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

WELCOME TO SHANNON ELEMENTARY!

Helpful Tips for the Fall:
The School Handbook will provide much of the information that you will need. However, some information to help start the year include the following:

First Week of School
The middle school serves as a bus transfer location – meaning students get off of their route bus to get on a shuttle bus that takes them to their school. During the first week, we have extra support at the middle school in the mornings and afternoons. For that reason, it's recommended that you start the year with the routine that you will normally use for sending your child to and from school. Please make sure that your child knows the name of his/her teacher so that adults can help direct children to the appropriate entrance when unloading from the bus at Shannon.

Pick Up and Drop Off Times
Drop your child off no earlier than 7:50 am. Before that time, there is no designated supervision for your child.
Do not park in the bus zone during the times posted on the signs. The bus zone is from the west corner to the last posted sign.
Additionally, please reserve the east end for pickup and drop off traffic flow.
Do not park to the north of the road extension that travels west off of W. South Street. (Apartment Complex)
Do not park in the west parking lot. The parking lot is already full and it is used as a pick up and drop off area.

If you take your child to school and need to enter the building… Please park on a side street and walk your child to the school.
Note: If you are visiting outside of pick up and drop off times, you may park in front of the school or in the parking lot.

Entering the School Building
When entering the school building, you must enter through the front door. If supervision is not present, the door will be locked. If the door is locked, you may push the button to contact the office.

Red Communication Folder
This folder goes to and from school with your child, one side Keep at Home the other Return to School.
There will also be a communication log that is where teachers will have what they are doing for the week,
and also check for notes from parents, such as picking up early for an appointment, different plans for after school etc.
If you end up having a change that comes up please call the office at: 319-465-3000 Press 5 and then 2 for Mrs. Hinrichs.
Teachers during the day do not have time to check messages on SeeSaw or their email.

Panther Academy
If you are interested in the before and after school program please go to: https://www.monticello.k12.ia.us/pantheracademy/

Menus - Prices - Free/Reduced Application form
https://www.monticello.k12.ia.us/food-nutrition/lunch-menus/

School Calendar
https://www.monticello.k12.ia.us/calendar/

Friday Folder (Events & Activities)
https://www.monticello.k12.ia.us/friday-folders-2

Monticello Community School Information
Please go to our website: http://www.monticello.k12.ia.us

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			

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.**

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_____

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

11/13

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) .

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	