



## Kindergarten Instructions and Checklist

All required items must be returned to L. Hollingworth for Talented and Gifted Office, 824 Sixth Street, Toledo, OH 43605. All checklist documents must be turned in at one time to reserve a spot!

**No partially completed packets will be accepted!**

### THE CHECKLIST ITEMS BELOW MUST BE TURNED IN TO COMPLETE THE REGISTRATION PROCESS

- Your child must turn 5 years of age by September 30<sup>th</sup> of the current school year.

The following is required documentation to enroll in Kindergarten at L. Hollingworth School for Talented and Gifted. Please return completed packet along with:

- Kindergarten Roundup Pre-registration Form
- 2 Proofs of Residency (lease, rent receipt, utility bill, etc.)
- Child's original birth certificate (birth record from hospital will **NOT** be accepted)
- Social Security Card
- Completed Home Language Survey
- Emergency Contact Form
- Parent Questionnaire
- Picture Release Form

Required BEFORE first day of school:

- Physician's Forms (both sides)
- Dental Screening
- Medication Information
- Ohio School Health History Form

The school has established a standardized testing program and designated minimum standards acceptable for the early admission of a child to kindergarten. On request of the parents or guardian the school shall provide testing to children who will be 5 years of age on or before the first day of January for which admission is requested, and shall admit the children who pass such tests. R.C. 3321.01



2012-2013

**STUDENT REGISTRATION**

824 Sixth St  
Toledo, OH 43605  
419.705.3411

Grade \_\_\_\_\_

**STUDENT INFORMATION**

Last name \_\_\_\_\_ First name \_\_\_\_\_ Middle name \_\_\_\_\_ Home telephone (\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_ Apartment # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
City of birth \_\_\_\_\_ Sex M or F (circle one) Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

**PREVIOUS SCHOOL INFORMATION**

Name of last school attended \_\_\_\_\_ Dates attended \_\_\_\_/\_\_\_\_/\_\_\_\_ - \_\_\_\_/\_\_\_\_/\_\_\_\_ Telephone number (\_\_\_\_) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ School district in which parent or guardian lives \_\_\_\_\_

**FAMILY INFORMATION**

	<i>Last name</i>	<i>First name</i>	<i>Employer</i>	<i>English proficient</i>	<i>Other language spoken and/or read</i>	<i>Daytime phone</i>	<i>Evening phone</i>
Father				Yes or No			
Mother				Yes or No			
Step-parent				Yes or No			
Guardian				Yes or No			
Guardian				Yes or No			

*Student lives with* \_\_\_\_\_ *check one*

Parents	
Father & stepmother	
Mother & stepfather	
Mother only	
Father only	
Guardians	
Court-appointed guardians	
Foster parents	

*Information on other children in home*

<i>Name of other children in home</i>	<i>Birth date</i>	<i>Grade</i>
	____/____/____	
	____/____/____	
	____/____/____	
	____/____/____	
	____/____/____	
	____/____/____	
	____/____/____	

Please check the box that applies to this student (*optional*)

Native American or Aleutian       Asian or Pacific Islander       African American       Hispanic/Latino       Caucasian, non-Hispanic origin  
Language spoken in home \_\_\_\_\_ Is child proficient in English? Yes or No      Other language child speaks and/or reads \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date Enrolled \_\_\_\_\_

**FOR SCHOOL USE ONLY**

Date enrolled \_\_\_\_\_ Date records requested \_\_\_\_\_ Date records received \_\_\_\_\_ Pupil ID # \_\_\_\_\_ Homeroom teacher \_\_\_\_\_  
SSID # \_\_\_\_\_ U.S. Citizen? Yes or No      Copy of birth certificate? Yes or No      Social Security card? Yes or No      2 forms of proofs of residency? Yes or No



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### HOME LANGUAGE SURVEY

Student's name \_\_\_\_\_ Grade \_\_\_\_\_ Date of birth \_\_\_\_\_

Parent(s) name \_\_\_\_\_ Phone number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

What was the first language your child learned? \_\_\_\_\_

What language is spoken most often by your child? \_\_\_\_\_

What languages, other than English, are spoken in the home? \_\_\_\_\_

Was your child receiving help with English in their previous school? \_\_\_\_\_

Comments

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\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date



# EMERGENCY CONTACT AND MEDICAL INFORMATION FOR YOUR CHILD

## School Year 2012-13

M F

Teacher

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

Parent's/Guardian's Name \_\_\_\_\_ Parent's/Guardian's Name \_\_\_\_\_

( ) ( ) ( ) ( )

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

( ) ( ) ( ) ( )

Cell Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### Alternative Emergency Contact

Grade

Primary Emergency Contact \_\_\_\_\_ Secondary Emergency Contact \_\_\_\_\_

( ) ( ) ( ) ( )

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

( ) ( ) ( ) ( )

Cell Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### Medical Information

First Name

Hospital/Clinic Preference \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Allergies/Special Health Considerations \_\_\_\_\_

I authorize all medical and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. This waiver applies only in the event that neither parent/guardian can be reached in the case of an emergency.

Last Name

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

I give permission for my child to go on field trips. I release L. Hollingworth School for Talent and Gifted and individuals from liability in case of accident during activity related to L. Hollingworth School for Talented and Gifted as long as normal safety procedures have been taken.

Parent's/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

Additional information on back





**TO BE FILLED OUT BY CHILD'S PHYSICIAN**

<b>Child's Name</b>	<b>Gender</b> ___ male ___ female	<b>Age</b>	<b>Birth date</b>
<b>Ethnicity</b>	___ America Indian/Alaskan Native ___ White (Non-Hispanic) ___ Hispanic ___ Asian/Pacific Islander	___ Black (Non-Hispanic) ___ Multiracial	

**Objective Data**

Height	Weight	B.P.
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<b>Immunizations</b> Shaded boxes are required for school entry.						
Type	Date M/D/Y					
<b>DTaP</b>						5 <sup>th</sup> dose required if 4 <sup>th</sup> dose given before age 4
<b>DT/Td</b>						
<b>POLIO</b>						4 <sup>th</sup> dose required if 3 <sup>rd</sup> dose was given before age 4.
<b>MMR</b>						2 <sup>nd</sup> dose required for K 2 <sup>nd</sup> dose required for gr. 7-12
<b>HEPATITIS B</b>						
<b>VARICELLA</b>						If child has had the Chicken Pox, a note stating that will be required for his/her file.
<b>HIB</b> (prior to age 5 only)						0-14 months: 3-4 doses 15-59 months: 1 dose
<b>TUBERCULIN TEST</b>						
<b>ROTAVIRUS</b> (given @ 2-4-6 mo, not after 12 months)						
<b>OTHER</b>						

**Screening Tests**

Vision	Hearing
<b>Date</b> Distance Acuity ___ Right ___ Left Muscle Balance ___ Pass ___ Fail ___ Not done Farsightedness ___ Pass ___ Fail ___ Not done Color ___ Pass ___ Fail ___ Not done Child wears glasses ___ Yes ___ No Tested with glasses ___ Yes ___ No Referral made? ___ Yes ___ No Specify Test/Equipment _____	<b>Date</b> Pure tone testing: Right ear ___ Pass ___ Fail ___ Not done Left ear ___ Pass ___ Fail ___ Not done Child wears hearing aid ___ Yes ___ No Testing with hearing aid? ___ Yes ___ No Referral made? ___ Yes ___ No Other test (specify) _____

**Speech Assessment Date**

___ Child has no discernible speech problem ___ Child has possible problem with: ___ Articulation            ___ Rhythm ___ Voice                    ___ Language Speech evaluation is recommended: ___ Yes ___ No
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**Laboratory Tests**

___ Hemoglobin/Hematocrit	___ Urine protein
___ Urine blood	___ Urine glucose
___ Other _____	



## Physical Examination

Date of examination: \_\_\_\_\_

\_\_\_\_ this child is essentially within normal limits

\_\_\_\_ This child is not within normal limits

Explain:

Does this child have any physical, developmental or behavioral problems? Suggest special programs, placement or attention that the school can provide.

### Activities & Limitations

Can the child participate fully in the following activities?

Classroom and academic activities \_\_\_\_ yes \_\_\_\_ no

Physical education classes \_\_\_\_ yes \_\_\_\_ no

Competitive athletics \_\_\_\_ yes \_\_\_\_ no

Contact & collision sports \_\_\_\_ yes \_\_\_\_ no

Specify any limitations:

Is this child on any medications? \_\_\_\_ yes \_\_\_\_ no

Explain:

Examiner's Signature \_\_\_\_\_ Date signed \_\_\_\_\_

Examiner's Printed Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_



**TO BE FILLED OUT BY CHILD'S DENTIST**

**Oral Assessment**

Child's Name _____	Gender _____ _____ male _____ female	Age _____	Birth date _____
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The following services have been performed:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Examination by dentist                | <input type="checkbox"/> Orthodontic assessment | <input type="checkbox"/> Oral screening |
| <input type="checkbox"/> Dental sealants                       | <input type="checkbox"/> Fluoride application   | <input type="checkbox"/> Radiographs    |
| <input type="checkbox"/> Oral prophylaxis (cleaning)           | <input type="checkbox"/> Diagnosis              |   |
| <input type="checkbox"/> Prescription for fluoride supplements |   |   |

The following oral hygiene instruction was provided:

- |   |   |
|---|---|
| <input type="checkbox"/> Tooth brushing | <input type="checkbox"/> Diet counseling related to dental health |
| <input type="checkbox"/> Flossing       | <input type="checkbox"/> Home/school use of fluoride mouth rinse  |

The following statements are applicable:

- No apparent care needed at this time.
- All necessary preventive services have been performed. (Fluoride treatment, prophylaxis)
- No restorative services are required at this time.
- Further treatment is indicated. (See comments)
- Further appointments have been arranged. (Ex. Orthodontic, restorative)

**Comments:**

Examiner's Signature \_\_\_\_\_ Date signed \_\_\_\_\_

Examiner's Printed Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_



**Medication Information**

Please describe any medications that your child takes daily or frequently.

Name of Medication	What is the medication taken for?	How often is the medication taken? What time is the medication Administered?

**Health Conditions**

Please check any medical conditions that the child currently has or has had in the past.

- |  |  |
|--|--|
| <input type="checkbox"/> Abnormal spinal curvature                       | <input type="checkbox"/> Hemophilia                      |
| <input type="checkbox"/> Allergies/hay fever                             | <input type="checkbox"/> Hepatitis                       |
| <input type="checkbox"/> Anemia  | <input type="checkbox"/> HIV positive                    |
| <input type="checkbox"/> Anaphylactic reaction                           | <input type="checkbox"/> Hyperactivity                   |
| <input type="checkbox"/> Asthma or wheezing                              | <input type="checkbox"/> Juvenile Arthritis              |
| <input type="checkbox"/> Attention deficit disorder (ADD)                | <input type="checkbox"/> Kidney disease Type _____       |
| <input type="checkbox"/> Behavior problem                                | <input type="checkbox"/> Measles (10 day)                |
| <input type="checkbox"/> Birth or congenital malformation                | <input type="checkbox"/> Meningitis or Encephalitis      |
| <input type="checkbox"/> Cancer Type _____                               | <input type="checkbox"/> Mumps                           |
| <input type="checkbox"/> Chickenpox When _____                           | <input type="checkbox"/> Mutism                          |
| <input type="checkbox"/> Chronic diarrhea or constipation                | <input type="checkbox"/> Near-drowning/Near suffocation  |
| <input type="checkbox"/> Chronic ear infections                          | <input type="checkbox"/> Nervous twitches or tics        |
| <input type="checkbox"/> Concern about relation with siblings or friends | <input type="checkbox"/> Poisoning                       |
| <input type="checkbox"/> Cystic Fibrosis                                 | <input type="checkbox"/> Rheumatic fever                 |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Seizure disorder/Epilepsy       |
| <input type="checkbox"/> Eczema/Chronic skin conditions                  | <input type="checkbox"/> Sickle Cell Disease             |
| <input type="checkbox"/> Emotional problems                              | <input type="checkbox"/> Speech difficulties             |
| <input type="checkbox"/> Eye problems, poor vision                       | <input type="checkbox"/> Stool soiling                   |
| <input type="checkbox"/> Frequent headaches                              | <input type="checkbox"/> Toothaches or dental problems   |
| <input type="checkbox"/> Frequent sore throats                           | <input type="checkbox"/> Tourettes syndrome              |
| <input type="checkbox"/> Heart disease Type _____                        | <input type="checkbox"/> Urinary tract infections        |
|  | <input type="checkbox"/> Wetting during the day or night |



## Ohio School Health History

Child's Name	Gender ____ male ____ female	Age	Birth date
Ethnicity: ____ Caucasian ____ African American ____ Hispanic ____ Asian American ____ Other			
Who is the child's legal guardian? Who does the child live with? Child's address:			
Parent/Guardian Address		Home phone number	

### Social Service History

"X" the line if you have contact with any of the following agencies:

- \_\_\_\_ Child Protective Services If yes, Case Worker's Name \_\_\_\_\_
- \_\_\_\_ Legal/Court System
- \_\_\_\_ Family Counseling Services
- \_\_\_\_ Mental Health Provider
- \_\_\_\_ Other \_\_\_\_\_

### Allergies

Please list and describe allergies or reactions.

Medications/drugs
Foods/plants/animals/other
Recommended treatment if allergy is severe

### Injuries, Illness & Hospitalizations

Please list any severe injuries, illnesses, and hospitalizations including inpatient and outpatient surgical procedures.

Injuries/Illness/Hospitalizations	Age	If hospitalized, please explain.

### Behavioral History

The child is usually: \_\_\_\_ very active \_\_\_\_ normally active \_\_\_\_ rather inactive

Has your child ever been violent or acted out the following manner towards adults or children:

\_\_\_\_ Hitting \_\_\_\_ Kicking \_\_\_\_ Biting \_\_\_\_ Fighting \_\_\_\_ Scratching

Do you have any concern about how your child gets along with other children? \_\_\_\_ yes \_\_\_\_ no  
if yes, explain \_\_\_\_\_

Please add any comments or concerns you have about your child's health, development, behavior, family or home life that you would like the school to be aware of \_\_\_\_\_

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