2017 - 2018 Kindergarten Registration
Crestwood Primary School

Saturday, April 8th - 9:00 a.m. - 2:00 p.m.

or

Thursday, April 20th - 4:00 p.m. - 8:00 p.m.

*Your child must be five years old *on or before* August 1st, 2017, to be eligible to register for Kindergarten.

Please note: you MUST have the following items completed and available when you register your child for Kindergarten. If you do not have ALL of the requested items with you at the time of registration, you will be unable to register at that time.

- ✓ Completed Crestwood Local Schools Registration Forms
- ✓ $75.00 Registration fee payable to Crestwood Board of Education
- ✓ Child's original birth certificate issued by the state
- ✓ Child's social security card
- ✓ Proof of residency for the parent (See P. 4 Section 9 of the registration paperwork for specifics)
- ✓ Custody Papers - if applicable
- ✓ Health History (completed by parents)
- ✓ Child's Current Immunization Record

If you have any questions regarding Kindergarten Registration, please contact Crestwood Primary School at (330) 357-8202

Crestwood Primary School 2017-2018 Kindergarten Information

Kindergarten Parents,

Welcome to Kindergarten at Crestwood Primary School. We are looking forward to an excellent school year with you and your child. As we begin the 2017-2018 school year, please note the following important information:

Kindergarten Phase-In Schedule:

We will phase-in kindergarten students this school year. Students will attend school on their assigned day based on the first letter of their last name. Students will follow their regular school day schedule (8:50 a.m. - 3:20 p.m.). Your child will attend the first week of school according to the following phase-in schedule:

August 28th - A - M
August 29th - N - Z
Beginning August 30th all kindergarten students attend everyday

Important Dates for the 2017-2018 School Year:

Kindergarten Screening: August 23, 24, 25
(you will receive a scheduled day and time at Kindergarten Registration)

CPS Open House: August 24th from 4:00 p.m. - 6:00 p.m.

Kindergarten Parent Meeting (parents only): August 25th

Please note that at Kindergarten Registration you will receive a folder of information regarding Safety Town, Kindergarten Readiness Information, a scheduled day and time for Kindergarten Screening for your child and more information about the Kindergarten Parent Meeting.

Updated: 10/26/2015

SECTION 1 – STUDENT DEMOGRAPHIC INFORMATION:

Full Name: _____ **School Year:** _____
(First, Middle and Last)

Gender: Male Female **DOB:** _____ **Age:** ____ **Grade:** ____ **Homeroom:** ____

Is this student Hispanic/Latino? Y or N **Teacher:** _____

Is this child from one or more of the following races: White, Asian American or Alaskan Native
(Please circle all that apply)
Black or African American Native Hawaiian or Pacific Islander

Mailing Address: _____ **Physical Address:** _____

_____ _____

Phone Number: _____ **Email Address:** _____

SECTION 2 – PARENT/GUARDIAN INFORMATION:

Biological/Adoptive
Father's Name: _____

Address: _____

_____

Home #: _____

Cell# _____

Employer Name: _____

Work #: _____

Email: _____

Should this parent receive copies of correspondence? Y or N
(If no, documentation must be provided)

Biological/Adoptive
Mother's Name: _____

Address: _____

_____

Home# _____

Cell# _____

Employer Name: _____

Work #: _____

Email: _____

Should this parent receive copies of correspondence? Y or N
(If no, documentation must be provided)

With whom does this child live (circle one)? Biological/Adoptive Parents Biological/Adoptive Father Grandparent
Biological/Adoptive Mother Legal Guardian Foster Parents

***If this child lives with anyone other than the biological parents, court-papers must be furnished or on file in our office.*
***If this child's parents are divorced, a copy of the divorce decree must be furnished or on file in our office.*

If this child lives with someone other than his biological or adoptive parent, please complete this section:

Foster
Parent's Names: _____

Address: _____

_____

Home #: _____

Cell# _____

Employer Name: _____

Work #: _____

Email: _____

Guardian/Caseworker's
Name: _____

Address: _____

_____

Home# _____

Cell# _____

Employer Name: _____

Work #: _____

Email: _____

The name of the school district in which the biological parents live: _____

Updated: 10/26/2015

STUDENT NAME: _____

SECTION 3: CUSTODIAL PARENT/GUARDIAN TO GRANT CONSENT FOR EMERGENCY MEDICAL TREATMENT

Purpose: To enable parents/guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority when parents or guardians cannot be reached.

Emergency Contact #1 Relationship: _____
(Other than Parent/Guardian)

Name: _____

Address: _____

_____

Home #: _____

Cell# _____

Employer Name: _____

Work #: _____

Email: _____

Emergency Contact #2 Relationship: _____
(Other than Parent/Guardian)

Name: _____

Address: _____

_____

Home# _____

Cell# _____

Employer Name: _____

Work #: _____

Email: _____

Preferred Dentist: _____ **Phone #**: _____

Preferred Doctor: _____ **Phone #**: _____

Specialist to be called: _____ **Phone #** _____

Preferred Hospital: _____ **Phone #** _____

Facts Concerning the child's medical history and Physical impairment to which a physician should be notified: _____

_____

Medications that this child is taking: _____

_____

Please list any allergies: _____

PLEASE CHECK ONE:

☐ To grant consent:
In the event that reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the above-mentioned doctor or, in the event, the designated practitioner isn't available, by any other licensed physician or dentist: and (2) the transfer of the child to the preferred hospital or, any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists concur in the necessity for such surgery, and are obtained prior to the performance of such surgery.

☐ Refusal to consent:
I DO NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to: _____

_____

Signature/Parent or Guardian: _____ **Date**: _____

Updated: 10/26/2015

STUDENT NAME: _____

SECTION 4 – ONLY NEW STUDENTS (or students that are re-enrolling) NEED TO COMPLETE THIS SECTION:

SSN: _____

Is your child in any special programs or do they receive special services (Special Education, Gifted Program, Speech/Language Therapy)? Y or N

If yes, please explain: _____

Has your child ever attended Crestwood Local Schools in the past? Y or N **Is your child in Band/Choir?** (please circle)

Has your child ever been retained? Y or N **If so, in which grade was (s)he retained?** _____

Has your child moved to the U.S. from another country and been in school less than 3 years? Y or N

The child's Native Language (the language the child first spoke): _____ **The language spoken in the home:** _____

The name of the School District where the child was previously enrolled: _____

SECTION 5 – SIBLINGS:

The name and ages/grades of the child's siblings: _____ _____

_____ _____

_____ _____

SECTION 6 – CONTACTING YOU

Student Absences

The Ohio Missing Children's Act became effective on April 1985. The law states that each day a student is absent from school the parent/guardian must notify the school between 8:00 A.M. – 10:00 A.M. the day the child to be absent from school. If you do not notify the school it will become necessary for the school to contact you either at home, on your cell phone or at your place of employment. Please indicate by checking the appropriate column next to number below.

Blackboard Connect

The Crestwood Local School District uses the Blackboard Connect Notification Service which will allow us to send telephone messages to you about school emergencies, various announcements, and school delays and cancellations due to inclement weather.

What you need to know about receiving calls through Blackboard Connect:

- Caller ID will display the schools main number when a general announcement is delivered.
- Caller ID will display 411 if the message is an emergency.
- The primary phone number (the phone number listed as the home number for the student) will be called for standard announcements. For emergency calls the home number will be called as well as the numbers of the Primary Contact and the Emergency Contacts.
- Press 1 to replay the message if necessary.

The successful delivery of information is dependent upon us having accurate contact information for you. Please complete the section below:

Person to call	Relationship – type of number	Number	Call if school is cancelled	Call in case of emergency	Call if my child is absent & I didn't call in	Call with standard announcements
Example 1: Susan Smith	Mother – Home	330.555.1212	√	√	√	√
Example 2: Susan Smith	Mother – Work	330.555.1234		√		

Updated: 10/26/2015

STUDENT NAME: _____

SECTION 7 - INTERNET USE POLICY

Board Policy 7540.03 entitled Student Network and Internet Acceptable Use and Safety (adopted 5/4/06) required written agreement to abide by the terms and conditions of this policy. I have discussed the use of the Internet with my child and grant permission for my child to use the internet in school in a responsible manner.

Signature: _____ **Date:** _____

SECTION 8 - PERMISSION FOR PHOTOS/VIDEOS

I give my permission for this child's picture and name to be included in photographs and video tapes which positively represent him/her, the curriculum, and Crestwood Schools in publications such as the Yearbook, Crestwood Comments, social media area newspapers, television or the District's Website.

Signature: _____ **Date:** _____

SECTION 9 - RESIDENCY AFFIDAVIT

This section is to be completed and proof of residency must be furnished if the student is new to the district or the address has changed.

The undersigned parent (or legal guardian) of the afore mentioned student attests that he/she resides at the afore mentioned address within the Crestwood Local School District.

I (we) understand that residency means the family is physically present and living as a household at this address (eats there, sleeps there, receives mail there, etc). I (we) further understand that providing false residency information will be reported to Law Enforcement Officials for falsification of records and we will be responsible for full recovery of tuition. We understand that I (we) must provide one of the following as proof of residency if my child (ren) is new to the district or if we have moved (The district may require additional documentation, if necessary):

- Deed, lease, or signed rental agreement to residence
- Purchase/construction contract
- Current Property Tax Statement
- Official voter registration card from Board of Elections
- Notarized affidavit of residency (Form 5111 F2a) living with another family in our District)

Signature: _____ **Date:** _____

SECTION 10 - PARENT INTERNET VIEWER

The Parent Internet Viewer is available to all parents of Crestwood High School and Middle School and Intermediate School students. Parents are able to view their child's grades and attendance on the internet. It is accessible on the www.crestwoodschools.org website using a pin code. An individual pin code/password is needed for each child.

While parents are able to check their student's records throughout the school year, we ask that parents understand the reality that teachers do not import grades every day. This information does not replace the official report card or transcript.

As in all education facilities, all individuals accessing and using the internet should follow the local policy. Please review the Network and Internet Acceptable Use and Safety Policy on the Crestwood Website or in the school office.

If you would like to have access to the Parent Internet Viewer please complete the information below. All school fees must be paid to date to receive an access code. Pin numbers will be mailed out once a signed request is received from the parent.

Yes, I would like a pin code to access my child's records. I understand that the pin code access is for my use and will not be given to anyone else.

I will review the Internet Acceptable Use Policy and abide by its beliefs.

Signature: _____ **Date:** _____

SECTION 12 - FIELD TRIP PERMISSION

I give my permission for my child to go on school sponsored field trips.

Signature: _____ **Date:** _____

Akron Children's Hospital
SCHOOL HEALTH SERVICES

Crestwood LOCAL SCHOOLS

Kindergarten Registration Letter

Dear Kindergarten Parents/Guardians:

It is with much anticipation that we await your child's entrance into Kindergarten! Nursing services in this school district are provided by Akron Children's Hospital School Health Services. Akron Children's Hospital School Health Services is dedicated to supporting the academic success of all children and youth through health promotion, education and child advocacy.

The following forms are needed for school entry:

1. **School Health History Record/Update** provides a student health history, completed by parent, REQUIRED AT REGISTRATION.
2. Current **Immunization Record**, completed by a healthcare provider, REQUIRED AT REGISTRATION. Please bring the record even if your child has not had the final boosters yet. We can make a copy if you have the original. State of Ohio health law requires the following immunizations for school entry:

DPT, DTaP	5 doses	Hepatitis B	3 doses
Polio	4 doses	Varicella	2 doses or documented date of disease
MMR	2 doses		

*Please note: Immunizations must be completed within 15 days of starting school, or your child may be excluded from attendance by the principal. Immunizations can be obtained through your child's primary healthcare provider or through the Portage County Health Department (330) 296-9919.

3. **Physician/Healthcare Provider Report**, completed by the doctor. Can be mailed or faxed in to the school clinic by August 15th, 2017.
4. **Dentist report**, completed by a dentist. Can be mailed or faxed in to the school clinic by August 15th, 2017.

***Please send/fax forms to:

ATTN: School Nurse
Crestwood Primary
11256 Bowen Rd.
Mantua, OH. 44255
Phone: (330) 357-8202
Fax: (330) 274-3838

In addition, if your child has a medical condition that may need intervention at school, for example asthma, food allergies, medications, etc., please call us so accommodations can be arranged.

We are looking forward to a healthy school year!

Sincerely,

M Lukes, RN

Akron Children's Hospital School Health Staff
Melissa Lukes, BSN, RN
Akron Children's Hospital: School Health Services
Email: clsnurse@crestwoodschools.org
Phone: (330) 357-8202 Ext. 4123

Akron Children's Hospital
SCHOOL HEALTH SERVICES

Crestwood LOCAL SCHOOLS
EVERY CHILD EVERY DAY

School Health History Record/Update

School Year: _____

Student Name: _____ **Male** _____ **Female** _____

Date of Birth: _____ **Grade:** _____

How does this child's development compare to other children, such as brothers/sisters or playmates?
About the same_____ Delayed_____ Advanced_____

Health Conditions: Please check any that your child has or had

Current	Past		Current	Past		Current	Past	
____	____	Allergies	____	____	Cancer	____	____	Hepatitis
____	____	Anaphylactic reaction	____	____	Chickenpox	____	____	Juvenile Arthritis
____	____	Asthma or wheezing	____	____	Cystic Fibrosis	____	____	Meningitis/Encephalitis
____	____	Attention Deficit	____	____	Diabetes	____	____	Seizures/Epilepsy
____	____	Behavior/Emotional concerns	____	____	Ear problems/poor hearing	____	____	Sore throat (frequent)
____	____	Birth/Congenital malformations	____	____	Eczema/skin conditions	____	____	Speech difficulties
____	____	Blood problems	____	____	Eye problems/poor vision	____	____	Toothaches/dental problems
____	____	Bone/Joint problems	____	____	Headache (frequent)	____	____	Urinary tract infections
____	____	Bowel problems	____	____	Heart Disease	____	____	Wetting during day/night

Current Health: Tell us about any current health conditions or concerns.

_____

_____

_____

Illness, Injuries & Hospitalizations (please explain):

_____

_____

_____

Medical Home: Please provide us with your child's current health care provider's name and contact information.

Healthcare Provider/Physician Name: _____ Phone: _____

Address: _____

Please continue to the back

Student Name:_____

Allergies: If your child has any food or environmental allergies, please obtain the Allergy Action Plan form from the school clinic for your child's health record.

Allergy	Reaction	Treatment

Medications: Describe medicine your child takes regularly. If your child must take medication at school, please obtain the Medication Administration Authorization form from the school clinic to be completed by you and your child's healthcare provider.

Medication	Reason	How often?	What time?

Explain any special assistance your child may need during the school day:

_____

_____

_____

Please add any comments or concerns you have about your child's health, development, behavior, family or home life that you would like the school to be aware of: _____

_____

_____

Please check with your health care provider to be sure your child's immunizations are all current and up to date. You will be requested to provide an updated copy of immunization records to the school if the records on file with the school are not current.

If you have questions or concerns about your child's health or would like information about a medical home for your child or community services that may be available, please contact your school clinic.

_____ _____ _____

Name of Person Completing Form Signature Date

Akron Children's Hospital
SCHOOL HEALTH SERVICES

Crestwood LOCAL SCHOOLS
EVERY CHILD EVERY DAY

Physician/Healthcare Provider Report

School Year:_____ **Grade:**_____

Name: _____ **Male** _____ **Female** _____ **Date of Birth:** _____

Height: _____(_____%ile) **Weight:** _____(_____%ile) **B.P.:**_____ **Pulse:** _____

Vision	**Hearing**
Distance Acuity Right____ Left ____ Tested with glasses? ___ yes ___ no Muscle Balance: ___ pass ___ fail ___ not done Farsightedness: ___ pass ___ fail ___ not done Color vision with pseudo Isochromic plates: ___ pass ___ fail ___ not done Child wears glasses? ___ yes ___ no Glasses for: ___ distance ___ reading ___ all times Referral made? ___ yes ___ no	Pure Tone testing (20 dB @ 1000, 2000, 4000 Hz) Right Ear: ___ pass ___ fail Left Ear: ___ pass ___ fail Other tests (specify) _____ Child wears hearing aid? ___ yes ___ no Tested with Hearing aid? ___ yes ___ no Referral made? ___ yes ___ no

Speech/Language

Speech assessment: ____ done ____not done ____ Child has no discernible speech problem
Child has possible problem with: ____ Articulation ____ Rhythm ____Voice ____Language
Speech Evaluation recommended: ____ yes ____no

Physical Examination

Does this child require any special assistance during the school day? _____ yes_____ no
If yes, please explain:

_____

_____

Is child able to participate in the following?

Classroom and academic activities:	_____ yes	_____ no	Competitive athletics:	_____ yes	_____ no
Physical education classes:	_____ yes	_____ no	Contact sports:	_____ yes	_____ no

If limitations are advised, please explain these limitations:

_____

_____

Medications

Current Medications/Reason for Taking:

_____

_____

Will these medications need to be given at school? _____ yes _____ no

PLEASE COMPLETE FRONT AND BACK

Name: _____

Immunizations: (Required by Ohio Law)

Vaccine	1st Dose	2nd Dose	3rd Dose	4th Dose	5th dose	Comments
DPT						**Preschool** 1 dose to start **Kindergarten** 5th dose required if 4th dose before age 4 **Grades 1-12** 3-4 doses **Grades 7-12** One (1) dose of Tdap prior to entry
Polio					**N/A**	**Preschool 1 dose to start** Final dose required on or after 4th birthday
MMR			**N/A**	**N/A**	**N/A**	**Preschool 1 dose to start** Two doses required for grades K-12
Hepatitis B				**N/A**	**N/A**	**Preschool 1 dose to start** Three doses required for K-12
Varicella (Chicken Pox)			**N/A**	**N/A**	**N/A**	**Preschool 1 dose to start** **Kindergarten-5** One dose on or after the 1st birthday Second dose at least 28 days after 1st dose. **Grades 6-9** One dose on or after the 1st birthday
HIB (preschool entry)					**N/A**	0-14 months: 3-4 doses OR 15-59 months: 1 dose
Hepatitis A (preschool entry)			**N/A**	**N/A**	**N/A**	First dose between 12-23 months Second dose 6-18 months later
Pneumococcal Disease (preschool entry)					**N/A**	4 doses at 2, 4, 6 months and between 12-18 months
Influenza (preschool entry)			**N/A**	**N/A**	**N/A**	2 doses at least 4 weeks apart for age 6 mo to 8 years if first time dose. After first dose annually.
Rotavirus (preschool entry)				**N/A**	**N/A**	3 doses at 2, 4 and 6 months

Lead Poisoning (PRESCHOOL ONLY):

Date_____ Results_____

Hemoglobin/Hematocrit (PRESCHOOL ONLY):

Date_____ Results_____

_____ _____ _____

Physician/Healthcare Provider Signature **Date** **Physician/Healthcare Provider Name (please print)**

_____ _____

Physician/Healthcare Provider address **Physician/Healthcare Provider phone**

PLEASE COMPLETE FRONT AND BACK

Akron Children's Hospital
SCHOOL HEALTH SERVICES

Crestwood LOCAL SCHOOLS
EVERY CHILD EVERY DAY

Dentist Report

Child's Name: _____ **Birth Date:** _____

The following services have been performed:

_____ Examination Date of Exam: _____

_____ Radiographs _____ Prescription for fluoride supplements

_____ Diagnosis _____ Oral prophylaxis _____ Topical application of fluoride

The following oral hygiene instruction was provided:

_____ Toothbrushing _____ Diet counseling

_____ Flossing _____ Home/school use of fluoride mouth rinse

The following statements are applicable:

_____ All necessary services have been performed
_____ Further treatment is indicated
_____ No restorative services are required at this time
_____ Further appointments have been arranged

Comments:

Please Print or Stamp:

Dentist's Name:	**Signature:**
Address:	**Date Signed:**
Phone:	

Please return this completed and signed dentist form to your child's school clinic.