West Linn-Wilsonville School District
2020-2021 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 2020-2021 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. Language Survey Form
3. Dual Language Application of Interest Form (if applicable).
   NEW THIS YEAR – the Dual Language Application of Interest Form is available online at: https://www.wlwv.k12.or.us/domain/1467
   Deadline for online Dual Language Application of Interest Form – 4:00 pm, January 31, 2020.
4. Proof of age. A copy of one of the following: birth certificate, passport, hospital announcement, baptismal certificate, health insurance forms w/birth date, or state services documentation such as welfare benefits w/birth date. Children must be 5 years old by September 1 of the calendar year for which they are registering to enter Kindergarten.
5. Immunization Record - don't forget to sign and date this form. Vaccines required for school entry: DPT**,** Polio**,** Measles**,** Hepatitis A**,** Hepatitis B, and Varicella or History of Chickenpox.
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. A copy of one of the following: current property tax bill, rental/lease agreement or letter from property owner/manager (which must include the 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.

Important Dates:

January 7, 2020	Kindergarten Registration begins at all Primary Schools
January 14, 2020	Lowrie Dual Language Program Information Night, 6:00 pm – 7:30 pm
January 16, 2020	Trillium Creek Dual Language Program Information Night, 6:30 pm – 8:00 pm
January 31, 2020	Deadline for completion of online Dual Language Application of Interest Form (4:00 pm)
February 3, 2020	Early Childhood Special Education Kindergarten Parent Meeting, 6:00 pm, District Office
February 7, 2020	Dual Language Program Lottery (if necessary)
February 12, 2020	Parents are notified of child's placement in Dual Language Program
February 19, 2020	Parent must confirm child's placement in Dual Language Program
May 2020	Kindergarten Open House in Primary Schools

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

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

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.

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_____

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.

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
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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)

For Office Use Only:
Bus Information (If Known)
AM_____ PM_____

Name_____ **West Linn-Wilsonville School District #3JT Registration Form** Teacher/Counselor _____
(Last Name, First Name)

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)

(BACK) (BACK)

Language Use Survey

The purpose of this survey is to determine if your child's current language exposure and use might make your child eligible to receive English Learner (EL) services.

Student Name: _____ Grade Level: _____
School: _____ Date of Birth: _____

1. What language(s) does your child hear or use regularly in your household (i.e., spoken, media, music, literature, etc)? hear _____ use (i.e., ASL) _____

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

3. 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: _____

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

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

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

7. 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 _____

Will you need interpretation/translation for?
Meetings _____ Conferences _____ Paperwork_____

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

Parent or Guardian Signature _____ Date _____

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		☐	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 _____

12/14/18

West Linn-Wilsonville School District 3Jt

Administration Building/Nursing Services

22210 SW Stafford Road • Tualatin, OR 97062 • (503) 673-7041 or Fax (503) 673-7003 • www.wlwv.k12.or.us

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.
- Please return this form to the school office.

[ ] My child _____ has received a dental screening.
(First Name) (Last Name)

Parent/Guardian or Dental Provider
Print Name_____
Signature _____ Date_____

TO OPT-OUT OF THE DENTAL SCREENING REPORTING REQUIREMENT

Parent/Guardian: You may choose to have your child opt–out of the required dental screening reporting 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 a screener

Parent/Guardian

Print Name_____

Signature_____ Date_____