

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

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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 _____

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: _____



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: <input type="checkbox"/> Male <input type="checkbox"/> 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 decay¹ or a white spot lesion² is suspected in one or more teeth, or gum infection³ is suspected.
- Requires Urgent Dental Care** – obvious tooth decay¹ 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 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 <i>If applicant has a history of natural disease write "Immune to Varicella"</i>		
Pneumococcal PCV/PPSV		
Meningococcal MCV/MPSV/ Mening B		
Hepatitis A		
Rotavirus		
Human Papilloma Virus HPV		
Other		

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



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

Visual Acuity Without correction With present correction With new correction**At Distance**

R20/ L20/

R20/ L20/

R20/ L20/

At Near

R20/ L20/

R20/ L20/

R20/ L20/

External Eye Health Normal Other**Internal Eye Health** Normal Other**Vision Analysis****R****L** Normal eyesight Nearsighted (myopia) Farsighted (hyperopia) Astigmatism Amblyopia Other _____ Eye teaming difficulty Crossed-eyes (strabismus) Eye focusing difficulty Sensitivity to light**Vision Correction Recommendations** No correction necessary No change in present prescription New prescription needed

To be worn for:

 Constant wear Distance vision only Near vision only As needed**TO THE EYE CARE PROFESSIONAL:** Please sign and date this card after examination.

Dr. Name: (Please Print) _____

Date _____

Signature _____



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:		

- Has your family moved in order to work in another city, country, or state in the last three (3) years
YES___ NO___
 - If so, what date did your family move? _____
 - 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)



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).