LITTLE ROADRUNNER
PRESCHOOL REGISTRATION
For school year 2017-2018

Officially register your child by:

- **Completing forms provided and providing a copy of confirmation of age (I.E., birth certificate, passport, baptismal certificate or physicians certificate) to elementary school office.**

- **Please complete all forms in the registration packet. Letters explaining transportation and health are attached.**

- **The first month's tuition ($35 for August) will be due during registration. All tuition after that is due in full by the first of each month (September through May). If your family qualifies for low-income assistance, please fill out the accompanying forms and leave them with the office staff. You may qualify for financial help.**

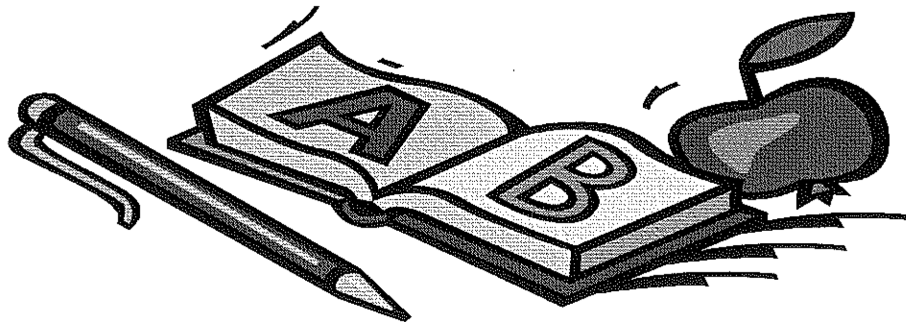
Other Important Information

- **Final tuition, student placement, classroom teacher, and format will be determined in August and will be communicated to you with a letter sent at that time. You can also check for updates on our elementary and preschool websites.**

- **Priority for placement will be in this order: Ages 4, 5 and then 3 year-olds by order in which they register. If student numbers exceed NAEYC classroom guidelines, your child will be placed on a waiting list and you will be notified as such.**

- **As a part of enrolling in the Little Roadrunner Preschool program, you will be contacted by your teacher in the fall to schedule a home visit to help meet NAEYC accreditation guidelines.**

- **If you have any questions please call the Interstate 35 Elementary Office at 641-765-4901.**



Interstate 35 School Registration Form - Preschool
2017-2018

Students Full Legal Name:		Address Status? (Circle one below)
Birth Date:		Single Family Dwelling
Birth State:		Doubled Up
Birth Country:		Shelter/Transitional
Gender:		Unsheltered
District Resident: (Circle)	Yes or No If no, what district?	Homeless
Resident County:		Foster Care: Yes No
Do you live within 2 miles (radius) of the Truro school building? Yes No		

Ethnicity		Race		
Yes No	Hispanic/Latino	Yes	No	American Indian or Alaska Native
Language spoken at home?		Yes	No	Asian
		Yes	No	Black or African American
____________________		Yes	No	Native Hawaiian or other Pacific Islander
		Yes	No	White

Parents/Guardians Information

Parents/Guardians Name	
Physical Address	
Mailing Address if different	
City	
State. Zip Code	
Home phone only if one:	

Additional Resident Information

Parent/Guardian Name	
Physical Address	
Mailing Address if different	
City	
State, Zip Code	
Home phone only if one:	

Contact Information

Work Phone(s)	***Emergency Contact*** **OTHER THAN PARENTS/GUARDIANS**
Mom	Emergency Name 1:
Dad	Emergency Phone 1:
Cell Phone(s)	Circle One: Cell phone Work phone Home phone
Mom	Relationship to Student:
Dad	Emergency Name 2:
E-mail Address(es)	Emergency Phone 2:
Mom	Circle One: Cell phone Work phone Home phone
Dad	Relationship to Student:

Little Roadrunner Preschool Options (Please check one)

_____Full-time option PK1 & PK2: All day Monday, Tuesday, Thursday and Friday (CIRCLE - ages 4 and 5)

_____Part-time optionPK3: AM Monday, Tuesday, Thursday and Friday (age 3 only)

Notice: Your child will have supervised access to the internet during school hours. He/she may have their picture in district documents or on the school website. If you have questions or choose not to have these options please call the school so we can put your child's name on the appropriate list.

Parent Signature: ______________________________ Date: ____________

___Registration Fee ___Proof Of Birth Date:__________Reg.Fee Paid________Cash________Check #

Preschool Checklist

Welcome to Preschool! Before the start of the school year, your child will need the following forms turned into the health office.

___**Signed 2017-2018 Annual Health Update** (Form attached)

___**Immunization Record – Iowa Law requires your child to have a current immunization record to be admitted to preschool.**

___ **Current Medical Physical** (From physician's office – this can be on any form from your physician's office. A physical is current if done within the previous 12 months.)

___**Dental Screening** (Recommended but not required for preschool – form attached)

___**Vision Screening** (Recommended but not required for preschool – form attached)

Your child's health is very important to us at Interstate 35 Elementary. If you have any questions or concerns regarding these forms or any health issues your child may have, please call Brandi Ransom, RN in the health office at 641-765-4901, fax: 641-765-4905

Interstate 35 Community School District

Student Name: ______________________________ **Grade:** ________ **Date of birth:** ___________

HEALTH INFORMATION

Name of Health Provider: ______________________ **Phone Number:** __________________

Date of most recent physical: ____________________

Name of Dental Provider: ______________________ **Phone Number:** __________________

Date of most recent exam: ________________

Preferred Hospital: ____________________________

Check next to any condition or illness that applies to your child. Use "Comments" section at the bottom of the page for explanations.	
1	□ **MY CHILD DOES NOT HAVE ANY KNOWN MEDICAL CONDITIONS.**
2	□ **Allergies** □ Food ________________________ □ Medicine________________ □ Insects (please specify)____________________ □ Environmental □ Latex □ Other (please specify)____ **Specify reaction to allergy or allergen** □ Rash □ Swelling □ Hives □ Trouble Breathing □ Vomiting □ Diarrhea □ Local Reaction □ **Takes medication for any allergies: Name medication(s)**________________________ Does the child need a special diet? □ Yes □ No (If yes, school requires a prescription from doctor.)
3	□ **Asthma:** List triggers____________________________ Diagnosed at age______ □ Takes medication: Name medication(s)_________________________________ Under doctor care now? □Yes □ No **See nurse for Asthma Action Plan**
4	□ **Diabetes:** □ Type 1 □ Type 2 □ Insulin______________________________ □ Pump □ Pen □ Syringe/Needle **See Nurse with Additional Instructions**
5	□ **Ear Problems** □ Frequent infections □ Tubes, date(s)_________ □ Uses hearing aid
6	□ **Heart condition:** Explain____ Under doctor's care for this condition? □Yes □ No **Any physical restrictions?** □ Yes □ No If yes, explain_____________________________
7	□ **Migraines:** Is child under a doctor's care for this condition? □ Yes □ No □ Takes medication: Name of medication_____________________________________
8	□ **Mental Health/Behavioral diagnosis** ____ □ Takes medication: Name of medication_____________________________________
9	□ **Seizures:** Type:_________ Length:_______ Frequency:_________ Medication(s)______________ Triggers/Warning Signs: ____________________ **See Nurse for Seizure Action Plan**
10	□ **Surgeries:** What for____
11	□ **Vision** problems: Explain___________________________ □ Glasses □ Contacts
12	**Additional Medical Diagnosis/Health Problems: (check all that apply)** □ Bleeding Tendencies □ Eczema □ Head Injury □ Urinary Problem □ Bowel Problems □ Epistaxis (bloody nose) □ Speech Problem □ Other (please list below)
Comments or other health information____	

****PLEASE COMPLETE REVERSE SIDE OF THIS FORM****

FORM VALID 2017-18 SCHOOL YEAR ONLY

Interstate 35 Community School District

Student Name: ______________________________ **Grade:** ________ **Date of birth:** ___________

CONSENT FOR OVER THE COUNTER MEDICATION

A registered nurse/certified staff will have the following over-the-counter medication available to give to students according to written protocol and with written parental authorization. Please check which medications your child may receive for minor problems such as a cold, menstrual cramps, headache, sore throat, sore muscles, backache, sprains, upset stomach and rashes. These medications are for occasional use only. If your child requires any medication more frequently please provide medication and a signed parental authorization form.

Check one:

☐ May give **ALL** medications listed ☐ Do **NOT** give any medications ☐ Give **ONLY** medications checked

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☐ **Cough / Sore Throat Lozenge** - 1 lozenge every 2 hours as needed for sore throat and/or cough

☐ **Antacid Chewable Tablets** - take 1 every 2 hours for indigestion, heartburn, nausea, diarrhea

☐ **Triple Antibiotic Ointment** - may be applied as needed

☐ **Lip Balm** - may be applied as needed

☐ **Lubricant Eye Drops** - may be used to remove irritant in eye

☐ **Hydrocortisone 1% Ointment** - may be applied as needed for itching/rash

☐ **Acetaminophen (Tylenol)**-Dose according to age and weight

☐ **Ibuprofen (Motrin/Advil)** – Dose according to age and weight

Please list name and dose of student's prescription medications:

Name/Dose:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Parent/Guardian Signature: ______________________________ **Date:** ________________

****PLEASE COMPLETE REVERSE SIDE OF THIS FORM****

FORM VALID 2017-18 SCHOOL YEAR ONLY

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 • www.idph.state.ia.us/ohds/OralHealth.aspx
A designee of the local board of health or Iowa Department of Public Health may review this certificate for survey purposes.

9/13/2012

Iowa Department of Public Health
Child Vision Screening

1. Parents or guardians need to make sure their child has a vision screening at least once before starting kindergarten and again before starting 3rd Grade.

2. Kindergarten Screenings: A screening will be counted if it is done no earlier than 1 year before and no later than 6 months after school starts.

3. 3rd Grade Screenings: A screening will be counted if it is done no earlier than 1 year before and no later than 6 months after school starts.

4. The requirement for a child vision screening will count by any of the following:
   a. A vision screening or comprehensive eye exam by an eye doctor (ophthalmologist or optometrist).
   b. A vision screening conducted at a doctor's office, a free clinic, a child care center, a local public health department, a public or accredited nonpublic school, or a community-based organization or by an advanced registered nurse practitioner or physician assistant.
   c. A vision screening done by Prevent Blindness Iowa volunteers or Iowa KidSight and Lion's Club Volunteers.

5. The child vision screening requirement does not apply if the child vision screening conflicts with a parent's or guardian's genuine and sincere religious belief.

6. A child will not be withheld from school because a parent or guardian did not provide proof that the child received a vision screening.

Please direct questions regarding vision screening to
Iowa Department of Public Health• Bureau of Family Health
FAX 515-725-1760• Phone 800-383-3826

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 • Bureau of Family Health FAX 515-725-1760 • 800-383-3826 •
www.idph.iowa.gov

3/01/2015

2017-2018 INTERSTATE 35 C.S.D. TRANSPORTATION REQUEST

Complete ONE form PER FAMILY and return with registration materials

STUDENT INFORMATION:

STUDENT NAME:______________________________GRADE:__________

STUDENT NAME:______________________________GRADE:__________

STUDENT NAME:______________________________GRADE:__________

STUDENT NAME:______________________________GRADE:__________

STUDENT NAME:______________________________GRADE:__________

STUDENT NAME:______________________________GRADE:__________

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CONTACT INFORMATION:

PARENT OR GUARDIAN:____

HOME ADDRESS:____

CITY:___________________ STATE:________ ZIP CODE:_________________

HOME PHONE:____________WORK:____________CELLULAR:_____________

EMAIL ADDRESS:____

EMERGENCY CONTACT:_____________________PHONE#:_________________

....

BUS TRANSPORTATION NEEDED: YES_____NO_____SOMETIMES_____

TOWN (WALKING HOME): YES____NO____SOMETIMES____

PARENT PICK UP: YES____NO____SOMETIMES____

Approximately how far do you live from the Interstate 35 School building?

_____ LESS THAN 2 MILES

_____ 2 TO 3 MILES

_____ GREATER THAN 3 MILES

STOP #1) NAME:____

ADDRESS:__________________________________CITY:________________

HOME PHONE:___________WORK PHONE:___________CELLULAR:____________

BUS NUMBER:____ DRIVERS NAME:___________________________________

STOP #2) NAME:____

ADDRESS:__________________________________CITY:________________

HOME PHONE:___________WORK PHONE:___________CELLULAR:____________

BUS NUMBER:____ DRIVERS NAME:___________________________________

STOP #3) NAME:____

ADDRESS:__________________________________CITY:________________

HOME PHONE:___________WORK PHONE:___________CELLULAR:____________

BUS NUMBER:____ DRIVERS NAME:___________________________________

SPECIAL INSTRUCTIONS:

IF YOU HAVE SPECIAL REQUIREMENTS FOR TRANSPORTATION (PICK UP AT GRANDMA'S ON MONDAYS, DROP OFF AT DAYCARE ON WEDNESDAYS, THURSDAY, AND FRIDAY.) PLEASE DESCRIBE THEM HERE.

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PLEASE RETURN THESE FORMS TO THE ELEMENTARY OR SECONDARY OFFICE.

NO CHANGES WILL BE ALLOWED AFTER SEPTEMBER 30, 2015 UNLESS IT IS APPROVED BY THE TRANSPORTATION DIRECTOR.

PARENT OR GUARDIAN SIGNATURE:___________________________DATE:____________