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

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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 __________________

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):

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 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 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
1-866-528-4020 • 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.

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			

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	
☐ 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
☐	☐	Nearsighted (myopia)
☐	☐	Farsighted (hyperopia)
☐	☐	Astigmatism
☐	☐	Amblyopia

☐ Eye teaming difficulty
☐ Crossed-eyes (strabismus)
☐ Eye focusing difficulty
☐ Sensitivity to light

☐ 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____

11/13

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)

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) .