Welcome to Kindergarten Round-Up! We are looking forward to having you at our school.

You will need the following items for registration:

Birth Certificate

Social Security Card

Immunizations

Proof of Residence (A bill sent to you from the gas or water company)

Kindergarten is an exciting learning experience and we look forward to working with your child! **School will begin on Thursday, August 9th, 2018. Meet the Teacher Night will be Wednesday, August 8th from 5:00-6:30 PM.**

The day will begin at 8:10AM and end at 2:58PM. Exciting educational activities are being planned for your child and we look forward to watching them learn through an excellent kindergarten experience.

Last Name_____ **First Name**_____

Middle Name_____ **SSN**_____

Address_____ **DOB**_____

Grade_____ **County**_____

Phone_____ **Bus Number**_____

Sex Male_____ Female_____

Guardian Parents_____ Father_____ Mother_____ Grandparent____ Foster____ Other_____

Email Address _____

Text Messaging Number_____

Responsible for Book Fees_____

Father_____ **Employer**_____

Address_____ **Work Phone**_____

(If Different than Student) **Work Address**_____

Phone_____ **Cell Phone**_____

Mother_____ **Employer**_____

Address_____ **Work Phone**_____

(If Different then Student) **Work Address**_____

Phone_____ **Cell Phone**_____

Guardian (If other than Parent)_____

Address_____ **Employer**_____

(If Different than Student) **Work Phone**_____

Phone_____ **Cell Phone**_____

Emergency Contact Information (They will be called if we are not able to get in touch with parents)

Last Name First Name Phone Relationship to Student

1. _____
2. _____
3. _____
4. _____

Sibling Information

Name **Grade** **Name** **Grade**

_____

_____

Racial and Ethnic Data

Date _____

Parent or Guardian's Signature _____

Student's Name _____ Grade _____

Race and Ethnicity: (Note: Both Part 1 and Part 2 of the question must be answered.)

Part 1: Ethnicity	Is this individual Hispanic/Latino? (Choose only one) ☐ No, not Hispanic/Latino ☐ Yes, Hispanic/Latino (A person of Cuban, Mexican, Puerto Rican, Cuban, 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: _____ **Grade:** _____

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: _____

A Note from the School Nurse

Welcome to Kindergarten at Bloomfield Elementary School!

Please remember that your child must be up to date on all required immunizations before school starts in August. This is a state regulation. Feel free to stop in my office and I can let you know if your child's record is available in the CHIRP database.

Please take your child for a physical before school starts and let me know if your child has any health concerns. A physical form for your child's doctor is included in this packet of information. It is not required for your child's physician to use our form, but sometimes they prefer to.

It is very important that we know of any allergies or health problems that your child may have so that we can give your child the best care while he/she is at school. Please fill out the Nurse's Emergency Form and return it by the first day of school. If you feel that you need to meet with me concerning your child's health, please contact me to set up a time to do this.

If your child will need to take any prescription medication during the school day, please contact me.

I would also like to request that you keep an extra set of clothing in your child's backpack if possible. Accidents happen…….and children are more comfortable in their own clothes.

In August you will complete several forms online. One of those forms is the Over-The-Counter medication form. On this form you will indicate if you would like your student to be given ibuprofen, acetaminophen, tums and cough drops as needed at school.

Please feel free to call or stop by my office with any questions or concerns you may have. I want to help in any way I can to make the transition to kindergarten positive for your child.

Thank you.

Renee McIntosh, RN-BSN
Bloomfield School Nurse
(812) 384-2402 phone
(812) 381-9715 fax
rmcintosh@bsd.k12.in.us

Bloomfield School District

I, _____, give the Bloomfield School District permission to release the following information concerning my child

_____to the Indiana State Department of Health's Children and Hoosiers Immunization Registry Program (CHIRP):

Child's Name, Immunization Information, Date of Birth, and Any Other Information as Applicable.

I understand that the information in the registry may be used to verify that my child has received proper immunizations and to inform me or my child of my child's immunization status or that an immunization is due according to recommended immunization schedules.

I understand that my child's information may be available to the immunization data registry of another state, a healthcare provider or a provider's designee, a local health department, an elementary or secondary school, a child care center, the office of Medicaid policy and planning or a contractor of the office of Medicaid policy and planning, a licensed child placing agency, and a college or university. I also understand that other entities may be added to this list through amendment to I.C. 16-38-5-3.

I hereby consent to the release of such information.

_____ _____

Signature Date

_____

Printed Name of Parent or Guardian

_____ (____)_____

Address Telephone Number

_____ _____

Child's Name Grade Level

_____

School

Bloomfield School District
Kindergarten Health Assessment Report

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

PHYSICAL EXAMINATION

EXAM / HISTORY	Normal	Abnormal	COMMENTS (please comment if abnormal)
HEENT:			
DENTAL/ORAL:			
BACK/EXTREMITIES:			
CARDIAC:			
LUNGS:			
ABDOMEN:			
ENDOCRINE:			
GENITO-URINARY:			
MUSCULOSKELETAL:			
NEUROLOGICAL:			
DEVELOPMENTAL:			
SOCIAL:			
SPEECH/LANGUAGE:			
VISION:			
HEARING:			
HT: WT:			
BP: HR:			

ALLERGIES: _____

MEDICATIONS: _____

DIET RESTRICTIONS: _____

HISTORY OF SERIOUS ILLNESS: _____

PAST SURGURIES: _____

RESTRICTIONS/SPECIAL HEALTH NEEDS AT SCHOOL: _____

HISTORY OF VARICELLA DISEASE? IF YES, PLEASE INDICATE MONTH/YEAR: _____

OTHER INFORMATION/HEALTH CONCERNS FOR SCHOOL: _____

THIS CHILD (**MAY or MAY NOT**) PARTICIPATE IN PE CLASSES. Free of Lice: ____ Free of Scabies: ____

_____

- **Kindergarten students must have all required immunizations**
  (Please attach immunization record)

Date of Exam: _____ Signature & Title of Health Care Professional: _____

Practice/Clinic Name: _____ Practice/Clinic Phone: _____