

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 Name _____ Phone _____ Cell _____

(specify relationship) 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

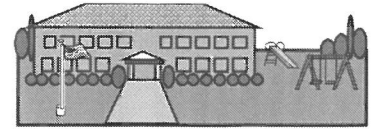
Medical Injury

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 _____

Shannon Elementary School



PARENTS:

PLEASE COMPLETE THE FOLLOWING:

Child's Name _____

Parent's Name _____

AFTER SCHOOL Plans for my child:

_____ **Panther Academy**

_____ **Walk Home**

_____ **Walk to Sitters Name** _____ **Phone:** _____

_____ **Bus Home Bus #** _____ **Bus Driver** _____

_____ **Bus to Sitter Bus #** _____ **Sitter's Name** _____

_____ **Shuttle bus to Carpenter then** _____

_____ **Shuttle bus to Middle School then** _____

_____ **Automobile Who?** _____

Early Dismissal Plans for my child:

_____ Follow usual dismissal arrangement

_____ Other _____

It is essential that all children and the school staff know after school plans each day.

***If you do need to make a change from the above plan, we must have a note from the parents giving us that information on your child's Communication Log or Red Communication Folder.**

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 C. Native Pacific Islander
 B. Alaska Native 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 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.

 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.)

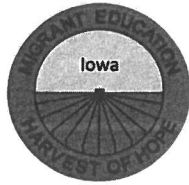
_____ **Black or African American** (A person having origins in any of the black racial groups of Africa.)

_____ **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 _____



IOWA MEP PARENT FORM

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 Education 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. Have both parents lived in this town continuously for the past 3 years or more?

YES _____ NO _____

2. If YES you may stop filling out the form, if NO please continue to question 3.

3. Please select any of the following jobs that the family have done in the last 3 years?

- Tyson, JBS, Monsanto, Smithfield, Seaboard,
- Feeding, Taking care of Cows, Goats (Dairy Farm), Milking
- Planting/ Detasseling- Corn, Soybeans (Monsanto, Syngenta, Stine)
- Pork, Chicken, Egg, Turkey Farms (Daybreak, Rembrand)
- Preparing farm fields
- Other agricultural work activity/Company _____

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

_____	/	_____	/
_____	/	_____	/
_____	/	_____	/
_____	/	_____	/

Disclaimer at bottom of the form-

Please return this form to the school. Note for the school/district: When both "No" 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)

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 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			
<i>Haemophilus influenzae type b</i> Hib			
Hepatitis B			

	Vaccine	Date Given	Doctor / Clinic / Source
Varicella Chicken Pox If patient has a history of natural disease write "Immune to Varicella"			
Pneumococcal PCV/PPV			
Meningococcal MCV4/MPSV4			
Hepatitis A			
Rotavirus			
Human Papilloma Virus HPV			
Other			



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):
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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 health 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 on this form from another health department. 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 Delivery Systems
515-242-3683 • 866-528-4020 • <https://idph.iowa.gov/ohds>

A designee of the local board of health or Iowa Department of Public Health may review this certificate for survey purposes.

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

	At Distance	At Near
<input type="checkbox"/> Without correction	R20/ L20/	R20/ L20/
<input type="checkbox"/> With present correction	R20/ L20/	R20/ L20/
<input type="checkbox"/> With new correction	R20/ L20/	R20/ L20/

External Eye Health

Normal Other

Internal Eye Health

Normal Other

Vision Analysis

- | R | L | | |
|--------------------------------------|--------------------------|------------------------|----------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Normal eyesight | <input type="checkbox"/> Eye teaming difficulty |
| <input type="checkbox"/> | <input type="checkbox"/> | Nearsighted (myopia) | <input type="checkbox"/> Crossed-eyes (strabismus) |
| <input type="checkbox"/> | <input type="checkbox"/> | Farsighted (hyperopia) | <input type="checkbox"/> Eye focusing difficulty |
| <input type="checkbox"/> | <input type="checkbox"/> | Astigmatism | <input type="checkbox"/> Sensitivity to light |
| <input type="checkbox"/> | <input type="checkbox"/> | Amblyopia | |
| <input type="checkbox"/> Other _____ | | | |

Vision Correction Recommendations

- | | | |
|------------------------------------------------------------|-----------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> No correction necessary | To be worn for: | |
| <input type="checkbox"/> No change in present prescription | <input type="checkbox"/> Constant wear | <input type="checkbox"/> Near vision only |
| <input type="checkbox"/> New prescription needed | <input type="checkbox"/> Distance vision only | <input type="checkbox"/> As needed |

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

Dr. Name: (Please Print) _____

Date _____ Signature _____

Parents and Guardians

You can take advantage of our Text Messaging Service

Our school utilizes the SchoolMessenger system to deliver text messages, straight to your mobile phone with important information about events, school closings, safety alerts and more.

You can participate in this free service* just by sending a text message of “Y” or “Yes” to our school’s short code number, **68453**.

You can also opt out of these messages at any time by simply replying to one of our messages with “**Stop**”.

SchoolMessenger is compliant with the Student Privacy Pledge™, so you can rest assured that your information is safe and will never be given or sold to anyone.



**Opt-In from
your mobile
phone now!**



**Just send
“Y” or “Yes”
to 68453**

i Information on SMS text messaging and Short Codes:

SMS stands for Short Message Service and is commonly referred to as a “text message”. Most cell phones support this type of text messaging. Our notification provider, SchoolMessenger, uses a true SMS protocol developed by the telecommunications industry specifically for mass text messaging, referred to as “short code” texting. This method is fast, secure and highly reliable because it is strictly regulated by the wireless carriers and only allows access to approved providers. If you’ve ever sent a text vote for a TV show to a number like 46999, you have used short code texting.