

CLAYMONT CITY SCHOOLS

201 North Third Street
Dennison, OH 44621

Phone: (740) 922-5478 Fax: (740) 922-7325



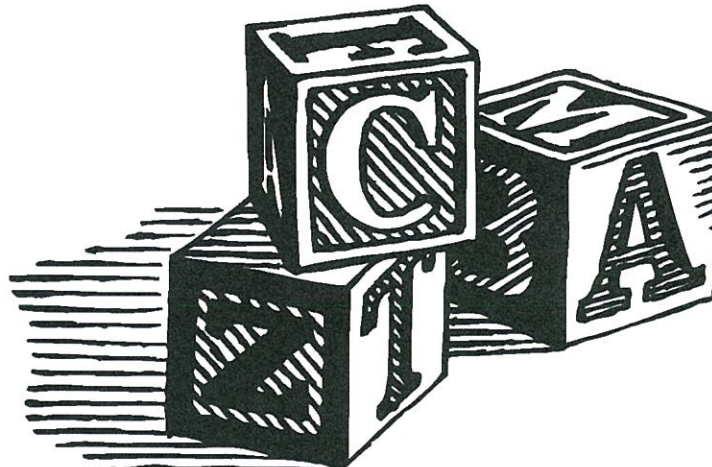
Kindergarten Registration

The Claymont City School District will hold kindergarten registration and screening. **Registration and screening will be held at the First Christian Church in Uhrichsville (across from the Uhrichsville Police Station). You can pick up registration packets at the Superintendent's office. During the school year they can be picked up at Park Elementary, Eastport Avenue Elementary or Trenton Avenue Elementary.**

1. **Age:**
Children, who will be five years of age on or before August 1st. of the school year in which they will be attending, may enter kindergarten.
2. **Parents are to bring with them:**
 - a) A copy of the child's birth certificate & social security card.
(A hospital certificate is not acceptable; it should be a legal birth certificate.)
 - b) A copy of the child's immunization record.
 - c) A copy of any court papers that relate to the child.
 - d) All registration forms that are inside the Kindergarten packet completed, (the packet should be picked up before your appointment).
 - e) Make sure your child is rested and wears comfortable shoes and clothes.

You will need to call Tammy McMillen at 922-5888 for an appointment time August through June, during the month of July please call 922-5478 and ask for Bonnie.

We will fill each day's appointments before going on to the next day.



BUILDING _____
BUS STUDENT _____

ENROLLMENT DATE _____
TEACHER _____

CLAYMONT CITY SCHOOLS

KINDERGARTEN REGISTRATION FORM

The confidential information requested below is necessary for the protection of your child and for completion of his/her permanent school record. **PLEASE PRINT**

STUDENT'S FULL NAME: _____ (LAST) (FIRST) (MIDDLE) _____ MALE _____
FEMALE _____

CALLED NAME: _____

DATE OF BIRTH: ____/____/____ PLACE OF BIRTH: _____ (CITY) (STATE)

STUDENT'S SOCIAL SECURITY NUMBER: _____ - _____ - _____

ADDRESS: _____ PHONE: _____

_____ COUNTY: _____

Please give any information which will help us locate your house if it is outside the city limits. _____

Was this child registered in school before? _____ If yes what district _____

Address of district _____

MEDICAL INFORMATION THE SCHOOL SHOULD KNOW IMMEDIATELY

HANDICAPPED:

- ____ * Not Applicable (No handicap)
- ____ 1. Multi-Handicapped (Not deaf or blind)
- ____ 2. Deaf/Blind
- ____ 3. Hearing Handicapped
- ____ 4. Visually Handicapped
- ____ 5. Speech Handicapped
- ____ 6. Orthopedic ally Handicapped
- ____ 7. Other Health handicapped
- ____ 8. Severe Behavior Handicapped
- ____ 9. Developmentally handicapped(DH)
- ____ 10. Specific Learning Disability (LD)
- ____ 11. Non-Specific Handicapped(Ages 3-5)

RACE

- ____ Asian
- ____ Am. Indian
- ____ Black
- ____ Hispanic
- ____ Multi-Racial
- ____ White

WHICH DID CHILD ATTEND:

- ____ Licensed Preschool
- ____ Head Start
- ____ BJVS Preschool

- Birth Certificate
- Social Security
- Immunization

CITIZENSHIP:

- ____ United States Citizen
- ____ Exchange Student
- ____ Other/Non U.S. Citizen

Father's Name _____

Address _____

Phone _____

Date of Birth _____

Place of Birth _____

Occupation _____

Work Phone _____

Highest Grade completed _____ College _____

Mother's Name _____

Mother's Maiden Name _____

Address _____

Phone _____

Date of Birth _____

Place of Birth _____

Occupation _____

Work Phone _____

Highest Grade completed _____ College _____

Present marital status of parents (Check where applicable)

- Married
 - Separated
 - Divorced
 - Single Parent
 - Remarried
 - Deceased
- Mother Father

If divorced, list who has legal custody: Name _____
Relationship _____

Are there any court orders regarding this child? Yes ___ NO ___ If yes, please furnish the school with a copy of this document immediately.

BROTHERS and SISTERS in SCHOOL

<u>NAME (First & Last):</u>	<u>BUILDING ATTENDING:</u>	<u>GRADE:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child ever received any of the following special services? YES ___ NO ___
If yes please check the correct one below.

- Speech and Hearing
- DH (Developmentally Handicapped)
- LD (Learning Disability)
- Psychological Testing
- SBH (Severe Behavior Handicapped)
- An active I.E.P.
- Other

IF YOU CAN NOT BE REACHED WHOM SHALL WE CALL IN CASE OF AN EMERGENCY?

NAME: _____ PHONE: _____
PHYSICIAN: _____ PHONE: _____

I hereby state that the information I provided on this form is true to the best of my knowledge.

Signature

Claymont City Schools
Home Language Survey

Date _____

Name of Student _____
Family Name
First Name
Middle I.

Date of Birth _____ / _____ / _____ Place of Birth _____
Month
Day
Year
City
State
Country

Name of Parent/Guardian _____
Family Name
First Name

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

For Parents/Guardians:

Please answer the following questions:

1. What language did your son/daughter speak when he/she first learned to talk? _____
2. What language does your son/daughter use most frequently at home? _____
3. What language do you use most frequently to your son/daughter? _____
4. What language do the adults at home most often speak? _____
5. How long has your son/daughter attended school in the United States? _____

For School District Personnel:

If the answer to any of the first four questions above is a language other than English, indicate the student's native/home language in EMIS Student Data Element (G-1270), and proceed to assess the student's English language proficiency.

INITIAL ENGLISH LANGUAGE ASSESSMENT

Communication Skill

Proficiency Level

Listening	_____	Pre-functional	_____	Beginning	_____	Intermediate	_____	Advanced	_____	Proficient
Speaking	_____	Pre-functional	_____	Beginning	_____	Intermediate	_____	Advanced	_____	Proficient
Reading	_____	Pre-functional	_____	Beginning	_____	Intermediate	_____	Advanced	_____	Proficient
Writing	_____	Pre-functional	_____	Beginning	_____	Intermediate	_____	Advanced	_____	Proficient
Comprehension*	_____	Pre-functional	_____	Beginning	_____	Intermediate	_____	Advanced	_____	Proficient
Composite**	_____	Pre-functional	_____	Beginning	_____	Intermediate	_____	Advanced	_____	Proficient

*The Comprehension level is derived from Listening and Reading

**The Composite level is derived from Listening, Speaking, Reading, Writing and Comprehension

Assessment instrument(s) used: _____

Student is LEP? _____ Yes _____ No

Indicate the student's status as LEP or not LEP in EMIS Student Data Element (G-1230)

If student has been in U.S. schools for less than three years, is the student eligible for extended accommodations for statewide academic assessments? _____ Yes _____ No

1. Is the respondent Hispanic/Latino? . _____ YES _____ NO (a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

2. Which of the following five racial groups applies to the respondent. Check all that apply:

_____ **American Indian or Alaska Native** - Persons having origins in any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment.

_____ **Asian** - Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent. This area includes, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

_____ **Black or African American** - Persons having origins in any of the black racial groups in Africa.

_____ **Native Hawaiian or Other Pacific Islander**

_____ **White** - People who have origins in any of the original peoples of Europe, North Africa, or the Middle East.

(The US Department of Education will allow educational entities to use "observer identification" of the race and ethnicity of elementary and secondary school students when self-identification or identification by the parents does not occur.)

Ohio Department of Health • School and Adolescent Health

Health History

Student's name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth / /
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Family Health History Please list allergies, heart problems, diabetes, cancer or other serious health conditions.

Father
Mother
Brothers and Sisters

Birth and Developmental History No unusual birth or developmental history

Did the mother have any unusual physical or emotional illness during this pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Was infant born full term? <input type="checkbox"/> Yes <input type="checkbox"/> No Did the infant have any sickness or problems? <input type="checkbox"/> Yes <input type="checkbox"/> No
Briefly explain illness or problems. _____
How does the child's development compare to other children, such as his or her brothers/sisters or playmates? <input type="checkbox"/> About the same <input type="checkbox"/> Delayed <input type="checkbox"/> Advanced

Student Health Conditions

<input type="checkbox"/> YES , my child receives regular medical/health care for the following conditions:		<input type="checkbox"/> NO medical conditions
<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Seizure disorder
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Sickle cell anemia
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Ear problem/hearing difficulty	<input type="checkbox"/> Skin conditions
<input type="checkbox"/> Autism	<input type="checkbox"/> Emotional concerns	<input type="checkbox"/> Speech problems
<input type="checkbox"/> Behavior concerns	<input type="checkbox"/> Headaches	<input type="checkbox"/> Traumatic brain injury
<input type="checkbox"/> Birth/congenital malformations	<input type="checkbox"/> Heart problems	<input type="checkbox"/> Vision problems (glasses, contacts)
<input type="checkbox"/> Bone/muscle/joint problems	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Other _____
<input type="checkbox"/> Blood problems	<input type="checkbox"/> Juvenile arthritis	<input type="checkbox"/> Other _____
<input type="checkbox"/> Bowel/bladder problems	<input type="checkbox"/> Lead poisoning	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Migraines	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> Neuromuscular disorder	<input type="checkbox"/> Other _____

Please explain any conditions above or any reasons for hospitalizations.

Please indicate any allergies your child may have.

Allergy type	Reaction	School restrictions or recommended actions
<input type="checkbox"/> Bee/Insect		
<input type="checkbox"/> Food		
<input type="checkbox"/> Medication		
<input type="checkbox"/> Other		

Health History continued

Please list any prescription and over the counter medication that your child takes on a regular basis.

Medication and dose	Time	Reason

Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?

Yes No If YES, please explain.

Does the student require any special procedures and/or treatments for their health condition(s)?

Yes No If YES, please explain.

Please indicate any other information about your child's health or development that you think would be helpful for the school to know.

Form completed by	Relationship to student	Date / /
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Ohio Department of Health • School and Adolescent Health

Physical Examination

Student's name		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth / /
Height	Weight	BMI percentile	BP

Screening Tests

Vision	Hearing	Postural
Date performed / /	Date performed / /	Date performed / /
Distance Acuity <input type="checkbox"/> R <input type="checkbox"/> L Muscle Balance <input type="checkbox"/> Pass <input type="checkbox"/> Fail Stereopsis <input type="checkbox"/> Pass <input type="checkbox"/> Fail Color <input type="checkbox"/> Pass <input type="checkbox"/> Fail Child wears glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Tested with glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Referral made? <input type="checkbox"/> Yes <input type="checkbox"/> No	Pure Tone Right ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail Left ear <input type="checkbox"/> Pass <input type="checkbox"/> Fail Child wears hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No Child under the care of a hearing specialist <input type="checkbox"/> Yes <input type="checkbox"/> No Referral made? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No abnormality noted <input type="checkbox"/> Screening not done <input type="checkbox"/> Referral made Comments _____ _____ _____

Speech/Language

Speech assessment completed Yes No
 Child has no discernible speech problem Yes No
 Speech evaluation recommended Yes No
 Child has possible problem with _____

Lead Poisoning

Date _____ Type C V Results _____ µg/dL
 Date _____ Type C V Results _____ µg/dL

Tuberculin Test

Date _____ Type _____ Results _____

Health History (Serious or chronic illnesses/injuries/surgeries)

Physical Examination Date of most recent examination / /

Essentially normal Abnormalities as follows

Is this child able to participate fully in:

Classroom and academic activities	<input type="checkbox"/> Yes <input type="checkbox"/> No	Physical education classes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Competition athletics	<input type="checkbox"/> Yes <input type="checkbox"/> No	Contact and collision sports	<input type="checkbox"/> Yes <input type="checkbox"/> No

If limitations are advised, please specify

Does this child have any physical, developmental or behavioral issues that may affect his/her educational process?

HealthCare Provider's signature	Print name	Phone ()
Address		Date / /
City	State	ZIP

Ohio Department of Health • School and Adolescent Health

Oral Assessment

Student's name	Date of birth / /
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The following services have been performed (please check all that apply)

<input type="checkbox"/> Examination	<input type="checkbox"/> Fluoride application	<input type="checkbox"/> Oral prophylaxis (cleaning)	<input type="checkbox"/> Prescription for fluoride supplement
<input type="checkbox"/> Orthodontic assessment	<input type="checkbox"/> Radiographs	<input type="checkbox"/> Dental sealant	<input type="checkbox"/> Treatment (restoration, pulp therapy)
<input type="checkbox"/> Other _____			

The following oral hygiene instruction was provided (please check all that apply)

<input type="checkbox"/> Toothbrushing	<input type="checkbox"/> Flossing	<input type="checkbox"/> Dietary counseling	<input type="checkbox"/> Use of fluoride mouthrinse
<input type="checkbox"/> Other _____			

The following statements are applicable (please check all that apply)

<input type="checkbox"/> All necessary preventive services have been performed. (Fluoride treatment, prophylaxis)
<input type="checkbox"/> No restorative services are required at this time.
<input type="checkbox"/> Further treatment is indicated. (See comments)
<input type="checkbox"/> Further appointments have been arranged. (Orthodontic, restorative)
<input type="checkbox"/> Routine recall visits recommended.

Comments

Dentist's signature	Print name	Phone ()
Address		Date / /
City	State	ZIP

Claymont City Schools

201 N. Third Street
Dennison, OH 44621



IMPORTANT - PLEASE READ

To all Kindergarten Parents:

Unless otherwise exempt, all Kindergarten students enrolled in public or private schools in Ohio shall be immunized as follows:

1. **THREE** dose series of **Hepatitis B Vaccine**
2. **TWO** doses of **MMR Vaccine**
3. **FIVE** doses of **DPT (DT) Vaccine**
(If 4th dose was given after 4th birthday, the 5th dose is not required)
4. **FOUR** doses of **Polio Vaccine**
(4th dose must be administered on or after the 4th birthday)
5. **TWO** doses of **Varicella** are required

Children not in compliance may be excluded from school.

If you have any questions, please contact your school office or the Tuscarawas County Health Department @ 330-343-5555 Monday thru Friday, 8:00 AM to 4:00 PM.



