Distrito Escolar West Linn-Wilsonville
Lista de Inscripción para Kindergarten 2016-2017

Le damos la bienvenida a Uds. y su hijo/a a Kindergarten! Sera un año maravilloso lleno de aprendizaje y experiencias de crecimiento. Por favor comience por registrar a su hijo/a. La lista de abajo incluye los elementos que necesita para inscribir a su estudiante para el año escolar 2016-2017. Por favor asegúrese de que sus formas estén incluidas para completar el proceso de inscripción.

Nombre del Estudiante ____Fecha _____________

1. Forma de Inscripción (dos paginas; asegúrese de firmar y poner fecha)
2. Forma de Interés para la Aplicación al Programa de Lenguaje Dual (si es que aplica)
3. Fotocopia del Acta de Nacimiento (esta puede ser del estado o del hospital)
   Los niños deben de tener 5 años para el 1° de septiembre del año calendario al que se están registrando para entrar a Kindergarten.
4. Historial de Inmunizaciones-no se le olvide firmar y poner fecha a esta forma
   Las vacunas requeridas para entrar a la escuela son:
   a. DPT
   b. Polio
   c. Sarampión
   d. Hepatitis B
   e. Varicela o historial de Varicela
   f. Hepatitis A
5. Forma de Examen de la Vista (todos los estudiantes de edad de 7 años o menores que entran a un programa de educación por primera vez deben de entregar un examen de la vista dentro de los primeros 120 días de que el estudiante comience la escuela).
6. Certificación de Examen Dental (todos los estudiantes de edad de 7 años o menores que entran a un programa de educación por primera vez, deben de entregar una Certificación de Examen Dental dentro de los primeros 120 días de que el estudiante comience la escuela).

Fechas importantes:

5 de enero de 2016	Inscripción de Kindergarten comienza en todas las Escuelas Primarias
19 de enero de 2016	Noche de Información del Programa del Lenguaje Dual en la Primaria Lowrie a las 6:00 p.m. (habrá cuidado de niños)
20 de enero de 2016	Reunión para Padres de Kindergarten de Educación Especial de Edad Temprana (ECSE) a las 6:00 p.m. en la Oficina del Distrito de West Linn-Wilsonville. Salón de Reuniones del Consejo Educativo
2 de febrero de 2016	Lotería del Programa del Lenguaje Dual (si es necesario)
5 de febrero de 2016	Notificación de la ubicación del estudiante a padres en el programa del Lenguaje Dual
12 de febrero de 2016	Padres deben de confirmar la ubicación del estudiante en el Programa de Lenguaje Dual
Mayo 2016	Junta en las escuelas primarias para el comienzo de Kindergarten

PARA REGISTRARSE: TRAIGA ESTA LISTA CON SUS FORMAS A LA OFICINA DE LA ESCUELA

Name: ___________________________
(Last Name then First Name)

West Linn - Wilsonville School District #3Jt
Registration Form

For Office Use Only:
Teacher/Counselor: _______________________

Last Name: ____________ **First Name:** ____________
Middle Name: ____________ **Preferred Name:** ____________
Grade Level: ____________ **Date of Birth:** ____________
Gender: ___ Male ___ Female **Birthplace:** ____________
Ethnicity: Hispanic/Latino? ___ Yes ___ No
Race (check all that apply): ___ Amer Indian/Alaskan Native ___ Asian
(You must select at least one.) ___ Black or African American ___ Native Hawaii/Pac Islander
___ White

Student Cell Phone/Texting: Schools may begin contacting students via cell phone or text messaging. Please provide the following information if your student has a cell phone or text messaging device.
Cell Number: ____________ **Service Provider**: ____________
___ I do NOT approve of the school using my child's cell phone or text messaging for communications.

Parent/Guardian Info: *The address provided **must** be the student's primary residence.*
Relationship: Mother / Father / Other (Please Specify): ____________
Last Name: ____________ **First Name:** ____________
Home Address: ____________ **City/Zip:** ____________
Mailing Adr: ____________ **County:** ____________
Email: ____________
Initial to Confirm the Above Address is the Student's Residence: ____________
Home Phone: ____________ **Work Phone:** ____________
Home Phone Unlisted? **Yes** **No** **Employer:** ____________
Cell Phone: ____________ **Occupation:** ____________
Additional Parent/Guardian (at same address):
Relationship: Mother / Father / Other (Please Specify): ____________
Last Name: ____________ **First Name:** ____________
Work Phone: ____________ **Employer:** ____________
Cell Phone: ____________ **Occupation:** ____________
Email: ____________

Extra Mailing Information:
Under certain circumstances, the district is willing to send second mailings, for example, to non-custodial parents. If a second mailing is desired, please provide the information below:
Last Name: ____________ **First Name:** ____________
Relationship: ____________ **Email:** ____________
Home Address: ____________ **City/Zip:** ____________
Mailing Adr: ____________
Home Phone: ____________ **Work Phone:** ____________
Home Phone Unlisted? ___ Yes ___ No **Employer:** ____________
Other Phone: ____________ **Occupation:** ____________
Describe the circumstances that you believe warrant a second mailing: ____________
____

Legal/Custody Documents:
Please list the names of anyone who has legal guardianship of this child: ____________
____
Are there legal documents concerning the custody of this child? ___ Yes ___ No
If Yes, you will need to provide copies of the documents when submitting this form.

Other Emergency Contacts: The parties (include the Day Care Provider, if appropriate) listed below are authorized to pick up this child from school and to make decisions regarding cases of emergency, serious illness, or accident.

Name	Primary Phone/Work Phone/Other Phone	Relationship
____________	______/______/______	____________
____________	______/______/______	____________
____________	______/______/______	____________

Siblings: Please list the names, ages, grades, and schools of any siblings:

Name	Age	Grade	School
____________	______	______	____________
____________	______	______	____________
____________	______	______	____________

Previous School(s) (Name, Location, & Dates): ____________
____

Medical Conditions: Please check all conditions that apply and elaborate below:

___ Life-Threatening Allergies ___ Heart disease ___ Orthopedic problems
___ Asthma ___ Kidney disease ___ Hearing problems
___ Seizure disorder ___ Diabetes ___ Vision problems

Details/Other Health Concerns: ____________
____

Medications Taken/Dosage: ____________

District Nursing Staff will be in touch regarding specifics of these situations.

Permission Denials: (Initial each item for which you deny permission):

___ I **do not** approve of my child being photographed or videotaped for educational purposes, including usage of such on the school or district website.

___ I **do not** want any of my family's contact information disclosed by the school district. This means that school directories will not include my family's address, phone number, or email.

___ I **do not** want any other information about my child or my family to appear in any school publication. I understand that this means that my child will not be included in yearbooks, sports rosters, playbills, and other activity-related publications.

___ (For HS Age Student) I **do not** approve of my student being included in data sent to the military for recruiting purposes.

Please continue on the back side of this form.

(Front)

Name: ___________________________
(Last Name then First Name)

West Linn - Wilsonville School District #3Jt
Registration Form

For Office Use Only:
Teacher/Counselor: _______________________

Bus Information (If Known):
Morning Bus _______ Afternoon Bus: ________

Special Services (please check any areas in which your child has received special services in the last year):

___ Title I
___ ESL (English as a Second Language)
___ Gifted Education
___ 504 Plan
___ Special Education (IEP)
___ Other: ________________

Emergency Early Closure Plan (For Primary School Children Only) - If school should close early, what should your child do (***Please choose ONLY two***):

___ Take the bus home and can get into the house.
___ Will be picked up by _____________________.
___ Is to take the bus to __________________ day care.
___ Alternate Plan: ____
___ Take the bus and stay with ________________.
___ Is to walk home and can get in the house.

Language Survey:

What language did the student learn first? ______________________________

What is the student's primary language? ______________________________

What language(s) are spoken at home? ______________________________

Have you moved during the past three years for the purpose of obtaining seasonal or temporary employment in agriculture, forestry, or fishing? ___ Yes ___ No

Has this student ever missed more than 3 months of school? ___ Yes ___ No

If yes, when? ____

Complete these questions only if English is not the only language listed above.

Father's Native Language ____________________

Mother's Native Language ____________________

What language is most often used by adults in the family? ______________________________

What language does the student use to communicate with the adults at home? ______________________________

What language does the student use most often to communicate with friends? ______________________________

All information provided on both sides of this form is accurate to the best of my knowledge.

Parent/Guardian Signature: ____ **Date:** ______________________

(Back)

DISTRITO ESCOLAR WEST LINN – WILSONVILLE

Forma de Interés para Aplicación al Programa de Lenguaje Dual 2016-2017

Nombre del Estudiante ______________________________________Escuela _______________
Nombre del Padre o Tutor ____
Dirección____
Ciudad_____________________________ Estado ______ Código Postal __________________
Tel. Casa ________________________________ Tel. de Trabajo/Celular ________________
Email ____

☐ Si, me gustaría que mi hijo/a sea ubicado/a en el Kindergarten de Lenguaje Dual (español)
Entiendo que este es un programa de K-5. Entiendo que la inscripción a este programa esta sujeto a un proceso de lotería si el interés excede la capacidad de la clase, por lo tanto la forma debe de ser entregada no más tarde del 29 de enero, 2016. La lotería se llevara a cabo el 2 de febrero, 2016 si es necesario.

Tenemos un modelo 50:50, lo cual significa que el 50% de la instrucción es en Español y 50% de la instrucción es en Ingles.

Por favor marque la preferencia de escuela:

☐ Primaria Lowrie - el programa en Lowrie es un programa de inmersión de “dos vías”, lo que significa que la mitad de los estudiantes hablan Español como lenguaje primario y la mitad de los estudiantes hablan Ingles como su lenguaje primario.

☐ Primaria Trillium Creek – el programa en Trillium Creek es primariamente un programa de inmersión de “una vía” ya que casi todos los estudiantes son nativos de habla Inglesa, ya que aprenden Español como su segunda lengua.

☐ Cualquiera

El proceso de lotería del Kindergarten para el Programa de Lenguaje Dual (si hay mas interés que capacidad) involucra:

1) Un paquete completo de Inscripción de Kindergarten, incluyendo esta aplicación entregada a la escuela a la que pertenece no más tarde del 29 de enero del 2016.
2) Todos lo niños con una Forma de Interés para Aplicación será inscrito en la lotería del 2 de febrero, 2016 a las 10:00 a.m. en la Ofician del Distrito en el Salón de Juntas de la Planta Baja. La lotería es un proceso publico; los padres están bienvenidos a observar.
3) La notificación a los padres en la ubicación en el Programa de Lenguaje Dual será mandada a casa el 5 de febrero, 2016.
4) Los padres deben de confirmar su intención de aceptar la ubicación al Programa de Lenguaje Dual no mas tarde del 12 de febrero, 2016, 4:00 p.m.; de otra manera, el espacio será hecho disponible al siguiente estudiante en la lista de espera.

*** Programa de Lenguaje Dual-Entrega de la Forma de Interés entregada no más tarde del 29 de enero, 2016***

Oregon Certificate of Immunization Status
Oregon Health Authority, Immunization Program

Oregon law requires proof of immunization be provided or an exemption be signed prior to a child's attendance at school, preschool, child care or home day care. This information is being collected on behalf of the Oregon Health Authority, Immunization Program and may be released to the Authority or the local public health department by the school or children's facility upon request of the Authority. Please list immunizations in the order they were received.

Complete for all	Up-to-date	Medical	Non medical

Child's Last Name *Apellido*	First *Primer Nombre*	Middle Initial *Segundo Nombre*	Birthdate *Fecha de Nacimiento*
Mailing Address *Dirección*	City *Ciudad*	State *Estado*	Zip Code *Codigo Postal*
Parents' or Guardians' Names *Nombre de los padres o guardian*		Home Telephone Number *Número de Teléfono*	

Vaccines	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Diphtheria/Tetanus/Pertussis (DTaP, Tdap, Td)	(mm/dd/yy)	(mm/dd/yy)	(mm/dd/yy)	(mm/dd/yy)	(mm/dd/yy)
Booster Dose Tdap					
Polio (IPV or OPV)					
Varicella (Chickenpox) [VZV or VAR] ☐ Check here if child has had chickenpox disease _____________ (mm/dd/yy)					
Measles/Mumps/Rubella (MMR)					
or Measles vaccine only					
Mumps vaccine only					
Rubella vaccine only					
Hepatitis B (Hep B)					
Hepatitis A (Hep A)					
Haemophilus Influenzae Type B (Hib) (Only children less than 5 years)					

I certify that the above information is an accurate record of this child's immunization history.

Signature* ______________________________ Date

Update Signature ______________________________ Date

Update Signature ______________________________ Date

Update Signature ______________________________ Date

*Parent, guardian, student at least 15 years of age, medical provider or county health department staff person may sign to verify vaccinations received.

For school/facility use only
School/facility Name
Student ID Number
Grade

Continued On Reverse Side

Oregon Certificate of Immunization Status, Page 2
Oregon Health Authority, Immunization Program

Child's Last Name	First	Middle Initial	Birthdate
Apellido	*Primer Nombre*	*Segundo Nombre*	*Fecha de Nacimiento*

Recommended Vaccines

Recommended Vaccines	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Pneumococcal (PCV) (Only in children less than 5 years)					
Meningococcal (MCV4, MPSV4)					
Human Papilloma Virus (HPV) (9 years or older)					
Influenza (Flu)					
Other Vaccine Please specify:					
Other Vaccine Please specify:					

For medical exemptions:

Please submit a *letter* signed by a licensed physician stating:

- Child's name
- Birth date
- Medical condition that contraindicates vaccine
- List of vaccines contraindicated
- Approximate time until condition resolves, if applicable
- Physician's signature and date
- Physician's contact information, including phone number

For Immunity Documentation (history of disease or positive titer)**: Please submit a *letter* signed by a licensed physician stating:**

- Child's name and birth date
- Diagnosis or lab report
- Physician's signature and date

Nonmedical Exemption:

I have received information regarding the benefits and risks of immunizations. I understand that my child may be excluded from school or child care attendance if there is a case of disease that could be prevented by vaccine. I have attached the required document from (check one):

- ☐ A health care practitioner
- ☐ The vaccine educational module approved by the Oregon Health Authority

I understand that I may decline one or more vaccinations for my child and request that my child be exempted from the following required immunizations (check all that apply):

- ☐ Diphtheria/ Tetanus/Pertussis
- ☐ Polio
- ☐ Varicella
- ☐ Measles/Mumps/Rubella
- ☐ Hepatitis B
- ☐ Hepatitis A
- ☐ Hib

Signature of Parent or Guardian _______________ Date

Optional:
ORS 433.267 states that this document may include the reason for declining the immunization. Immunization is being declined because of:
☐ Religious belief ☐ Philosophical belief ☐ Other

I certify that the above information is an accurate record of this child's immunization history and exemption status.

Signature _______________ Date

Update Signature _______________ Date

Update Signature _______________ Date

Update Signature _______________ Date

(OFFICE ONLY) Student ID Number: Date Enrolled:

VISION HEALTH SCREENING CERTIFICATION

STUDENT INFORMATION

Last Name (LEGAL NAME)	First Name	Middle	Suffix

Date of Birth	Gender
	☐ M ☐ F

VISION HEALTH SCREENING REQUIREMENTS

Student Vision Screening or Eye Exam Requirements

OAR 581-021-0031

1. All students age seven or younger entering an educational program for the first time must submit vision screening/eye examination certification within 120 days of the student beginning school, that the student received:
   A. A vision screening or an eye examination; and
   B. Any further eye examinations or necessary treatments or assistance of the powers or range of vision of the eye.
2. Vision screenings **must be provided by** a person licensed by the Oregon Board of Optometry, Oregon Medical Board, a health care practitioner, school nurse, employee of an education provider, or another person who has completed instruction on how to perform vision screenings.
3. Certification of vision screening is not required if the educational program receives a statement that certification was submitted to a prior education provider or if the student's or parent's religious beliefs are contrary to vision screening.
4. Failure to meet the requirements of OAR 581-021-0031 may not result in prohibiting the student from attending school.

VISION SCREENING OR EYE EXAMINATION RESULTS

Childs Name	Date of Exam
Screening or Examing Entity Name	**Phone Number**

Right	Left	Corrective Lenses		☐ Results vary slightly from normal limits.
20/	20/	☐ Yes	☐ No	☐ Results are not within normal limits.

Are there any special instructions?

Physician Signature ____________________ Date ____________

NON-MEDICAL EXEMPTION

I have reviewed the requirements of vision screening or eye examination for students age seven or younger entering an educational program. My child is being raised as an adherent to a religion the teachings of which are opposed to vision screening or eye examinations and I request that my child be exempted from such requirement.

Parent or Guardian Signature ____________________ Date ____________

OTHER EDUCATIONAL ENTITY STATEMENT

I have met the vision screening or eye examination certification requirement by providing certification to another educational entity.

Educational Entity Name: ____________________

Parent or Guardian Signature ____________________ Date ____________

PARENT/GUARDIAN SIGNATURE

The information provided on this form is true and accurate of this date.

Parent or Guardian Signature ____________________ Date ____________

DENTAL SCREENING CERTIFICATION

West Linn Wilsonville School District

HB 2972 requires Education providers (includes Oregon Prekindergarten and Head Start) to collect and file certifications of dental screenings (within the previous 12 months) on all students 7 years of age or younger who are either beginning educational programs, or who are new to an educational program (within 120 days from school start date).

Please have your child screened by your dentist prior to the start of school. Your dentist will complete this certification form and you will bring it in to school.

PATIENT NAME: ______________________________ DATE OF BIRTH: __________________

Result of screening: Normal _________ Abnormalities _________________

Other ____

Further exam or treatment suggested _______________________________________

Preventative care (Fluoride/Sealants) ____

NAME OF PROVIDER: __________________________ DATE OF EXAM: __________________

SIGNATURE OF PROVIDER_________________________