Monticello Community Schools
Shannon Elementary / Carpenter Elementary
321 W. South St. / 615 N. Gill St., Monticello, IA 52310
(319) 465-3000

January, 2019

Dear Parents and Guardians,

Thank you for participating in Kindergarten Roundup. Kindergarten Roundup is an important series of events that helps ensure a smooth transition for our incoming kindergarten class. This yearly process is made up of three parts: 1.) Pre-registration, 2.) Hearing, Vision, and Preacademic Checks, and 3.) Parent-Student Night. All of these events take place at Shannon Elementary School.

Pre-registration (January 3-31, 2019) involves the exchange of important information and required medical forms. The Medical Exam Form, Immunization Card and Dental Exam Form will be handed out at this time. **According to Iowa law, we must have all of these completed medical forms on school file prior to your child attending school.** ***The completed Immunization form is due by May 1, 2019,** the Dental and Physical can be returned at Registration in August or the first day of school (at the latest). You may mail the completed forms to Sandy Hinrichs (school secretary) at Shannon Elementary School, or you may drop them off to her during school hours. If you have any questions regarding the medical forms, please call our school nurse, Jen Speltz at ext. 1327. (Please note that the Kindergarten Roundup Pre-registration does not take the place of the Monticello Community School District registration in August.)

New incoming Kindergarten Students will also need:
Proof of Age: Birth certificate or hospital certificate of birth, baptismal record, signed physician's statement showing date of birth
Proof of Residency: Utility bill, rental agreement, etc. (something that shows your current address and that you live within our district boundary)

Hearing, Vision, and Pre-academic Checks (**April 9, 2019)** provides Grant Wood Area Education Agency staff and Monticello CSD staff an opportunity to check students' hearing, vision, and pre-academic skills. Additional information (including an appointment time) will be mailed to you prior to this event. (Please note: The purpose of these checks is to provide information… not to determine readiness for kindergarten.)

Parent-Student Night (**May 7, 2019)** is an event that allows children and their parents to meet staff and explore the building. Please feel free to contact the teachers or me to learn more about our kindergarten program - or better yet, we could arrange for you to visit a kindergarten classroom. Please call the school office if you would like to arrange a classroom visit.

As you can see, Kindergarten Roundup allows families and school personnel to prepare for the following school year. The more accurate our numbers are, the better we can prepare. Therefore, if you are aware of someone with a child who will turn five on or before September 15, please encourage them to contact Shannon Elementary School.

For more information and copies of required forms, please visit our district web site: www.monticello.k12.ia.us, and click on Kindergarten Roundup and Registration Info.

Sincerely,

Denny Folken
Elementary Principal

Frequently Asked Questions by Kindergarten Parents

Q: Is my son or daughter ready for Kindergarten?

A: Our school staff tries to be ready for your son or daughter. We know that Kindergarten students come into our school with a variety of skills, past experiences and different stages of development. We try to meet these needs at a variety of levels and do our best to teach your son or daughter at his or her level - whatever that may be. It is very normal for kids to develop at different levels, but most often children "level out" after one or two years of instruction. We also have several programs in place that help students who are struggling or achieving at high levels. If you have any specific questions or concerns, please contact Mr. Folken, Mrs. Hospodarsky, or one of the Kindergarten or Multiage teachers.

Q: How will my son or daughter get to and from school?

A: If your child will ride a bus to school, bus routes will be handed out at Registration time in the Fall. The first few days of school, several adults will be at pick up and drop off sites to ensure your child does get to where they need to go. If your child lives in town, you can drop them off or they may walk to school. Again, adults will always be outside at 7:50 in the morning to watch children as they cross the streets. Shuttle buses will also be available at each of the school sites so that students simply can walk to the closest school and ride a shuttle bus to Shannon. Arrival and departure times will be available at registration.

Q: What if my child still takes a nap?

A: Again, teachers make every attempt to meet all students needs. As with all of us, it takes time to develop habits. At the beginning of the year, more time will be devoted to play and rest. As the year progresses students will start to do more academic tasks.

Q: Does my child need to know how to tie his or her shoes, letters of the alphabet, address and phone number, etc.?

A: No. It is great if your child knows those things, but those skills are not necessary to enter Kindergarten. Those skills will be taught or reinforced during the school year.

Q: What if my son or daughter gets sick at school and I work?

A: Our school nurse or building secretary will call parents/guardians or emergency contacts if your child is injured and needs to be seen by a doctor, is running a fever or has vomited. Otherwise, we try to keep the students in school. Of course, if parents/guardians cannot by reached we will seek medical help when necessary. At registration time, you will fill out E-Registration with Emergency Contact, doctor or a hospital of your choice for your child.

Q: What will my Kindergartener be working on throughout the school year

A: Kindergarten students work on a variety of early reading and math skills to include letter sounds, sight words, counting, and number sense. Students also receive instruction in social skills, science, and social students.

If you have any further question, please call Mr. Folken, Mrs. Hospodarsky, or one of our teachers.

Thank you for coming today, and welcome to Shannon Elementary !!!!

MONTICELLO COMMUNITY SCHOOL DISTRICT

NEW STUDENT REGISTRATION FORM (please print)

Enrollment Fee: _____

Monticello School District now requires proof of age (copy of birth certificate, etc) and proof of residency (utility bill, etc.). Please present these documents when turning in registration forms. Thank you!

Name_____ Enrollment Grade _____ Age _____
Last First Middle

Address _____ Gender _____ Date of Birth_____
City State Zip Code

Student lives with (circle all that apply)
Mother Father Step Father Step Mother Guardian Self

Student information should be sent to (circle all that apply)
Mother Father Step Father Step Mother Guardian Self

FAMILY INFORMATION

FATHER Name _____ Phone _____ Cell _____

Address _____

Place of Employment/Phone _____

Email _____

MOTHER Name _____ Phone _____ Cell _____

Address _____

Place of Employment/Phone _____

Email _____

OTHER GUARDIAN (specify relationship) Name _____ Phone _____ Cell _____

Address _____

Place of Employment/Phone _____

List siblings (name & age) _____

EDUCATIONAL HISTORY

School Last Attended _____
School Name Address Phone

____ Yes, my child attended preschool in the year _____. Name of preschool _____
____ No, my child did not attend preschool.

Does your student have an IEP (Individual Education Plan)? YES NO

ETHNICITY

Was student born in the United States? YES NO If no, Country of Birth _____ Date entered US _____

Is your student Hispanic/Latino? YES NO

What is your student's race? _____ Asian _____Black/African American _____White

_____American Indian/Alaskan Native _____Pacific Islander/Native Hawaiian

EMERGENCY CONTACTS

This should be someone that will be able to care for your child if the event of illness or accident at school and you are unable to be reached. Please list the names and phone numbers (preferably someone living in your neighborhood and/or in the school district) that we could contact.

Name _____ Phone_____ Relationship _____

Name _____ Phone_____ Relationship _____

FOR OFFICE USE ONLY

Enrollment Date _____ Start Date _____ Student ID # _____ Locker _____

Monticello Community School Board Policy #501.1 *(Check off when received*):

_____ Proof of Age – copy of birth certificate, copy of hospital birth certificate, baptismal record, etc

_____ Proof of Residence – copy of utility bill, copy of rental agreement or any other proof of current address

MONTICELLO COMMUNITY SCHOOL DISTRICT

HEALTH INFORMATION FORM (please print)

Student Name _____

MEDICAL INFORMATION

Family Doctor: _____ Phone: _____ Last Physical: _____

Last Tetanus: _____ Hepatitis B Series: _____ Other immunizations: _____
(received this past year)

Dentist: _____ Phone: _____ Last Appointment: _____

Injuries or operations: _____ Date: _____

Insurance Information

Insurance Company: _____

ID #: _____ Plan/Group #: _____

Special Needs

Specialist: _____ Phone: _____ Last Appointment: _____

Health Diagnosis/Medical Alerts: _____
[Asthma, Diabetes, Seizures, ADD/ADHD, Other (explain)]

Special Diet: _____ Allergies: _____

Other needs: _____
[Glasses, Contacts, Orthodontics, Other (explain)]

Medications

Medications taken daily at school _____ At home _____
Any medication given at school including over-the counter (Tylenol, Ibuprofen, cough drops, etc) requires parent written authorization. Additional for daily medications are located in the nurse's office.

I give authorization for over-the-counter medication to be administered. _____
(Tylenol, Ibuprofen, cough drops, etc) Parent/Guardian Signature

Medical Injury

I give permission for my child, in case of an injury or emergency, to be given first aid treatment. YES NO

I give permissions for my child to be transported by ambulance to the hospital. My hospital choice: _____

Parent/Guardian Signature _____ Date _____

Grant Wood AEA

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? ❑ Yes ❑ No

   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? ❑ Yes ❑ No

   If yes, please provide school name(s), state, and dates attended:

   Name of School _____ State _____ Dates Attended _____

   Name of School _____ State _____ Dates Attended _____

   Name of School _____ 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. Please check if your child is:

   A. ❑ Native American Indian
   B. ❑ Alaska Native
   C. ❑ Native Pacific Islander
   D. ❑ Native U.S. Virgin Islander

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

If you responded "Yes" to question number 6 above, please answer the following questions:

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

8. What language does your child most frequently speak at home? _____

9. What language do you most frequently speak to your child? (Father) _____

   (Mother) _____

10. Please describe the language <u>understood by your child</u>. (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.

_____ Parent or Guardian's Signature

_____ Date

OFFICE USE ONLY			
Student ID #	Date Distributed	Date Received	

RACE/ETHNICITY

The Iowa Department of Education is requiring the following information be identified each year and kept on file for a period of three years.

The following two-part question should be answered through self-identification by parent(s).

In the event that a student and/or parent(s) refuses to identify an ethnicity and/or race, observer identification may be used as a last resort.

Is this student Hispanic/Latino? (Choose only one)

_____ **No, not Hispanic/Latino**

_____ **Yes, Hispanic/Latino** (A person of Cuban, Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race.)

What is the student's race? (Choose one or more)

_____ **American Indian or Alaska Native** (A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.)

_____ **Asian** (A person having origins in any of the original peoples of the Far East, Southeast, Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)

_____ **Black or African American** (A person having origins in any of the black racial groups of Africa.)

_____ **Native Hawaiian or Other Pacific Islander** (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)

_____ **White** (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

Student _____

Parent/Guardian Signature _____

Date _____

School District: _____ Date completed: _____

Migrant Education Parent Form

The answers to this form will help determine if your child (ren) is eligible to receive supplemental services from the Migrant Program.

Name of Parent(s) or Legal Guardian(s)		
Current Street Address:	Apt #	
City:	State:	Zip Code:
Phone Number:		
Best Time to be Contacted:		

1. Has your family moved in order to work in another city, country, or state in the last three (3) years YES___ NO____
2. If so, what date did your family move? _____
3. Has anyone in your family been involved in one of the following jobs, either full or part-time or temporarily during the last three (3) years? **Yes_____** **No_____**

(Check all that apply)

[ ] Meat Packing/Meat processing
[ ] Dairy/Poultry/Egg/Livestock
[ ] Agriculture; planting/picking fruits and vegetables
[ ] Planting, Growing, Detasseling or Farm labor
[ ] Processing/packing agricultural products
[ ] Fishing or fish farms
[ ] Other **(Please specify other agricultural job)**:_____

4. Name of student(s) Name of School Grade

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Thank you!

Please return this form to the school. Note for the school/district: When both "yes" to #1 and one or more of the boxes from #3 is/are checked, please give this form to the migrant liaison to scan and email to alex.johnson@iowa.gov. Please file original in student's records. For additional questions regarding this form, please contact Geri McMahon at 515-2813944 (geri.mcmahon@iowa.gov)

Spanish

Distrito Escolar: _____ Fecha completada: _____

Forma para Padres Programa de Educación Migrante

Las Respuestas en esta forma, ayudaran para la determinación en la elegibilidad de su niño(a) para recibir servicios suplementarios por parte del Programa de Educación Migrante.

Nombre de los Padres o Custodio Legal		
Dirección Residencial Ciudad:	Estado:	Código Postal:
Teléfono:		
Mejor Hora para llamar:		

1. ¿Se ha movido su familia para trabajar en otra ciudad, estado o país en los últimos 3 años?
   Si___ NO____
2. Si la respuesta es Sí, ¿Cuál es la fecha en que llegaron a la ciudad o pueblo? _____
3. ¿Alguien de su familia ha estado envuelto en los siguientes trabajos, ya sea tiempo completo, tiempo parcial o temporero en los últimos (3) años? (Marque todas las que apliquen)

   [ ] Agricultura; plantando/cosechando frutas o Vegetales
   [ ] Plantando, sembrando, espiga o labor de Rancho
   [ ] Procesando/Empaque de productos agrícolas
   [ ] Lecherías/Aves/Huevos/Ganadería o Marranos
   [ ] Empaque o Procesamiento de carne
   [ ] Pesca / Criando pescado
   [ ] Otra actividad (Por favor especifique trabajo en agricultura):_____

4. Nombre del estudiante(s) Nombre de la Escuela Grado

_____ _____ _____

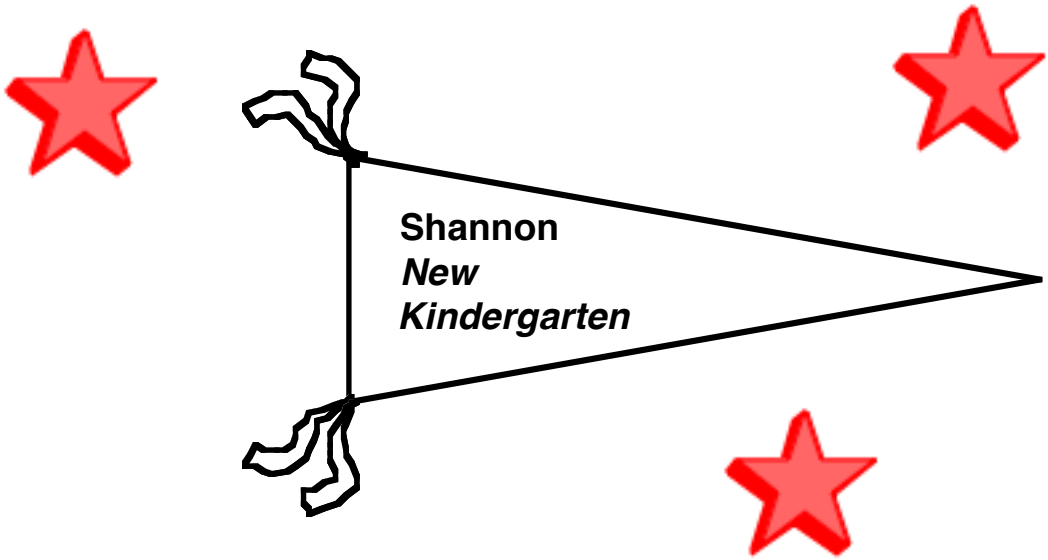
_____ _____ _____

_____ _____ _____

_____ _____ _____

Muchas Gracias!

Por favor regresar esta forma a la escuela. Note for the school/district: When both "yes" to #1 and one or more of the boxes from #3 is/are checked, please give this form to the migrant liaison to scan and email to alex.johnson@iowa.gov. Please file original in student's records. For additional questions regarding this form, please contact Geri McMahon at 515-2813944 (geri.mcmahon@iowa.gov) .



Dear Parents/Guardians,

Attached to this note you will find a **Medical Exam Form** with a copy of the **Immunization Card** printed on back of Medical Exam Form, also attached is a **Dental Form** for your child's dentist to fill out at their next appointment. The Medical Exam Form, Immunization Card, Vision C ard and Dental Form are being given to you now to allow more time for you to get your child to the doctor, and dentist. The doctor and dentist will know how to fill out each form. **We must have completed Immunization form by May 1, 2019 in order for your child to attend school.** The Dental & Physical can be returned at Registration in August, or the first day of school. When you have completed the forms you may either mail them to Sandy Hinrichs, Secretary, at Shannon Elementary School, drop them off during school hours or fax them to 319-465-3370.

****If there is a problem with completing the above exams by May 1, 2019, please call Jen Speltz, School Nurse at Shannon Elementary (319-465- 3000 ext. 1327).**

*** Please let us know on the back of this sheet any additional information regarding your child that the teacher or other personnel should be aware of (allergies, medications, significant developmental history, etc.) or email Jen Speltz at**
jennifer.speltz@monticello.k12.ia.us

Thank you for your cooperation in getting the medical records completed and turned in ASAP.
If you have any questions, please call our school nurse, Jen Speltz at 319-465-3000 (ext. 1327)

Kindergarten
Information to return to Shannon

- ☐ Home Language and Race Ethnicity Form Return by January.
- ☐ Student - Parent Information Return by January.
- ☐ Birth Certificate - Proof of Residency- District Migrant Form Return by January.
- ☐ Immunization-Dental- Physical-with LEAD screening date by May 1, 2019.

Monticello Community Schools
Medical Exam Form

Name_____ Date of Birth_____
Parent/Guardian Name_____
Doctor/Clinic Name_____
Health History:

Condition:	Date(s)
Hepatitis	_____
Pneumonia	_____
Strep Infection	_____
Chicken Pox	_____
Bladder/Kidney Trouble	_____
Seizure Disorder	_____
Ear Infection	_____

Major Injuries/Surgeries: _____
Allergies: _____

Physical Exam:

Ht. _____ Wt. _____ BP _____P _____
Urinalysis _____
HGB _____

General Exam:

Head _____	Throat _____	GU_____
Eyes _____	Neck _____	Ext. _____
Ears_____	Lungs _____	
Nose _____	Heart _____	
Mouth _____	Abd. _____	

Conditions which could effect school work _____

*** Lead Testing: Results _____ Date _____
Immunization Plan: IPV #4 _____ Dtap #5 4 _____ MMR #2 4 _____
Hep B _____ Varicella Vac _____

- Please fill out Immunization form on back of Medical Exam Form, or attach signed copy from IRIS.

Examiner's Signature _____
Date: _____

Monticello Community Schools
Shannon Elementary / Carpenter Elementary
321 W. South St. / 615 N. Gill St., Monticello, IA 52310
(319) 465-3000
Shannon ext. 4114/Carpenter ext. 3111

Dear Parent / Guardian of Incoming Kindergartners,

The Iowa Immunization Law states that for your child to attend a public or private school in Iowa, he or she must be fully immunized against DPT, Polio, Chicken pox, MMR, and Hepatitis B. This means that to be fully immunized your child will need to have had:

Polio: 4 doses – with one dose given after the age of 4
DPT (Diphtheria, Pertussis, and Tetanus): 5 doses with one dose given after the age of 4
MMR (Measles, Mumps, and Rubella): 2 doses (usually the second dose is given after age 4)
Varicella (Chicken Pox): 2 doses (usually the second dose is given after age 4)
Hepatitis B: 3 doses

IT IS MANDATORY that a COMPLETED IMMUNIZATION CERTIFICATE for your child be RETURNED TO SCHOOL by MAY 1, 2019. Your child will not be able to attend school the first day if immunizations are not completed.

If there is a problem with completing the above vaccines by the first day of school, please call Jen Speltz, School Nurse at Shannon Elementary (319 – 465 – 3000 ext. 1327).

The state law has provided for religious, medical, or provisional certificates in the case that your child, for some reason, cannot complete the required immunizations by August. If you need one of these certificates, please contact your physician, the Community Health Office, or Jen Speltz.

We are happy to receive your child's immunization certificate as soon as it is completed, but it MUST BE ON FILE AT SCHOOL by the FIRST DAY of CLASSES in AUGUST of 2019. Your child, according to the state immunization law, is to be excluded from school if there is not one of the certificates (completed immunization certificate; provisional; religious; or medical) on file the first day of school in August 2019.

Sincerely,
Jen Speltz RN, BSN
Shannon Elementary School Nurse

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 • http://idph.iowa.gov/ohds/oral-health-center
A designee of the local board of health or Iowa Department of Public Health may review this certificate for survey purposes.

Iowa Department of Public Health
Certificate of Immunization

Name Last: _____ First: _____ Middle: _____ Date of Birth: _____

Parent/Guardian: _____ Address: _____ Phone: _____

I certify that the above named applicant has a record of age-appropriate immunizations that meet the requirement for licensed child care or school enrollment.

Signature: _____ Date: _____

Physician, Physician Assistant, Nurse, or Certified Medical Assistant

A representative of the local Board of Health or Iowa Department of Public Health may review this certificate for survey purposes.

	Vaccine	Date Given	Doctor / Clinic / Source
Diphtheria, Tetanus, Pertussis DTaP/DTP/DT/ Td/Tdap			
Polio IPV/OPV			
Measles, Mumps, Rubella MMR			
***Haemophilus influenzae* type b** Hib			
Hepatitis B			

	Vaccine	Date Given	Doctor / Clinic / Source
Varicella Chicken Pox *If applicant has a history of natural disease write "Immune to Varicella"*			
Pneumococcal PCV/PPSV			
Meningococcal MCV/MPSV/ Mening B			
Hepatitis A			
Rotavirus			
Human Papilloma Virus HPV			
Other			

January 2013

STUDENT VISION CARD

Student First/Last Name _____ Exam Date _____

Student Date of Birth _____/_____/_____ Student Home Zip Code _____

TO THE PARENT OR GUARDIAN: To fully assess the health of your child's visual system and prevent future learning problems associated with undetected vision problems, regular professional eye exams are essential. Experts estimate that 80% of learning is obtained through vision. Good vision directly contributes to a child's ability to learn while in school. As a part of your back-to-school preparations, it is recommended that you take your child and this card to your family eye doctor for a complete eye health examination. **This card should be signed by the eye care professional and returned to the school nurse or teacher by your child.**

The following organizations recommend the use of the Student Vision Card

Iowa Department of Education

IDPH Iowa Department of Public Health

Iowa Optometric Association

Iowa PTA everychild. onevoice.

Prevent Blindness Iowa®

To order more cards call 1-800-444-1772 • www.iowaoptometry.org

Visual Acuity	**At Distance**		**At Near**	
☐ Without correction	R20/	L20/	R20/	L20/
☐ With present correction	R20/	L20/	R20/	L20/
☐ With new correction	R20/	L20/	R20/	L20/

External Eye Health
☐ Normal ☐ Other

Internal Eye Health
☐ Normal ☐ Other

Vision Analysis

R	**L**		
☐	☐	Normal eyesight	☐ Eye teaming difficulty
☐	☐	Nearsighted (myopia)	☐ Crossed-eyes (strabismus)
☐	☐	Farsighted (hyperopia)	☐ Eye focusing difficulty
☐	☐	Astigmatism	☐ Sensitivity to light
☐	☐	Amblyopia	

☐ Other _____

Vision Correction Recommendations
☐ No correction necessary
☐ No change in present prescription
☐ New prescription needed

To be worn for:
☐ Constant wear ☐ Near vision only
☐ Distance vision only ☐ As needed

TO THE EYE CARE PROFESSIONAL: Please sign and date this card after examination.

Dr. Name: (Please Print) _____

Date_____Signature_____