March 2017

Dear Parents:

The registration and roundup of Roosevelt kindergarten children for the 2017-2018 school year will be held on Tuesday, April 18, 2017, at the Roosevelt Elementary School located at 1800- 19th Avenue SW, Willmar. To be eligible for enrollment in kindergarten, a child must be five years of age on or before September 1, 2017. According to our records, you have a child who meets this requirement.

The purpose of this registration is to collect the necessary data to complete your child's entrance records and identify transportation needs. You may come between 3:30-6:30PM on April 18th. Registration should take approximately 30 to 40 minutes. We encourage you to bring your child so that they may tour the kindergarten rooms and meet the kindergarten teachers.

Please complete the enclosed forms and bring them with you to Roosevelt Elementary on April 18.

1. **Birth Certificate-** You can bring a copy of your child's birth certificate may be brought. It is not required for registration and your copy will be returned to you.
2. **Student/Family Information Forms-** These forms include household information, home language information, and permission for Title 1 assessment. Please be sure to complete these forms in their entirety before kindergarten registration.
3. **Transportation Form**
4. **Physical Examination-**Independent School District #347 policy requires a physical examination for all children before entering kindergarten in September, 2017. We will accept written documentation of a physical that has been given within the past 18 months. To schedule a current physical, please call your family physician NOW. **You should register your child now** even if the physical examination has not been completed.
5. **Immunization Form** Please bring immunization records with you to registration. To go to school in Minnesota, students must show they have had the required immunizations or file a legal exemption with the school. Before the start of school in September, kindergarten students **need to have dates turned into school** for:
   - **5 DPT**
   - **4 Polio**
   - **3 Hepatitis B**
   - **2 MMR**
   - **2 Varicella (Chickenpox)** or documentation (month/year) of history of chickenpox disease
6. **Dental Health Card** (to be returned no later than September, 2017)

Further reminders concerning registration will be in the daily newspaper. If you know of any children who are five years of age on or before September 1, 2017, who have not received correspondence from this office, please tell them to notify us immediately. If you have questions or concerns, please contact the Roosevelt Elementary office at 320-231-8470.

We are looking forward to meeting you and your child on April 18th. We are excited to share in your child's educational journey here at Roosevelt Elementary School.

WILLMAR
PUBLIC SCHOOLS

Student Registration

STUDENT'S FULL LEGAL NAME AS IT APPEARS ON BIRTH CERTIFICATE

Last Name: _____ First Name: _____ Middle: _____

Suffix: _____ Check if No Middle Name: ____ Nickname: _____

Grade: _____ Birth Date: _____ Gender: Male / Female

RACIAL/ETHNIC BACKGROUND – PLEASE COMPLETE ALL QUESTIONS

1. For Federal reporting purposes – **Is the student Hispanic or Latino?** Yes / No
   A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin regardless of race.

2. For Federal reporting purposes – Please check all that apply for the student. You must check at least one.
   ____ **American Indian or Alaska native** – a person having origins in any of the original people of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
   ____ **Asian** – a person having origins in any of the original peoples of the Far East, Southeast Asia or the 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, Middle East or North Africa.

ADDITIONAL INFORMATION

1. Is the student a teen parent? Yes / No
2. Is the student currently homeless (lacks a fixed, regular and adequate nighttime residence)? Yes / No
3. Is the student a Ward of the State (parental rights have been terminated by court order)? Yes / No

EDUCATIONAL INFORMATION

Please check: New Student ____ Student has previously attended a Willmar school ____ Dates _____

Student has previously attended a Minnesota school: ____ Location _____ Dates _____

Previous Schools Attended (list most recent school first)	City	State	Dates of Attendance	Grade Level

SPECIAL EDUCATION SERVICES

Does the student have a current Individual Education Plan (IEP)? Yes / No
***Please submit a copy of an IEP/IFSP/IIIP upon registration.**

Is Special transportation documented in the IEP? Yes / No

Did your child receive Special Education services at their last school? Yes / No

Does your child have a 504 Accommodation Plan? Yes / No

WILLMAR
PUBLIC SCHOOLS

Family Registration

Does the family need interpreter services? Yes / No Preferred Language: _____

Does the family currently live in the Willmar School District? Yes / No

If no, what district does the family live in? _____

If no, has an Application for Open Enrollment been completed and sent to the Superintendent's Office? Yes / No

Parent/Guardian – Mail Addressed to - RESIDES AT THE SAME ADDRESS WITH STUDENT – Use full legal name

Last Name: _____ First Name: _____ Middle: _____

Suffix: _____ Birth Date: _____ Gender: Male / Female

Attended Willmar Public Schools Under Different Name (List Name): _____

Cell Phone: _____ Work Phone: _____

Email: _____

Parent/Guardian – RESIDES AT THE SAME ADDRESS WITH STUDENT – Use full legal name

Last Name: _____ First Name: _____ Middle: _____

Suffix: _____ Birth Date: _____ Gender: Male / Female

Attended Willmar Public Schools Under Different Name (List Name): _____

Cell Phone: _____ Work Phone: _____

Email: _____

HOUSEHOLD INFORMATION

Primary Residence _____

City: _____ State: _____ Zip Code: _____

Date moved to this Address: _____

Mailing Address of Family (PO Box, including City) – if different from resident address:

_____

Primary Phone number: _____

Students Lives With (please circle):
Both Parents Mother Father Mother & Stepfather Father & Stepmother Foster Parents Host Family

Other: Please Specify Relationship _____

Parent/Guardian – DOES NOT RESIDE AT THE SAME ADDRESS WITH STUDENT – Use full legal name

Last Name: _____ First Name: _____ Middle: _____
Suffix: _____ Birth Date: _____ Gender: Male / Female
Student/Students this applies to _____
Relationship to Student: _____ Legal Guardian: Yes / No
Attended Willmar Public Schools Under Different Name (List Name): _____
Mailing address: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email: _____ Employer: _____
Send duplicate mailings to this address? Yes / No

List legal names of all children, including pre-school age, residing in the home:

First, Middle, Last Name	Birth Date	Gender	Relationship to Parent/ Guardian	Legal Guardian	Pre-School Screened (0-6 year old children only)	If yes, list location
		M / F		Y / N	Y / N	
		M / F		Y / N	Y / N	
		M / F		Y / N	Y / N	
		M / F		Y / N	Y / N	
		M / F		Y / N	Y / N	
		M / F		Y / N	Y / N	

AUTOMATED CALLING SYSTEM

Automated Calling System – Willmar Public Schools utilizes an automated calling system to notify parent/guardians for reasons such as weather related announcements, attendance absence, and any message administrators feel important to communicate via the automated caller. **All Emergency phone numbers/emails listed below will automatically be called for weather related announcements or emergencies. Please list the phone numbers/emails below for calls that are:**

Please list any and or all phone number and e-mails that you would like to be contacted on:

_____ _____ _____

If you would like your preferences changed, please log on to your portal account or contact your child's school.

MIGRANT STATUS

Has your family moved to seek or obtain agricultural related work in the last three years? Yes / No / Don't Know
Examples: meat, poultry, fish, timber, field work, or picking eggs.

PARENT/GUARDIAN SIGNATURE

I certify that all the information given is true and correct to the best of my knowledge.

Parent/Legal Guardian Signature: _____ Date: _____

WILLMAR

PUBLIC SCHOOLS

Home Language Questionnaire

The following is to be completed by a parent or guardian. In order to help your child learn, your child's teachers need to determine which language your child uses most. Please repond to the questions below by checking the appropriate box.

Student's Full Name: _____

Date of Birth: _____ Age: _____ Grade: _____

Phone: _____ Cell Phone: _____

STUDENT LANGUAGE INFORMATION

1. Which language did your child learn first? English ____ Other: _____
2. Which language is most often spoken in your home? English ____ Other: _____
3. Which language does your child usually speak? English ____ Other: _____
4. Which language do you usually use when speaking to your child? English ____ Other: _____

PARENT/GUARDIAN SIGNATURE

I hereby verify that the above information is true and correct to the best of my knowledge and belief. I understand the above designation cannot be changed for the duration of my child's enrollment in Willmar Public Schools.

Name (printed): _____

Parent/Legal Guardian Signature: _____

Date: _____

WILLMAR PUBLIC SCHOOLS
Transportation Information

Parents: Please complete the following to assist in arranging bus transportation for your child. Please complete the entire form even if your child does not need bus transportation.

Student Name:_____

Current Address:_____ Phone Number:_____

Parent/Guardian Name(s):_____

Child Care Information: Provider's name_____

Child Care Address:_____ Phone Number:_____

Please check below to indicate AM and PM transportation locations:

AM Pickup: (Check one)

_____Pick up my child at child care

_____Pick up my child at home

_____My child will walk (from home_____) (from child care _____)

_____Parent will transport

_____Cardinal Place

PM Drop Off: (Check one)

_____Drop off my child at child care

_____Drop off my child at home

_____My child will walk (home_____) (to child care _____)

_____Parent will transport

_____Cardinal Place

Other Relevant Information:

Father's place of employment:_____ Work phone:_____

Mother's place of employment:_____ Work phone:_____

WILLMAR PUBLIC SCHOOLS – KINDERGARTEN PHYSICAL EXAMINATION FORM (2/25/05)

Student's Name_____
(Last) (First) (Middle)

Student's Birth Date_____ Gender:_____ Immunizations Up-to-date ☐ No ☐ Yes –

TEST Indicate Normal (N); Abnormal (Ab) If abnormal, include comments below		MEASUREMENTS Blood Pressure_____ Height_____Weight_____BMI _____	
Test	N/Ab	Vision: R 20/	Vision: L20/
Hemoglobin/Hematocrit		W/glasses: Yes No	
Urine		Hearing: R	Hearing: L
Other (specify)		W/hearing aid: Yes No	

EXAMINATION Indicate Normal (N) Abnormal (Ab) with a check mark. If abnormal, include comments below.					
	Normal	Abnormal		Normal	Abnormal
Skin/Lymph			Lungs		
Eyes			Abdomen		
Ears			Genito-Urinary		
Nose			Orthopedic-Feet		
Mouth			Orthopedic-Spine		
Throat			Neurological		
Neck			Speech		
Heart			Other (specify)		

1. Does this child have a health concern that the school should be aware of?
   ☐ No ☐ Yes. If Yes, please describe_____

2. Does the student have any allergies?
   ☐ No ☐ Yes. If Yes, please describe_____

3. Are any allergies LIFE-THREATENING?
   ☐ No ☐ Yes. If Yes, does the student have an EPI pen?
   ☐ No
   ☐ Yes. ***Physician orders are required for a student to carry an EPI pen at school. Please attach orders.***

4. Is this student on medication the school needs to be aware of?
   ☐ No ☐ Yes. If Yes, please describe_____

   Physician orders are required for a student to receive medication at school. Please attach orders if applicable.

5. Are there any restrictions of physical activity or physical education in school?
   ☐ No ☐ Yes. If Yes, please describe _____

6. Are there any classroom accommodations needed at school?
   ☐ No ☐ Yes. If Yes, please describe _____

7. Does this student need special nutritional consideration?
   ☐ No ☐ Yes. If Yes, please describe _____

8 .Are there any other significant findings on exam, family or health history, or review of systems that may impact this child's health or learning during the school years?
   ☐ No ☐ Yes. If Yes, please describe _____

Signature and Title of Health Examiner:_____ Date of Exam:_____

Printed or Typed Name of Examiner:_____

Address and Telephone of Examiner:_____

Student Immunization Form

Student Name _____

Birthdate _____ Student Number _____

Minnesota law requires children enrolled in school to be immunized against certain diseases or file a legal medical or conscientious exemption.

FOR SCHOOL USE ONLY
( ) Complete; booster required in _____
( ) In process; 8 mos. expires _____
( ) Medical exemption for _____
( ) Conscientious objection for _____
( ) Parental/guardian consent _____

Parent/Guardian:
You may attach a copy of the child's immunization history to this form OR enter the MONTH, DAY, and YEAR for all vaccines your child received. Enter MED to indicate vaccines that are medically contraindicated including a history of disease, or laboratory evidence of immunity and CO for vaccines that are contrary to parent or guardian's conscientiously held beliefs.

Sign or obtain appropriate signatures on reverse. Complete section 1A or 1B to certify immunization status and section 2A to document medical exemptions (including a history of varicella disease) and 2B to document a conscientious exemption.

Additionally, if a parent or guardian would like to give permission to the school to share their child's immunization record with Minnesota's immunization information system, they may sign section 3 (optional).

For updated copies of your child's vaccination history, talk to your doctor or call the Minnesota Immunization Information Connection (MIIC) at 651-201-5503 or 800-657-3970.

School Personnel: Be sure to initial and date any new information that you add to this form after the parent/guardian submits it. Also, record combination vaccines (e.g., DTaP+HepB+IPV, Hib+HepB) in each applicable space.

Type of Vaccine DO NOT USE (✓) or (×)	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr
Required (The shaded boxes indicate doses that are not routinely given; however, if your child has received them, please write the date in the shaded box.)					
Diphtheria, Tetanus, and Pertussis (DTaP, DTP, DT) • for children age 6 years and younger • final dose on or after age 4 years					5th dose not required if 4th dose was given on or after the 4th birthday
Tetanus and Diphtheria (Td) • for children age 7 years and older • 3 doses of Td required for children not up to date with DTaP, DTP, or DT series above					
Tetanus, Diphtheria and Pertussis (Tdap) • for children in 7th - 12th grade					
Polio (IPV, OPV) • final dose on or after age 4 years			4th dose not required if 3rd dose was given on or after the 4th birthday		
Measles, Mumps, and Rubella (MMR) • minimum age: on or after 1st birthday					
Hepatitis B (hep B)					
Varicella (chickenpox) • minimum age: on or after 1st birthday • vaccine or disease history required					
Meningococcal (MCV, MPSV) • for children in 7th - 12th grade • booster given at age 16 years					
Recommended					
Human Papillomavirus (HPV)					
Hepatitis A (hep A)					
Influenza (annually for children 6 months and older)					

Additional exemptions:

- **Children 7 years of age and older:** A history of 3 doses of DTaP/DTP/DT/Td/Tdap and 3 doses of polio vaccine meets the minimum requirements of the law.
- **Students in grades 7-12:** A Tdap at age 11 years or later is required for students in grades 7-12. If a child received Tdap at age 7-10 years another dose is not needed at age 11-12 years. However, if it was only a Td, a Tdap dose at age 11-12 years is required.
- **Students 11-15 years of age:** A 3rd dose of hepatitis B vaccine is not required for students who provide documentation of the alternative 2-dose schedule.
- **Students 18 years of age or older**: Do not need polio vaccine.

Student Name _____

Instructions, please complete:
Box 1 to certify the child's immunization status
Box 2 to file an exemption (medical or concientious)
Box 3 to provide consent to share immunization information (optional)

1. Certify Immunization Status. Complete A or B to indicate child's immunization status.

A. Received all required immunizations:

I certify that this student has received all immunizations required by law.

_____
Signature of Parent / Guardian OR Physician / Public Clinic

_____ Date

B. Will complete required immunizations within the next 8 months:

I certify that this student has received at least one dose of vaccine for diphtheria, tetanus, and pertussis (if age-appropriate), polio, hepatitis B, varicella, measles, mumps, and rubella and will complete his/her diphtheria, tetanus, pertussis, hepatitis B, and/or polio vaccine series within the next 8 months.

The dates on which the remaining doses are to be given are:

_____
Signature of Physician / Public Clinic

_____ Date

2. Exemptions to School Immunization Law. Complete A and/or B to indicate type of exemption.

A. Medical exemption:

No student is required to receive an immunization if they have a medical contraindication, history of disease, or laboratory evidence of immunity. For a student to receive a medical exemption, a physician, nurse practitioner, or physician assistant must sign this statement:

I certify the immunization(s) listed below are contraindicated for medical reasons, laboratory evidence of immunity, or that adequate immunity exists due to a history of disease that was laboratory confirmed (for varicella disease see * below). List exempted immunization(s):

_____
Signature of physician/nurse practitioner/physician assistant

_____ Date

*History of varicella disease only. In the case of varicella disease, it was medically diagnosed or adequately described to me by the parent to indicate past varicella infection in _____ (year)

_____
Signature of physician/nurse practitioner/physician assistant (If disease occured before September 2010, a parent can sign.)

B. Conscientious exemption:

No student is required to have an immunization that is contrary to the conscientiously held beliefs of his/her parent or guardian. However, not following vaccine recommendations may endanger the health or life of the student or others they come in contact with. In a disease outbreak schools may exclude children who are not vaccinated in order to protect them and others. To receive an exemption to vaccination, a parent or legal guardian must complete and sign the following statement and have it notarized:

I certify by notarization that it is contrary to my conscientiously held beliefs for my child to receive the following vaccine(s):

_____
Signature of parent or legal guardian

_____ Date

Subscribed and sworn to before me this:
_____ day of _____ 20_____

_____
Signature of notary

3. Parental/Guardian Consent to Share Immunization Information (optional):

Your child's school is asking your permission to share your child's immunization documentation with MIIC, Minnesota's immunization information system, to help better protect students from disease and allow easier access for you to retrieve your child's immunization record. You are not required to sign this consent; it is voluntary. In addition, all the information you provide is legally classified as private data and can only be released to those legally authorized to receive it under Minnesota law.

I agree to allow school personnel to share my student's immunization documentation with Minnesota's immunization information system:

_____
Signature of parent or legal guardian Date

Willmar Public Schools

Today's Date: _____

Student Health Questionnaire

Child's Name: _____ Child's Birth date: _____ Sex: M FM

Parent / Guardian: _____ Daytime Phone #: _____

Medical History:

When was your child's last medical exam? _____

Physician or Clinic name: _____

Has your child been hospitalized within the last year? No Yes

If yes, state reason why: _____

Does your child take medication on a regular basis? No Yes

If yes, what medication? _____

Does your child have special dietary needs? No Yes

If yes, please explain? _____

Has your child had any of the following health concerns?

Frequent colds _____ Sore Throats _____ Ear Infections _____

Asthma _____ Eczema _____ Speech Difficulty _____

Allergies: *If yes, please identify trigger and describe symptoms.*

Foods _____

Bee Sting _____

Other _____

Heart Condition _____ Diabetes _____ Seizure disorder _____

Other health concerns: (please describe) _____

Vision:

Has your child ever had a vision examination or treatment? No Yes; when? _____

Results: Normal vision glasses/contacts "lazy eye" other _____

ELEMENTARY STUDENTS ONLY

Elementary Students Only (Check any concerns you have about the following behavior(s) in your child:

__ Bad Dreams	__ Irritable, easily upset	__ Destroys things purposely
__ Nervousness	__ Thumb sucking	__ Holds breath
__ Restlessness	__ Unable to share	__ Overly sensitive
__ Jealousy	__ Stubborn, uncooperative	__ Wants too much attention
__ Disobedient	__ Glum, sulky, moody	__ Bad temper
__ Nail Biting	__ Difficulty separating from parents	___Very sensitive to smells or textures

Other: _____

Can your child independently use the bathroom? No Yes

Does your child still have toileting accidents? No Yes

For office use only

Nurse Review Documentation

UTD for Kindergarten? ☐ yes ☐ NO, notice given to parent

Health History (include incidences which may impact their school experience).

_____

_____

Kindergarten Physical Complete? ☐ **Dental card returned?** ☐

Current Health Issues: ☐ None Known ☐ Yes : Dx and details _____

_____

_____

_____

_____

_____

If Asthma – Asthma questionnaire and Care Plan option given to parent ☐

Daily medication? ☐ None ☐ Yes, Name and time given: _____

If medication is needed at school - Medication policy and consent form given to parent. ☐

Dietary needs? ☐ None ☐ Yes _____

If yes – Dietary Policy and Medical Statement Form given to parent. ☐

_____ Date _____

signature of nurse completing interview with parent

SCHOOL DENTAL HEALTH CARD

FOR PARENT

Child's Name _____

Date of Birth _____

To Parent or Guardian:

Your child's health, comfort, behavior, progress in school, and in personal appearance may be strongly affected by neglecting their teeth. We advise you to call your family dentist to make an appointment for an examination of your child's teeth and whatever dental care is necessary. This card should be signed by the dentist and returned to Kennedy School.

FOR DENTIST

I have performed an oral examination for _____ and have informed his/her parent(s) of all necessary dental treatment.

Is in Treatment_____ Treatment Complete_____

Date _____ Signature _____D.D.S.

(Dentist: Please do NOT sign this card unless necessary work is actually completed or anticipated to be completed.)

Willmar Public Schools - Kindergarten
611 - 5 Street SW
Willmar, MN 56201

The American Dental Association says:
"Dental health is the responsibility of the individual, the family, and the community." As parents, you can practice your responsibility to your child's dental health by:

1. Checking your child's intake of excessive amounts of sweets.
2. Teaching your child to brush and floss as directed by your family dentist.
3. Providing your child with fluoridated water (1 to 1.5 p.p.m.) during the growing period of their teeth - from birth to eight years. If fluoridated water is not available, have your dentist recommend an alternative procedure.
4. Having dental examination twice a year by your family dentist or as often as your dentist may designate.