



**West Linn-Wilsonville School District
2020-2021 Preschool Registration Check-List**

We welcome you and your child to Preschool!
It will be a wonderful year filled with learning and growing experiences.
Please begin by registering your child – registration begins January 7, 2020.

The checklist below includes the items you will need to enroll your child for the 2020-2021 school year. Please make sure all your forms are included to complete the enrollment process.

Student's Name _____ **Date** _____

1. District Registration Form (two pages; be sure to sign and date).
2. Preschool Preference Form (choice of location and program).
3. Tuition Agreement Form (complete the form for the specific program you are registering for – eg: 3 day/week program, 4 day/week program, 5 day/week program). If you need financial assistance, please contact the school office and speak with the principal.
4. Photo copy of Certified Birth Certificate (this can be from the state or the hospital).
5. Oregon Certificate of Immunization Record - don't forget to sign and date this form.
6. 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).
7. 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).
8. Proof of residence/address (eg: current property tax bill, rental/lease agreement or letter from property owner/manager (which include: parent legal name, address, property owner/manager name, phone number and signatures from parent and property owner/manager), current mortgage statement, electric, water/sewer, cable, or garbage bill (dated within the last 45 days), or state/federal revenue documents).

If you have any questions, please contact a school office where a preschool program is located.

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



West Linn-Wilsonville School District
2020-2021 Preschool Program

West Linn-Wilsonville School District offers preschool programs at seven of our primary schools. The preschool program is tuition-based. Sessions and cost are detailed below. Families who need financial assistance to access preschool may contact the school office and speak with the principal.

Parents will need to provide transportation for their child.

Registration begins January 7, 2020. For more information, contact one of the schools listed below.

Boeckman Creek Primary School - 6700 SW Wilsonville Road, Wilsonville 503-673-7750	
Age	FOUR years old on or before September 1, 2020
Session/Time	5-Day Morning program: Monday, Tuesday, Wednesday, Thursday, and Friday / 8:30 am - 11:30 am
Tuition	\$4,392.00 (Payment may be made in 9 monthly installments of \$488.00) *Spanish Language Integration
Bolton Primary School - 5933 SW Holmes Street, West Linn 503-673-7900	
Age	THREE or FOUR years old on or before September 1, 2020
Session/Time	3-Day Morning program: Monday, Tuesday, and Thursday / 9:00 am - Noon
Tuition	\$2,637.00 (Payment may be made in 9 monthly installments of \$293.00)
Age	THREE or FOUR years old on or before September 1, 2020
Session/Time	4-Day Morning program: Monday, Tuesday, Wednesday, and Thursday / 9:00 am - Noon
Tuition	\$3,510.00 (Payment may be made in 9 monthly installments of \$390.00)
Boones Ferry Primary School - 11495 SW Wilsonville Road, Wilsonville 503-673-7300	
Age	FOUR years old on or before September 1, 2020
Session/Time	5-Day Morning program: Monday, Tuesday, Wednesday, Thursday, and Friday / 7:50 am – 10:50 am
Tuition	\$4,392.00 (Payment may be made in 9 monthly installments of \$488.00)
Age	FOUR years old on or before September 1, 2020
Session/Time	5-Day Afternoon program: Monday, Tuesday, Wednesday, Thursday, and Friday / 11:10 am – 2:10 pm
Tuition	\$4,392.00 (Payment may be made in 9 monthly installments of \$488.00)
Cedaroak Park Primary School - 4515 Cedaroak Drive, West Linn 503-673-7100	
Age	THREE or FOUR years old on or before September 1, 2020
Session/Time	3-Day Morning program: Tuesday, Wednesday, and Thursday / 8:30 am - 11:30 am
Tuition	\$2,637.00 (Payment may be made in 9 monthly installments of \$293.00) *Spanish Language Integration
Age	FOUR years old on or before September 1, 2020
Session/Time	4-Day Morning program: Monday, Tuesday, Wednesday, and Thursday / 8:30 am - 11:30 am
Tuition	\$3,510.00 (Payment may be made in 9 monthly installments of \$390.00) *Spanish Language Integration

Stafford Primary School - 19875 SW Stafford Road, West Linn 503-673-7150	
Age	FOUR years old on or before September 1, 2020
Session/Time	4-Day Morning program: Monday, Tuesday, Wednesday, and Thursday / 8:30 am - 11:30 am
Tuition	\$3,510.00 (Payment may be made in 9 monthly installments of \$390.00) *Chinese Language Integration
Sunset Primary School - 2351 Oxford Street, West Linn 503-673-7200	
Age	THREE or FOUR years old on or before September 1, 2020
Session/Time	3-Day Morning program: Monday, Tuesday, and Thursday / 8:30 am - 11:30 am
Tuition	\$2,637.00 (Payment may be made in 9 monthly installments of \$293.00) *Chinese Language Integration
Age	FOUR years old on or before September 1, 2020
Session/Time	4-Day Morning program: Monday, Tuesday, Wednesday, and Thursday / 8:30 am - 11:30 am
Tuition	\$3,510.00 (Payment may be made in 9 monthly installments of \$390.00) *Chinese Language Integration
Willamette Primary School - 1403 12th Street, West Linn 503-673-7250	
Age	THREE or FOUR years old on or before September 1, 2020
Session/Time	4-Day Morning program: Monday, Tuesday, Wednesday, and Thursday / 8:00 am - 11:00 am
Tuition	\$3,510.00 (Payment may be made in 9 monthly installments of \$390.00)

3/27/18

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 M _____ F _____ X _____ 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

___ 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.

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 _____

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.

(FRONT)

Please continue on the back side of this form

(FRONT)

Name _____
(Last Name, First Name)

West Linn-Wilsonville School District #3JT Registration Form

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 _____

Services: Is a parent or guardian of this student on active duty in the Armed Forces or the National Guard? Yes _____ No _____

Language Use Survey:

What language(s) does your child hear or use regularly in your household? Hear _____ Use _____

Describe the language(s) your child understands: ☐ No English ☐ Mostly another language and a little English ☐ English and another language equally
☐ Only English ☐ Mostly English and a little of another language ☐ Tribal or Native Language

What language(s) do adults most frequently use when speaking/conversing to your child?

Father/Guardian: _____ Mother/Guardian: _____ Other Adults in the Home: _____ Child-care Providers: _____

What language(s) did your child speak/express from 0 – 4 years of age? _____

What language(s) does your child currently speak/express most frequently outside of school? _____

Does your child frequently participate in cultural activities that are in a language other than English? Please list the activity and how often your child participates in the activity (for example: once/week, 2 times/week, once a month, etc. _____

Is there anything else you think the school should know about your child's language use? _____

Parent Questions: In what language(s) do you want to receive information from the school (if available)?

Father/Guardian: Oral _____ Written _____ American Sign Language _____

Mother/Guardian: Oral _____ Written _____ American Sign Language _____

Have you moved during the last three years for the purpose of obtaining seasonal/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? _____

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

Parent/Guardian Signature _____ Date _____

What is your relationship to the student? (i.e., parent, grandparent, etc.) _____

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
2020-2021 PRESCHOOL PREFERENCE FORM

Child's Name _____ Birth Date _____

Parent's Name _____ Phone _____

From the options below please indicate which preschool session you would like your child to attend. Please (✓) any other sessions that would possibly suit the needs of your child.

This information will aid us in setting up class sessions to meet the needs of our community. Knowing your preference will help us plan the appropriate number of sessions. If we cannot provide a session that meets your needs, we will refund your deposit.

Boeckman Creek Primary School

- ☐ 5-Day Program (AM) Monday, Tuesday, Wednesday, Thursday, and Friday
FOUR years old 8:30 am – 11:30 am
*Spanish Language Integration

Bolton Primary School

- ☐ 3-Day Program (AM) Monday, Tuesday, and Thursday
THREE or FOUR years old 9:00 am – Noon
- ☐ 4-Day Program (AM) Monday, Tuesday, Wednesday, and Thursday
THREE or FOUR years old 9:00 am – Noon

Boones Ferry Primary

- ☐ 5-Day Program (AM) Monday, Tuesday, Wednesday, Thursday, and Friday
FOUR years old 7:50 am – 10:50 am
- ☐ 5-Day Program (PM) Monday, Tuesday, Wednesday, Thursday, and Friday
FOUR years old 11:10 am – 2:10 pm

Cedaroak Park Primary School

- ☐ 3-Day Program (AM) Tuesday, Wednesday, and Thursday
THREE or FOUR years old 8:30 am – 11:30 am
*Spanish Language Integration
- ☐ 4-Day Program (AM) Monday, Tuesday, Wednesday, and Thursday
FOUR years old 8:30 am – 11:30 am
*Spanish Language Integration

Stafford Primary School

- ☐ 4-Day Program (AM) Monday, Tuesday, Wednesday, and Thursday
FOUR years old 8:30 am – 11:30 am
*Chinese Language Integration

Sunset Primary School

- ☐ 3-Day Program (AM) Monday, Tuesday, and Thursday
THREE or FOUR years old 8:30 am – 11:30 am
*Chinese Language Integration
- ☐ 4-Day Program (AM) Monday, Tuesday, Wednesday, and Thursday
FOUR years old 8:30 am – 11:30 am
*Chinese Language Integration

Willamette Primary School

- ☐ 4-Day Program (AM) Monday, Tuesday, Wednesday, and Thursday
THREE or FOUR years old 8:00 am – 11:00 am



West Linn-Wilsonville School District

**Boones Ferry Primary School
2020-2021 PRESCHOOL TUITION AGREEMENT**

**5 DAYS/WEEK MORNING OR AFTERNOON PROGRAM
(Four years old on or before 9/1/20)**

Please complete this form and return to the school office with your \$125.00 non-refundable deposit. Please make check payable to: **West Linn-Wilsonville School District**. The deposit applies towards the first month's tuition.

AGREEMENT FOR PAYMENT OF TUITION

Payment for the 2020-2021 school year will total \$4,392.00, which may be made using one of two payment plans. **Make checks payable to: West Linn-Wilsonville School District.**

Option 1: **A single payment** of \$4,392.00 which is due before the first day of school.

Option 2: **9 payments** in the amount of \$488.00 due the first day of each month.

The first payment is due in your school office before school begins. You may mail or hand-deliver your check to the school office. Following the initial payment, an invoice will be sent to you on the 25th of each month. If payment is not received, a 2nd notice will be sent on the 10th of the month. If we do not receive payment by the end of a given month the principal will contact you to consider alternatives.

Student's Name: _____

I acknowledge that my deposit is non-refundable unless West Linn-Wilsonville School District cannot provide placement. I understand the deposit will be applied to the first month's tuition. I agree to the payment requirements as stated above.

I understand participation in the West Linn-Wilsonville School District Pre-School Program is not considered "currently enrolled" for the purpose of K-12 Open Enrollment or Inter-District Transfer Requests.

*Please be aware that we will hold your deposit until a placement has been made.

Parent or Legal Guardian

Date

For office use only:

Received: _____

Name: _____



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>	Complete for all Up-to-date Medical Non medical
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>		

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)					
<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 _____

*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 <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	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 | ☐ Hepatitis B |
| ☐ Polio | ☐ Hepatitis A |
| ☐ Varicella | ☐ Hib |
| ☐ 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 ☐ 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 Form

State law now requires a child who is 7 years of age or younger to have a dental screening before entering school for the first time. (HB 2972 (2015))

IF YOUR CHILD HAS ALREADY RECEIVED A DENTAL SCREENING

Parent/Guardian:

- If you know your child has already had a dental screening, please check the box below, fill out this section, and sign it.
- If you do not know if your child has had a dental screening, please have a dental provider fill out this section and sign it.
- Please return this form to the school office.

☐ My child _____ has received a dental screening.
(First name) (Middle initial) (Last name)

Parent/Guardian or Dental Provider

Print Name: ✍ _____

Signature ✍ _____ Date ✍ _____

TO OPT-OUT OF THE DENTAL SCREENING REQUIREMENT

Parent/Guardian: You may choose to have your child opt-out of a dental screening due to a reason listed below. Please fill out this section and sign it. Then return this form to the school office.

My child was not screened due to the following: (please check all that apply):

- ☐ We already submitted a certification form at a previous school.
- ☐ The dental screening is contrary to student or families religious beliefs.
- ☐ The dental screening is a burden.

The dental screening is a burden for the student or the parent or guardian of the student when:

(A) The cost of obtaining the dental screening is too high;

(B) The student does not have access to a screener or;

(C) The student was unable to obtain an appointment with an screener

Parent/Guardian

Print Name ✍: _____

Signature ✍ _____ Date ✍ _____