

Bellevue City Schools

NEW STUDENT REGISTRATION FORM

Please complete ALL sections

Entry Date: _____

Legal Last Name	First	Middle	Suffix	Grade
Address		City	Zip	
Email Address:		Phone: <input type="checkbox"/> unlisted	Cell:	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	City of Birth	Citizenship (ex. US)	

Ethnicity: Is this student Hispanic/Latino? <input type="checkbox"/> No <input type="checkbox"/> Yes, Hispanic/Latino	(A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)	Primary Language <input type="checkbox"/> English <input type="checkbox"/> Other:
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Race: Regardless of what you selected above, please continue to answer the following by marking one or more of the boxes you consider your child's race to be:

- A** Asian (Origins in any of the original peoples of the Far East or the Indian subcontinent)
- B** Black or African American (Origin in any of the black racial groups of Africa)
- I** American Indian or Alaskan Native (Origin in any of the original people of North/South America, including Central America)
- P** Native Hawaiian or Pacific Islander (Origins in any of the original people of Hawaii, Guam, Samoa, or other Pacific Islands)
- W** White (Origins in any of the original peoples of Europe, North Africa, or the Middle East)

Father's information (do not list step-father)

Name: _____

Address: _____

City _____ State: _____ Zip: _____ Phone _____

Cell Phone: _____ Email Address _____

Work Phone: _____ Place of Employment: _____

Mother's information (do not list step-mother)

Name: _____ Maiden Name: _____

Address: _____

City _____ State: _____ Zip: _____ Phone _____

Cell Phone: _____ Email Address _____

Work Phone: _____ Place of Employment: _____

Legal Guardian (if other than parents listed above) attach legal documentation

Name: _____ Maiden Name: _____

Address: _____

City _____ State: _____ Zip: _____ Phone _____

Cell Phone: _____ Email Address _____

Work Phone: _____ Place of Employment: _____

Marital Status of Parents: Married Single Separated Divorced Remarried Widowed Never Married

Student resides with: Biological/Adoptive Parents Mother only Father only Grandparents
 Mother/Stepfather Father/Stepmother Foster Family Other:

If parents are divorced or legally separated who is custodial parent? Please circle Father Mother Joint Custody

SIBLINGS

Name:	Grade	Name	Grade
Name:	Grade	Name	Grade
Name:	Grade	Name	Grade

Student Education Information

Has student previously attended Bellevue Schools? No Yes If, yes, grade level at withdrawal:

Elementary School Year(s) of Attendance: _____ Grade(s) _____

Middle School Year(s) of Attendance: _____ Grade(s) _____

High School Year(s) of Attendance: _____ Grade(s) _____

Former School Information

Name of School District _____

Name of Previous School attended: _____ Phone Number: _____

Address: _____ State _____ Zip _____

Additional Educational Information

Is this child currently receiving any special education programs or services: No Yes

If Yes, please check the following:

_____ Autism	_____ OHI--Other Health Impaired
_____ CD--Cognitive Disability	_____ SLD--Specific Learning Disability
_____ Deafness--Hearing Impairment	_____ Speech/Language
_____ ED--Emotional Disturbance	_____ TBI--Traumatic Brain Injury
_____ MD--Multiple Disabilities	_____ VI--Visually Impaired
_____ OH--Orthopedic Handicap	

Is this child currently on a 504 Plan: _____ No _____ Yes

Is this child currently receiving Title I Reading services: _____ No _____ Yes

Is this child currently enrolled in a gifted/talented class? _____ No _____ Yes

To the best of my knowledge, the above information is correct and may be filed with my my child's records.

Signature of Person Enrolling Student	Relationship to Student	Date
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Superintendent	Date
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FOR OFFICE USE ONLY	ENROLLMENT INFORMATION
_____ Birth Certificate	GRADE: _____
_____ Immunization Record	START DATE: _____
_____ Proof of Residency	
_____ Custody Papers	

BELLEVUE CITY SCHOOL SCHOOL ENTRANCE HEALTH HISTORY

Name _____ Grade _____ Birth Date _____ Sex _____

Daytime Phone # _____ Cell Phone # _____

Health History

Life Threatening Allergic Conditions: (Check all that apply)

- Severe allergic reaction to Bee Stings, other insects: _____
- Severe reaction to Nut, Peanuts: _____
- Severe reaction to other Food Products: _____
- Other severe allergies affecting school: _____

Please indicate any of your child's symptoms which would indicate a severe allergy: (Local swelling does not indicate a severe allergic reaction.)

- Itching and/or tightness in the throat, hoarseness
- Itching or swelling of the eyes, lips, tongue or mouth
- Shortness of breath, coughing, and/or wheezing
- "Thready pulse", "passing out"/loss of consciousness
- Hives

Has your physician prescribed an Epi-Pen or other medicine for a severe life threatening allergy? Yes* No

Specify medication: _____ *If you answered "Yes", please contact Health Services, 419-484-5094.

Does your child have a history of any of the following conditions, if yes please circle and explain below:

Developmental Delay	Yes	Heart Disease	Yes	Pre-mature Birth	Yes
Surgeries/Hospitalizations	Yes	Chicken Pox	Yes	Ear Infections or Tubes	Yes
Asthma	Yes	Kidney Disease	Yes	Hearing Problem or Aides	Yes
Blood Disorder	Yes	Nervous System Disorder	Yes	Mental Illness	Yes
Cancer	Yes	Skin Disorder	Yes	Behavioral Problems	Yes
Convulsions/Seizures	Yes	Stomach/Intestinal Disorder	Yes	Head Injury	Yes
Diabetes Type I or Type II (circle one)	Yes	Glasses/Contacts used full-time or for reading only (circle one)	Yes	Currently Under a Doctor's Care	Yes

Please explain any "Yes" answers to the above: _____

Describe any physical condition/disabilities not listed above: _____

Are there any precautions/limitations in school activities Yes/No _____

Family Health History that the school should be aware of _____

Medications: Please list

Name of Medication	Dosage	Time of Day	Reason

I understand that if my child's health status changes, I will provide the Health Services with the updated information at 419-484-5094.

Parent/Guardian Signature _____ Date _____

HURON COUNTY GENERAL HEALTH DISTRICT
Timothy Hollinger, MPH, Health Commissioner

180 Milan Avenue, Suite 8
Norwalk, OH 44857
e-mail: information@huroncohealth.com

419-668-1652 or 1-888-694-2443 Toll-Free
419-668-5423 General Fax
419-660-0129 Environmental Health Fax

January 13, 2012

Dear Parents,

Children who will be attending kindergarten in the fall of 2012 are required to have certain immunizations. Your school nurse will review your child's record and discuss needed vaccines with you at the kindergarten screening/registration. The Huron County General Health District has many appointments available for you at our 5 locations. Please contact us at 419-668-1652 extension 252 or 888-694-2443 extension 252 to schedule an appointment.

No child is turned away for required vaccines if their family is unable to pay for the shots. For families covered by private insurance, we can give you a receipt for the vaccines given for you to turn into your insurance company.

"Kindergarten shots" are often stressful for children of this age. The Registered Nurses at the Huron County General Health District recommend that you be very matter of fact about the need for the shots with your child. You may want to prepare them by using these 'talking points':

"The shots are needed so you don't get sick."

"Sometimes the shots hurt a little bit, but it's over very quick and mom/dad will give you a big hug when you're all done."

"Mom/Dad will be right with you when you get your shots/pokes."

"It's ok to cry."

"The Nurses will have a sticker for you when you're all done."

Most adults are not up to date on their immunizations. We can schedule a parent's tetanus booster at the same time as the child's shots.

Most children require 3 to 4 shots at this visit and we usually administer these in the thighs and the back of the arms. Please feel free to call and ask to speak to the nurse on call if you have questions about the vaccinations or about how to prepare your child.

Contact us at 419-668-1652 or toll free at 1-888-694-2443 or find us at www.huroncohealth.com.

We look forward to seeing you and your child soon!

Sincerely,

Chris Cherry BSN, RN
Director of Public Health Nursing

HURON COUNTY GENERAL HEALTH DISTRICT
Timothy Hollinger, MPH, Health Commissioner

180 Milan Avenue, Suite 8
Norwalk, OH 44857
e-mail: information@huroncohealth.com

419-668-1652 or 1-888-694-2443 Toll-Free
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Dear Parents of Incoming Kindergarten Students:

To register your child for school, it is necessary for you to have a certified copy of their birth certificate. A 'mother's certificate' issued from the hospital is not a certified copy of a birth certificate. The birth certificate must have a raised seal and a certification statement from the health department.

If your child was born in Ohio, your child's birth certificate is available from the Huron County General Health District. The cost is \$25.

You may obtain a certified copy of the birth certificate:

1. In person at the Health District, 180 Milan Ave. Suite 8 Norwalk OH 44857 between the hours of 9 AM & 4:30 PM Mondays and 8 AM & 4:30 PM Tuesday through Friday, excluding legal holidays

2. by mail. Each request must include the child's name, date of birth and the signature of the person requesting the certificate. You will find a copy of a request form at our website: www.huroncohealth.com . Please include a check or money order for \$25.00 along with a self-addressed stamped envelope.

3. by phone. During regular business hours with a credit card (there is an additional \$3.00 charge to use this service). Please call 419-668-1652 or toll-free 1-888-694-2443 x 223.

If your child was born outside of Ohio, you must obtain it from the state where your child was born. If you need assistance locating your child's birth certificate, please call the Huron County General Health District Vital Statistics Registrar at 419-668-1652 extension 223 or 1-888-694-2443 extension 223.

Child's Name _____ Date _____

The purpose of this survey is to find out what types of early organized experiences children have had before coming to kindergarten. Please check all of the experiences your child has participated in and for approximately how long. Thank you.

<u>Program</u>	<u>How long?</u>
___ Help Me Grow (County: _____)	_____
___ Early Intervention (Birth to age 3) (County: _____)	_____
___ Parents As Teachers (County: _____)	_____
___ Child Care Center	_____
___ WSOS/Head Start Home-Based Program (County: _____)	_____
___ WSOS/Head Start Center-Based Program (County: _____)	_____
___ Preschool _____	_____
___ Preschool Special Education Services (IEP) (School District: _____)	_____
___ None of the above	

Huron County General Health District
 180 Milan Avenue Norwalk OH 44857
 (419)668-1652 or 1-888-694-2443
 (Within Huron County)

Authorization for Immunizations of children birth through 10 years

I, _____ the undersigned parent, legal guardian, or person
 (Parent/Guardian's Full Name)
 having legal custody of _____ do hereby authorize
 (Please Print Full Name of Child)
 _____ to represent me as Guardian and provide consent

(Please print name of Adult bringing child to clinic)
 to the appropriate licensed health care provider of the Huron County General Health District to proceed with the administration of the appropriate vaccines based on age and the schedule recommended by the Ohio Department of Health for my child, a minor, noted above. I understand that the Immunization Guidelines followed by the Huron County General Health District are the same as recommended by the Ohio Department of Health and the American Academy of Pediatrics. Please complete on this form any vaccines the child has already received or send the child's record along to the appointment.

CHILD'S DATE OF BIRTH _____
It is mandatory that you bring the child's shot record with you

Please complete other information about the above named child;

YES	NO	Has the above named child ever had:
		Convulsions or seizures; or
		A severe reaction to any vaccine, eggs, medication, or gelatin?
		Does the patient have cancer, leukemia, AIDS, or any other immune system problem, or have they taken cortisone, prednisone, other steroids, anticancer drugs, or x-ray treatments in the last 3 months?
		Is the patient sick today?
		Is this person pregnant or at the risk of becoming pregnant in the next month?
		Has the patient had any blood, plasma, or immune (gamma) globulin transfusion in the last six months?

Parent, Guardian, and Adult signature's are in recognition and acceptance of the content of this page.

Parent/Guardian Signature: _____ Date ____ / ____ / ____

Home telephone _____ Work telephone _____

Adult bringing child to clinic Signature: _____ Date ____ / ____ / ____

I have received a copy or had one made available to me through the Huron County General Health District's web site and have read, or had read to me, the information contained in the appropriate Vaccine Information Statement (V.I.S) about the disease(s) and vaccine(s) that my dependent will receive. I have had a chance to ask questions, (by calling the Health Department at 1-888-694-2443 toll free) which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) to be received. (V.I.S. forms are located at <http://www.cdc.gov/vaccines/pubs/vis/default.htm>)

I understand the information is being sent to a central registry at the Ohio Department of Health.
 Users/Clinic Forms/HDCL1280 Revised 4/23/2009

Children with special dietary needs: Disability or Life-threatening allergy

PART A		
Child's Name	DOB	Date
School	Grade	Classroom
Does this child have a life-threatening allergy or disability? If yes, describe the reaction or major life activities affected.		Yes No
Does the child have special nutritional or feeding needs? If yes, complete Part B of this form and have it signed by a licensed healthcare specialist (Physician, Nurse Practitioner, Physician Assistant).		Yes No
If the child does not require special nutritional or feeding needs, the parent can sign the bottom of this form and return it to the school.		

PART B (to be completed by Licensed Healthcare Provider)
List any dietary restrictions or special diet. Please be specific.
List any food life-threatening food allergies.
List any food to be substituted.
List foods that need the following change in texture. If all foods need to be prepared in the manner, indicate "All". Cut-up or chopped into bite size pieces: Finely ground: Pureed:
List any special equipment or utensils that are needed.
Indicate any other comments about the child's eating or feeding that are pertinent to school.

Signature of Licensed Healthcare Provider _____ Date _____

Please return form to	From
Jackie Hess Bellevue City Schools, Food Services	Printed Name of Health Care Provider
125 North Street	Address
Bellevue, OH 44811	City, State ZIP
Phone: 419-484-5190 Fax: 419-484-5016	Date

Parent Signature: _____ Date: _____

Reviewed by: _____ Date: _____
 _____ Date: _____