South Central Calhoun Schools
4-year-old Preschool
2019-2020

Program Facts:

Students must be four-years-old on or before September 15, 2019.

Students must be potty-trained.

Classes meet at both the SCC High School in Lake City and the SCC Elementary School in Rockwell City.

Students attend for 4 days a week (M, T, Th, F).

Morning classes meet from 8:20-11:20 in Lake City and 8:00-11:00 in Rockwell City. Afternoon classes meet from 12:45-3:45 in Lake City and 12:15-3:15 in Rockwell City. Students who eat school meals will come earlier and stay later.

Breakfast and lunch are available only for students who are funded by Head Start. Students who eat breakfast and/or lunch at school must eat school meals. Bringing something from home is not permitted.

There is no tuition. Students are funded either by Head Start or by the State.

Transportation is provided for students who live outside the city limits of the attendance center or who choose to ride to/from an existing in-town stop.
Registration Checklist for 4-year-olds:

☐ Complete the enrollment form and return it to either school building by April 15.

☐ Turn in a copy of your child’s birth certificate if he/she hasn’t previously attended at SCC.

☐ Turn in proof of a recent physical if not already on file at school. The physical must have been within the last calendar year. Please ask your physician to use the form provided. *

☐ Turn in proof of a recent dental screening on the provided form. The screening must have been within the last calendar year, and the form must be turned in prior to the first day of school. *

☐ Provide a valid certificate of immunization with up-to-date immunizations as required by Iowa schedule. *

☐ Turn in the “Diet Modification Request” form only if your child will be eating breakfast or lunch at school and has a known food allergy.

☐ Families of students who are funded by Head Start will have additional paperwork to complete with the Head Start Family Advocate.

☐ You will receive a letter in May verifying your child’s enrollment and assigned section.

☐ Attend school registration in August. Dates, times, and locations will be published.

* No child will be allowed to start preschool in the fall without a physical form, dental form, and immunization record on file at the school. Please make your appointments accordingly.
South Central Calhoun Schools
Registration & Emergency Information Form

Please List All Students (full names) Oldest to Youngest:

1. ___________________________ Grade: ___ Birth Date: ___ M/F Race: __________
2. ___________________________ Grade: ___ Birth Date: ___ M/F Race: __________
3. ___________________________ Grade: ___ Birth Date: ___ M/F Race: __________
4. ___________________________ Grade: ___ Birth Date: ___ M/F Race: __________
5. ___________________________ Grade: ___ Birth Date: ___ M/F Race: __________

Home Phone #: ____________________________

Primary Language: __________

Address: ____________________________

County: __________

Email Address: ____________________________

Father’s name: ____________________________ Mother’s name: ____________________________ (H.S. Only)
Father’s Cell #: ____________________________ Mother’s Cell #: ____________________________ Student’s Cell #: ____________________________
Father’s Employer: ____________________________ Mother’s Employer: ____________________________ Student’s Employer: ____________________________
Father’s Work #: ____________________________ Mother’s Work #: ____________________________ Student’s Work #: ____________________________

In Case of an Emergency and YOU cannot be reached - CONTACT: Name ____________________________ Phone # ____________________________

If there is another adult in your household who has your permission to act as a parent’s authority for your child, please provide information.

Name: ____________________________ Cell #: ____________________________ Work #: ____________________________

If the family has experienced a separation or divorce, please complete this section:

Provide the parent’s name and address if the school is expected to mail school information to the parent.

Name: ____________________________ Has there been a court order that limits the contact this parent may have with the child, or that restricts parental rights? Yes __ No __
Address: ____________________________
City, State, Zip: ____________________________ If yes, please provide a copy of the court document to be placed in student’s cum. folder.

Signature of Parent/Guardian: ____________________________ Date: ____________________________
South Central Calhoun
HOME LANGUAGE SURVEY

Student Name: ____________________________ Birth Date: ________________ Sex: □ Male □ Female

Parent/Guardian Name: ______________________

Address: __________________________________________________________

Home Telephone: __________________________ Work Telephone: ____________

School: __________________________ Grade: ____________ Date: ____________

1. Was your child born in the United States?
   If yes, in which state?
   If no, in what other country?

2. Has your child attended any school in the United States for any three years during their lifetime?
   If yes, please provide school name(s), state, and dates attended:
   Name of School __________________________________________________________
   Name of School __________________________________________________________
   Name of School __________________________________________________________

   State ______ Dates Attended ______
   State ______ Dates Attended ______
   State ______ Dates Attended ______

3. What language is spoken by you and your family most of the time at home?

4. If available, in what language would you prefer to receive communication from the school?

5. Is your child's first-learned or home language anything other than English? □ Yes □ No

If you responded "Yes" to question number 5 above, please answer the following questions:

6. What language did your child learn when he/she first began to talk?

7. What language does your child most frequently speak at home?
   (Father) __________________________________________________________
   (Mother) __________________________________________________________

8. What language do you most frequently speak to your child?

9. Please describe the language understood by your child. (Check only one)
   A. □ Understands only the home language and no English.
   B. □ Understands mostly the home language and some English.
   C. □ Understands the home language and English equally.
   D. □ Understands mostly English and some of the home language.
   E. □ Understands only English.

__________________________________________ Date ___________________________
Parent or Guardian's Signature

OFFICE USE ONLY

Student ID # Date Distributed Date Received

© 2013 Trans/ACT Communications, Inc.
South Central Calhoun
Student Race and Ethnicity Reporting

Student Name: ___________________________ Date Form Completed: ________________________

Date of Birth: ___________________________ ☐ Male ☐ Female

Person Completing This Form: ☐ Parent/Guardian ☐ Student ☐ Other: __________________________

The U.S. Department of Education has implemented new standards for school districts to report student race and ethnicity. Your answers to the following will be held strictly confidential and data will be used only in the aggregate.

1. Is your child of Hispanic, Latino, or Spanish ethnicity: ☐ Yes ☐ No
   Includes persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin.

2. Racial Categories:

   ☐ American Indian or Alaska Native
     Origins in any of the original peoples of North, Central, and South America who maintain a tribal affiliation or community attachment.

   ☐ Asian
     Origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent for example Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, Philippine Islands, Thailand, and Vietnam.

   ☐ Black or African American
     Origins in any of the black racial groups of Africa

   ☐ Native Hawaiian or Other Pacific Islander
     Origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

   ☐ White
     Origins in any of the original peoples of Europe, the Middle East, or North Africa.

Please complete the entire form and return it to:

Name: ___________________________ Phone Number: ___________________________

Address: ___________________________ City: ___________________________ State: ____________ Zip: ___________

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232837
Student Health Registration Form

Student Legal Last Name: ____________________________
First Name: ____________________________
Gender: ____________________________
Birthdate: ____________________________
Home Phone: ____________________________
Grade: ____________________________

Student Primary Address: ____________________________
City, State, Zip Code: ____________________________
County: ____________________________
School Building: ____________________________

Please contact your school nurse if your student has any health concerns that need to be addressed in the school setting.

Medical History
Is your child currently being treated for any of the following? Please check all that apply.

- Asthma/Reactive Airway
- Seizure Disorder
- Diabetes
- Bone/muscle disease
- Heart Condition
- Mental health condition (e.g., depression, anxiety, eating disorder)
- Bleeding Disorder
- Skin Condition
- Pregnancy
- ADD/ADHD
- Physical disability
- Other

Does your child experience any of the following?

- nose bleeds
- frequent earaches
- overweight for age
- physical disability
- poor appetite
- frequent stomachaches
- frequent headaches
- fainting spells
- tires easily
- underweight for age
- learning disability
- other

Allergies
Is your child allergic to anything? ______ Yes ______ NO If yes, please check all that apply.

- Food (list what types of food)
- Medicine (list what types of medicine)
- Other

Describe what happens when your child has an allergic reaction:

Does your child need an Epi-Pen at school? ______ Yes ______ No If yes, the parent is required to supply school with an Epi-Pen

Hearing/Vision
Do you have concerns about our child’s hearing? ______ Yes ______ No Does your child wear hearing aides? ______ Yes ______ No

Do you have concerns about your child’s vision? ______ Yes ______ No Does your child wear glasses or contacts? ______ Yes ______ No

Medication
Please list all of your student’s medications.

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Time medication is given</th>
<th>Reason for medication</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

Over-the-counter Medication
Do you want your child to receive over-the-counter medication at school? ______ Yes ______ No If no, continue to Insurance section

If yes, please check which medications you want your child to receive:

- Acetaminophen (Tylenol) and/or Ibuprofen (Advil, Motrin)

If your child cannot have Ibuprofen or Tylenol please specify: ____________________________

Parent’s Signature: ____________________________ Date Signed: ____________________________
A total of 10 doses of over-the-counter medication will be given per year unless there is an order from a physician.

Insurance

Does your child have health insurance? ______ Yes ______ No If yes, please check one that applies:

- Private Provider ____________________________
- Medicaid # ____________________________

Immunizations: What, if any, immunizations did your child receive in the last year?

In case of emergency:

Contact #1: Parent ____________________________ Phone Number(s) ____________________________
Contact #2: Name ____________________________ Phone Number ____________________________ Relationship ____________________________

Emergency Release
I give permission to the appropriate personnel of the South Central Calhoun Community Schools to secure and authorize emergency medical care and treatment for my child that in their judgment is necessary in the best interest of my child while under their supervision. I also agree to assume and pay for the fees for the emergency medical treatment as authorized in this statement. I understand that this health information sheet is confidential but the information will be shared with other South Central Calhoun personnel as needed.

Parent/Guardian Signature: ____________________________ Date Signed: ____________________________
SOUTH CENTRAL CALHOUN COMMUNITY SCHOOL DISTRICT
Student-Parent Acknowledgement
Effective: 2019-20 School Year and summer months of June, July, August 2020

HANDBOOKS (PS/Elementary, Middle School, High School)
Located on our website: www.scc.k12.ia.us or available from school offices

I hereby acknowledge that I have read the Parent/Student Handbook and understand its contents. I understand all the rules and regulations governing the school through this handbook (including transportation conduct and consequences and acceptable usage policy for technology).

<table>
<thead>
<tr>
<th>(Signature of Student)</th>
<th>(Date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Signature of Parent)</td>
<td>(Date)</td>
</tr>
</tbody>
</table>

I give my permission for the following:

Field Trips: Yes No
Internet Usage: Yes No
For H.S. Students ONLY
Open Campus Privileges: Yes No
(9th Hour Only If Earned)

Photos: Yes No (for media coverage/website)
Directory Info: Yes No (names & contact info released to public for awards, programs, colleges, addresses for birthdays, graduation invites, etc.)

| (Signature of Parent) | (Date) |

ELIGIBILITY (For 7th-12th Grade Students Only)
(Good Conduct Rule/Scholarship Rule)

I hereby acknowledge and understand that the District’s Good Conduct Policy is available on the school’s website or by requesting a copy from the school office. I understand it is my responsibility to read the rules and regulations as expressed in the Parent/Student Handbook eligibility code section, and that I agree to adhere to these rules to the best of my own ability. I further understand the penalty involved for any act in violation of this eligibility code.

| (Signature of Student) | (Date) |
| (Signature of Parent)  | (Date) |
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)

<table>
<thead>
<tr>
<th>Student Last Name:</th>
<th>Student First Name:</th>
<th>Birth Date (M/D/YYYY):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Parent or Guardian Name:</th>
<th>Telephone (home or mobile):</th>
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</table>

<table>
<thead>
<tr>
<th>Street Address:</th>
<th>City:</th>
<th>County:</th>
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</table>

<table>
<thead>
<tr>
<th>Name of Elementary or High School:</th>
<th>Grade Level:</th>
<th>Gender:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>□ Male □ Female</td>
</tr>
</tbody>
</table>

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 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/nhrds/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 Child Care Infant, Toddler, Preschool Age – Child Health Exam Form

HEALTH PROFESSIONAL COMPLETE THIS PAGE
Child's Name: ____________________________

Birthdate: ____________________________
Date of Exam: ____________________________
Height/Length: ____________________________
Weight: ____________________________
Head Circumference—for children age 2 yr and under:
Blood Pressure-start @ age 3 yr:
Hgb or Hct—anytime between 6-9 mo:
Blood Lead Level-start @ 12 mo:

Sensory Screening:
Vision: Right eye _______ Left eye _______
Hearing: Right ear _______ Left ear _______
Tympanometry (may attach results)

Developmental Screening:
Developmental screening results:
Autism screening results:
Psychosocial/behavioral results
Developmental Referral Made Today: □ Yes □ No

Exam Results: (n = normal limits) otherwise describe
HEENT
Oral/Teeth
Oral Health/Dental Referral Made Today: □ Yes □ No
Heart
Lungs
Stomach/Abdomen
Genitalia
Extremities, Joints, Muscles, Spine
Skin, Lymph Nodes
Neurological

Allergies
Environmental: ____________________________
Medication: ____________________________
Food: ____________________________
Insects: ____________________________
Other: ____________________________

Immunization: May attach a copy of Iowa Department of Public Health Immunization Certificate
DtaP/DTP/Td MMR
Hepatitis B Pneumococcal
HIB Varicella
Polio Other
Influenza
TB testing (only for high-risk child)

Medication: Health professional authorizes the child may receive the following medications while at child care or preschool: (include over-the-counter and prescribed)

Medication Name
☐ Cough medication
☐ Diaper crème:
☐ Fever or Pain reliever:
☐ Sunscreen:
☐ Other:

Other Medication should be listed with written instructions for use in child care.

Referrals made:
☐ Referred to hawk-i today 1-800-257-8563
☐ Other: ____________________________

Health Provider Assessment Statement:
☐ The child may participate in developmentally appropriate child care/preschool with NO health-related restrictions.
☐ The child may participate in developmentally appropriate child care/preschool with the following restrictions:

Signature ____________________________

Circle the Provider Credential Type: MD DO PA ARNP

Address ____________________________

Expiration ____________________________

 spacing is available on back page for detailed comments or instructions pertaining to enrollment at child care or preschool.

1 Iowa Child Care Regulations require an admission physical exam report within the previous year. Annually thereafter, a statement of health condition signed by an approved health care provider. The American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (RE9936, March 2000) www.aap.org
2 Developmental screening procedures were expanded to include autism, developmental surveillance, and psychosocial/behavioral screening July 2006 by the Iowa EPSDT Medicaid program. Toll-free 800-383-3826.