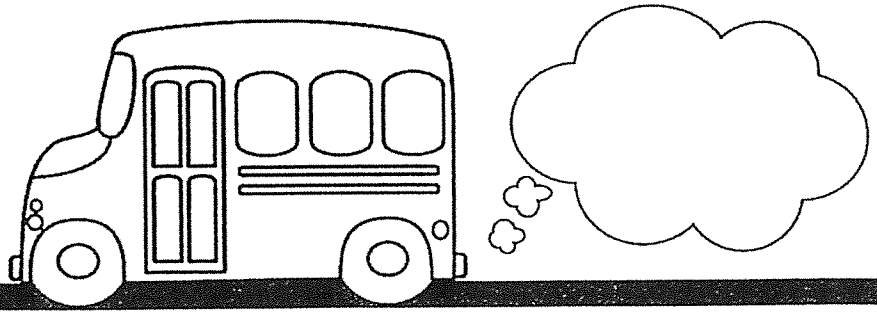
To help with a smooth transition into kindergarten you can follow these additional helpful ideas; provide opportunities to play with other children, teach your children socially acceptable ways to disagree, and encourage social values such as helpfulness, cooperation, sharing and concern for others.

•Additional Resources•

The Leap Frog Letter Factory DVD is a fun and engaging way to teach children the letters and the sounds of the alphabet.



Starfall.com has several free educational videos and games for teaching children the letters of the alphabet, and more!



Taylorville Community Unit School District #3

Dear Parent/Guardian:

The following health information is **required** for entry into kindergarten. Please obtain the necessary paperwork and submit by the first day of school. Failure to do so may result in exclusion from school until submitted.

1. Current physical exam with completed diabetes risk section completed and signed by physician. Exams must be completed within one year prior to the start date of kindergarten.
2. Complete immunization record including:
    a. 4 or more DTP (last dose on or after 4th birthday)
    b. 4 Polio (last dose on or after 4th birthday)
    c. 2 MMR
    d. 3 Hepatitis B (last dose on or after 6 months of age)
    e. 2 Varicella or date of confirmed chicken pox case
3. **Completed health history on physical form with parent signature.**
4. Lead screening date with results
5. Dental exam OR signed waiver. (required for both kindergarten and 2nd grade)
6. Vision exam OR signed waiver.

If you have questions or concerns, please contact us.

Thank you,

Jenny Moats, BSN, RN, PEL-CSN
Elementary School Nurse
217-824-5765

Susie McClure, BSN, RN, PEL-CSN
Elementary School Nurse
217-824-3315

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 _____ Dental ☐ Braces ☐ Bridge ☐ Plate Other

Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)

Ear/Hearing problems?	Yes	No	
Bone/Joint problem/injury/scoliosis?	Yes	No	

Information may be shared with appropriate personnel for health and educational purposes.

Parent/Guardian Signature _____ Date _____

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		
			Other		

Currently Prescribed Asthma Medication:
☐ Quick-relief medication (e.g. Short Acting Beta Agonist)
☐ Controller medication (e.g. inhaled corticosteroid)

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

State of Illinois
Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides eye examinations be submitted to the school no later than October 15 of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

Student Name _____ (Last) _____ (First) _____ (Middle Initial)

Birth Date _____ (Month/Day/Year) Gender _____ Grade _____

Parent or Guardian _____ (Last) _____ (First)

Phone _____ (Area Code)

Address _____ (Number) _____ (Street) _____ (City) _____ (ZIP Code)

County _____

To Be Completed By Examining Doctor

Case History

Date of exam _____

Ocular history: ☐ Normal or Positive for _____

Medical history: ☐ Normal or Positive for _____

Drug allergies: ☐ NKDA or Allergic to _____

Other information _____

Examination

	Distance			Near
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation? ☐ Yes ☐ No

	Normal	Abnormal	Not Able to Assess	Comments
External exam (lids, lashes, cornea, etc.)	☐	☐	☐	_____
Internal exam (vitreous, lens, fundus, etc.)	☐	☐	☐	_____
Pupillary reflex (pupils)	☐	☐	☐	_____
Binocular function (stereopsis)	☐	☐	☐	_____
Accommodation and vergence	☐	☐	☐	_____
Color vision	☐	☐	☐	_____
Glaucoma evaluation	☐	☐	☐	_____
Oculomotor assessment	☐	☐	☐	_____
Other _____	☐	☐	☐	_____

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

Diagnosis

☐ Normal ☐ Myopia ☐ Hyperopia ☐ Astigmatism ☐ Strabismus ☐ Amblyopia

Other _____

Continued on back

State of Illinois
Illinois Department of Public Health

PROOF OF SCHOOL DENTAL EXAMINATION FORM

Illinois law (Child Health Examination Code, 77 Ill. Adm. Code 665) states all children in kindergarten and the second, sixth and ninth grades of any public, private or parochial school shall have a dental examination. The examination must have taken place within 18 months prior to May 15 of the school year. A licensed dentist must complete the examination, sign and date this Proof of School Dental Examination Form. If you are unable to get this required examination for your child, fill out a separate Dental Examination Waiver Form.

This important examination will let you know if there are any dental problems that need attention by a dentist. Children need good oral health to speak with confidence, express themselves, be healthy and ready to learn. Poor oral health has been related to lower school performance, poor social relationships, and less success later in life. For this reason, we thank you for making this contribution to the health and well-being of your child.

To be completed by the parent or guardian (please print):

Student's Name: Last	First	Middle	Birth Date: (Month/Day/Year)

Address: Street	City	ZIP Code

Name of School:	ZIP Code	Grade Level:	Gender: ☐ Male ☐ Female

Parent or Guardian: Last Name	First Name

Student's Race/Ethnicity:

☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian
☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ Multi-racial ☐ Unknown
☐ Other_____

To be completed by dentist:

Date of Most Recent Examination:_____ (Check all services provided at this examination date)

☐ Dental Cleaning ☐ Sealant ☐ Fluoride treatment ☐ Restoration of teeth due to caries

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present on Permanent Molars**

☐ Yes ☐ No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

☐ Yes ☐ No **Untreated Caries** — At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

☐ Yes ☐ No **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling.

Treatment Needs (check all that apply). For Head Start Agencies, please also list appointment date or date of most recent treatment completion date.

☐ Restorative Care — amalgams, composites, crowns, etc. Appointment Date:_____
☐ Preventive Care — sealants, fluoride treatment, prophylaxis Appointment Date:_____
☐ Pediatric Dentist Referral Recommended Treatment Completion Date:_____

Additional comments: _____

Signature of Dentist _____ License #:_____ Date:_____

Student Health Questionnaire

Student Name: _____ Birthdate: _____

Grade: _____ Parent/Guardian: _____

MEDICATIONS

Daily Medications: _____

Medications to be given at school: _____ No _____ Yes (list) _____
(ALL prescription and over-the-counter medications MUST have a doctor order)

ALLERGIES

- ☐ None known
- ☐ Yes (list below)

	Type	Reaction	Treatment
Animals	_____	_____	_____
Medications	_____	_____	_____
Bees/Wasps	_____	_____	_____
Foods	_____	_____	_____

- ☐ Allergy is life threatening (medication and physician order MUST be given to school)
- ☐ Allergy is non-life threatening

HEALTH HISTORY (Please check all that apply)

- ☐ ADD/ADHD
- ☐ Asthma
- ☐ Bowel Problems
- ☐ Diabetes
- ☐ Hearing Concerns
- ☐ Heart Condition
- ☐ Migraines
- ☐ Seizures
- ☐ Other: _____

Parent/Guardian Signature: _____