West Linn-Wilsonville School District
2016-2017 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 2016-2017 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).

Important Dates:

January 5, 2016	Kindergarten Registration begins at all Primary Schools
January 19, 2016	Dual Language Program Information Night at Lowrie Primary School, 6:00 pm (child care will be available)
January 20, 2016	Early Childhood Special Education (ECSE) Kindergarten Parent Meeting, 6:00 pm, West Linn-Wilsonville School District Office, Boardroom
February 2, 2016	Dual Language Program Lottery (if necessary)
February 5, 2016	Parents are notified of child's placement in Dual Language Program
February 12, 2016	Parent must confirm child's placement in Dual Language Program
May 2016	Kindergarten Round-Up in Primary Schools

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

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.

(Front)

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)

WEST LINN – WILSONVILLE SCHOOL DISTRICT
2016-2017 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 29, 2016. The lottery will be held on February 2, 2016 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 29, 2016.

2) All children with an Application of Interest Form will be entered into the lottery drawing on February 2, 2016 at 10:00 am at the District Office in the Lower Conference Room. 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 5, 2016.

4) Parents must confirm intent to accept the Dual Language placement by February 12, 2016, 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 29, 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 *Apellido*	First *Primer Nombre*	Middle Initial *Segundo Nombre*	Birthdate *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			
20/	20/	☐ Yes	☐ No	☐	Results vary slightly from normal limits.
				☐	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

4.4.2014

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_____