

DANBURY LOCAL SCHOOL DISTRICT

9451 E. Harbor Rd.
Marblehead, Ohio 43440
Telephone: 419-798-4081

Please complete and return the Pre-K registration packet to Danbury Local School's elementary office as soon as possible. Please bring your child's original birth certificate, immunization records and custody papers (if applicable) at the time of registration. The Physical form will need to be completed by your child's physician and returned to the office on or before the first day of school.

Please register early to reserve your space as classes fill up quickly.

No student will be enrolled without proper documentation.

You will receive a letter in late August with more information. This letter will include your Roundup appointment date and time.

18/19 Preschool Roundup: September 5 and 6, 2018.

18/19 Preschool first day: September 10, 2018.

If you have any questions, please feel free to call 419-798-4081.

PRE-KINDERGARTEN REGISTRATION FORM

4 YEAR OLD PRESCHOOL
(MUST BE 4 BY AUGUST 1st)

3 YEAR OLD PRESCHOOL
(MUST BE 3 BY AUGUST 1st)

What session would you prefer? AM PM
(We can not guarantee your choice)

(Please Print)

Today's Date _____

Child's name exactly as it appears on birth certificate including the full middle name:

First Middle Last

City and State that child was born in _____

Child's Birth Date _____ Sex: Male Female

How do you want your child's name to appear in the classroom on papers, name tags, labels, etc.
(Example: Billy in place of William) _____

Child's Address _____

City _____ State _____

Child's Home Telephone Number _____

Father's name _____
(From student's Birth Certificate-Do not list step-parent)

Mother's name _____
(From student's Birth Certificate -Do not list step-parent)

Father's address _____

Mother's address _____

City _____ St/Zip _____

City _____ St/Zip _____

Father's telephone #
Home _____ Work _____

Mother's telephone #
Home _____ Work _____

Parent's Marital Status: Never married Married Separated Divorced

Do you have custody papers? Yes No Custody in Process

Parent/Guardian Name(s) with whom the child lives _____
First and last names (Do not list stepparents)

- _____ - Parents
- _____ - Grandparents
- _____ - Guardian
- _____ - Mother (if student is living with mother only)
- _____ - Father (if student is living with father only)
- _____ - Court (if student has been placed by the court)

Please choose one of the following:

- A – Active Duty – Student is a dependent of a member of the Active Duty Forces (Army, Navy, Air Force, Marine Corps, or Coast Guard)
- B – Student is a dependent of a member of the National Guard (Army National Guard or Air National Guard)
- C – Student is a dependent of a member of the Military Reserve
- Not Applicable (Not a Military Student)

Ethnic: Please circle one

W –White B-Black H-Hispanic A-Asian or Pacific Islander I-American Indian or Alaskan Native M-Multi Racial

Child’s native language _____ Parent’s native language _____

Is there another language spoken in the home? Yes No
(If yes, what is the language?) _____

Has your child been served by any of the following Programs?

Special Education Yes No

Speech and Hearing Yes No

If yes, please explain: _____

Is your child toilet trained? Yes No

Can your child perform proper hygiene practices without assistance? Yes No

How often does your child have toileting accidents? Never Seldom Often

Is there a stepparent (a person to whom you are married) that your child lives with at the child’s address? Yes No

If yes, what is the stepparent’s name? _____

May we contact you by e-mail? Yes No

If yes, what is your e-mail address: _____

I wish to be included on the classroom roster _____

Do not include me/my child on the classroom roster _____

Parent’s Signature

DANBURY LOCAL SCHOOLS

RE: CUSTODY PAPERS

This statement is in regards to my child who is a student at Danbury Local Schools.

_____ Child lives with both parents listed on birth certificate and so custody is not applicable. We are married_____ We are not married_____

_____ Parents are divorced, we have custody papers.

_____ No father is listed on the birth certificate.

_____ I am the child's mother and was not married at the time of the child's birth and so custody is not applicable.

_____ My spouse and I are not living together, but there has been no legal action started that could result in custody being awarded to the other spouse.

_____ Separation (divorce, dissolution, etc.) action has been started, but no final decree has been rendered. I will bring in a copy of the papers once they are complete.

_____ Child does not live with either parent. I am the child's legal guardian and I have custody papers.

Parent/Guardian Name/Signature_____

Student's Name _____

Date _____

HEALTH INFORMATION

DATE _____

CHILD'S NAME _____ DATE OF BIRTH _____

FAMILY HISTORY Please list this child's brothers and sisters:

Name _____	Birth date _____	Sex _____
Name _____	Birth date _____	Sex _____
Name _____	Birth date _____	Sex _____
Name _____	Birth date _____	Sex _____

HEALTH HISTORY Please check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Allergies or hay fever
<input type="checkbox"/> Bedwetting
<input type="checkbox"/> Behavior problem
<input type="checkbox"/> Birth or congenital malformation
<input type="checkbox"/> Chicken pox
<input type="checkbox"/> Chronic diarrhea or constipation
<input type="checkbox"/> Eye problems, poor vision
<input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Frequent sore throat infections
<input type="checkbox"/> Multiple ear infections (3 or more)
<input type="checkbox"/> Poor hearing
<input type="checkbox"/> Seizures or epilepsy
<input type="checkbox"/> Stool soiling of undergarments
<input type="checkbox"/> Toothaches or dental infections
<input type="checkbox"/> Urinary tract infection
<input type="checkbox"/> Wetting pants during the day |
|--|--|

ALLERGIES: Please list and describe all allergies or reactions to:

Medicines/drugs _____
 Foods/plants/animals/other _____
 Recommended treatment of allergy is severe _____

INJURIES AND ILLNESSES: Please list any severe injuries or illnesses:

Injuries/Illnesses	Age of Child	Hospitalized
_____	_____	Y N
_____	_____	Y N
_____	_____	Y N
_____	_____	Y N

ADDITIONAL INFORMATION:

What medications are given daily? _____

What medications are given frequently, but not daily? _____

This child is usually: Very Active Normally Active Rather inactive

Do you have any concern about how your child gets along with other children?:

Do you have other comments or concerns about this child's health, development, behavior, family or home life that you would like the school to be aware of? If yes, explain briefly _____

FOOD ALLERGY TREATMENT

STUDENT NAME _____ BIRTHDATE _____

SCHOOL _____ GRADE _____

The above student is allergic to the following food(s):

These foods and foods containing these substances must be avoided in order to prevent a serious reaction. The following specific instructions are given to assist you in providing emergency care as needed during school hours.

To control reactions, these are prescribed:

_____ EPI PEN _____ BENEDRYL OR _____ ATARAX DOSAGE _____ OTHER _____

The above medication(s) are to be given:

_____ IMMEDIATELY (do not wait for symptoms)

AFTER THE FOLLOWING SYMPTOMS OCCUR:

- | | |
|-----------------------------|------------------------------------|
| _____ APPREHENSION | _____ FLUSHING |
| _____ SNEEZING/COUGHING | _____ ITCHING/BURNING SKIN |
| _____ HIVES | _____ WHEEZING/SHORTNESS OF BREATH |
| _____ LOSS OF COLOR | _____ TURNING BLUE |
| _____ LOSS OF CONSCIOUSNESS | _____ DROWSINESS |

_____ OTHER SYMPTOMS: _____

PHYSICIAN'S SIGNATURE _____ DATE _____ PHONE _____

PARENT'S SIGNATURE _____ PHONE _____

IF NO ALLERGIES, PLEASE WRITE N/A AND SIGN BELOW

PARENT SIGNATURE _____

Physical/Immunization

Child's

This is to certify all of the following:

- I have examined this child and found that he or she is in suitable condition for participation in a school setting.
- The child has had the age appropriate immunizations recommended by the Ohio Department of Health.
- My office has entered the child's immunizations record below or attached a printed record of the immunizations or found that this child should be exempt from immunizations for the following reasons: _____

List any physical, developmental or behavioral issues or health conditions for this child (including allergies, daily medication, dietary restrictions): _____

Recommended Immunizations (enter mm/dd/yyyy)	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Vaccines					
*Diphtheria, Tetanus, Pertussis (DTaP)					
*Hepatitis B (Hep B)					
Haemophilus Influenza type b (HIB)					
*Measles, Mumps, Rubella (MMR)					
*Inactivated Polio					
*Varicella (chicken pox)					
Influenza					
Pneumococcal Conjugate (PCV)					
Rotavirus					
Hepatitis A					
Other					

The immunizations above are recommended by the Centers for Disease Control and Prevention and the Ohio Department of Health.

*Required for Public School Enrollment

Recommended Assessments/Screenings:

Vision: Yes No Date: _____ Hearing: Yes No Date: _____
 Dental: Yes No Date: _____ Lead: Yes No Date: _____
 BMI: Yes No Date: _____ Other: _____

Signature of examining Physician/Physician's Assistant/Advanced Practice Nurse	Date of Examination
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Name of Physician/Physician's Assistant/Advanced Practice Nurse

Telephone Number

Street Address

City, State, Zip Code

IT IS REQUIRED THAT THIS EXAM BE GIVEN NO MORE THAN 12 MONTHS PRIOR TO THE DATE OF ADMISSION

Date: _____

I _____ give the following persons permission to pick up my child, _____, from Danbury Elementary Pre-K School for the current school year, 2017-2018. Please provide the name and phone number for each person allowed to pick-up your child.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Parent Signature