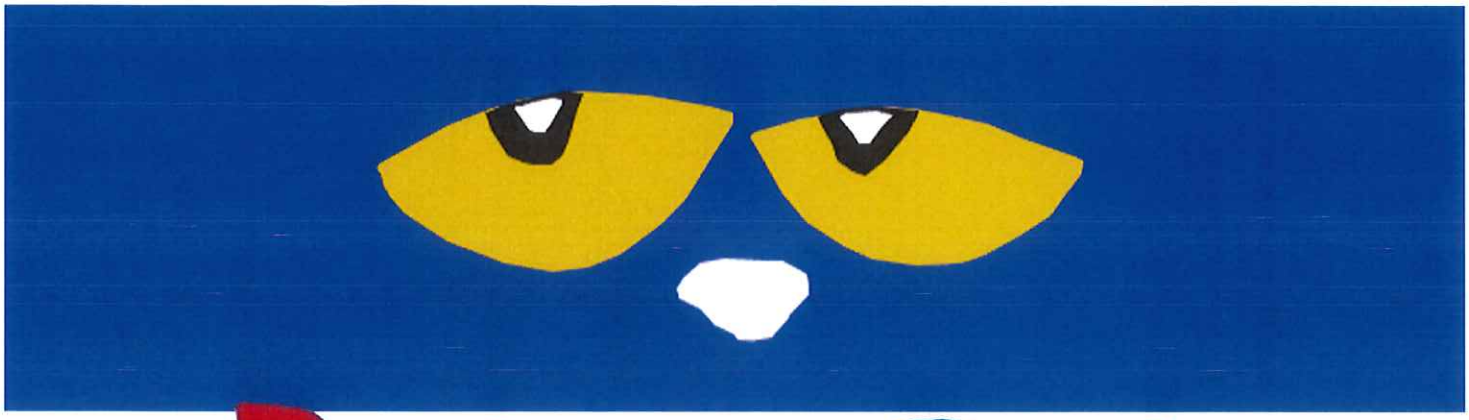
Morrill Elementary
Kindergarten Registration Checklist

The following items will need to be completed and returned to the Morrill Elementary School Office for Kindergarten Registration. In order for your child to be enrolled and placed into a classroom, we will need to receive all paperwork back prior to the start of school in the fall. Please use the below checklist to ensure all paperwork is completed and returned. Forms can be checked off this list and placed back in this envelope so all paperwork stays together when returning it to the office. Thank you!

- ☐ **Completed Registration Form**
- ☐ **Home Language Survey (Pink Form)**
- ☐ **Raised Seal Birth Certificate (This document has to be state certified and is NOT the hospital issued document that verifies birth.)**
  - **-Can be ordered by going to http://dhhs.ne.gov/**
  - **-Select "Vital Records"**
  - **-Select "Birth Certificates"**
- ☐ **Current Immunization Record or Signed Medical/Religious Waiver**
- ☐ **Physical Exam Form (Can be used by the medical provider unless they have a form of their own. Appt must be completed within 6 months of starting school.)**
- ☐ **Vision Exam (Can be used by the medical provider unless they have a form of their own. Appt must be completed within 6 months of starting school.)**
- ☐ **Bus Transportation Card (Only applicable to families who live outside the city limits)**

Completed packets can be returned or mailed to the office using the following address:

Morrill Elementary School
505 Center Avenue
Morrill, NE 69358



Pete the Cat

Documents Needed to Start Kindergarten:

1) Registration Form
2) Home Language Survey
3) Raised Seal Birth Certificate
   -Can be ordered by going to http://dhhs.ne.gov/
   -Select "Vital Records"
   -Select "Birth Certificates"
4) Current Immunization Record or Signed Medical/Religious Waiver
5) Physical
6) Vision Exam
   **Appts for the physical and vision exam have to be completed within 6 months of starting school in the fall.
7) Bus Transportation Card (Only applicable to families who live outside city limits)

New Student Registration Form

Morrill Public Schools

Student Information: Date: _____ Grade: _____

Legal Student Name: _____
LAST FIRST MIDDLE SUFFIX

Date of Birth: _____ Place of Birth: _____ Gender: ☐ Male ☐ Female

Ethnicity: *Is this student Hispanic/Latino?* ☐ No, Not Hispanic/Latino ☐ Yes, Hispanic/Latino

Student's Race (Choose one or more): ☐ White ☐ Asian ☐ American Indian/Alaska Native
☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander

Primary Home Language: ☐ English ☐ Spanish ☐ Other _____

Is your student currently on an Individualized Educational Plan (IEP)? ☐ Yes ☐ No

Has your student ever been on an Individualized Educational Plan (IEP)? ☐ Yes ☐ No

School Previously Attended: School Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Legal Parent/Guardian Information:

Father (Last Name):	Father (First Name):	Father (Middle Initial):
Mother (Last Name):	Mother (First Name):	Mother (Middle Initial):
Guardian's Name (Relationship to Student):		

Home/Physical Address: _____ Mailing/PO Box: _____

City: _____ State: _____ Zip: _____ Home Phone: _____

Father's Cell Phone: _____ Father's Work Phone: _____

Mother's Cell Phone: _____ Mother's Work Phone: _____

Primary Email Address: _____

Emergency Contact(s): Name: _____ Phone: _____

Name: _____ Phone: _____

Brothers/Sisters:

Last Name:	First Name:	Middle Name:	Date of Birth:	Gender:	Grade:

Bus Student: ☐ Yes ☐ No

Nebraska Department of Education

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 your 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 first learn to speak? _____

8. What language is spoken most often by your child? _____

9. What language is primarily used in the student's home regardless of the language spoken by the student?
   (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 Received	Received By

Physical Examination

(to be completed by a physician, physician's assistant, or nurse practitioner)

Name of Student (Last / First / Middle) _____ Grade _____ School _____

Height _____ Neck _____ Mouth/Teeth _____

Weight _____ Lungs _____ Abdomen _____

BP _____ Eyes _____ Spine _____

Pulse _____ Ears _____ Scoliosis _____

Heart _____ Skin _____ Extremities _____

Urinalysis Results _____ Hgb/Hct Results _____

Hearing Test (please circle) Normal/Abnormal

Left Ear	Right Ear	Hz
dB	dB	500
dB	dB	1000
dB	dB	2000
dB	dB	400

Comments: _____

List any additional information regarding this student that may affect safety or optimal performance in school: _____

A School Vision Evaluation is required for all children within six months prior to entering Nebraska schools for the first time (includes beginner grades including Kindergarteners, transfers, and other students new to Nebraska) [NE revised Statute 79-214]

Vision Test (please circle) Normal/Abnormal

Required Tests	Pass	Fail	Recommendations	Vision	Glasses / Contacts / Neither
Amblyopia				Right eye @ Far (20')	20 / _____ aided / unaided
Strabismus				Left eye @ Far (20')	20 / _____ aided / unaided
Internal Eye Health					
External Eye Health				Right eye @ Near (16")	20 / _____ aided / unaided
Visual Acuity				Left eye @ Near (16")	20 / _____ aided / unaided

Provider's Signature _____ *Date:* _____

WAIVER of PHYSICAL EXAMINATION

I, the parent/guardian of _____, do not feel it necessary for he/she to a
Name of Child

physical examination and therefore exercise my right to waiver his/her physical and/or vision examination.

Parent/Guardian Signature _____ *Date:* _____

OVER

Nebraska Law requires a physical examination prior to entrance into kindergarten, 7th grade, and all students transferring into the state of Nebraska.

Name of Student (Last / First / Middle) _____ Birthdate _____ Age _____ Grade _____ School _____

Name of Parent / Guardian _____ Address _____ Phone / Cell Number _____

Family Provider _____ City _____ Family Dentist _____ City _____

Immunizations

DtaP / DTP/Tdap / DT/Td #1_____ #2_____ #3_____ #4_____ #5_____ #6_____

Polio (IPV/OPV) #1_____ #2_____ #3_____ #4_____ #5_____

HIB #1_____ #2_____ #3_____ #4_____

PCV / Prevnar #1_____ #2_____ #3_____ #4_____

MMR / MMRV #1_____ #2_____

Hepatitis B (Hep B or HBV) #1_____ #2_____ #3_____ #4_____

Hepatitis A #1_____ #2_____ Menactra (Meningitis Vaccine) #5_____ #6_____

RotaTeq (Rota Virus Vaccine) #1_____ #2_____ #3_____

Varicella (Chickenpox Vaccine) #1_____ #2_____ Year of Chickenpox Disease:_____

HPV / Gardisil (Females Only) #1_____ #2_____ #3_____

Other Immunizations:_____

Health History (Please check Yes or No for each)

Bowel / Bladder Problems ☐ Yes ☐ No

Kidney Problems ☐ Yes ☐ No

Hearing Loss ☐ Yes ☐ No

ADHD ☐ Yes ☐ No Meds:_____

Allergy to Meds ☐ Yes ☐ No Explain Reaction:_____

Allergy to Food ☐ Yes ☐ No Explain Reaction:_____

Other Allergies ☐ Yes ☐ No Explain Reaction:_____

Diabetes ☐ Yes ☐ No Meds:_____

Seizures / Convulsions ☐ Yes ☐ No Explain / Meds:_____

Concussions / Dates ☐ Yes ☐ No Explain / Meds:_____

Additional Medications ☐ Yes ☐ No Explain / Meds:_____

Asthma ☐ Yes ☐ No Meds:_____

Asthma Action Plan ☐ Yes ☐ No

Family History of Early Cardiac Death Explain:_____

Psychiatric / Behavior / Emotional Concerns Explain:_____

Surgery / Dates Explain:_____

Other Health Problems Explain:_____

Additional Information:_____

I verify that the above information is correct to the best of my knowledge.

*Parent/Guardian Signature*_____ *Date:*_____

OVER

SCHOOL VISION EVALUATION

Please return this form to your child's school health office.

A *School Vision Evaluation* is required for all children **within six months prior to entering** Nebraska schools for the first time *(includes beginner grades including Kindergarteners, transfers, and other students new to Nebraska)* [Nebraska Revised Statute 79-214]. No such visual examination will be required of any child whose parent or guardian objects to this testing in writing.

Name: _____ Date of Birth: _____

School: _____ Date of Exam: _____

Student Status (*check one*): ____ Beginner Grade ____ Transfer Student from Out of State

REQUIRED TESTS*	Pass	Fail	Recommend Further Evaluation *(comments noted below)*
Amblyopia	____	____	____
Strabismus	____	____	____
Internal Eye Health	____	____	____
External Eye Health	____	____	____
Visual Acuity			
Right eye @ distance (20 ft.):		20/____	aided/unaided
Left eye @ distance (20 ft.):		20/____	aided/unaided
Right eye @ near (16 in.):		20/____	aided/unaided
Left eye @ near (16 in.):		20/____	aided/unaided

**A vision evaluation consisting of these required tests meets the legal requirements for the State of Nebraska but is not a complete eye examination such as most eye doctors perform.*

ADDITIONAL TESTS	Pass	Fail	Recommend Further Evaluation	Did Not Test
Eye Alignment at Distance	____	____	____	____
Eye Alignment at Near	____	____	____	____
Depth Perception	____	____	____	____
Color Vision	____	____	____	____
Focusing Amount	____	____	____	____
Focusing Flexibility	____	____	____	____
Focusing Lag (Accuracy)	____	____	____	____
Convergence (Crossing) Ability	____	____	____	____
Saccade (Rapid) Eye Movement	____	____	____	____
Pursuit (Tracking) Eye Movement	____	____	____	____
Other: _____	____	____	____	____

COMMENTS/RECOMMENDATIONS: _____

_____

Evaluation performed by: _____ ___ O.D. ___ M.D. ___ P.A. ___ A.P.R.N.
(signature)

Office Phone Number: (_____ **)** _____ **-** _____ **Date:** _____

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WAIVER OF VISUAL EXAMINATION

I do not wish to obtain a visual examination for my child _____.
Child's Name

_____ _____
Parent/Guardian Signature Date

BUS PASSENGER INFORMATION SHEET
TRANSPORTATION DEPARTMENT

School Year_____

Student's Name_____ Grade in School_____

Parent(s) / Guardian(s) Name_____

Brother(s) / Sister(s)_____

Physical Home Address_____

City / Town_____ Zip_____

Home Phone_____ Cell Phone_____

*In Case of Emergency Please Notify (Other than Parent / Guardian):

Name / Telephone_____

Any Special Medical Problems_____

_____

**Please be aware that bus transportation for students is only offered to those who live outside city limits. If you live within city limits, there is not a bus route available.