

NOTE TO NEW PRE-K/ECC PARENTS:

Here are a few things to remember when turning in your Pre-K registration paperwork;

- 1) Make sure student's social security number is on the completed registration packet. If information changes at any time, be sure to call the school and update your information as soon as possible. \$100 Deposit is due to hold your spot for the fall. (ECC is exempt)
- 2) Turn in a copy of the student's certified birth certificate from the courthouse (NOT the one from the Hospital) with the completed registration form.
- 3) Be sure that you have your three proofs of residency turned in at the same time you turn in your registration form if at all possible. Proofs of residency usually consist of an Occupancy Permit, Lease or Mortgage statement, and a utility bill. All submitted documents must have a parent name and current address on them. Please refer to the attached document regarding acceptable proofs of residency.
- 4) Please have the student's physical exam form completed and turned **in by their first day of school**. If for any reason you cannot get it in by the deadline, please contact the nurse by emailing kbarton@mccsd160.com or calling 618-476-7100 ext 1071 and let her know when your child's physical appointment is scheduled.
- 5) Contact your child's teacher for any questions regarding their specific classroom/ program.

NOTE: Please keep in mind that this is just the first step to the registration process so we can get your child started in the classroom and get them entered into our computer system and the administration process started. Here is a heads up on what is to come....

-Appointments will be made at the end of the current school year to come in for a Pre-K screening to let the teachers know where your child is developmentally. If your student was accepted into the ECC program in the middle of the school year, this has already been done.

-You will still have to complete the online registration at the end of the summer or shortly after your start date, if you began in the middle of the school year, in order to cover more information and permissions before school starts in the fall. You will be contacted by MCS when the online registration is ready for our students starting the first day of school in the fall. When you complete this final part of your registration online, please keep in mind that I will already have all your student's information in the computer so you will need to check that your student is an **EXISTING STUDENT**, not a new one.

If you have any questions, please contact Mrs. Sosa via email csosa@mccsd160.com or by calling 618-476-7100 Ext. 1021.

Please turn in all paperwork and documentation electronically through fax or email. Photos are acceptable. Documentation can be sent to csosa@mccsd160.com. If you need to pick up or turn in paperwork to the school, please call the above number to make an appointment.

**FAMILIES ENROLLING IN THE
MILLSTADT SCHOOL DISTRICT #160**

Please present the following items at time of registration:

1. Proof of Parent or Guardian Relationship

- Driver's License or other acceptable photo ID of parent/guardian
- Copy of certified birth certificate of student (the certificate you received from the hospital is not sufficient). A copy can be obtained from the county clerk where the child was born.
- Proof of guardianship (if applicable)
- Court Order Agreement, Judgement, or Divorce Decree that awards custody of the child to any person (if one exists).

2. Social Security number of the student.

3. Three proofs of residency. (Follow the guidelines for either Section A or B)

A. District residents occupying homes or rental units

1. Provide at least two of the following

- Current Real Estate Tax Bill
- Home Ownership Title or Deed
- Rental Lease Agreement
- One Current Utility Bill (gas, sewer, water, or electric)
- Homeowner or Renter Insurance Bill

2. Plus at least one of the following:

- Driver's License with Address in District
- Current Paycheck stub or proof of income with address in district
- Documentation of TANF or Approval letter from Nutrition Program and Support Services
- Current Utility Bill (if not used as proof of residency in number A1 above)
- Occupancy Permit

B. Requirement if you are living with a District resident:

1. Affidavit of Residency Requirements:

- District Homeowner/renter and the Parent/Guardian must both sign an Affidavit of Residency
- AND**
- Follow the requirements for Section A
 - Homeowner/renter must follow Section A1
 - Parent/Guardian must follow Section A2

(OVER)

MILLSTADT PRIMARY CENTER

NEW STUDENT INFORMATION

GRADE/HR: _____ SCHOOL YEAR: _____
(Please print)

LAST NAME: _____

FIRST NAME: _____

MIDDLE NAME: _____ Birth Place: _____

SS#:

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 DATE OF BIRTH:

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RACE: _____ GENDER: M: _____ F: _____

ADDRESS: _____
 _____ (street) _____ (city) _____ (zip)

HOME PHONE #: () _____

CELL PHONE #: Mother: _____ Father: _____

Email Address: _____

Name of Mother or Legal Guardian: _____ Maiden Name: _____

Address: _____

Occupation: _____ Federally Employed: Yes _____ No _____

Employer: _____ Phone #: () _____

Name of Father or Legal Guardian: _____

Address: _____

Occupation: _____ Federally Employed: Yes _____ No _____

Employer: _____ Phone #: () _____

Parent (s) are a member of a branch of the Armed Forces? If so, (please list)
 Future deployment date Indicated: _____

Status of Parents or Legal Guardians: Married: _____ Separated: _____ Divorced: _____

Child Living with: Parents: _____ Mother: _____ Father: _____ Legal Guardian: _____ Other: _____

EMERGENCY CONTACT: If student should get ill, in the event parents cannot be reached, call the following:

Name	Relationship to Student	Emergency Phone Number

If a language other than English is spoken in the home, what is the language: _____

Does the student speak a language other than English? Yes: _____ No: _____

If Yes, what is the language? _____

Please list names and birth dates of all other children living in your home:

The State of Illinois furnishes, on a loan basis, some of the textbooks used in the various classrooms.
 (Public Act 79-961 OF 1975) Do we have your permission to let your child use these textbooks? YES NO
 My child has permission to go on Field Trips with the students and teachers of Millstadt Grade School
 District #160, as designated by the School. (Parents will be notified of such designated Field Trips) YES NO

If student is going to a sitter or address other than home - please list:
 Name: _____
 Address: _____
 Phone Number: _____

SIGNATURE OF PARENT OR GUARDIAN: _____



**State of Illinois
Certificate of Child Health Examination**

Student's Name				Birth Date	Sex	Race/Ethnicity	School /Grade Level/ID#					
Last	First	Middle		Month/Day/Year								
Address				Parent/Guardian	Telephone # Home	Work						
Street				City	Zip Code							
IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for every dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.												
REQUIRED Vaccine / Dose	DOSE 1		DOSE 2		DOSE 3		DOSE 4		DOSE 5		DOSE 6	
	MO	DA	YR									
DTP or DTaP												
Tdap; Td or Pediatric DT (Check specific type)	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT
Polio (Check specific type)	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV		<input type="checkbox"/> IPV	<input type="checkbox"/> OPV		<input type="checkbox"/> IPV	<input type="checkbox"/> OPV		<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	
Hib Haemophilus influenza type b												
Pneumococcal Conjugate												
Hepatitis B												
MMR Measles Mumps Rubella												
Varicella (Chickenpox)												
Meningococcal conjugate (MCV4)												
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose												
Hepatitis A												
HPV												
Influenza												
Other: Specify Immunization Administered/Dates												
Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.												
Signature				Title				Date				
Signature				Title				Date				
ALTERNATIVE PROOF OF IMMUNITY												
1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result. *MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR												
2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official. Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease. Date of Disease Signature Title												
3. Laboratory Evidence of Immunity (check one) <input type="checkbox"/> Measles* <input type="checkbox"/> Mumps** <input type="checkbox"/> Rubella <input type="checkbox"/> Varicella Attach copy of lab result. *All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence. **All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.												
Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____ Physician Statements of Immunity MUST be submitted to IDPH for review.												

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and Maintained by the School Authority.

Last	First	Middle	Birth Date Month/Day/Year	Sex	School	Grade Level/ ID
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HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)	Yes	No	List:	MEDICATION (Prescribed or taken on a regular basis)	Yes	No	List:
Diagnosis of asthma?	Yes	No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Child wakes during night coughing?	Yes	No		Hospitalizations?	Yes	No	
Birth defects?	Yes	No		When? What for?			
Developmental delay?	Yes	No		Surgery? (List all.)	Yes	No	
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		When? What for?			
Diabetes?	Yes	No		Serious injury or illness?	Yes	No	
Head injury/Concussion/Passed out?	Yes	No		TB skin test positive (past/present)?	Yes*	No	*If yes, refer to local health department.
Seizures? What are they like?	Yes	No		TB disease (past or present)?	Yes*	No	
Heart problem/Shortness of breath?	Yes	No		Tobacco use (type, frequency)?	Yes	No	
Heart murmur/High blood pressure?	Yes	No		Alcohol/Drug use?	Yes	No	
Dizziness or chest pain with exercise?	Yes	No		Family history of sudden death before age 50? (Cause?)	Yes	No	
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____				Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate Other			
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)							
Ear/Hearing problems?	Yes	No		Information may be shared with appropriate personnel for health and educational purposes.			
Bone/Joint problem/injury/scoliosis?	Yes	No		Parent/Guardian Signature	Date		

PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA

HEAD CIRCUMFERENCE if <2-3 years old	HEIGHT	WEIGHT	BMI	B/P
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DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMD>85% age/sex Yes No And any two of the following: Family History Yes No
 Ethnic Minority Yes No Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes No At Risk Yes No

LEAD RISK QUESTIONNAIRE: Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered? Yes No Blood Test Indicated? Yes No Blood Test Date _____ Result _____

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

No test needed Test performed Skin Test: Date Read / / Result: Positive Negative mm _____

Blood Test: Date Reported / / Result: Positive Negative Value _____

LAB TESTS (Recommended)	Date	Results	Date	Results
Hemoglobin or Hematocrit				Sickle Cell (when indicated)
Urinalysis				Developmental Screening Tool

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs	Normal	Comments/Follow-up/Needs
Skin			Endocrine	
Ears		Screening Result:	Gastrointestinal	
Eyes		Screening Result:	Genito-Urinary	LMP
Nose			Neurological	
Throat			Musculoskeletal	
Mouth/Dental			Spinal Exam	
Cardiovascular/HTN			Nutritional status	
Respiratory		<input type="checkbox"/> Diagnosis of Asthma	Mental Health	
Currently Prescribed Asthma Medication: <input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist) <input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)			Other	

NEEDS/MODIFICATIONS required in the school setting **DIETARY** Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
 If you would like to discuss this student's health with school or school health personnel, check title: Nurse Teacher Counselor Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
 Yes No If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in _____ (If No or Modified please attach explanation.)
PHYSICAL EDUCATION Yes No Modified **INTERSCHOLASTIC SPORTS** Yes No Modified

Print Name _____ (MD, DO, APN, PA) Signature _____ Date _____
 Address _____ Phone _____