Cypress Elementary School Student Registration Form 2020-2021

Student Data **Date:** _____

First Name:	Middle Name:	Last Name:
Mailing Address:	Physical Address:	SSN:
Grade Level:	Birth Date:	Birth Place:
Primary Home Language:		
Allergies/Health Information: ***Please list any medical diagnosis or medication that your child takes.***		
Parent Email Address:		

Contact Information

Father's Name:	Place of Employment:		
Address:	Home Phone:	Cell Phone:	Work Phone:
Mother's Name:	Place of Employment:		
Address:	Home Phone:	Cell Phone:	Work Phone:
Is a parent or guardian a member of a branch of the armed forces of the US who is or expects to be deployed to active duty during the school year?			

Other Emergency Contacts: *Please provide at least two other emergency contacts.*

Name:	Relation:	Home Phone:	Cell Phone:
Name:	Relation:	Home Phone:	Cell Phone:
Name:	Relation:	Home Phone:	Cell Phone:
Name:	Relation:	Home Phone:	Cell Phone:
Name:	Relation:	Home Phone:	Cell Phone:
If there are individuals your child CANNOT be released to, please list names:			

I hereby certify that the residency information on this registration form is correct. I understand that supplying false information may result in prosecution. (105 ILSC 5/20.12b)

Cypress Elementary School District #64

Pre-K Income Guidelines

In order to serve students with the greatest need, we are required by the State of Illinois to verify family income. Please circle your family's income below and return proof of income as well as proof of residency with the registration packet.

Name (List all household members with income)	Gross Income and How Often It Is Received							
	Earnings from Week (Before Deductions)		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		Worker's Com, Unemployment, SSi, all other income	
	Amount	How Often	Amount	How Often	Amount	How Often	Amount	How Often

Income Verification Forms (At least one is required)

Pay Stubs (2 most recent)
Proof of WIC,SNAP,TANF,SSI,or CCAP Benefit
Most Recent Tax Return Statement
Verification Letter from Employer
Proof that parent is enrolled in Medicaid

_____ _____ _____

Parent/Caregiver's Signature Relationship to Child Date

Early Screening Inventory·Revised™ Meisels et al.

Parent Questionnaire

Date _____

CHILD INFORMATION

CHILD'S NAME _____ ☐ Male ☐ Female

HOME ADDRESS Street _____ Apt _____

City _____ State _____ Zip _____

Phone (_____) _____ Date of Birth _____

Who is completing this Parent Questionnaire? Name _____

Relationship to child _____

FAMILY

With whom has the child lived for most of the past year? _____

_____

Other children in the family – How many older? _____ How many younger? _____

Other people living in the household _____

What language(s) are spoken at home? ☐ English ☐ Other (specify) _____

PRESCHOOL/CHILD CARE HISTORY

Has your child attended preschool/child care before? ☐ Yes ☐ No

If yes, for how long? ☐ 6 months ☐ 1 year ☐ 2 years ☐ more than 2 years

Name of child's present or most recent school _____

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MEDICAL HISTORY

Birth

Were there any significant problems during pregnancy? ☐ Yes ☐ No

If yes, please explain:

Was your child more than 3 weeks premature? ☐ Yes ☐ No

If yes, how many weeks premature? _____

Baby's birth weight _____

Did the baby stay in the hospital longer than the mother? ☐ Yes ☐ No

If yes, please explain:

At the time of birth, did the baby — have seizures ☐ Yes ☐ No

turn blue? ☐ Yes ☐ No

Child's Health Since Birth

EYES

Has your child ever had trouble seeing? ☐ Yes ☐ No

Does your child hold books and objects close to his or her face? ☐ Yes ☐ No

Have your child's eyes ever looked crossed? ☐ Yes ☐ No

Have you ever suspected that your child has vision problems? ☐ Yes ☐ No

If yes, please explain:

EARS

Has your child had frequent ear infections? ☐ Yes ☐ No

Has your child ever had trouble hearing? ☐ Yes ☐ No

Have you ever suspected that your child has hearing problems? ☐ Yes ☐ No

If yes, please explain:

COORDINATION

Has your child ever had trouble walking, climbing, reaching, holding on to things? ☐ Yes ☐ No

If yes, please explain:

MEDICAL HISTORY (continued)

Child's Health Since Birth continued

Has your child ever had any significant injuries or hospitalizations? ☐ Yes ☐ No

If yes, please explain:

Does your child have allergies? ☐ Yes ☐ No

If yes, please explain:

Is your child presently on any medications? ☐ Yes ☐ No

If yes, please explain:

Please describe any other health concerns: ☐ Yes ☐ No

SOCIAL, EMOTIONAL, AND SELF-HELP SKILLS

Can your child —

feed him or herself using a spoon and/or a fork?	☐ Yes	☐ No
wash and dry his or her own hands?	☐ Yes	☐ No
help with dressing or dress with little assistance?	☐ Yes	☐ No
stay with a babysitter?	☐ Yes	☐ No
speak so that he or she can be understood by others?	☐ Yes	☐ No
express his or her thoughts and needs easily?	☐ Yes	☐ No

Do you have any concerns about your child's appetite or willingness to try different foods? ☐ Yes ☐ No

If yes, please explain:

CHILD'S DEVELOPMENT (continued)

Do you have any concerns about your child's sleeping patterns (going to bed with difficulty or waking often during the night)? ☐ Yes ☐ No

If yes, please explain:

_____

_____

_____

Is your child —	highly active?	☐ Yes ☐ No
	very quiet?	☐ Yes ☐ No
Is your child —	toilet trained during the day?	☐ Yes ☐ No
	in need of help with toileting?	☐ Yes ☐ No
Does your child —	play with blocks, boxes, cups, or other construction toys without help?	☐ Yes ☐ No
	use crayons and/or markers to scribble or draw?	☐ Yes ☐ No
	listen to stories being read?	☐ Yes ☐ No
	turn pages of a book and look at pictures?	☐ Yes ☐ No
	recall stories or events?	☐ Yes ☐ No
	enjoy playing alone or with imaginary friends?	☐ Yes ☐ No
	talk with your friends/relatives who come to visit?	☐ Yes ☐ No
	follow simple, age-appropriate directions?	☐ Yes ☐ No

What are your child's favorite activities?

_____

_____

_____

Does your child have opportunities to play with other children? ☐ Yes ☐ No

How many hours a day does your child spend watching TV? _____

Does he or she sit very close to the TV? ☐ Yes ☐ No

Does he or she turn up the volume very high? ☐ Yes ☐ No

Are there other things you would like to tell us about your child?

_____

_____

_____

_____

_____

_____

_____

_____

Things You Need For Pre-K

Each child must have these items in their file by the FIRST DAY OF SCHOOL: a copy of the child's birth certificate, current physical, shot record in order for them to attend Pre-K. No child will be allowed to start Pre-K without these items.

Each child will need to bring the following:

- An extra change of clothes that can be left at school.
- A clean pair of gym shoes to keep at school to play in the gym.
- A backpack
- Blanket, stuffed animal and/or small pillow for rest time.

Please write your child's name on all of their belonging so that they will note get lost.

SCHOOL MEDICATION AUTHROIZATION FORM

Student's Name_____ Birthdate_____
Address_____ Phone_____
School_____ Grade_____ Teacher_____
Emergency Phone_____

TO BE COMPLETED BY STUDENT'S PHYSICIAN OR PARENT:
Name of medication_____
Duration of administration_____
Type of illness or disease_____
MUST THIS MEDICINE BE ADMINISTERED DURING THE SCHOOL DAY IN ORDER TO ALLOW THE CHILD TO ATTEND SCHOOL OR TO ADDRESS THE STUDENTS MEDICATION CONDITION?_____

Doctor's Name (Print) _____ Date_____
Address_____ Phone_____
Further Instruction Remarks:_____

I hereby confirm my primary responsibility to administer medication to my child; however, in the event that I am unable to do so, I hereby authorize Cypress Elementary School and its designated agent in my behalf and stead, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the agent of Cypress Elementary School lawfully prescribed medication in the manner described above. IACKNOWLEDGE THAT IT MAY BE NECESSARY FOR THE ADMINISTRATION OF MEDICATION TO MY CHILD TO BE PERFORMED BY AN INDIVIDUAL OTHER THAN A SCHOOL NURSE OR HEALTH AIDE, AND SPECIFICALLY CONSENT TO SUCH PRATICES. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against Cypress Elementary School, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify cypress elementary School, its employees and agents, either jointly or separately, from and against any and all claims, damages, causes of action or attempts at administration of said medication.

_____ _____
Parent's Signature Date

FOR OFFICE USE ONLY

_____ _____
Person obtaining permission by phone Person granting permission by phone

Child's Name: _____ Date: _____

PERMISSION TO PICK UP CHILD

Please list individuals who are authorized to bring and pick up your child. Use the back of the paper if additional space is needed. Please call or send a note if someone who is not on the list will be picking up your child.

Name	Relationship	Phone

EMERGENCY MEDICAL CARE

This authorizes the Pre-K staff and school personnel to secure EMERGENCY medical care for my child when I/we cannot immediately reached at the time of the emergency. I/we will be responsible for the emergency medical charges.

Preferred doctor/clinic: _____ Phone: _____

Preferred hospital: _____ Phone: _____

_____ _____ _____

Date Signature of Parent/Legal Guardian Relationship to Child

Child's Name: _____

Each child enrolled in the Cypress Grade School Pre-K Class will be screening and testes in the following areas:

1. Gross and fine motor skills
2. Vocabulary development
3. Vision and Hearing
4. Speech and Language Development
5. Social/ Emotional development

Those children who exhibit a deficiency in any of the areas will be eligible for Pre-K. There is no tuition for the program.

Your signature is necessary to comply with the requirements of our program.

_____ _____

Parent's Signature Date

PERMISSION FOR SPEECH/LANGUAGE THERAPY

I authorize the Cypress Grade School Pre-K Class to provide speech/language therapy services for my child if warranted as determined through speech and language screening.

_____ _____

Parent's Signature Date

Child/Family Inventory

Child's Name: _____ Birthday: _____ Sex: ____
Address: _____ Telephone: _____
_____ Child's SS#: _____

Parent/Guardian Information

Father: _____ Mother: _____
Address: _____ Address: _____
_____ _____
Father's Age: ____ Marital Status: _____ Mother's Age: _____ Marital Status_____
Occupation: _____ Occupation: _____
Work Phone: _____ Work Phone: _____
Level of Education: _____ Level of Education:_____

Family Background

Are both parents in the home? YES NO Number of children living in the home: ____

Other Children	Birthdate	Sex	Grade in School	Problems in School?

Lunch Status (if known): FULL PRICE REDUCED PRICE FREE

Does anyone in the home smoke? YES NO

Has your child attended preschool/daycare before? YES NO *If yes, when, where and for how long?* _____

Medical Information

Birth weight of your child: _____ Was the child premature? YES NO

Were there any significant problems during pregnancy? YES NO *If yes, please explain:*

_____
_____

Did the child remain in the hospital longer than the mother? YES NO *If yes, please explain:*

_____
_____

STATE OF ILLINOIS
DEPARTMENT OF HUMAN SERVICES
CERTIFICATE OF CHILD HEALTH EXAMINATION

Please Print

Student's Name (Last, First, Middle)	Birth Date (Month/Day/Year)	Sex	School	Grade Level /ID#

Address (Street, City, ZIP code) | Parent/Guardian | Telephone # Home / Work

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.

VACCINE/DOSE	1 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	6 MO DA YR
Diphtheria, Tetanus and Pertussis (DTP or DTaP)						
Diphtheria and Tetanus (Pediatric DT or Td)						
Inactivated Polio (IPV)						
Oral Polio (OPV)						
Haemophilus influenzae type b (Hib)						
Hepatitis B (HB)						
Varicella (Chickenpox)				Comments		
Combined Measles, Mumps and Rubella (MMR)						
Measles (Rubeola)						
Rubella (3-day measles)						
Mumps						
Pneumococcal (not required for school entry)	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23
Check specific type (PCV7, PPV23)						
Other (Specify hepatitis A, meningococcal, etc.)						

Health care provider (MD; DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.

Signature — Title — Date

Signature
(If adding dates to the above immunization history section, put your initials by date(s) and sign here.) — Title — Date

Signature
(If adding dates to the above immunization history section, put your initials by date(s) and sign here.) — Title — Date

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

*MEASLES (Rubeola) MO DA YR MUMPS MO DA YR VARICELLA MO DA YR Physician's Signature

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying 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 — Date

3. Laboratory confirmation (check one) ☐ Measles ☐ Mumps ☐ Rubella ☐ Hepatitis B ☐ Varicella
Lab Results Date MO DA YR (Attach copy of lab report, if available.)

VISION AND HEARING SCREENING DATA

Pre-school – annually beginning at age 3; School age – during school year at required grade levels

Date																								
Age/Grade																								
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L
Vision																								
Hearing																								

Code:
P = Pass
F = Fail
U = Unable to test
R = Referred
G/C = Glasses/Contacts

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(Complete Both Sides)

Student's Name (Last / First / Middle)	Birth Date (Month/Day/Year)	Sex	School	Grade Level/ ID #

HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)				MEDICATION (List all prescribed or taken on a regular basis.)			
Diagnosis of asthma? Child wakes during the night coughing	Yes Yes	No No	Indicate Severity	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Birth defects?	Yes	No		Hospitalizations? When? What for?	Yes	No	
Developmental delay?	Yes	No					
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		Surgery? (List all.) When? What for?	Yes	No	
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 ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Dental ☐Braces ☐Bridge ☐Plate Other Other concerns?			
Ear/Hearing problems?	Yes	No		Information may be shared with appropriate personnel for health and educational purposes. Parent/Guardian Signature Date			
Bone/Joint problem/injury/scoliosis?	Yes	No					

Entire section below to be completed by MD/DO/APN/PA (*INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES)

PHYSICAL EXAMINATION REQUIREMENTS HEIGHT WEIGHT BMI B/P

DIABETES SCREENING BMI>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 Indicated? Yes ☐☐ No ☐☐☐ Blood Test Date Blood Test Result (Blood test required in Chicago and other high risk zip codes.)

TB SKIN TEST Recommended only for children in high-risk groups including children who are immunosuppressed due to HIV infection or other conditions, recent immigrants from high prevalence countries, or those exposed to adults in high-risk categories. See CDC guidelines. Date Read / / Result mm

LAB TESTS *INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES	Date	Results		Date	Results
Hemoglobin * or Hematocrit *			Sickle Cell * (as indicated)		
Urinalysis			Other		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin			Endocrine		
Ears			Gastrointestinal		
Eyes Normal Yes☐ No☐ Objective screening Yes☐ No☐ Result_____ Amblyopia Yes☐ No☐ Referred to Opthalmologist/Optometrist Yes☐ No☐			Genito-Urinary		LMP
			Neurological		
Nose			Musculoskeletal		
Throat			Spinal examination		
Mouth/Dental			Nutritional status		
Cardiovascular/HTN			Mental Health		
Respiratory					

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 (for one year) Yes ☐ No ☐ Limited ☐

Physician/Advanced Practice Nurse/Physician Assistant performing examination

Print Name Signature Date

Address Phone

(Complete both sides)