

# CIRCLEVILLE CITY SCHOOLS



## KINDERGARTEN REGISTRATION PACKET

2018-2019

Circleville City Schools are preparing to begin the registration process for the 2018-2019 Kindergarten class. If your child will be five years old on or before August 1, 2018, you may register him/her for kindergarten.

Registration will be held on the following dates and times by APPOINTMENT ONLY:

Tuesday, April 17 <sup>th</sup>	8:30 a.m. - 3:30 p.m.
Wednesday, April 18 <sup>th</sup>	8:30 a.m. - 3:30 p.m.
Thursday, April 19 <sup>th</sup>	2:00 p.m. - 6:00 p.m.

You will need to contact our District Office at 740.474.4340 ext. 48005 to set up an appointment. Your child will NOT need to be present for the registration.

Please bring the completed packet and all required documents to your scheduled appointment. The list of required documents is available in the packet.

If you have any questions in regards to registering your child, please contact the District Office at 740.474.4340 ext. 48005. Our office hours are Monday through Friday 8:00 a.m. to 4:30 p.m.

## CIRCLEVILLE CITY SCHOOLS NEW STUDENT ENROLLMENT PROCEDURES

We want to welcome you to Circleville City Schools. Student registration is by appointment only. Please contact the District Office at 740.474.4340 ext. 48005 to schedule an appointment. All new students must be registered by a custodial parent or legal guardian. The registration process includes the completion of enrollment forms as well as providing required documents. Lists of required documents are provided below. Registration will be considered incomplete until we have received all forms and required documentation.

Enrollment packets can be found on our website at [www.circlevillecityschools.org](http://www.circlevillecityschools.org) and will be available at all buildings. To print the packet go to *Parent Resources* and click on *Student Registration*.

Kindergarten students must be five years old on or before August 1<sup>st</sup>.

- Custodial parent/ guardian photo I.D.
- Copy of Certified Birth Certificate
- Immunization Records
- Proof of Residency
  - Verification of your address must be provided through TWO (2) acceptable forms of documentation. Examples of acceptable forms of documentation include but are not limited to the following:
    - Official Rental/Lease Agreement
    - Property Tax Statement
    - Utility Bill (within 30 days)
      - *Only ONE (1) utility bill will be accepted for verification. You will need to provide us with another type of documentation for your second verification.*
    - Mortgage Coupon/ Closing Settlement Statement of purchase
    - Ohio Driver's License or State issued I.D.

### OR

- Special Circumstances
  - Applicant resides with another person. The person with whom you are living with **MUST COMPLETE THE RESIDENCE VERIFICATION AFFIDAVIT II** form and have it notarized. They **MUST ALSO PROVIDE PROOF OF RESIDENCY** to school officials through TWO (2) acceptable forms of documentation. Acceptable forms of documentation include but are not limited to the examples above.
- Copy of Custody Orders, if parents are divorced and/or legally separated

## ADDITIONAL PRESCHOOL ONLY REQUIREMENTS

~In addition to the documentation requested above, preschool parents will also need to provide the following documentation at the time of registration.

- Proof of Income- *if you are applying for the Tiger Cub Academy Preschool you will not need to provide proof of income*
  - Please bring in one of the following:
    - Individual Income Tax Form (current year)
    - Check stub (will need at least two consecutive copies)
    - Written statement from employer
    - Documentation of current status as recipients of public assistance
- Physical Examination Form
- Dental Health Record Form

Completing this preschool application does not necessarily guarantee that your child will be attending our program next school year. Proof of income must be verified and application approved.

*For Office Use Only:*

- DASL
- Google Docs

Preschool Income Verification Level \_\_\_\_\_

**Special Needs:**

- Registration Form
- Records Request
- Copy of IEP
- Copy of ETR
- Foster Placed with Special Needs
- Scanned and Emailed forms

**Foster Placed:**

- Registration Form
- Foster Placed Paperwork
- Journal Entry
- Scanned and Emailed forms

Notes:

## KINDERGARTEN IMMUNIZATION REQUIREMENTS

Ohio State Law requires that the following immunizations be obtained for school enrollment. Students who do not have the required immunizations will be excluded from school per Ohio State Law until such record is provided. **You must bring an immunization record with the month/date/year for each of the shots below to kindergarten registration in order to complete enrollment requirements.**

- 5 - DPT (Dose 5 required if 4<sup>th</sup> dose given prior to the 4<sup>th</sup> birthday)
- 4 - Polio (Dose 4 required: Final dose must be given on or after the 4<sup>th</sup> birthday)
- 2 - MMR (this is a combination of the measles, mumps, rubella vaccines)
- 3 - Hepatitis B
- 2 - Varicella (chicken pox) – (or documentation of having disease)

Please contact your family physician or the Pickaway County Health Department at (740) 477-9667 to arrange for your child to receive an update on his/her immunizations. The health department might be able to provide vaccinations to your child for a minimal amount or on a sliding fee scale. You must call the Health Department at (740) 477-9667 to make an appointment. A parent (or legal guardian) and a copy of the child's current immunization record must accompany the child to the Health Department. If you have any questions concerning your child's immunizations, please contact the District School Nurse's office at (740) 474-2495, ext. 49099 or the Health Department at (740) 477-9667.

In closing, if your child has any serious medical concerns (i.e. seizures, diabetes, hemophilia, heart condition, etc.) or will require medication during school hours, please contact the District School Nurse's office at (740) 474-2495, ext. 49099 before the start of school and list this information on the Emergency Medical Form. There are certain permission forms that will need to be completed and it may be necessary to create a care plan to ensure your child's health at school. Please remember that student health information will be shared with school personnel unless you request otherwise. **In addition, all kindergarteners will receive a vision and hearing screening in the fall as part of our school health program.** We look forward to meeting your child in the fall.

Thank you,

Jaime McKeivier, BSN, RN, LSN

District School Nurse

Circleville City Schools

740-474-2495, ext. 49099

[jaime.mckeivier@cvcgsd.com](mailto:jaime.mckeivier@cvcgsd.com)

### REGISTRATION FORM

School Year: \_\_\_\_\_

Has your child ever been enrolled in the Circleville City School District?  Yes  No

If yes, what school building did they attend? \_\_\_\_\_

Student's Legal Name: \_\_\_\_\_  
First Middle Last

Preferred Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Gender:  Male  Female

Date of Birth: \_\_\_\_\_ Grade \_\_\_\_\_ Place of Birth: \_\_\_\_\_  
City State Country

Home Address: \_\_\_\_\_  
Street # Lot #, Apartment#, P.O. Box City County Zip

**Primary Phone:** \_\_\_\_\_ (This number will be used for the **OneCallNow Phone System**. This system is used for school delays, closings, special announcements, etc.)

**Parent/Guardian Information:**

Mother's Maiden Name: \_\_\_\_\_

Status of biological parents:  Married  Divorced  Separated  Widowed  Never Married

Student resides with:  Mother  Father  Guardian

If divorced, who has legal custody?  Mother  Father  Shared If shared, who is residential? \_\_\_\_\_

Are you the biological/adoptive parent (s) of the child?  Yes  No If no, what is your relationship to the child? \_\_\_\_\_

If foster/guardian, what district did the natural parent(s) reside in at the time you received custody? \_\_\_\_\_  
 (If other than Circleville, assignment of tuition is required)

**Foster Agency:**

**Case Worker:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Father**  **Guardian**

Please Check One

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell: \_\_\_\_\_

Work: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

**Mother**  **Guardian**

Please Check One

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell: \_\_\_\_\_

Work: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

**REGISTRATION FORM**

Step-Mother (if applicable): \_\_\_\_\_  
Work Phone: \_\_\_\_\_  
Cell: \_\_\_\_\_

Step-Father (if applicable) \_\_\_\_\_  
Work Phone: \_\_\_\_\_  
Cell: \_\_\_\_\_

**Citizen Status of Student**

U.S. Citizen       Non-U.S. Citizen       Exchange Student

**Racial/Ethnic Group**

Is the student Hispanic or Latino?    Yes    No

What is the student's race? **You must choose at least one.**

White                                       American Indian or Alaskan Native                                       Asian  
 Black or African American                                       Native Hawaiian or Other Pacific Islander

**Language**

Native Language \_\_\_\_\_                                      Language spoken in the home \_\_\_\_\_

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**Special Services:**

Has your child been identified or received services for one of the following?   **(Please check all that apply)**

Individual Educational Plan (IEP)                                       504 Individualized Accommodation Plan  
 English as Second Language (ESL)

Has your child ever been identified as gifted?    Yes       No

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Is this student currently expelled or under suspension from any other school district?    Yes       No

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*I attest as evidenced by my signature below that all of the above information is correct to the best of my knowledge:*

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/ Guardian E-Mail: \_\_\_\_\_

**CIRCLEVILLE CITY SCHOOLS  
Residence Verification Form – Affidavit I**

I certify that I am a resident of the \_\_\_\_\_ *School District* at the following address:

Address: \_\_\_\_\_

City/Zip Code: \_\_\_\_\_

Date of Occupancy: \_\_\_\_\_

Verification of the above residence must be provided to school officials through **two** acceptable forms of documentation. Examples of acceptable forms of documentation include, but are not limited to the following:

- Official Rental/Lease Agreement
- Mortgage Coupon/Closing
- Property Tax Statement
- Settlement Statement of purchase
- Current Utility Bill *\*only one utility bill will be accepted for documentation\**
- Ohio Driver’s License or State issued ID
- Other \_\_\_\_\_

**Special Circumstances**

Applicant resides with another person. The person with whom you are living with **MUST COMPLETE THE RESIDENCE VERIFICATION AFFIDAVIT II FORM** and **HAVE IT NOTARIZED**. They **MUST ALSO PROVIDE PROOF OF RESIDENCY** to school officials through **two** acceptable forms of documentation. Acceptable forms of documentation include but are not limited to the examples above.

Please list other children enrolled with Circleville City Schools:

<b>Student(s)</b>	<b>Date of Birth</b>	<b>Grade</b>

I further certify that the above information is true and accurate. I understand that if residency at any time is verified to be false that immediate withdrawal can occur.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Relationship to Child

\_\_\_\_\_  
Date

**CIRCLEVILLE CITY SCHOOLS**  
**Special Circumstances Verification Form Affidavit II**

*To be completed by the person(s) with which you claim to reside*

I, \_\_\_\_\_, being duly cautioned, do solemnly swear or affirm the following:

- 1. I am the owner or renter of the residence at

\_\_\_\_\_

in \_\_\_\_\_, Ohio located in the \_\_\_\_\_

School District.

- 2. The following individual(s) is/are living at my above stated residence and have so since the \_\_\_\_day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- 3. I acknowledge and understand that if the above information is not true and correct, that knowingly swearing of affirming the truth thereof constitutes criminal falsification, a violation of Ohio Revised Code Section 2921.13, a first degree misdemeanor, punishable by a maximum fine of \$1,000.00 and/or a maximum term of imprisonment of six months. Inaccurate and/or falsified information will result in immediate withdrawal of stated student(s) from Circleville City Schools.

- 4. Owner/renter of the above residence must provide two forms of proof of residency. ***See Affidavit I Special Circumstances.***

I agree that Circleville City Schools, if they deem necessary, has the right to investigate my residency. I agree to allow the release of ownership, rental, and utility information to a representative of Circleville City Schools.

Signature: \_\_\_\_\_  
(Property owner/Lessee)

Sworn to and ascribed in my presence this \_\_\_\_\_day of \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_  
Notary Public

Stamp or Seal

3/15



**CIRCLEVILLE CITY SCHOOLS  
EMERGENCY MEDICAL AUTHORIZATION FORM**

**NOTIFY THE SCHOOL OF ANY CHANGE IN PHONE OR EMERGENCY NUMBERS**

Student Name \_\_\_\_\_ School \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

**The following is required by section 3313.712 of the Ohio Revised Code.**

**Purpose** – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached. Only individuals listed on this form will be permitted to pick up a child upon providing proof of identification.

**Residential Parent or Guardian:**

Mother's Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Father's Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Other's Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_

**Name of Relative or Childcare Provider** \_\_\_\_\_

Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

**PART I OR II MUST BE COMPLETED**

**PART I – (TO GRANT CONSENT)**

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Medical Specialist \_\_\_\_\_ Phone \_\_\_\_\_

Local Hospital \_\_\_\_\_ Emergency Room Phone \_\_\_\_\_

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the above-named doctor, or, in the event the designated preferred physician is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. **This authorization DOES NOT cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity of such surgery, are obtained prior to the performance of such surgery.**

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

**PART II – (REFUSAL TO GRANT CONSENT)**

I do **NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

\_\_\_\_\_

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

SCHOOL: \_\_\_\_\_

STUDENT'S NAME: \_\_\_\_\_

**PARENTS/GUARDIANS:**

**PLEASE COMPLETE CONFIDENTIAL INFORMATION TO BE SHARED WITH TEACHING STAFF AND EMS IF NECESSARY – If an emergency situation occurs, every effort will be made to transport your child to the hospital of choice. But, if necessary, protocol of EMS personnel is to transport to the nearest hospital.**

1. Does your child have *asthma* diagnosed by a physician? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please list any treatments given or medication taken \_\_\_\_\_  
\_\_\_\_\_
2. Does your child have *allergies* (reactions to medications, foods, or insects) diagnosed by a physician? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please list the care or medication required \_\_\_\_\_  
\_\_\_\_\_
3. Does your child have *ADD or ADHD* diagnosed by a physician? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, and he/she takes medication, please list medication, amount, and time of administration \_\_\_\_\_  
\_\_\_\_\_
4. Does your child have a *seizure disorder* diagnosed by a physician? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, and he/she takes medication, please list medication, amount and time of administration \_\_\_\_\_  
\_\_\_\_\_
5. Does your child have a *cardiac (heart) defect* diagnosed by a physician? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please list any restrictions and medications, amount, and time of administration \_\_\_\_\_  
\_\_\_\_\_
6. Does your child have a *bleeding disorder/tendency* diagnosed by a physician? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please give diagnosis or description of problem \_\_\_\_\_  
\_\_\_\_\_
7. Does your child have *diabetes* diagnosed by a physician? Yes \_\_\_\_\_ No \_\_\_\_\_ Type \_\_\_\_\_  
If Type 1, please list insulin pen/insulin pump and time glucose is checked or insulin is given \_\_\_\_\_  
\_\_\_\_\_
8. Does your child have *vision/hearing impairment*? Yes \_\_\_\_\_ No \_\_\_\_\_  
Wear glasses, contact lenses, or hearing aid(s)/auditory device? \_\_\_\_\_  
\_\_\_\_\_
9. Any other pertinent medical information or medications being given that could affect your child while in school \_\_\_\_\_  
\_\_\_\_\_

## AUTHORIZATION TO DISCLOSE IMMUNIZATION INFORMATION

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_\_

I, \_\_\_\_\_ as the **parent or guardian** of the above named child, hereby authorize  
(name of doctor(s)) \_\_\_\_\_

to disclose the specific and individually identifiable immunization records of the above named child to ***Circleville City Schools*** for the specific purpose of presenting written evidence, satisfactory to the person in charge of admission, that the above named child has been immunized by a method of immunization approved by the Department of Health as required by section 3313.671 of the Ohio Revised Code.

This authorization will expire upon the presentation of written evidence sufficient to comply with section 3313.671 of the Ohio Revised Code or for the period of time needed to fulfill its purpose. I also understand that I may revoke this authorization, in writing, at any time and that I may be asked to sign the *Revocation Section*. I further understand that any action taken by the above named Provider(s) or School in accordance to this authorization prior to it being revoked is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information unless otherwise provided for by state or federal law. **Please note: medical records provided to schools that receive federal funding are protected by the Family Education Rights and Privacy Act (FERPA).**

I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given.

**I also understand that my refusal to sign this authorization may prevent the school from verifying that the above named child has been immunized. I further understand that if the school cannot verify and I cannot provide satisfactory written evidence that the above named child has been immunized the child may be excluded from school pursuant to section 3313.671 of the Ohio Revised Code.**

I further understand that I may request a copy of this signed authorization.

\_\_\_\_\_  
(Signature of Personal Representative)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Relationship/ Authority)

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Note: *This Authorization was revoked on:* \_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Staff)

## AUTHORIZATION TO DISCLOSE IMMUNIZATION INFORMATION

*Fill out this section if you do not want the school to contact your health care provider.*

### REVOCAION SECTION

I do hereby request that this authorization to disclose health information of \_\_\_\_\_  
*(Name of Child/Patient)*

signed by \_\_\_\_\_ on \_\_\_\_\_  
*(Name of person who signed authorization) (Date of Signature)*

be rescinded, effective \_\_\_\_\_.  
*(Date)*

I understand that any action taken by the named Provider(s) or School in accordance to this authorization prior to the revocation date is legal and binding.

\_\_\_\_\_  
*(Signature of Client/Patient)*

\_\_\_\_\_  
*(Date)*

\_\_\_\_\_  
*(Signature of Witness)*

\_\_\_\_\_  
*(Date)*

\_\_\_\_\_  
*(Signature of Personal Representative)*

\_\_\_\_\_  
*(Date)*

\_\_\_\_\_  
*(Relationship/ Authority)*

N52-04

## CIRCLEVILLE CITY SCHOOLS

Circleville, Ohio 43113

### Parent Authorization for Release of Confidential Information

<b>Student's Name</b>	<b>Grade</b>	<b>Date of Birth</b>
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I hereby request and authorize that confidential information concerning my child be released to:

<b>Student Services Department</b> 100 Tiger Drive Circleville, Ohio 43113 740.477.6663 Fax: 740.477.6681	<b>Circleville District Office</b> 388 Clark Drive Circleville, Ohio 43113 740.474.4340 Fax: 740.474.6600	<b>Circleville Elementary</b> 100 Tiger Drive Circleville, Ohio 43113 740.474.2495 Fax: 740.477.6681	<b>Circleville Middle School</b> 360 Clark Drive Circleville, Ohio 43113 740.474.2345 Fax: 740.477.6684	<b>Circleville High School</b> Guidance Department 380 Clark Drive Circleville, Ohio 43113 740.477.5553 Fax: 740.477.5571
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Date Mailed: \_\_\_\_\_

Date Faxed: \_\_\_\_\_

Has your child been identified or received services for one of the following? Please check below.

**DISTRICT IRN # 043760**

**Records to be released should include those that apply to student:**

Attendance/ Academic Records (Assessment Data, Grading Scale, etc.)  
Special Education Documents (ETR/MFE, IEP, Reports, Diagnostics, etc.)  
General Education Documents (504 Plans)  
ESL, Gifted Education, SSID

	<b>Special Education and Related Services (ETR/IEP)</b>
	<b>Gifted Education (WEP)</b>
	<b>504 Plan (Accommodation in General Education Setting)</b>
	<b>ESL (English as Second Language)</b>
	<b>NOT APPLICABLE</b>

**COMPLETE THE FOLLOWING INFORMATION ABOUT THE LAST SCHOOL ATTENDED:**

<b>School Name</b>			
<b>School Address</b>			
<b>City</b>		<b>State</b>	
<b>School Phone</b>		<b>School Fax</b>	

**LAST DATE OF ATTENDANCE:** \_\_\_\_\_

**Reason for Request**

	<b>Child has moved into Circleville City School District</b>
	<b>My child has been accepted at Circleville City Schools under Open Enrollment</b>
	<b>Child is COURT PLACED in Circleville City School District</b>

**Parent/Guardian Name PRINTED:** \_\_\_\_\_

**Parent/ Guardian Signature:** \_\_\_\_\_

**Parent/ Guardian Current Address:** \_\_\_\_\_

**SPEECH, HEARING AND LANGUAGE SUMMARY**  
**KINDERGARTEN SCREENING**  
**For Kindergarten Registration Only**

Child's Name: \_\_\_\_\_

Please check those statements, which apply to your child:

- I am worried about my child's speech or language skills.
- My child has a history of hearing problems (tubes, frequent earaches).
- My child has difficulty following directions or answering questions.
- My child has difficulty using complete sentences. Example: Me going school.
- My child has difficulty pronouncing certain sounds: Example: poon for spoon or tat for cat.
- My child has had speech therapy at:

◇ Head Start

◇ Summer Clinic

◇ Other \_\_\_\_\_

- I am interested in talking with a speech therapist about my child's speech.
- Any other information the speech therapist may need to know:

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