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 at Claymont Preschool in Dennison (the old Park Elementary building). Registration packets are available at the Superintendent's Office, Claymont Preschool, Claymont Primary or Claymont Elementary.

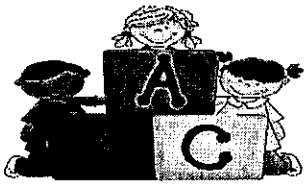
1. **Age:**
   Children who will be five years of age on or before **August 1st of the school year in which they will be attending, may enter kindergarten.**

2. **Parents are to bring with them:**
   a) A copy of the child's birth certificate & social security card
   (A hospital certificate in not acceptable; it should be a legal birth certificate.)
   b) A copy of the child's immunization record.
   c) A copy of any court documents pertaining to the child.
   d) All registration forms that are inside the kindergarten packet, completed.
   (The packet should be picked up before your appointment. It can also be found at www.claymontschools.org under the FORMS tab.)
   e) Please make sure your child is well rested and wears comfortable clothing and shoes.
   f) Please arrive 15 minutes before your scheduled screening to complete any additional paperwork.

Please contact Shannon Tarbert at Claymont Primary, (740) 922-5641 for an appointment.

The screening dates are as follows; April 28th, May 12th, May 19th

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



Claymont City Schools

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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.

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: _____ MALE_____
(LAST) (FIRST) (MIDDLE) 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 Impairment)
____1. Multiple Disabilities (Other than deaf or blind)
____2. Deaf-Blindness
____3. Deafness (Hearing Impairment)
____4. Visual Impairments
____5. Speech and Language Impairments
____6. Orthopedic Impairments
____7. Other Health Impaired
____8. Emotional Disturbance (SBH)
____9. Intellectual Disability
____10. Specific Learning Disability (SLD)
____11. Non-Specific Handicapped(Ages 3-5)

WHICH DID CHILD ATTEND:

____Licensed Preschool
____Head Start
____BJVS Preschool

CITIZENSHIP:

____United States Citizen
____Exchange Student
____Other/Non U.S. Citizen

Check if Received

☐ Birth Certificate

☐ Social Security

☐ Immunization

Biological Father's Name _____

Address (if different from student) _____

_____

Phone (home) _____

Phone (Work/Cell) _____

Date of Birth _____

Place of Birth _____

Occupation _____

Highest Grade completed _____College _____

Biological Mother's Name _____

Mother's Maiden Name _____

Address (if different from student) _____

_____

Phone (home) _____

Phone (Work/Cell) _____

Date of Birth _____

Place of Birth _____

Occupation _____

Highest Grade completed _____College _____

Present marital status of parents (Check where applicable)	
____Married	____ Never Married
____Separated	____Divorced
____Single Parent	____Remarried
_____Mother Deceased	____ Father Deceased

Student lives with *(Check one)*

- ☐ Mother ONLY
- ☐ Father ONLY
- ☐ Mother & Father
- ☐ Father/Stepmother
- ☐ Mother/ Stepfather
- ☐ Grandparents
- ☐ Ward of court
- ☐ Legal guardian _____
- ☐ Other _____

Guardian Name: *(If student does not live with biological parent)* _____

Address (if different from student) _____

Phone (home) _____ Phone (Work/Cell) _____

Are there any court orders regarding this child? Yes____NO____ If yes, please furnish the school with a copy of this document immediately.

SIBLING INFORMATION

NAME (First & Last):	BUILDING ATTENDING:	GRADE:

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

NAME: _____ PHONE: _____

PHYSICIAN: _____ PHONE: _____

Ethnic Category and Race

1. Is the student 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 student. Check all that apply:
   - _____ American Indian or Alaska Native 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 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 Having origins in any of the black racial groups in Africa.
   - _____ Native Hawaiian or Other Pacific Islander
   - _____ White Having origins in any of the original peoples of Europe, North Africa, or the Middle East.

To the best of my knowledge, all of the above information is true. I certify that the student's name listed on the front page is his/her legal name, I/we have legal custody, and I/we reside within the Claymont City School District boundaries or have applied for open enrollment.

_____ _____

Signature Date

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-I230)

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

Ohio Department of Health • School and Adolescent Health

Health History

Student's name	Sex ☐ Male ☐ Female	Date of birth / /
Address	Phone	

Family Health History Please list allergies, heart problems, diabetes, cancer or other serious health conditions.

Father's Name	Date of Birth	Health History
Mother's Name	Date of Birth	Health History
Brothers and Sisters Name(s)	Date of Birth	Health History
1.		
2.		
3.		
4.		

Birth and Developmental History ☐ No unusual birth or developmental history

Did the mother have any unusual physical or emotional illness during this pregnancy? ☐ Yes ☐ No

Was infant born full term? ☐ Yes ☐ No Did the infant have any sickness or problems? ☐ Yes ☐ No

Infant birth weight _____ Mother's age when this child was born _____

Briefly explain illness or problems. _____

How does the child's development compare to other children, such as his or her brothers/sisters or playmates?

☐ About the same ☐ Delayed ☐ Advanced

Student Health Conditions

☐ YES, my child receives regular medical/health care for the following conditions: ☐ NO medical conditions

☐ Allergies (give details on next page)	☐ Diabetes	☐ Seizure disorder
☐ Asthma	☐ Depression	☐ Sickle cell anemia
☐ ADD/ADHD	☐ Ear problem/hearing difficulty	☐ Skin conditions
☐ Autism	☐ Emotional concerns	☐ Speech problems
☐ Behavior concerns	☐ Headaches	☐ Traumatic brain injury
☐ Birth/congenital malformations	☐ Heart problems	☐ Vision problems (glasses, contacts)
☐ Bone/muscle/joint problems	☐ Hemophilia	☐ Other _____
☐ Blood problems	☐ Juvenile arthritis	☐ Other _____
☐ Bowel/bladder problems	☐ Lead poisoning	☐ Other _____
☐ Cancer	☐ Migraines	☐ Other _____
☐ Cystic fibrosis	☐ Neuromuscular disorder	☐ Other _____

Please explain any conditions above or any reasons for hospitalizations.

_____

_____

_____

_____

_____

Health History continued

Please indicate any allergies your child may have.

Allergy type	Reaction	School restrictions or recommended actions
☐ Bee/Insect		
☐ Food		
☐ Medication		
☐ Other		

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
		/ /

Ohio Department of Health • School and Adolescent Health

Physical Examination

Student's Name		Sex ☐ Male ☐ Female	Date of Birth / /
Height	Weight	BMI percentile	BP

Screening Tests

Vision

Date performed / /

Distance Acuity	☐R ☐L
Muscle Balance	☐Pass ☐Fail
Stereopsis	☐Pass ☐Fail
Color	☐Pass ☐Fail
Child wears glasses?	☐Yes ☐No
Tested with glasses?	☐Yes ☐No
Referral made?	☐Yes ☐No

Hearing

Date performed / /

Pure Tone
- Right ear ☐Pass ☐Fail
- Left ear ☐Pass ☐Fail

Child wears hearing aid? ☐Yes ☐No

Child under the care of a hearing specialist? ☐Yes ☐No

Referral made? ☐Yes ☐No

Postural

Date performed / /

☐No abnormality noted
☐Screening not done
☐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	☐ Yes	☐ No	Physical education classes	☐ Yes	☐ No
Competition athletics	☐ Yes	☐ No	Contact and collision sports	☐ Yes	☐ 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 / /

The following services have been performed (please check all that apply)

☐ Examination ☐ Fluoride application ☐ Oral prophylaxis (cleaning) ☐ Prescription for fluoride supplement
☐ Orthodontic assessment ☐ Radiographs ☐ Dental sealant ☐ Treatment (restoration, pulp therapy)

☐ Other _____

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

☐ Toothbrushing ☐ Flossing ☐ Dietary counseling ☐ Use of fluoride mouth rinse

☐ Other _____

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

☐ All necessary preventive services have been performed. (Fluoride treatment, prophylaxis)
☐ No restorative services are required at this time.
☐ Further treatment is indicated. (See comments)
☐ Further appointments have been arranged. (Orthodontic, restorative)
☐ Routine recall visits recommended.

Comments

_____

_____

_____

_____

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