United Community School

Kindergarten Registration Checklist

Child's Name______________________________ **Birth Date**____________________

Has your child attended Preschool   Yes   No   Preschool attended________________________

Complete, sign and return the following items:

- ☐ Student Information Form
- ☐ Health Services Form
- ☐ Home Language Survey
- ☐ Field Trip Permission Form
- ☐ Proof of Child's Birth (ex. Birth certificate, passport, adoption papers, etc.)
- ☐ Medical Documents to be turned in **PRIOR** to the First Day of School (8/26/19)
  - Copy of your Child's Current Immunization
  - Dental Screen Form *(attached)*
  - Vision Screen Form & Green Vision Card *(attached)*
  - Copy of Physical

Meal Assistance applications for free and reduced price meals will be mailed after July 1, 2019 and also available on the United Community website or in the district office. If applying for meal assistance, please wait to pay your registration fees until you receive approval. It is necessary to **submit a signed Fee Waiver** if you would like your meal status also applied to your child's Registration Fees.

Fees for 2019-20

Book Fee	$50.00	Student Lunch	$2.65/day
Milk	$.50	Student Breakfast	$1.75/day

Fees need to be paid by August 26, 2019, and can be paid by check *(made payable to United Community Schools)* or use our online payment processing system (PaySchool). Go to www.unitedcomets.org, click on "PaySchool" and follow the prompts.

The following information will be available for viewing and downloading on the United Community web page at www.unitedcomets.org.

- School Supply List
- School Meal Fees List
- Meal Assistance Application (*available after July 1st*)
- Medication Permission Form
- FERPA information
- Beginning of school information
- 2019-20 School Calendar

UNITED COMMUNITY SCHOOL DISTRICT

STUDENT INFORMATION
2019-20 SCHOOL YEAR

For Office Use Only

First Name:

Middle Name:

Last Name:

Preferred Name:

Grade:

Gender (M/F):

Date of Birth:

Place of Birth:

Is this student Hispanic/Latino?
(Choose one)
*(0), not Hispanic/Latino
*(1), Hispanic/Latino
Currently marked as

Home Phone Number:

Ethnicity:
What is the student's race?(choose one or more)
*American Indian or Alaskan Native (I)
*Asian (A)
*Black or African American (B)
*Native Hawaiian or Other Pacific Islander (P)
*White (W)
*Two or more listed above (M)

Home Address:

Primary Language at Home:
(English, Spanish, Other)

City: **State:** **Zip:**

Student is open enrolling from another school district:
(No, Yes)

Mailing Address:

City: **State:** **Zip:**

School District Open Enrolling From:

Mother/Female Guardian

Name:

Relationship:

Employer:

Day Phone:

Cell Phone:

Email Address:

Father/male guardian

Name:

Relationship:

Employer:

Day Phone:

Cell Phone:

Email Address:

Living With:
(Both Parents, Father Only, Mother Only, Guardian, Other)

Specify Other:

(OVER)

Parent student does NOT live with:

Name: **Relationship:** **Day Phone:**

Home Phone: **Cell Phone:** **Employer:**

Should this parent/guardian receive duplicate mailings? **yes or no**
Currently marked as: no

Mailing Address:

City: **State:** **Zip:**

List three (3) LOCAL adults who will assume responsibility for student if parent, step-parent, or guardian CANNOT be reached. Please name someone with a LOCAL daytime phone number.

Emergency Contact 1: **Day Phone:** **Phone Type:** (Cell, Home, Work)

Relationship (Aunt, Uncle, Friend, Neighbor, Sister, Brother, Grandparent, Sitter):

Emergency Contact 2: **Day Phone:** **Phone Type:** (Cell, Home, Work)

Relationship (Aunt, Uncle, Friend, Neighbor, Sister, Brother, Grandparent, Sitter):

Emergency Contact 3: **Day Phone:** **Phone Type:** (Cell, Home, Work)

Relationship (Aunt, Uncle, Friend, Neighbor, Sister, Brother, Grandparent, Sitter):

In an emergency the school is to contact the following at parents' expense:

Hospital: **Hospital Phone:**

Doctor: **Doctor Phone:**

Dentist: **Dentist Phone:**

Medical Alert:

Please indicate type of health insurance coverage.

United has your current insurance as: . If there is a change, please check applicable type.

____ **Private Insurance** ____ **Medicaid#**________________ ____ **No Insurance**

I have read all information and corrected any inaccuracies as it pertains to my student. I verify that all information given is correct and accurate. In the event of any changes that would affect this information, I will contact the school to make the appropriate updates.

Signature of Parent or Guardian: ______________________________ Date ____________

United Community School
Health Services

Name of Student________________________ **Grade for Next School Year**__________

To best serve your child's education, we are updating our health files. The following is a list of some major health concerns, please check any that apply to your child.

Yes	No	
___	___	Asthma Uses inhaler________ Name of medication__________________
___	___	Allergies to medications, foods, or pollens: please list__________________
		______________________________________
___	___	Respiratory (please describe)__________________
___	___	Diabetes: Insulin__________________ Pump__________
___	___	Migraines: Medication__________________
___	___	Seizure Disorder: Medication__________________ Type__________
		Date of last seizure__________________
___	___	Bladder or Kidney Problems__________________
___	___	Vision Problems: Glasses________ Contacts________ Last Exam__________
___	___	Nutrition Problems__________________
___	___	Surgeries (please list date & type)__________________
___	___	Behavior Problems__________________
___	___	Hearing: Last Exam__________________ Tubes__________
___	___	Physical: Doctor__________________ Date__________
___	___	Heart Disease__________________
___	___	Regular Medication (Name & Dosage)
		______________________________________
		______________________________________
		______________________________________

Med Certified staff member may administer the following medications to my child, as medically indicated:

Acetaminophen (Tylenol)	Yes	No	Cough Drops	Yes	No
Ibuprofen	Yes	No	Hydrocortisone Cream	Yes	No

> I give permission for my child to receive school health screenings (vision, hearing, height, and weight) for the 2019-20 school year.
>
> **YES** **NO**

In case of emergency, permission is given for my son/daughter to receive immediate first aid and/or treatment as necessary. I also give consent for school personnel to use their own judgment in securing medical aid and ambulance services or other emergency transport in the event that I cannot be reached.

YES **NO**

Parent/Guardian Signature______________________________ **Date**__________

United Community School District

HOME LANGUAGE SURVEY

Student Name: ______________________ Birth Date: ____________ Sex: ❑ Male ❑ Female

Parent/Guardian Name: ______________________

Address: ______________________

Home Telephone: ______________________ Work Telephone: ______________________

School: ______________________ Grade: ____________ Date: ____________

1. Was your child born in the United States? ❑ Yes ❑ No
   If yes, in which state? ____________
   If no, in what other country? ____________

2. Has your child attended any school in the United States for any three years during their lifetime? ❑ Yes ❑ No
   If yes, please provide school name(s), state, and dates attended:
   Name of School ______________________ State ________ Dates Attended ____________
   Name of School ______________________ State ________ Dates Attended ____________
   Name of School ______________________ State ________ Dates Attended ____________

3. What language is spoken by you and your family most of the time at home? ____________

4. If available, in what language would you prefer to receive communication from the school? ____________

5. Is your child's first-learned or home language anything other than English? ❑ Yes ❑ No

If you responded "Yes" to question number 5 above, please answer the following questions:

6. What language did your child learn when he/she first began to talk? ____________

7. What language does your child most frequently speak at home? ____________

8. What language do you most frequently speak to your child? (Father) ____________
   (Mother) ____________

9. Please describe the language understood by your child. (Check only one)
   A. ❑ Understands only the home language and no English.
   B. ❑ Understands mostly the home language and some English.
   C. ❑ Understands the home language and English equally.
   D. ❑ Understands mostly English and some of the home language.
   E. ❑ Understands only English.

______________________ Parent or Guardian's Signature

______________________ Date

OFFICE USE ONLY			
Student ID #	Date Distributed	Date Received	

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253271

United Community School District

Student Race and Ethnicity Reporting

Student Name: ______________________________ Date Form Completed: ______________

Date of Birth: ______________________________ ❑ Male ❑ Female

Person Completing This Form: ❑ Parent/Guardian ❑ Student ❑ Other: ______________

The U.S. Department of Education has implemented new standards for school districts to report student race and ethnicity. Your answers to the following will be held strictly confidential and data will be used only in the aggregate.

1. Is your child of Hispanic, Latino, or Spanish ethnicity: ❑ Yes ❑ No
   Includes persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin.

If you answered **"Yes"** to question #1, you may also check one or more of the racial categories in question #2. If you answered **"No"**, please check one or more of the following racial categories.

2. Racial Categories:

❑ American Indian or Alaska Native
Origins in any of the original peoples of North, Central, and South America who maintain a tribal affiliation or community attachment.

❑ Asian
Origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent for example Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, Philippine Islands, Thailand, and Vietnam.

❑ Black or African American
Origins in any of the black racial groups of Africa

❑ Native Hawaiian or Other Pacific Islander
Origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

❑ White
Origins in any of the original peoples of Europe, the Middle East, or North Africa.

Please complete the entire form and return it to:

United Community School
1284 U Avenue
Boone, IA 50036
515-432-5319

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Parental Consent for United Community School Sponsored Field Trips

Grades K - 6th

_____ I give my permission for ______________________________ in grade __________ to take the school-sponsored field trips throughout the year for which a note will be sent home informing me of such field trips before they occur.

_____ I **DO NOT** give my permission for ______________________________ in grade __________ to take the school-sponsored field trips throughout the year.

______________________________ ____________________

Signature of Parent/Guardian Date

Iowa Department of Public Health
CERTIFICATE OF DENTAL SCREENING

This certificate is not valid unless all fields are complete.
RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Student Information (please print)

Student Last Name:	Student First Name:	Birth Date (M/D/YYYY):
Parent or Guardian Name:	Telephone (home or mobile):	
Street Address:	City:	County:
Name of Elementary or High School:	Grade Level:	Gender: ☐ Male ☐ Female

Screening Information (health care provider must complete this section)

Date of Dental Screening: ____________________

Treatment Needs (check ONE only based on screening results, prior to treatment services provided):

☐ **No Obvious Problems** – the child's hard and soft tissues appear to be visually healthy and there is no apparent reason for the child to be seen before the next routine dental checkup.

☐ **Requires Dental Care** – tooth decay[1] or a white spot lesion[2] is suspected in one or more teeth, or gum infection[3] is suspected.

☐ **Requires Urgent Dental Care** – obvious tooth decay[1] is present in one or more teeth, there is evidence of injury or severe infection, or the child is experiencing pain.

[1] Tooth decay: A visible cavity or hole in a tooth with brown or black coloration, or a retained root.
[2] White spot lesion: A demineralized area of a tooth, usually appearing as a chalky, white spot or white line near the gumline. A white spot lesion is considered an early indicator of tooth decay, especially in primary (baby) teeth.
[3] Gum infection: Gum (gingival) tissue is red, bleeding, or swollen.

Screening Provider (check ONE only):
☐ DDS/DMD ☐ RDH ☐ MD/DO ☐ PA ☐ RN/ARNP (High school screen must be provided by DDS/DMD or RDH)

Provider Name: (please print) ____________________ Phone: ____________

Provider Business Address: ____________________

Signature and Credentials of Provider or Recorder*: ____________________ Date: ________

*Recorder: An authorized provider (DDS/DMD, RDH, MD/DO, PA, or RN/ARNP) may transfer information onto this form from another health document. The other health document should be attached to this form.

A screening does not replace an exam by a dentist.
Children should have a complete examination by a dentist at least once a year.
RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Iowa Department of Public Health • Oral Health Center
515-242-6383 • 866-528-4020 • http://idph.iowa.gov/ohds/oral-health-center
A designee of the local board of health or Iowa Department of Public Health may review this certificate for survey purposes.

8/17/2016

Kindergarten & 3rd Grade Students Only

Iowa Department of Public Health
CERTIFICATE OF VISION SCREENING

RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Student Information (please print)

Student Last Name:	Student First Name:	Birth Date (M/D/YYYY):
Parent/Guardian Telephone Number:	Student Address:	
Zip Code:		

Screening Information (vision screening provider must complete this section *or parents may attach a copy of vision screening results given to them by a provider.*)

Date of Vision Screening: ______________________

Results (visual acuity):

Right Eye__________ Left Eye__________

Overall Result (Please select one):

Pass ○ or Fail ○

Referral to eye health professional (Please select one):

Yes ○ or No ○

Screening Provider: ______________________________

Provider Business Name/Source of Screening: (please print) ______________________

Provider Name: (please print) ______________________ Phone: ____________

Signature and Credentials of Provider: ______________________ Date: __________

A parent or guardian of a child who is to be enrolled in a public or accredited nonpublic elementary school shall ensure the child is screened for vision impairment at least once before enrollment in Kindergarten and again before enrollment in the 3rd grade.

To be valid, a minimum of one child vision screening shall be performed no earlier than one year prior to the date of enrollment in Kindergarten and no later than six months after the date of the child's enrollment in Kindergarten.

To be valid, a minimum of one child vision screening shall be performed no earlier than one year prior to the date of enrollment in 3rd grade and no later than six months after the date of the child's enrollment in 3rd grade.

RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Iowa Department of Public Health – Breau of Family Health
321 E 12th Street - Des Moines, IA 50319
FAX 515-725-1760 – Phone 800-*383-3826*
http://idph.iowa.gov/family-health/child-health/vision-screening

STUDENT VISION CARD

Student First/Last Name ______________________ Exam Date __________

Student Date of Birth ____/____/______ Student Home Zip Code __________

TO THE PARENT OR GUARDIAN: To fully assess the health of your child's visual system and prevent future learning problems associated with undetected vision problems, regular professional eye exams are essential. Experts estimate that 80% of learning is obtained through vision. Good vision directly contributes to a child's ability to learn while in school. As a part of your back-to-school preparations, it is recommended that you take your child and this card to your family eye doctor for a complete eye health examination. **This card should be signed by the eye care professional and returned to the school nurse or teacher by your child.**

The following organizations recommend the use of the Student Vision Card

To order more cards call 1-800-444-1772 • www.iowaoptometry.org

Visual Acuity	**At Distance**		**At Near**	
☐ Without correction	R20/	L20/	R20/	L20/
☐ With present correction	R20/	L20/	R20/	L20/
☐ With new correction	R20/	L20/	R20/	L20/

External Eye Health
☐ Normal ☐ Other

Internal Eye Health
☐ Normal ☐ Other

Vision Analysis

R	L		
☐	☐	Normal eyesight	☐ Eye teaming difficulty
☐	☐	Nearsighted (myopia)	☐ Crossed-eyes (strabismus)
☐	☐	Farsighted (hyperopia)	☐ Eye focusing difficulty
☐	☐	Astigmatism	☐ Sensitivity to light
☐	☐	Amblyopia	

☐ Other ______________________________

Vision Correction Recommendations

☐ No correction necessary
☐ No change in present prescription
☐ New prescription needed

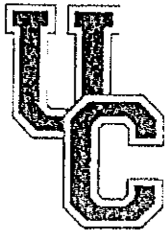
To be worn for:
☐ Constant wear ☐ Near vision only
☐ Distance vision only ☐ As needed

TO THE EYE CARE PROFESSIONAL: Please sign and date this card after examination.

Dr. Name: (Please Print) ______________________________

Date __________ Signature ______________________________

11/13



United Community PTO

Student Directory Opt-Out Form

United Community PTO publishes a student directory using the information provided on your registration forms. A copy of this directory will be sent home to every family. If you would prefer to opt-out of having your information shared, please complete the box below with your signature.

Please sign, date, and return to the school office if you **DO NOT** wish to be in the United Community School Directory.

Parent Signature: ______________________________

Date: ______________

NO ACTION IS REQUIRED IF YOU WOULD LIKE TO BE IN THE SCHOOL DIRECTORY.

If you would like to be included in the directory, but do not want all of the following information published, please **fill-in how you would like published, OR cross off the items you DO NOT want published.**

Student Name: ______________________

Parent(s) Name: ______________________

Primary Email Address: ______________________

Primary Phone Number: ______________________

Primary Home Address: ______________________

If you have any questions about this form or the directory, please contact UnitedCommunityPTO@gmail.com