

2019-2020 Kindergarten Registration

Crestwood Primary School



Tuesday, April 16th - 4:30 p.m. - 7:00 p.m.

or

Saturday, April 27th - 9:00 a.m. - 12:00 p.m.

**Your child must be five years old on or before August 1st, 2019, 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, you will be unable to register at that time.

- ✓ Completed Crestwood Local Schools Registration Forms
- ✓ \$75.00 Class 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
- ✓ Custody Papers - if applicable
- ✓ Child's Current Immunization Record
- ✓ School Health History (completed by parents)
- ✓ Healthcare Provider Report & Dentist Report (due by 8/12/19)

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

11260 Bowen Road, Mantua, Ohio 44255
330-357-8206

WELCOME TO CRESTWOOD LOCAL SCHOOL DISTRICT

Student Name _____ Grade _____ Start Date _____

Absent legal exceptions, all forms must be completed and all documents provided for your child to begin school.

Enrollment documents include:*** Birth Certificate or alternative birth documentation including:**

- Birth certification from another state, territory, possession, or nation
- Passport or attested transcript of a passport filed with a registrar of passports at a point of entry of the United States showing the date and place of birth of the child
- Attested transcript of the certificate of birth
- Attested transcript of the certificate of baptism or other religious record showing the date and place of birth of the child
- Attested transcript of a hospital record showing the date and place of birth of the child
- Birth affidavit

*** Immunization records, most current***** All court documents which show custody, guardianship or foster care***** Proof of Residency, 2 required:**

Signed Lease, Purchase Agreement, Mortgage Statement, Deed
Current utility bill with enrollee's address, such as electric, water or gas bill (no phone),
Municipal Income Tax Bill, Homeowner Insurance Policy, Property Tax Statement, Voter Registration Card
Notarized Residency Verification Form, *required if living with friend or relative*

*** Latest report card, if available***** IEP or 504 plan, if applicable***** Transcripts, if available****The following forms are required to be completed:**

- * Student Enrollment Form (5 Pages)
- * Home Language Survey (2 pages)
- * Records Request Form

If the students' residency changes without notification, upon discovery, the student may be immediately withdrawn, and the parties may be responsible for tuition from the time the student no longer resided in the district to the time s/he withdrew. A student will be immediately withdrawn if false information is given.

NOTE: Be sure you have read this statement carefully before you sign. Giving false information under oath is punishable as a criminal offense under the Ohio Revised Code 2921.13 and 2921.21, a misdemeanor of the first degree with a fine or jail term. In cooperation with the City Prosecutors, each violation may be thoroughly and vigorously prosecuted.

Please complete the enclosed paperwork and return with this checklist, and the required documents to the Central Registrar as soon as possible.

CRESTWOOD LOCAL SCHOOL DISTRICT

STUDENT ENROLLMENT FORM

11260 Bowen Road, Mantua, Ohio 44255
330-357-8206

PLEASE PRINT

SECTION 1: STUDENT DEMOGRAPHIC INFORMATION

Student's Legal Name: _____

Last Name

First Name

Middle Name

Grade: _____**

School Year: _____

Gender: Male Female

Date of Birth: ____/____/____ Age: _____

Complete the following if different from parent information:

Physical Address: _____

SECTION 2: ONLY NEW STUDENTS (OR STUDENTS THAT ARE RE-ENROLLING) NEED TO COMPLETE THIS SECTION

SSN: _____

Is the student identified as: _____ Special Ed (IEP) _____ On a 504 Plan _____ Gifted _____ EL

Is the student currently: _____ Expelled _____ Suspended

Has the student been retained? Y or N If so, in which grade was student retained? _____

The student's Native Language: _____
(the language the student first spoke)

The language spoken in the home: _____

Admission Reason:

- _____ Enrolled 1st time in an Ohio Public/community school because of age (KDG)
- _____ Transferred from homeschool (not online school)
- _____ Transferred from out of state or country
- _____ Transferred from non public school
Name of School: _____
- _____ Transferred from another Ohio public, community or online school
Name of School District: _____
- _____ Not newly enrolled in this school district (attended Crestwood previously)
- _____ Exchange Student

**Grade placement subject to adjustment upon receipt of previous school records

REQUIRED BY THE U.S. DEPARTMENT OF EDUCATION

Race/Ethnicity:

Is the student Hispanic/Latino? Y or N

What is the student's race?

(Please check all that apply)

- _____ White
- _____ Asian
- _____ American or Alaskan Native
- _____ Black or African American
- _____ Native Hawaiian or Pacific Islander

SECTION 3: HOUSEHOLD INFORMATION

Residence Address: _____
of student Number Street City Zip

Mailing Address if different: _____
 Number or PO BOX Street City Zip

____ Own ____ Rent ____ Other (explain) _____

Residence is: ____ temporary ____ permanent

PRIMARY PHONE: _____

COUNTY: _____ (will be used for Emergency Alert and informational phone calls, such as snow days)

Student resides with: * ____ Both parents ____ Father only ____ Grandmother ____ Other
 ____ Foster parent(s) ____ Father/Stepmother ____ Grandfather ____ Self**
 ____ Mother only ____ Mother/Stepfather ____ Guardian

Does the student have a parent that is active in the military or national guard? Y or N.

*If this student lives with anyone other than the biological parents, court-papers must be furnished or on file in our office.

*If this student's parents are divorced, a copy of the divorce decree must be furnished or on file in our office.

**Student must provide proof of emancipation

SECTION 4: PARENT/GUARDIAN INFORMATION (Custodial/Caregivers complete this section)**Mother/Guardian Information**

Name: _____ DOB: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
Employee Name: _____
Email: _____

LIVING WITH THE STUDENT? Y or N

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

Address, if different than student: _____

Father/Guardian Information

Name: _____ DOB: _____
Home Phone: _____
Cell Phone: _____
Work Phone: _____
Employee Name: _____
Email: _____

LIVING WITH THE STUDENT? Y or N

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

Address, if different than student: _____

List all other siblings or step-siblings under the age of 22 who reside in the student's home:

Last Name	First Name	Middle	Gender	DOB
_____	_____	_____	M F	_____
_____	_____	_____	M F	_____
_____	_____	_____	M F	_____
_____	_____	_____	M F	_____

Complete the following section, if custodial/caregiver is not biological parent:

Biological Parent Name: _____ Guardian/Caseworker's Name: _____
Address: _____ Case #: _____
District of Residence: _____ Home/Cell #: _____
Email: _____

SECTION 5: CUSTODIAL PARENT GUARDIAN TO GRANT CONSENT FOR EMERGENCY MEDICAL TREATMENT

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

Emergency Contact #1 Relationship: _____
(Other than parent/guardian)

Emergency Contact #2 Relationship: _____
(Other than parent/guardian)

Name: _____

Name: _____

Address: _____

Address: _____

Home #: _____

Home #: _____

Cell #: _____

Cell #: _____

Employer Name: _____

Employer Name: _____

Work #: _____

Work #: _____

Email: _____

Email: _____

Preferred Dentist: _____

Phone #: _____

Preferred Doctor: _____

Phone #: _____

Specialist to be called: _____

Phone #: _____

Preferred Hospital: _____

Phone #: _____

Facts concerning the student's medical history and Physical impairment to which a physician should be notified:

Medications that this student 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 student 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 student. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to: _____

Signature Parent/Guardian: _____

Date: _____

SECTION 6: 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 student and grant permission for my student to use the internet in school in a responsible manner.

Signature: _____ Date: _____

SECTION 7: PERMISSION FOR PHOTOS/VIDEOS

I give my permission for this student'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 8: 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 student 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
- Official voter registration card from Board of Elections
- Notarized Residency Verification, Form 5111F2c
- Municipal Income Tax Bill
- Current Property Tax Statement
- Homeowner's Insurance Policy
- Utility Bill

Signature: _____ Date: _____

SECTION 10: FIELD TRIP PERMISSION

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

Signature: _____ Date: _____

Appendix A: Language Usage Survey

Parents and Guardians: Please only complete this page of the survey. The back of this form will be completed by the school. A completed language usage survey is required for all students upon enrollment in Ohio schools. This information will tell school staff if they need to check your child's proficiency in English. Answers to these questions ensure your child receives the education services to succeed in school. The information is not used to identify immigration status.

Student Name: <i>(First Name and Last Name)</i> _____		Student Date of Birth: <i>(mm/dd/yyyy)</i> _____
Communication Preferences Indicate your language preference so we can provide an interpreter or translated documents at no cost when you need them. All parents have the right to information about their child's education in a language they understand.	1. In what language(s) would your family prefer to communicate with the school? _____	
	Language Background Information about your child's language background helps us identify students who qualify for support to develop the language skills necessary for success in school. Testing may be necessary to determine if language supports are needed.	
Prior Education Responses about your child's birth country and previous education give us information about the knowledge and skills your child is bringing to school and may enable the school to receive additional funding to support your child.	2. What language did your child learn first? _____	
	3. What language does your child use the most at home? _____	
Additional Information Please share additional information to help us understand your child's language experiences and educational background.	4. What languages are used in your home? _____	
	5. In what country was your child born? _____ 6. Has your child ever received formal education outside of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many years/months? _____ If yes, what was the language of instruction? _____	
7. Has your child attended school in the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when did your child first attend a school in the United States? _____ / _____ / _____ Month Day Year		
Parent/Guardian First Name: _____ Parent/Guardian Last Name: _____ Parent/Guardian Signature: _____ Today's Date: <i>(mm/dd/yyyy)</i> _____		

Thank you for providing the information above. Contact your school or district office if you have questions about this form or about services available at your child's school. Translated information about schools' civil rights obligations to English learner students and limited English proficient parents can be found here: <https://www2.ed.gov/about/offices/list/ocr/ellresources.html>

*****COMPLETED BY SCHOOL EMPLOYEE*****

1. **Check.** Confirm the following statements related to the administration of Ohio's language usage survey:
 - The district or school presented the language usage survey, to the extent practicable, in a language and form that the parent or guardian understood.
 - The district or school informed the parent(s) or guardian(s) of the form's purpose. The language usage survey only is used to understand students' linguistic experiences and educational background.
 - The district or school reports information from the language usage survey in the appropriate Educational Management Information System (EMIS) records.
 - For students enrolling from other U.S. schools and districts, school officials request previous language survey data and refer to the information when identifying English learners.
 - Results of the language usage survey are kept with the student's cumulative records and follow the student if he/she transfers to another district or school.

2. **Note.** Record additional information to assist the review of the language usage survey.

3. **Record.** Indicate responses from the language usage survey in the table below. Refer to the Language Usage Survey Annotations on page 2 for item-specific guidance.

Student's native language See Language Usage Survey Question 2. Report for <u>all</u> students in EMIS.	_____
Student's home language See Language Usage Survey Question 3. Report <u>only</u> for English learners in EMIS.	_____
Potential English learner See Language Usage Survey Questions 2-4.	<input type="checkbox"/> Yes. Assess the student's English proficiency. <input type="checkbox"/> No. Do not assess the student's English proficiency.
Immigrant student status See Language Usage Survey Questions 5-7. Report for <u>all</u> students in EMIS.	<input type="checkbox"/> Yes, the student is an immigrant child. <input type="checkbox"/> No, the child is not an immigrant child.

4. **Validate.** Complete the information below.

Signature of validating school employee

Date (mm/dd/yyyy)

Printed name of validating school employee

Name of school or school district

CRESTWOOD LOCAL SCHOOL DISTRICT

RESIDENCY VERIFICATION

11260 Bowen Road, Mantua, Ohio 44255
330-357-8206

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PART 1 TO BE COMPLETED BY THE PARENT

Student's Names and grades: _____

Parent's Name: _____

Although I do not own or rent a residence in the district, or my landlord has not furnished me with a copy of a lease, this is to certify that I am the custodial parent of my child(ren) named above and our current permanent physical residence is:

(Street Address)

We are living as guests of, or in a house that is being rented to me, by:

_____ Who either () owns or () rents this residence.
(Name)

(Telephone Number)

Should I change this, my permanent physical residence, I understand that my child may no longer be eligible to attend school in the District. I promise to notify the school immediately if my residence changes.

(Parent Signature)

(Date)

PART 2 TO BE COMPLETED BY THE HOME OWNER/LEASEE

I certify that the above information is correct and the above named students currently reside in my home.

(Signature of the Residence Owner/Renter)

(Date)

PART 3 TO BE COMPLETED BY NOTARY

SWORN TO BEFORE ME and subscribed in my presence this _____ day of _____

(Signature of Notary Public)

(Date)

NOTICE: READY CAREFULLY: Knowingly falsifying this document is a violation of the Ohio Revised Code: Section 2921.13(A) (6) which is a First Degree Misdemeanor punishable by a prison term of six (6) months and/or a fine up to \$1000.00 . Further the affiant will be billed (and prosecuted in court, if necessary) to collect all back tuition which may be due.

Inaccurate and/or false information will result in immediate withdrawal of your child(ren) from the Crestwood Local School District.

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



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**, 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 in to the school clinic by August 12th, 2019.
4. **Dentist report**, completed by a dentist. Can be mailed in to the school clinic by August 12th, 2019.

***Please mail forms to:

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

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,

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

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

Name: _____

Immunizations: (Required by Ohio Law)

Vaccine	1 st Dose	2 nd Dose	3 rd Dose	4 th Dose	5 th dose	Comments
DPT						Preschool 1 dose to start Kindergarten 5 th dose required if 4 th dose before age 4 Grades 1-12 3-4 doses <u>Grades 7-12</u> One (1) dose of Tdap prior to entry
Polio					N/A	Preschool 1 dose to start Final dose required on or after 4 th 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 1 st birthday Second dose at least 28 days after 1 st dose. Grades 6-9 One dose on or after the 1 st birthday
HIB (preschool entry)					N/A	0-14 months: 3-4 doses <u>OR</u> 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



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.

11260 Bowen Road, Mantua, Ohio 44255
330-357-8207

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I, _____, hereby declare that I am unable to provide to the schools, within the required time, a certified birth certificate for the child named below, for the following reason(s):

In lieu of the required certified birth certificate, I am providing the following:

- non certified birth certificate
- certified baptismal record
- certified hospital record
- passport
- birth affidavit *(This must be signed by the attending physician and two (2) additional persons with knowledge of the birth)*

Name of the Child

Signature of Parent/Legal Guardian