Deerfield Elementary School

Kindergarten Pre-Registration

STUDENT INFORMATION:

First Name: ______________________ **Middle Name:** ________________

Last Name: ____

Address: Street ____

City, IN: _________________________________ Zip __________

Home Phone: __________________________

Age: _______________ **Sex:** M F

Date of Birth: _________________________ **City and State of Birth:** ______________________________

Race Category: (Circle)
1~Hispanic/Latino
2~Not Hispanic/Latino

~AND~

Ethnic Category: (Circle)
1~American Indian or Alaskan
2~Black, Non-Hispanic
3~Asian or Pacific
4~ Spanish or Hispanic
5~ White, Non-Hispanic
6~Multiracial

Name Of Parent(s) Or Guardian(s) Who Live(s) With Child:

Name: ____ **Relationship:** __________________________

Occupation: ____________________________ Place of Employment: __________________________

Cell Phone: _____________________________ Work Phone: _________________________________

Name: ____ **Relationship:** __________________________

Occupation: ____________________________ Place of Employment: __________________________

Cell Phone: _____________________________ Work Phone: _________________________________

Name of Divorced or Separated Parent Who is NOT Living with Child:

Occupation: ____________________________ Place of Employment: __________________________

Cell Phone: _____________________________ Work Phone: _________________________________

Brother and Sisters Living at Home & Their Ages:

Name:	Age:	Name:	Age:
___________________________	________	___________________________	________
___________________________	________	___________________________	________
___________________________	________	___________________________	________

Special School Services ~ Check if your child has been in the following:

Title 1 __________________ **Speech** ___________________ **Special Education** ___________________

Did your child have an IEP? YES NO

Former School: ________________________________ Phone: _________________________

Address: ____

Has your child ever attended ***Randolph Central Schools?*** Yes No

Parent or Legal Guardian's Signature ____ Date: ______________

Racial and Ethnicity Data Collection

Randolph Central School Corporation must collect racial and ethnic information from students and staff using a two-part question. The respondent should answer both questions.

Please complete a form for each child attending Randolph Central schools.

Please print.

Student's Name ____

Parent or Guardian Completing this Form ________________________________

Student's School (Check one)

_____WCHS

_____Driver

_____Baker

_____Deerfield

_____Willard

Please complete both sections.

Part I: Ethnicity

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

_____ **No**, not Hispanic/Latino

_____**Yes**, Hispanic/Latino (A person of Cuba, Mexico, Puerto Rico, South or Central America, or other Spanish culture or origin, regardless of race)

Part II: 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 maintaining 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 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.

Randolph Central School Corporation
Network and Internet Agreement Form

In consideration for the privileges of using the Corporation and/or Network resources, and in consideration for having access to the information contained on the Network, or by the Network, I hereby release the Corporation, Network and their operators and administration from any and all claims of any nature arising from my use, or inability to use the Corporation and/or Network resources.

I agree to abide by such rules and regulations of system usage as may be further added from time-to-time by the Corporation and/or Network. These rules will be available in hardcopy form in the Principal's office.

(Sign and return to your Principal's Office/Teacher)

Printed Name of Student____________________________________

____________________________________ ____________________

Signature of Parent Date

For Office Use Only

User name (assigned by Corporate Network Director or designee): ____________________

Randolph Central School Corporation
103 N East Street
Winchester, Indiana 47394

I, ______________________________________, give Randolph Central School Corporation permission to release the following information concerning my child, ________________________________, to the Indiana State Department of Health's Children and Hoosier Immunization Registry Program (CHIRP): Name, Date of Birth, Immunization Dates, Ethnicity, Parent or Legal Guardian Name and/or Address.

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 the 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

______________________________ ______________________________
Child's Name Telephone Number

______________________________ ______________________________
School Grade Level

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 in Indiana, 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 W-APT 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:______________________ District______________________ Date:__________

Randolph Central School Corporation
103 North East Street
Winchester, Indiana 47394

Parents of Kindergarten Children:

As your school health nurse of the Randolph Central School Corporation, I wish to welcome your child in his/her new experience. We hope for him/her the very best of health and happiness.

The school will supply you with the necessary physical and dental examination blanks, which you will take with you to your doctor and dentist. Through immunization and vaccination many diseases can be prevented.

The medical form and shot record must be filled out and completed **before your child registers in the fall**. Make your appointments now.

Each child, before entering school, is required by state law to be immunized against diphtheria, whooping cough, tetanus, measles, mumps, rubella, polio, hepatitis B, hepatitis A, and chickenpox. This will be done by your family doctor. If financially impossible for you to comply with this law, contact your local county health department. An appointment should be made with the local county health department and a record of any former immunizations the child has had should be taken with you. The Health Department's telephone number is 584-1155 and is located at 325 S. Oak Street, Suite 202. Your appointment with the Health Department should be made in April, May or June. Allow thirty to fifty minutes for your appointment. It is your responsibility to have his/her booster shots as recommended by your family doctor. State law requires that dates of immunization (month, day and year) be given and these become a part of your child's permanent school health records. The school is required to exclude your child from school if he/she does not have the required immunizations or if you have not written that you object to these for religious or medical reasons.

Minimum Immunization Requirements for All Children Newly Enrolled in Kindergarten or Grade 1 and less than 7 years of Age:

- 5 doses of diphtheria-tetanus-acellular pertusis (DTaP), diphtheria-tetanus-pertussis (DTP), or pediatric diphtheria-tetanus vaccine (DT) or **4 doses are acceptable if the third dose was administered on or after the fourth birthday;**

- 4 doses of either oral polio vaccine (OPV) or inactivated polio vaccine (IPV), in any combination or **3 doses of all OPV or all IPV are acceptable if the third dose was administered on or after the fourth birthday;**

- 2 doses of measles (rubeola) vaccine, on or after the first birthday;

- 1 dose of rubella (German measles) vaccine, on or after the first birthday;

- 2 dose of mumps vaccine, on or after the first birthday;

- **3 doses of hepatitis B vaccine.**

- **2 doses of Varicella (chickenpox)** on or after the first birthday and separated by three months or physician's documentation of history of chicken pox, including month and year of disease.

- **2 doses of hepatitis A vaccine.**

Vision screening tests are given each year to all first, third, fifth and eighth grade students with the Titmus vision testing equipment. Those students having difficulty are urged to see an eye doctor for further examination. Students in any other grades may have this test if they or their teacher feels it is needed.

Speech and hearing therapists test students' hearing in the first, fourth, seventh and tenth grades. Those having difficulty are urged to see their doctor.

FIRST AID

Medical care is not given at school; first aid only. Nothing is given by mouth. This is to prevent masking of symptoms and any allergic reaction. (This includes Advil, Tylenol, cough drops and all over the counter medications.) Please fill out appropriate forms regarding your child's health needs. Feel free to set up a meeting with the school nurse about any concerns or issues (for example, asthma, seizures, allergies etc.)

Parents should provide the school with any emergency telephone numbers so that an ill child can be sent home. An adult should be at home with an ill child. Students will be sent home if they come to school ill, unclean or with offensive odors. **Please do not send your child to school with any of the following**: A fever of 100 or more (your child should be fever free for 24hrs), vomiting, diarrhea, strep throat untreated (need to be on antibiotics for 24hrs), pink eye untreated, chickenpox.

Health education with emphasis on prevention is the most important function of the school nursing program. Regular school attendance is most important for the success of your child's future. The full cooperation of all school personnel, medical professionals and parents is very necessary to attain and maintain our goal for your children.

ADMINISTERING MEDICATION

In order to be in compliance with the state law and for the protection of teachers or persons designated by the school to give medication, these guidelines will be followed:

1. Only FDA approved medications will be given at school.
2. Parents must come to the school office and fill out school medication forms.
3. The medication must be given in good faith.
4. The medication must be given in compliance with written instruction of the physician on file in the school office.
5. The medication must be in a prescription bottle with label including the student's name, doctor's name and directions for giving the medication.

These regulations apply to all medications. The proper forms may be picked up at the school office and must be on file before any medication will be administered. Students are allowed to carry self-administered medications if the school has signed documentation from the doctor indicating medically necessary (for example, inhaler, epi-pen) and a signed parental permission form.

The school nurse is not in your child's building everyday so it is up to the secretary, health aide, or principal to dispense medication. If it can be avoided, please do not send medication to school. For example, if the medicine is to be given three times, it can be given in the morning before the child comes to school, when the child gets home from school and before they go to bed. Medication that is to be given every 3 or 4 hours as needed, the school needs a slip from the parent stating when they last had the medicine so we know when it can be given again.

Lacey Hummel, RN BSN
Corporation School Nurse

STUDENT PHYSICAL RECORD

Student ______________________________ Birth Date ________________ Sex __________

Address ____ Home Phone ___________

TO BE COMPLETED BY THE PHYSICIAN AND BROUGHT TO THE SCHOOL BY THE PARENT WHEN THE CHILD ENROLLS IN THE FALL.

Health History:

Asthma and/or Allergies: ____

Ear Conditions: ____

Operations: ____

Serious Injuries: ____

Chicken Pox Disease/Dates: ____

Other: ____

Lead Test Date: ___/___/___ ___ Capillary or ___ Venous Result _________

Ears:	________________	Height:	________________
Skin and Scalp:	________________	Weight:	________________
Teeth:	________________	B/P:	________________
Nose:	________________	Pulse:	________________
Tonsils:	________________	Temperature:	________________
Glands of Neck:	________________	State Of Nutrition:	________________
Thyroid:	________________	This pupil (should/should not) participate in	
Abdomen:	________________	Physical Education:	________________
Hernia:	________________	Remarks:	________________
Lungs:	________________	________________	
Heart:	________________	________________	

Musculo-Skeletal System: ____

O - Normal XX - Needs Attention OO - Corrected

PHYSICIAN'S SIGNATURE: ____

Address: ____

Date of Examination: ____________________ Phone: ________________

****PLEASE INDLUDE THE MOST UP-TO-DATE COPY OF THE ABOVE STUDENT'S IMMUNICATION RECORD WITH THIS PHYSICAL FORM****

Randolph Central School Corporation
103 North East Street
Winchester, Indiana 47394

DENTAL EXAMINATION

Name ____
(Last) (First) (Middle)

Address ______________________________ School ____________

Parent or Guardian ______________________________________

To the Parent(s):

In order to comply with the recommendations of the State of Indiana, please make an early dental appointment for the above-named child. Take this form with you, have it completed by the dentist and return it to the teacher.

THE FOLLOWING IS TO BE COMPLETED BY EXAMINING DENTIST

1. Untreated decay in deciduous teeth __ YES __ NO

2. Untreated decay in permanent teeth __ YES __ NO

If yes to 1 or 2 above, please answer a, b and c below.

a. Decay is classified as early childhood caries/babybottle caries (affecting the primary maxillary anterior teeth, followed by involvement of the primary molars; mandibular incisors may not be affected) __ YES __ NO

b. Decay is classified as rampant caries in permanent teeth __ YES __ NO

c. Child is experiencing pain and/or infection __ YES __ NO

3. Occlusion is within normal range for age __ YES __ NO

If no, immediate follow-up is indicated __ YES __ NO

4. Oral hygiene __ OPTIMAL __ NEEDS IMPROVEMENT

5. This is child's first dental examination __ YES __ NO

6. All necessary dental treatment completed __ YES __ NO

If no, appointments are made for completing treatment __ YES __ NO

Appointment date: ____________________

COMMENTS:

________________ ______________________________
Date Signature of Dentist

KINDERGARTEN REGISTRATION

Date: ____________________ School: ___ Baker ___ Deerfield

Student's Name ____
(Last) (First) (Middle)

What name do you call your child at home? ______________________________

Social Security # ____________________________ Sex: _____ Male _____ Female

Address ____

Tele. No. ______________________

Date of Birth: ________________ Place of Birth: ________________________
Month/Day/Year City/State

Father's Name: ____________________________ Living? ________________

Where Employed ____________________________ Tele. No. ________________

Mother's Maiden Name ____________________________ Living? ________________

Where Employed ____________________________ Tele. No. ________________

Stepfather's Name ____________________________ Living? ________________

Where Employed ____________________________ Tele. No. ________________

Stepmother's Name ____________________________ Living? ________________

Guardian's Name ____________________________ Living? ________________

List Other Children in Family and Their Ages ____

____

____

List All Adult Members of the Household ____

____

In case of emergency, which local doctor do you prefer we call? ________________________

______________________________ Telephone Number ____________________

Parent/Guardian Signature: ____

If you know the bus driver's name/number of the bus that passes your home, please list it here.

______________________________ ______________________________
Bus Driver's Name Bus Number

Randolph Central School Corporation
103 North East Street
Winchester, Indiana 47394

HEALTH RECORD OF KINDERGARTEN CHILD

(To be filled out by Parents or Guardian and returned to the School)

Child's Name ____

Has your child had Chicken Pox? _____ Yes _____ No

If yes, give dates ____

Other diseases: ____

____

Any health problems your child has had or now has: ______________________

____

____

____

Operations: ____

____

Name of Child's Doctor ____

Does Child have Speech Difficulties? ______ Does Child have Hearing Difficulties? ________

Has Child had Previous Speech Therapy? ______Yes ______No

Is Child Right or Left Handed? Left ________________ Right ________________

Does Child Eat Adequate Diet? ____

Fruit? __________ Vegetables? __________ Milk? __________ Protein? __________

At what age did Child walk? ____________ At what age did Child talk?____________

How many hours does Child sleep: at Night ____________ during the Day ____________

Please check if you are having difficulty with the following:

Persistent Crying __________ Finger Sucking __________ Fear __________

Temper Tantrum __________ Bed-Wetting __________ Nail Biting __________

Disturbed Sleep __________ Mouth Breathing __________ Shyness __________

Signed: ____ Date: ________________