Climax-Scotts Community Schools

Where Students Are More Than A Test Score!

Kindergarten Registration for 2020-2021

Come join us and enjoy small classes, positive behavior promotions, new textbooks, technology, furniture, and more!

You will be asked for more documents once enrolled, but at this time, the following registration packet must be completed.

You will also need to submit a state-required vision and hearing test. This is a free screening, and you may schedule an appointment at one of the following numbers at Kalamazoo County Health Department:

373-5031; 373-5029; 373-5008

Climax-Scotts Community Schools

11250 East QR Avenue. Scotts, MI 49088; (269) 497-2100

Home of the Panthers

Elementary Registration Required Documents/Forms

☐ Student's Birth Certificate (Certified Copy)

☐ Vision/Hearing Screening (Kindergarten & First Grade)

☐ Health Appraisal (Kindergarten)

☐ Student's Immunization Records (Official Copy)

☐ Student's Social Security Card

☐ Parent/Guardian driver's license

☐ Proof of Residency

Required Office Forms

☐ Student Information Sheet

☐ Ethnicity/Race/Language Survey

☐ Release Permissions

☐ Emergency Release Information

☐ Bus Transportation Request/Walk Permission

☐ Technology Acceptable Use Agreement

☐ Concussion Education Information

Additional Forms

☐ Legal Documents (As Applicable)

☐ Permission Form for Prescribed Medication (As Applicable)

☐ Permission Form for Non-Prescribed Medication (As Applicable)

☐ Free/Reduced Lunch Application (As Applicable)

☐ 105/105c Form (As Applicable)

☐ Request for Student Records (As Applicable)

C-S elementary Student Information 2020-2021 Grade_____ Teacher/Homeroom: _____

Student Name _____ **Date of Birth** _____

Parent(s)/Guardian(s)/Household #1 _____

Address _____ **City/Zip Code** _____

Mailing Address (if different) _____ **City/Zip Code** _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Email: _____

Relationship to child (circle): Both Parents Father/Stepmother Mother/Stepfather Father Only Mother Only Legal Guardian
Court Placed: Relative Foster Home

If a Second Household: Parent(s)/Guardian(s)/Household #2 _____

Address _____ **City/Zip Code** _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Relationship to child (circle): Both Parents Father/Stepmother Mother/Stepfather Father Only Mother Only Legal Guardian **Court Placed:** Relative Foster Home

Student resides with: _____ **Is there an official legal custody judgment?** Yes No

If "Yes" provide a certified copy of the document for office

Other emergency contact: Name _____ Relationship _____ Phone_____

Siblings (please list all siblings school aged or at home):

Name_____ Grade _____

Name_____ Grade _____

Name_____ Grade _____

Emergency Treatment: As the parent/guardian of the above student, I agree that as a result of participation in school activities emergency medical treatment may become necessary and that school personnel may not be able to contact me or our emergency contact for consent to emergency medical care: school personnel make seek medical treatment; including ambulance transportation and hospital services; for my child as deemed necessary under the existing circumstances.

Preferred Hospital _____ Allergies _____

Medications _____

Medical Concerns _____

Consent to receive over the counter medication: I give my permission for my child to receive from the office, as directed with my note of instructions, over the counter (non-prescription) medication that I have provided. Yes _____ No _____

Picture Release Consent: I give consent for my child's picture to be used in school/community publications as deemed appropriate by the school. Yes_____ No_____

Permission for Educational Travel: I give permission for my child to go on any trip which the school may sponsor for its groups. Yes_____ No_____

Permission for Technology Resources: I have read the technology code of ethics with my child and I give permission for my child to use district technology resources. Yes_____ No_____

Residency Verification: My child resides within the Climax-Scotts School District. Yes_____ No_____
(If No Above) I have filed a "Schools of Choice" or Release letter with the Superintendent's office. Yes_____ No_____

Parent/ Guardian Signature _____ **Date** _____ Rev. 2/26/18

HEALTH APPRAISAL

Dear Parent or Guardian: The following information is requested so that the school can work with the parent to meet the physical, intellectual and emotional needs of the child. Fill out the information requested in Section I. Section III may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse and dentist. **(BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION.)**

PERSONAL

CHILD'S NAME (Last, First, Middle)			DATE OF BIRTH (mm/dd/yy) / /
ADDRESS (Number & Street)	(City)	(ZIP Code) MI	TODAY'S DATE (mm/dd/yy) / /
PARENT/GUARDIAN (Last, First, Middle)			HOME TELEPHONE NUMBER ( )
ADDRESS (Number & Street)	(City)	(ZIP Code) MI	WORK TELEPHONE NUMBER ( )

SECTION I - HEALTH HISTORY

Yes	No	Resolved	# Is your child having any of the problems listed below?
☐	☐	☐	1 Allergies or Reactions (for example, food, medication or other)
☐	☐	☐	2 Hay Fever, Asthma, or Wheezing
☐	☐	☐	3 Eczema or Frequent Skin Rashes
☐	☐	☐	4 Convulsions/Seizures
☐	☐	☐	5 Heart Trouble
☐	☐	☐	6 Diabetes
☐	☐	☐	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)
☐	☐	☐	8 Trouble with Passing Urine or Bowel Movements
☐	☐	☐	9 Shortness of Breath
☐	☐	☐	10 Speech Problems
☐	☐	☐	11 Menstrual Problems
☐	☐	☐	12 Dental Problems: Date of Last Exam / /
☐	☐	☐	Other (please describe):

☐ ☐ Does your child take any medication(s) regularly?

Reason for Medication

_____ / / _____

Parent/Guardian Signature Date

Birth History:

Are there any current or past diagnosis(es) ☐ Yes ☐ No

If yes, please describe:

If yes, list medications:

Was the health history reviewed by a health professional?

☐ Yes ☐ No *Examiner's Initials:* _____

SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

Tests and Measurements

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	VISION Date: / /	Visual Acuity			
			Muscle Imbalance			
			Other:			
☐	☐	HEARING Date: / /	Audiometer			
			Other:			
☐	☐	URINALYSIS Date: / /	Sugar			
			Albumin			
			Microscopic			
☐	☐	BLOOD LEAD LEVEL Date: / /	Level _____ ug/dl ⇨			

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
☐	☐	HEIGHT & WEIGHT	Height			
			Weight			
☐	☐	Other: _____	Other			
☐	☐	HEMOGLOBIN / HEMATOCRIT	⇨			
☐	☐	BLOOD PRESSURE	Reading: _____			
☐	☐	TUBERCULIN Date: / /	Type: _____ Neg.: ☐ Pos.: ☐ _____ mm			

NOTE: Blood lead level required for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and six years of age if not previously tested. All children under age six living in high-risk areas should be tested at the same intervals as listed above.

Examinations and/or Inspections

Essential Findings Deviating from Normal:

Exam Date: / /

SECTION III - IMMUNIZATIONS

Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied on the basis of this information.*

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (Hep B)	1	3
	2	
DTaP/DTP/DT/Td	1	4
	2	5
	3	6
Tdap	1	
Haemophilus Influenzae type b (HIB)	1	3
	2	4
Polio (IPV/OPV)	1	3
	2	4
Pneumococcal Conjugate (PCV7/PCV13)	1	3
	2	4
Rotavirus (RV1/RV5)	1	3
	2	
Measles,Mumps, Rubella (MMR)	1	2
Varicella (Chickenpox)	1	2

History of Chickenpox Disease? ☐ Yes ☐ No If yes, date:

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis A (Hep A)	1	2
Influenza (TIV/LAIV)	1	3
	2	4
Meningococcal (MCV4 / MPSV4)	1	2
Human Papillomavirus (HPV4/HPV2)	1	3
	2	
OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
	1	
	2	
	3	

Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable

*NOTE: According to Public Act 368 of 1978, any child enrolling in a Michigan school for the first time must be adequately immunized, vision tested and hearing tested. Exemptions to these requirements are granted for medical, religious and other objections, provided that the waiver forms are properly prepared, signed and delivered to school administrators. Forms for these exemptions are available at your child's school or local health department.

Parent/Guardian refused immunizations: ☐

I certify that the immunization dates are true to the best of my knowledge

_____ *Health Professional's Signature* _____ Title _____ / / Date

SECTION IV - RECOMMENDATIONS

(Required for Child Care and Head Start/Early Head Start)

No	Yes	
☐	☐	Is there any defect of vision, hearing or other condition for which the school could help by seating or other actions? If yes, please explain:
☐	☐	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): ☐ Classroom ☐ Playground ☐ Gymnasium ☐ Swimming Pool ☐ Competitive Sports ☐ Other

Other Recommendations

SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)

I have examined _____ child's name 's teeth. As a result of this examination, my recommendation for treatment is: _____

_____ *Dentist's Signature* _____ / / Date

PHYSICIAN'S SIGNATURE

_____ *Examiner's Signature* _____ / / Date _____ *Examiner's Name (Print or Type)* _____ Degree or License

_____ Number & Street _____ City _____ MI ZIP Code (___) _____ Telephone

Information required for:

Early On - Hearing and Vision Status; Diagnosis; Health Status

Child Care Licensing - Physical Exam, Restrictions, Immunizations

Head Start/Early Head Start - Determination that child is up-to-date on a schedule of age-appropriate preventive and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-child care visit required by EPSDT and the latest immunizations schedule recommended by the Centers for Disease Control and Prevention, State, tribal, and local authorities. An EPSDT well-child exam includes height, weight, and blood tests for anemia at regular intervals based on age.

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Developed in Cooperation with the Departments of Human Services, Education, Community Health, Michigan American Association of Pediatrics, Early Childhood Investment Corporation, Child Care Licensing, Head Start, Michigan State Medical Society, Michigan Association of Osteopathic Physicians and Surgeons.

MICHIGAN Education

Michigan Department of Education
Office of Health and Nutrition Services

CACFP REQUEST FOR SPECIAL MEALS and/or ACCOMMODATIONS

The information on this form should be updated as necessary to reflect the current needs of the participant.

1. School/Sponsor Name:	2. Site Name:	3. Site Telephone:

4. Name of Participant/Student:	5. Participant Age:

6. Check One (Refer to instructions on reverse side of this form):

☐ **A.** Participant has a disability* or a medical condition which requires a special meal or accommodation. Program operators are required to make reasonable substitutions to meals for participants with a disability/medical condition that restricts their diet on a case-by-case basis when signed by a licensed medical professional. **A licensed physician (MD or DO), physician's assistant (PA), or nurse practitioner (NP) must sign this request.**

☐ **B.** Participant is requesting a special meal or accommodation due to religious, cultural or personal preference. **Any substitutions must fully meet the meal pattern.** Program operators are encouraged to make reasonable substitutions to meals on a case-by-case basis but are not required to do so. **A parent/guardian or adult participant may sign this request.**

***Disability Definition:** The Americans with Disabilities Act (ADA) Amendment Act defines a person with a "disability" as any person who has a physical or mental impairment which substantially limits one or more "major life activities," has a record of such impairment, or is regarded as having such impairment **"Major life activities"** include, *but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. Major life activities also include the operation of a major bodily function, including but not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.*
USDA Policy Memorandum on Modifications to Accommodate Disabilities in the CACFP and SFSP.

7. Foods to be omitted and substitutions (required): *Please list specific foods to be omitted and suggested substitutions. Attach a sheet with additional information as needed.*

A. Food(s) To Be Omitted:	B. Suggested Substitution(s)

8. Brief description of how exposure to this food affects participant:

9. Diet prescription and/or accommodation *(please describe in detail to ensure proper implementation- use extra pages as needed; see instructions on reverse side)* if applicable:

10. Indicate Texture:
☐ Regular ☐ Chopped ☐ Ground ☐ Pureed

11. List Adaptive Equipment if required:

12. Signature of Parent/Guardian/Participant:	13. Printed Name:	14. Telephone:	15. Date:

16. Signature of Medical Professional:	17. Printed Name: (include credentials)	18. Telephone:	19. Date:

Revised: July 2019

ETHNICITY/RACE/LANGUAGE SURVEY

Name of the Student: _____ **Date of Birth:** _____

Grade: _____

Part A: Home Language Survey (Required by State of Michigan)

Is your child's native tongue a language other than English?

☐ Yes ☐ No What is that language? _____

Is the primary language used in your child's home or environment a language other than English?

☐ Yes ☐ No What is that language? _____

Was the student born in the United States?

☐ Yes ☐ No If no, where was the student born? _____

Part B: Race/Ethnicity (Optional)

Is your student Hispanic/Latino? (Choose only one)

☐ **No,** not Hispanic/Latino

☐ **Yes,** is Hispanic/Latino (A person originally from Cuba, Mexico, Puerto Rico, Central America or South America, or from another country with a Hispanic culture regardless of race).

The previous question is about ethnicity or race. It does not matter what you selected. Please answer the following by marking the box or boxes that indicate the race that you consider your student.

What is the race of your student?

☐ **American Indian or Alaskan Native** (A person originally from North America, South America (including Central America), and is affiliated with a tribe or tribal community).

☐ **Asian** (A person originally from the far East, South East, Asia or the subcontinent of India, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, Philippine Islands, Thailand and Vietnam).

☐ **Black or African American** (A person originally from a black racial group from Africa).

☐ **Native Hawaiian or Pacific Islander** (A person originally from Hawaii, Guam, Samoa, or another Pacific Island).

☐ **White** (A person originally from Europe, the Middle East or North Africa).

Part C: Please list the name(s) and date(s) of birth of other children at home?

Name: _____ **Date of Birth:** _____

Name: _____ **Date of Birth:** _____

Name: _____ **Date of Birth:** _____

_____ _____

Signature of Parent or Guardian Date

Revised 4/23/18

BUS ASSIGNMENT

AM Driver _____ # ____

PM Driver _____ # ____

for transportation dept use only

CS COMMUNITY SCHOOLS DISMISSAL/RELEASE PERMISSIONS

If changes occur during the school year, please complete a new form as soon as possible

Student Name	Grade	Teacher/Homeroom

Parent/Guardian Names _____ Primary Phone _____

Home Address _____ Alternate Phone _____

DAILY RELEASE INFORMATION

Bus Transportation

Morning Pickup Address:

_____

Number Street City Who Lives Here?

Afternoon Drop Address:

_____

Number Street City Who Lives Here?

Walk Home from School/Regular Pick Up

☐ **I allow my child(ren) to walk** to _____ after the buses dismiss at the end of the day, or when school has a scheduled half day. At the elementary, I understand s/he will be released from the Panther Pickup Room after the busses leave the area.

☐ **My child(ren) will be a regular after school pick up** and I understand elementary students will be waiting for me in the Panther Pickup Room to be signed out.

EMERGENCY RELEASE INFORMATION

The district requires release information on each child in case of unplanned early dismissal due to severe weather or emergencies. In the event of an emergency dismissal, the student(s) listed above will:

- ☐ Ride the bus as usual
- ☐ Walk, drive, or ride bike as usual
- ☐ Be picked up by the parent/guardian listed above, who can be contacted during the school day at:
  - o Phone Number _____
  - o Email _____
- ☐ Be picked up by the friend or relative named below:
  - o Name and Relationship to student(s) _____
  - o Phone number for contact during the school day _____
- ☐ Follow a different plan *(please give detailed instructions below)*
  - o _____

I verify that I have reviewed this plan and these instructions with my child and s/he understands what procedure is to be followed in the event of an early dismissal due to weather or other emergencies. Initial here ☐

RELEASE PERMISSIONS

In an effort to help ensure the safety of our students, parents are required to provide the following permissions in the event someone other than the legal parent/guardian picks up a child from school. **Please note: students will not be release to anyone who is not listed below. If you need to update your list during the school year, you must come to the office to do so. Verbal additions or deletions will not be accepted.** *For each permission, please provide their name and relationship to the child.*

YES! My child(ren) can be released to:	NO! My child(ren) cannot under any circumstance release to:

_____ _____

Parent/Guardian Signature #1 Date Parent/Guardian Signature #2 Date