

2018-2019 NWCS Preschool Registration Packet

Please be sure that all of the following documents are filled out and returned to complete your child's registration.

1. NWCS Enrollment Form

2. Student Health Information

3. CHIRP form OR copy of immunization record

4. Transportation form

5. Race and Ethnicity

6. HLS Form

7. Get to know you form

8. Copy of birth certificate

9. \$60 registration fee

Bus # _____ Bus Driver _____

Northern Wells Community Schools Preschool Student Enrollment Form

Student's Legal Name _____ Date of Birth _____ Gender _____
Last First Middle Male Female

Student Legal Guardian(s) (circle one) Both Parents Mom Dad Joint Guardian

If the above student is not living with both parents in the same household, legal documentation concerning custody is required per Indiana Code 20-26-11-3

Father's Name _____ Email Address _____

Address (include P O Box) _____

Home Phone _____ Cell Phone _____ Work Phone _____

Mother's Name _____ Email Address _____

Address (include P O Box) _____

Home Phone _____ Cell Phone _____ Work Phone _____

Guardian's Name _____ Email Address _____

Address (include P O Box) _____

Home Phone _____ Cell Phone _____ Work Phone _____

Emergency Contact 1 Name _____ Relationship _____ Email Address _____

Address (include P O Box) _____

Home Phone _____ Cell Phone _____ Work Phone _____

Emergency Contact 2 Name _____ Relationship _____ Email Address _____

Address (include P O Box) _____

Home Phone _____ Cell Phone _____ Work Phone _____

I verify that the information provided above is correct and acknowledge that it is the parent's responsibility to notify the appropriate school should any changes occur during the school year.

Parent/Legal Guardian Signature

Today's Date

Student Schedule with Times and Tuition amounts

Class \$60 Registration fee	Monday	Tuesday	Wednesday	Thursday	Friday
AM 3-Day Class 4 yrs. old by 8-1-17	9:00-11:30 AM \$85 monthly		9:00-11:30 AM		9:00-11:30 AM
AM 2-Day Class 3 yrs. old by 8-1-17		9:00-11:30 AM \$75 monthly		9:00-11:30 AM \$75 monthly	
PM 3-Day Class 4yrs. old by 8-1-17	1:00-3:30 PM \$85 monthly		1:00-3:30 PM		1:00-3:30 PM
PM 2-Day Class 3 yrs. old by 8-1-17		1:00-3:30 PM \$75 monthly		1:00-3:30 PM	

Please list your first and second choice for a class and time. Ex. AM 3 day

School choice: Lancaster Ossian

First choice_____

Second choice_____

Student Health Information

Please fill out this form **completely**. This form is to be filled out on a yearly basis.

BE SURE TO SIGN THE BOTTOM LINE

Student's Name: _____ Date of birth: _____

Grade: _____ Teacher: _____

Does your child have? (Please circle the correct response):

Frequent colds	Yes	No	Fainting Spells	Yes	No
Asthma	Yes	No	Heart Condition	Yes	No
Earaches	Yes	No	Headaches	Yes	No
Diabetes	Yes	No	Rheumatic Fever	Yes	No
Seizure Disorder	Yes	No	Dizziness or blackouts	Yes	No
Epilepsy	Yes	No	Frequent Nosebleeds	Yes	No
Bee Sting Allergy	Yes Mild or Severe	No			

Does your child have allergies? Yes No If yes, please specify: _____

Does your child have asthma? Yes No If yes, list medication(s): _____

Is your child on medication? Yes No If yes, list medication(s): _____

Reason for taking medication: _____

Has your child had any surgeries? Yes No If yes, specify what kind of surgery and the date(s): _____

Does your child have a medical problem that would require us to follow a specific procedure in the case of an emergency situation? Yes No If yes, please specify the procedure in the order it is to be performed:

Are there any eating habits or dietary restrictions that the school should be aware of? Yes No If so, please list: _____

(If your child has a milk allergy, the school requires a doctor's note stating a milk allergy exists so that your child may get soy milk.)

Please add any additional information that might help us in protecting your child's health: _____

Immunizations (and dates) received in the past year: _____

Physician's Name: _____ Phone Number: _____

In case of serious illness or accident, I authorize the school to take whatever action is necessary and give my permission to transport to the hospital, if necessary.

Date

Parent or guardian signature (must be signed)

This information will be accessible to staff members to insure the health and safety of your child. If you do not wish this information to be distributed, you must notify the school in writing.

IT IS THE PARENT'S RESPONSIBILITY TO NOTIFY THE SCHOOL, IN WRITING, OF ANY CHANGES DURING THE SCHOOL YEAR.

CHIRP

Children and Hoosiers Immunization Registry Program

Northern Wells Community Schools participates in CHIRP, a free and innovative online system that scores and updates immunization records of both children and adults in Indiana. The State of Indiana now requires all public school systems to gather this information each year. It is confidential and free.

I give Northern Wells Community Schools Nurses permission to register my student's immunization records onto the Indiana State Department of Health's Children and Hoosiers Immunization Registry Program (CHIRP).

I understand that the information in the registry may be used to verify that my student has received proper immunizations and to inform me of my student's need to be vaccinated according to recommended immunization schedules.

I hereby consent to the release of such information.

Signature

Date

Printed Name of Parent / Guardian

Student's Name

Date of Birth

Name:
Student Number:

Race and Ethnicity: **Please check the appropriate line/lines.** (Note: Both Part 1 and Part 2 of the question must be answered.)

Part 1: Ethnicity

Is this individual Hispanic/Latino? (Choose only one)

(Note: One of the major changes in re-identifying race/ethnicity is the recognition that members of Hispanic/Latino populations can be of different races. The federal government would like to afford Hispanic/Latino populations the opportunity to better describe themselves according to their culture and heritage. You must select one or more races, even if you have indicated that you are Hispanic/Latino.)

_____ No, not Hispanic/Latino

_____ Yes, Hispanic/Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

Part 2: Race

What is the individual's race? (Choose one or more)

_____ American Indian or Alaska Native: A person having origins in any of the original peoples of North America and maintaining cultural identification through tribal affiliation or community recognition.

_____ Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

_____ Black or African American: A person having origins in any of the black racial groups of Africa.

_____ Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

_____ White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.



Home Language Survey (HLS)

The Civil Rights Act of 1964, Title VI, Language Minority Compliance Procedures, requires school districts and charter schools to determine the language(s) spoken in each student's home in order to identify their specific language needs. This information is essential in order for schools to provide meaningful instruction for all students as outlined Plyler v. Doe, 457 U.S. 202 (1982).

The purpose of this survey is to determine the primary or home language of the student. The HLS must be given to all students enrolled in the school district / charter school. The HLS is administered one time, upon initial enrollment, and remains in the student's cumulative file.

Please note that the answers to the survey below are student-specific. If a language other than English is recorded for ANY of the survey questions below, the LAS Links placement test will be administered to determine whether or not the student will qualify for additional English language development support.

Please answer the following questions regarding the language spoken by the student:

1. What is the native language of the **student**? _____
2. What language(s) is spoken most often by the **student**? _____
3. What language(s) is spoken by the **student** in the home? _____

Student Name: _____

Parent/Guardian Name: _____

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

By signing here, you certify that responses to the three questions above are specific to your student. You understand that if a language other than English has been identified, your student will be tested to determine if they qualify for English language development services, to help them become fluent in English. If entered into the English language development program, your student will be entitled to services as an English learner and will be tested annually to determine their English language proficiency.

For School Use Only:

School personnel who administered and explained the HLS and the placement of a student into an English language development program if a language other than English was indicated:

Name: _____ Date: _____

Getting to know your child

I want to learn all I can about your child so that they can have a fun and successful year.

Your child's name: _____

What does your child prefer to be called: _____

Your child's favorite color: _____

books: _____

toys: _____

What are some things your child enjoys (coloring, playing outside, etc.):

What are some things you would like me to know about your child?

Does your child have any siblings? What are their names and ages?

What are your expectations for your child this year?
