



West Linn-Wilsonville School District 2017-2018 Kindergarten Registration Check-List

We welcome you and your child to Kindergarten! It will be a wonderful year filled with learning and growing experiences. Please begin by registering your child. The checklist below includes the items you will need to enroll your child for the 2017-2018 school year. Please make sure all your forms are included to complete the enrollment process.

Student's Name _____ Date _____

1. Registration Form (two pages; be sure to sign and date)
2. Dual Language Application of Interest Form (If applicable)
3. Photo copy of Certified Birth Certificate (this can be from the state or the hospital). Children must be 5 years old by September 1 of the calendar year for which they are registering to enter Kindergarten.
4. Immunization Record - don't forget to sign and date this form
Vaccines required for school entry:
 - a. DPT
 - b. Polio
 - c. Measles
 - d. Hepatitis B
 - e. Varicella or History of Chickenpox
 - f. Hepatitis A
5. Vision Screening Form (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).
6. Dental Screening Certification (All students age seven or younger entering an educational program for the first time must submit dental screening certification within 120 days of the student beginning school).
7. Proof of residence/address (examples: current utility bill, rental agreement – please make sure that you cover sensitive information).

Important Dates:

January 3, 2017	Kindergarten Registration begins at all Primary Schools
January 17, 2017	Dual Language Program Information Night at Lowrie Primary School, 6:00 pm (child care will be available)
January 30, 2017	Early Childhood Special Education (ECSE) Kindergarten Parent Meeting, 5:00 pm, West Linn-Wilsonville School District Office, Boardroom
February 2, 2017	Dual Language Program Lottery (if necessary)
February 6, 2017	Parents are notified of child's placement in Dual Language Program
February 13, 2017	Parent must confirm child's placement in Dual Language Program
May 2017	Kindergarten Open House in Primary Schools

TO REGISTER: PLEASE BRING THIS CHECKLIST WITH YOUR FORMS TO THE SCHOOL.

Name _____
(Last Name, 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 - you must select at least one) _____ Native Hawaiian/Pac Islander _____ American Indian/Alaskan Native _____ Black or African American _____ Asian _____ White	

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	Home Phone	Work Phone	Other Phone	Relationship
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Student Cell Phone/Texting: Schools may begin contacting students via cell phone or texting 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/test messaging for communication.

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

Name	Age	Grade	School
_____	_____	_____	_____
_____	_____	_____	_____

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 Address _____ 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 _____

Previous School(s): Name, Location, Dates:

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

<input type="checkbox"/> Life-Threatening Allergies	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Orthopedic Problems
<input type="checkbox"/> Asthma	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Hearing Problems
<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Vision Problems

Details/Other Health Concerns _____

Medications Taken/Dosage _____

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 Address _____

Home Phone _____ Work Phone _____

Home Phone Unlisted? Yes No Employer _____

Other Phone _____ Occupation _____

Describe the circumstances that you believe warrant a second mailing _____

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

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.

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.

West Linn Wilsonville School District #3JT Registration Form

Name _____
(Last Name, First Name)

Teacher/Counselor _____

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

_____ Title I _____ Gifted Education _____ Special Education (IEP) _____ ESL (English as a Second Language) _____ 504 Plan

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. ___ Take the bus and stay with _____ . Will be picked up by _____ .
___ Is to walk home and can get into the house. ___ Is to take the bus to _____ day care.

Alternate Plan _____

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

Parent/Guardian Signature _____ Date _____

For office use only

Verified proof of residency Document provided/examined _____ and verified by (initials) _____ Date _____
(check box) (type of document)



WEST LINN – WILSONVILLE SCHOOL DISTRICT
2017-2018 Dual Language Program Application of Interest Form

Student Name _____ Home School _____

Parent(s) Name _____

Address _____

City _____ State _____ Zipcode _____

Home Phone _____ Day/Cell phone _____

Email _____

Yes, I would like my child placed in the Dual Language (Spanish) Kindergarten.

I understand this is a K-5 program. I understand that enrollment for this program is subject to a lottery process should interest exceed the class capacity, therefore the form is due by January 31, 2017. The lottery will be held on February 2, 2017 if needed.

We have a 50:50 model which means that 50% of the instruction is in Spanish and 50% of the instruction is in English.

Please mark your school location preference:

Lowrie Primary - the program at Lowrie is a Two-Way immersion program, meaning that half of the students speak Spanish as their primary language and half of the students speak English as their primary language.

Trillium Creek Primary - the program at Trillium Creek is primarily a One-Way immersion program as almost all of the students are native English speakers, learning Spanish as their second language.

Either

Dual Language Kindergarten lottery process (should there be more interest than capacity) involves:

- 1) A completed Kindergarten Registration Packet, including this Application Form turned in to your neighborhood school by January 31, 2017.
- 2) All children with an Application of Interest Form will be entered into the lottery drawing on February 2, 2017 at 10:30 am at the District Office in the Boardroom. The lottery is a public process; parents are welcome to observe.
- 3) Notification to parents of child's placement in the Dual Language Program will be sent on February 6, 2017.
- 4) Parents must confirm intent to accept the Dual Language placement by February 13, 2017, 4:00 pm; otherwise, the opening will be made available to the next child on the waiting list.

*** Dual Language Program - Application of Interest Form due by January 31, 2017 ***



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.

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

Complete for all
 Up-to-date
 Medical
 Non medical

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] <input type="checkbox"/> Check here if child has had chickenpox disease _____ (mm/dd/yy)					
Measles/Mumps/Rubella (MMR) <i>or</i> 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 _____

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

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

Continued On Reverse Side



Oregon Certificate of Immunization Status, Page 2

Oregon Health Authority, Immunization Program

Child's Last Name <i>Apellido</i>	First <i>Primer Nombre</i>	Middle Initial <i>Segundo Nombre</i>	Birthdate <i>Fecha de Nacimiento</i>
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	Recommended Vaccines	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Recommended Vaccines	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):

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Diphtheria/ Tetanus/Pertussis | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Varicella | <input type="checkbox"/> Hib |
| <input type="checkbox"/> Measles/Mumps/Rubella | |

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 <input type="checkbox"/> M <input type="checkbox"/> F		

VISION HEALTH SCREENING REQUIREMENTS

Student Vision Screening or Eye Exam Requirements
OAR 581-021-0031

- 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 vision screening or an eye examination; and
 - Any further eye examinations or necessary treatments or assistance of the powers or range of vision of the eye.
- 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.
- 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.
- 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

Child's Name	Date of Exam			
Screening or Examing Entity Name	Phone Number			
Right	Left	Corrective Lenses	<input type="checkbox"/>	Results vary slightly from normal limits.
20/	20/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	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 _____