



## West Linn-Wilsonville School District 2018-2019 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 2018-2019 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, 2018	Kindergarten Registration begins at all Primary Schools
January 16, 2018	Lowrie Primary School Dual Language Program Information Night
January 17, 2018	Trillium Creek Primary School Dual Language Program Information Night
January 29, 2018	Early Childhood Special Education (ECSE) Kindergarten Parent Meeting, 5:00 pm, West Linn-Wilsonville School District Office, Boardroom
February 7, 2018	Dual Language Program Lottery (if necessary)
February 9, 2018	Parents are notified of child's placement in Dual Language Program
February 16, 2018	Parent must confirm child's placement in Dual Language Program
May 2018	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

\_\_\_ Life-Threatening Allergies    \_\_\_ Heart Disease    \_\_\_ Orthopedic Problems  
 \_\_\_ Asthma    \_\_\_ Kidney Disease    \_\_\_ Hearing Problems  
 \_\_\_ Seizure Disorder    \_\_\_ Diabetes    \_\_\_ 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**  
**2018-2019 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, 2018. The lottery will be held on February 7, 2018 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, 2018.
- 2) All children with an Application of Interest Form will be entered into the lottery drawing on February 7, 2018 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 9, 2018.
- 4) Parents must confirm intent to accept the Dual Language placement by February 16, 2018, 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, 2018 \***

# 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

<b>For school/facility use only</b>
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	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):

<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	

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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

Childs 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?

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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 \_\_\_\_\_



## 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.wlww.k12.or.us](http://www.wlww.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))

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#### 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 \_\_\_\_\_

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#### 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 \_\_\_\_\_