Welcome to Kindergarten!

Registration Packet for New Kindergarten Students

Welcome to the Richmond Heights Local School District! We are excited to have you join our family of students, parents and educators.

To expedite the registration process, parents and guardians are asked to follow the three steps for a successful registration.

1. Pick up a registration packet at our Board Office or download packet from our website.
2. Complete the packet and gather required documentation listed on the next page.
3. Call (216) 692-7395 to schedule a registration appointment.

We look forward to a fantastic start to your child's educational journey!

"It's a New Day for the Richmond Heights Way"

www.richmondheightsschools.org

RICHMOND HEIGHTS LOCAL SCHOOLS

447 RICHMOND RD. RICHMOND HTS., OHIO 44143 PHONE 216-692-7395 FAX 216-692-8487

KINDERGARTEN REGISTRATION CHECKLIST

In order for the registration process to move quickly, please use the checklist below and supply the district with the following documents:

1. ____Completed **Registration forms** (attached).
2. ____A current **Driver's License** or current **State ID** of the adult registering the student.
3. ____**Original or certified** copy of child's **Birth Certificate.**
4. ____Child's **Social Security Card.**
5. ____**If applicable**, a stamped, certified copy of **Court Order establishing custody** or **guardianship**. (No photo copies)
6. ____**Notarized residency affidavit** (form included in packet).
7. ____**Lease, Mortgage, or Deed. The district will not enroll without proof of residence.**
8. ____Child's complete **Immunization records** signed by your physician (form attached).

As the parent or legal guardian of the child being registered, you have a continuing responsibility to inform the superintendent of schools of any change of residence or legal custody. Regarding legal custody or guardianship, a court of jurisdiction must award it before a student will be allowed to enroll in the Richmond Heights Local School District.

The Richmond Heights Schools attendance officer will confirm the accuracy of information provided during the registration process by making home visits to all new students.

I have read the above enrollment procedures, understand them and will abide by them. I will notify the superintendent of schools of any changes that may occur.

Signature______________________________ Date____________________

RICHMOND HEIGHTS LOCAL SCHOOL DISTRICT

RESIDENCY AND CUSTODY AFFIDAVIT

For the purpose of establishing school residence and custody (To be completed by parent or legal guardian)

SIGN ONLY AFTER CAREFULLY READING AND SIGNING IN THE PRESENCE OF A NOTARY

THE UNDERSIGNED, FIRST BEING DULY SWORN ACCORDING TO LAW, STATE THAT:

I,______________________________, certify that I am the custodial parent/legal guardian of ______________________
(Parent's or Legal Guardian's Full Name) (Student's Name)

and that I have established residency at ____
(Street Number, Name, Apt. #) (City) (State) (Zip Code)

Date of Occupancy:______________________ Lease End Date (if applicable): ______________

I, ______________________________, certify that I am a resident of the above residence located within **Richmond Heights Local School District.** The registrar has explained to me that legal residency is determined by certain conditions, among them are that mail delivery, voting residence, and payroll city tax deductions are based on the ***Richmond Heights Local School District*** address and also, that the residence where meals are taken, and where the resident parent sleeps must be the ***Richmond Heights Local School District/Richmond Heights*** residence. (Photo identification, such as an Ohio Driver's License with your most recent address, is required for identification)

List the names of <u>**ALL**</u> people, both adults and children, who reside at the above address. Also, please indicate their school (if applicable) and "status" (i.e., homeowner, lessee, renter, parent, guardian, student, preschooler, grandparent, etc.) Attach a separate piece of paper, if needed.

Last Name	First Name	School (If Applicable)	Last Name	First Name	School (If Applicable)
Last Name	First Name	School (If Applicable)	Last Name	First Name	School (If Applicable)
Last Name	First Name	School (If Applicable)	Last Name	First Name	School (If Applicable)

Please read each statement and then place your initials to the left of the statement.

_____ I/we certify **that the information provided in this document and registration packet is true** and no information has been withheld, concealed, or misrepresented for the purpose of circumventing the school attendance laws of the State of Ohio in order to enroll named students in the ***Richmond Heights Local School District.***

_____ I/we understand that I/we are responsible for informing school officials of any change(s) in the residence of any parent, legal guardian, or other responsible adult. If I change my present address to another address that is within the **Richmond Heights Local School District**, I will <u>**immediately**</u> file another residency and custody affidavit with the Board of Education of the **Richmond Heights Local School District.** I further understand that if the above noted address ceases to be my legal residence and my new residence is outside the boundaries of the **Richmond Heights Local School District**, I will withdraw my child(ren) from the district and will enroll my child(ren) in the new district of residence.

_____ I/we are also responsible for informing school officials of any changes to the legal custody or guardianship of the child(ren).

_____ I/we have provided the **Richmond Heights Local School District** with an official copy of any and all current court orders from the Domestic Relations, Juvenile, Probate or any other court which has exercised jurisdiction over the custody or residency of the children being enrolled as per Ohio Revised Code 3313.672.

_____ I/we acknowledge the student who is being registered has not been expelled or excluded from any other school pursuant to O.R.C. Sections 3301.121 and 3313.662.

_____ I/we understand that if the student attends school while not being eligible to do so tuition free, the student and all responsible parties will be liable for tuition at a rate set by the Ohio Department of Education according to the Ohio Revised Code 3317.08 , and related costs, and the student will immediately be withdrawn from the **Richmond Heights Local School District.**

_____ I/we understand that the **Richmond Heights Local School District** may use whatever legal means it has at its disposal to verify my residency. I/we hereby waive my rights to confidentiality of information relative to my/our residence and give permission to the **Richmond Heights Local School District**, the City Tax Administrator, and the Regional Income Tax Agency (RITA) to release information such as name, social security number, and current and former addresses to confirm or deny my residency for the current or prior years.

NOTE: Be sure you have read this statement carefully before you sign. **Giving false information under oath is punishable as a criminal offense** under the Ohio Revised Code 2921.13 and 2921.21, a misdemeanor of the first degree with a maximum fine of $1,000 and/or a jail term of six months. In cooperation with the City Prosecutors, each violation may be thoroughly and vigorously prosecuted.

<u>**Signature(s)**</u>

Parent/Legal Guardian/Custodian: ______________________________

Student 18 years of age or older: ______________________________

County of Cuyahoga)

)SS

State of Ohio)

Before me, a Notary Public of the State of Ohio, came the above-named who said that he/she/they did understand the statements set forth above and did adopt said statements and the information, herein as his/her/their own, as true to the best of his/her knowledge of the consequences and penalties of falsification, and did affix his/her signature in my presence,

This ______________ day of ____________________, 20____

____
Notary Public

RICHMOND HEIGHTS LOCAL SCHOOL DISTRICT

STUDENT REGISTRATION FORM

Student Name	Last Name	First Name	Middle Name	Entry Grade
Social Security # (optional)	- -	**Birth Date**	Month / Day / Year	
Student Home Address	Number Street	City	Zip Code	Up ☐ Down ☐ Apt. #
Parent/Guardian	Name		Phone Number	
Previous school attended Include homeschooling	Name of School	School District	City	State

Is this student Hispanic/Latino?	**Race** (choose one or more)
☐ No, not Hispanic/Latino ☐ Yes, Hispanic/Latino	☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaskan Native ☐ Native Hawaiian or Other Pacific Islander How Identified:

Gender	☐ Male ☐ Female	**Citizenship**	☐ Dual National ☐ Non-Resident Alien ☐ Resident Alien ☐ U.S. Citizen ☐ Other please name:
Birthplace	City State Country	**Native / Primary Language**	☐ English ☐ Other please name:

Student Lives With (check all that apply)	☐Mother ☐Father ☐Step-Parent ☐Other (explain):	☐Guardian ☐Spouse ☐Self
Legal Custody (check all that apply)	☐Mother ☐Father ☐Foster Parent Court Journal Entry: (____ / ____ / ____) County: ____________________ District Bearing Cost(for Foster Children only):	☐Guardian ☐CCDCFS ☐Other (explain): ☐ **Probate Court** ☐ **Juvenile Court** Restrictions: ____________________

Is the child in gifted or Advanced Placement?	Yes ☐	No ☐	If yes, describe services:
Does the child have a 504 plan?	Yes ☐	No ☐	If yes, describe services:
Has the child ever had an IEP?	Yes ☐	No ☐	If yes, list year of most recent evaluation:
If yes, do you have a copy of the IEP?	Yes ☐	No ☐	If yes, indicate program:
Is the child suspended?	Yes ☐	No ☐	If yes, from what district?
Is the child expelled?	Yes ☐	No ☐	If yes, from what district? End Date:

☐ I do not consent to the release of email, home address, and home phone number for outreach purposes

Daycare/Preschool/Kindergarten Questionnaire

Has your child been in a previous school setting: ☐ **Yes** ☐ **No**

If so, please name school(s): ______________________ Address ______________________

City ______________ State ______________ Phone Number ______________

Permission to Contact: ☐ **Yes** ☐ **No**

Parent/Guardian Signature: ______________________________ Date: ______________

PARENT(S) / GUARDIAN INFORMATION

STUDENT NAME:

Mother ☐Single ☐Married ☐Divorced ☐Separated ☐Remarried ☐Deceased

☐Residential ☐Non-Residential | Dual Mailing: ☐Yes ☐No | Last Name | First Name

Address | Number | Street | City | Zip Code

Workplace | Email

Home Phone | Work Phone | Cellular Phone

Father ☐Single ☐Married ☐Divorced ☐Separated ☐Remarried ☐Deceased

☐Residential ☐Non-Residential | Dual Mailing: ☐Yes ☐No | Last Name | First Name

Address | Number | Street | City | Zip Code

Workplace | Email

Home Phone | Work Phone | Cellular Phone

☐ **Legal Guardian** ☐ **Step Parent** ☐ **Foster Parent** ☐ **Other:**

Last Name | First Name

Address | Number | Street | City | Zip Code

Workplace | Email

Home Phone | Work Phone | Cellular Phone

Social Worker (*If Applicable*):

☐ **Legal Guardian** ☐ **Step Parent** ☐ **Foster Parent** ☐ **Other:**

Last Name | First Name

Address | Number | Street | City | Zip Code

Workplace | Email

Home Phone | Work Phone | Cellular Phone

Social Worker (*If Applicable*):

EMERGENCY CONTACT INFORMATION

Name / Relationship	Name / Relationship
Telephone	Telephone
Address	Address
Email	Email

PLEASE LIST ALL OTHER CHILDREN UNDER THE AGE OF 22 WHO LIVE AT THE HOME ADDRESS

Name	Grade	Date of Birth	Gender	Relationship To Student

I hereby certify, under penalty of perjury, that all of the information that I have given is correct in all respects to the best of my knowledge.

Date:_______________ **Parent/Legal Guardian/Independent Student:** _______________________
Signature

Date:	Information Verified By:

RICHMOND HEIGHTS LOCAL SCHOOLS

REQUEST FOR TRANSFER OF STUDENT RECORDS

RECORDS OF: ______________________________ ____________ ________________
Student Grade Date of Birth

______________________________________ ______________________________________
Former Address City, State, Zip, Country

RELEASED FROM: ____
School/Agency

____
Address

____
City, State, Zip

Phone________________ Fax________________

RELEASE TO: **Richmond Heights Board of Education**
Registrar
447 Richmond Road
Richmond Heights, OH 44143
Phone: 216/692-7395
Fax: 216/692-8487
Email: kbendes@richmondheightsschools.org

Please include any or all listed below:

_____ Transcripts/Academic Grades
_____ Grades to Date of Withdrawal
_____ Standardized Test Scores
_____ Individual Career Plan
_____ Health and Immunization Records
_____ IEP/ETR
_____ 504 Plan
_____Other, please specify ______________________________

I acknowledge notification of this transfer of records as required by the Family Educational Rights and Privacy Act of 1974 and I understand that I have the right to receive a copy, if requested, and have an opportunity for a hearing to challenge the content of the records. I understand that the information transferred will be treated in a confidential manner and will not be transmitted to a third party without my consent.

______________________________ __________________________ ________________
Signature Relationship Date

Richmond Heights Local Schools

Emergency Medical Authorization

To enable parents and guardians to provide necessary information and to authorize the provision of emergency treatment for a student who becomes ill or is injured while under school authority.

Student Name ______________________________ ______________
Last First Middle Birth Date

Home Address ______________________________ **Apt.** ________

Primary Phone (____) ______________ E-mail ______________

Parent(s) or Guardian with whom student lives:

______________________ / ______________________
Name / Relation to student Name / Relation to student

Cell Phone (____) ______________ **Cell Phone** (____) ______________

Daytime (____) ______________ **Daytime** (____) ______________

Non-Residential Parent (If Applicable)

______________________ (____) ______________
Name / Relationship to Student Primary Phone

______________ ______ ______________ ______ ______________
Address Apt. City State Zip Code

Is there a court order which limits / prohibits non-custodial parent contact? O Yes O No
If yes is marked, parent must contact the office and provide legal documentation.

Transportation

Bus # to school ________ Bus # from school ________ Car rider ________ Walk ________

* If your child does not go home after school, please list where the child goes, on what days, and phone number:

______________________ (____) ______________ M T W TH F
Name / Agency Phone Number Circle Days

Note: Requests to change normal transportation MUST be made in writing.

List the person(s) who will care for your child in the event that reasonable attempts to contact parent(s) have been unsuccessful. List contacts in the order in which you prefer them to be called.

1. ______________________ (____) ______________
Name / Relationship to Student Primary Phone

2. ______________________ (____) ______________
Name / Relationship to Student Primary Phone

3. ______________________ (____) ______________
Name / Relationship to Student Primary Phone

Please include name of an older sibling who is authorized to pick up student in the event of a disaster.

______________________ Grade ________

Information Concerning Student's Health – Please print

Medical History: ____

____

Allergies (insect, food, medications, etc.): ______________________________

____

Physical impairments that limit mobility: ______________________________

____

Medications taken (including dosage and times given): ______________________

____

****Please note: If your child would need to take any medication during a 24-hour period of "sheltering in place", please contact the school nurse to discuss this matter confidentially.**

Describe any **critical medical information** the bus driver should be aware of when transporting this student:

____

____

To Grant Consent

○ **I grant consent,** in the event that reasonable attempts to contact me have been unsuccessful, (1) for the administration of any treatment deemed necessary by the named doctors:

Dr. ______________________ Phone Number (_____) ______________
Preferred Physician

Dr. ______________________ Phone Number (_____) ______________
Preferred Dentist

or in the event the designated preferred practitioner is not available, by another licensed physician or dentist.

(2) the transfer of the child to (preferred hospital) ______________________, or any hospital reasonably accessible. This authorization does not cover major surgery, unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

______________________ ______________
Signature of Parent / Guardian Date

Refusal to Grant Consent

○ **I refuse to grant consent** for emergency medical treatment of my child. In the event of illness or injury requiring medical treatment, I wish the school authorities to take the following action:

____

____

______________________ ______________
Signature of Parent / Guardian Date

I understand that I am responsible for keeping ALL information current and correct.

RICHMOND HEIGHTS LOCAL SCHOOLS

Date:______________

Home Language Survey

Federal guidelines require that this form be completed for all enrolled students.

School:________________________ Grade:__________ Gender: ☐ Male ☐ Female

Student Name:________________________ Birthdate:__________ Country of Birth:__________

Home Address:____
(Street) (City) (ZIP)

Parent/Guardian Name:____

Home Phone:______________ Cell Phone:______________ Work Phone:______________

Please answer the following questions:

1. What language did your child speak when first learning to talk? ______________
2. What language does your child speak most often at home? ______________
3. What language do you use most frequently when communicating with your child? ______________
4. List the language(s), other than English, spoken by your child______________
5. List the language(s), other than English, spoken in the home. ______________

PARENT/GUARDIAN SIGNATURE: ________________________

ONLY COMPLETE BELOW IF ANY ANSWER ABOVE WAS ANOTHER LANGUAGE

If your answer was any language other than English to questions 1-5, please answer the following questions.

6. What is the Parent/Guardian's native language? Mother__________ Father __________ Guardian__________
7. Does your child: ☐ speak English ☐ read English ☐ write English (Check all that apply.)
8. Which adults in the home **speak** English? ☐ Mother ☐ Father ☐ Guardian
9. Which adults in the home **read** English? ☐ Mother ☐ Father ☐ Guardian
10. Do you need an interpreter? ☐ Yes ☐ No If yes, do you have one available? ☐ Yes ☐ No
11. Interpreter's Name (If available): ______________________ Phone #:__________
12. When did your child first attend school in the United States? Date:______________
13. List the schools your child attended in the United States

School Name	*City/State*	*Grade*	*Dates Enrolled*

14. List the schools your child attended in another country

School Name	*City/Country*	*Grade*	*Dates Enrolled*

Immunization Summary for School Attendance
Ohio

VACCINES	*FALL 2017* IMMUNIZATIONS FOR SCHOOL ATTENDANCE
DTaP/DT Tdap/Td Diphtheria, Tetanus, Pertussis	**K** Four (4) or more of DTaP or DT, or any combination. If all four doses were given before the 4th birthday, a fifth (5) dose is required. If the fourth dose was administered at least six months after the third dose, and on or after the 4th birthday, a fifth (5) dose is not required. * **1-12** Four (4) or more of DTaP or DT, or any combination. Three doses of Td or a combination of Td and Tdap is the minimum acceptable for children age seven (7) and up. **Grades 7-12** One (1) dose of Tdap vaccine must be administered prior to entry. **
POLIO	**K-7** Three (3) or more doses of IPV. The FINAL dose must be administered on or after the 4th birthday regardless of the number of previous doses. If a combination of OPV and IPV was received, four (4) doses of either vaccine are required. *** **Grades 8-12** Three (3) or more doses of IPV or OPV. If the third dose of either series was received prior to the fourth birthday, a fourth (4) dose is required; If a combination of OPV and IPV was received, four (4) doses of either vaccine are required.
MMR Measles, Mumps, Rubella	**K-12** Two (2) doses of MMR. Dose 1 must be administered on or after the first birthday. The second dose must be administered at least 28 days after dose 1.
HEP B Hepatitis B	**K-12** Three (3) doses of Hepatitis B. The second dose must be administered at least 28 days after the first dose. The third dose must be given at least 16 weeks after the first dose and at least 8 weeks after the second dose. The last dose in the series (third or fourth dose), must not be administered before age 24 weeks.
Varicella (Chickenpox)	**K-7** Two (2) doses of varicella vaccine must be administered prior to entry. Dose 1 must be administered on or after the first birthday. The second dose should be administered at least three (3) months after dose one (1); however, if the second dose is administered at least 28 days after first dose, it is considered valid. **Grades 8-11** One (1) dose of varicella vaccine must be administered on or after the first birthday.
MCV4 Meningococcal	**Grade 7-8** One (1) dose of meningococcal (serogroup A, C, W, and Y) vaccine must be administered prior to entry. **Grade 12** Two (2) doses of meningococcal (serogroup A, C, W, and Y) vaccine must be administered prior to entry. ****

NOTES:

- Vaccine should be administered according to the most recent version of the *Recommended Immunization Schedules for Persons Aged 0 Through 18 Years* or the *Catch-up Immunization Schedule for Persons Aged 4 Months Through 18 Years Who Start Late or Who Are More Than 1 Month Behind*, as published by the Advisory Committee on Immunization Practices. Schedules are available for print or download at http://www.cdc.gov/vaccines/recs/schedules/default.htm.
- Vaccine doses administered ≤ 4 days before the minimum interval or age are valid (grace period). Doses administered ≥ 5 days earlier than the minimum interval or age are not valid doses and should be repeated as age-appropriate. If MMR and Varicella are not given on the same day, the doses must be separated by at least 28 days with no grace period.
- For additional information please refer to the Ohio Revised Code 3313.67 and 3313.671 for School Attendance and the ODH Director's Journal Entry (available at www.odh.ohio.gov, Immunization: Required Vaccines for Childcare and School). These documents list required and recommended immunizations and indicate exemptions to immunizations.
- Please contact the Ohio Department of Health Immunization Program at (800) 282-0546 or (614) 466-4643 with questions or concerns.

*Recommended DTaP or DT minimum intervals for kindergarten students four (4) weeks between doses 1-2 and 2-3; six (6) month minimum intervals between doses 3-4 and 4-5. If a fifth dose is administered prior to the 4th birthday, a sixth dose is recommended but not required.
** Pupils who received one dose of Tdap as part of the initial series are not required to receive another dose. Tdap can be given regardless of the interval since the last Tetanus or diphtheria- toxoid containing vaccine. DTaP given to patients age 7 or older can be counted as valid for the one-time Tdap dose.
*** The final polio dose in the IPV series must be administered at age 4 or older with at least six months between the final and previous dose.
**** Recommended MCV4 minimum interval of at least eight (8) weeks between dose one (1) and dose two (2). If the first (1st) dose of MCV4 was administered on or after the 16th birthday, a second (2nd) dose is not required. If a pupil is in 12th grade and is 15 years of age or younger, only 1 dose is required. Currently there are no school entry requirements for meningococcal B vaccine.

Ohio Department of Health • School and Adolescent Health

Physical Examination

Student's name	Sex ☐ Male ☐ Female	Date of birth / /

Height	Weight	BMI percentile	BP

Screening Tests

Vision

Date performed / /

Distance Acuity	☐ R	☐ L
Muscle Balance	☐ Pass	☐ Fail
Stereopsis	☐ Pass	☐ Fail
Color	☐ Pass	☐ Fail
Child wears glasses?	☐ Yes	☐ No
Tested with glasses?	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Hearing

Date performed / /

Pure Tone		
Right ear	☐ Pass	☐ Fail
Left ear	☐ Pass	☐ Fail
Child wears hearing aid?	☐ Yes	☐ No
Child under the care of a hearing specialist	☐ Yes	☐ No
Referral made?	☐ Yes	☐ No

Postural

Date performed / /

☐ No abnormality noted
☐ Screening not done
☐ Referral made
Comments

Speech/Language

Speech assessment completed	☐ Yes	☐ No
Child has no discernible speech problem	☐ Yes	☐ No
Speech evaluation recommended	☐ Yes	☐ No
Child has possible problem with ______		

Lead Poisoning

☐ Date ______ Type ☐ C ☐ V Results______ µg/dL
☐ Date ______ Type ☐ C ☐ V Results______ µg/dL

Tuberculin Test

Date______ Type ______ Results______

Health History (Serious or chronic illnesses/injuries/surgeries)

Physical Examination Date of most recent examination / /

☐ Essentially normal ☐ Abnormalities as follows

Is this child able to participate fully in:

Classroom and academic activities	☐ Yes	☐ No	Physical education classes	☐ Yes	☐ No
Competition athletics	☐ Yes	☐ No	Contact and collision sports	☐ Yes	☐ No

If limitations are advised, please specify

Does this child have any physical, developmental or behavioral issues that may affect his/her educational process?

HealthCare Provider's signature	Print name		Phone ( )
Address			Date / /
City		State	ZIP

HEA 4242 8/06

Ohio Department of Health • School and Adolescent Health

Immunization Report

Student's name	Sex	Date of birth
	☐ Male ☐ Female	/ /

Students are required to be immunized in accordance with Ohio law (Ohio Revised Code 3313.67/3313.671).
A copy of the child's immunization record may be attached or dates may be entered below.
Please note the month, day, and year for each immunization should be on record.

Vaccine	Record complete dates (month, day, year) of vaccine doses given					
Diphtheria, Tetanus, Pertussis (DTP)						
DTaP, Tdap						
DT, Td						
Polio						
Hepatitis B (HBV)						
Measles, Mumps, Rubella (MMR)						
Varicella (Chickenpox)						
Hepatitis A						
Meningococcal (MCV4, MPSV4)						
Pneumococcal (PCV)						
Measles (Rubeola) only						
Rubella only						
Mumps only						
Haemophilus influenza Type b (Hib)						
Influenza						
Other						

This information was provided by ☐ Health Care Provider ☐ Parent/Guardian ☐ Other ____________

Signature	Print name	Date
		/ /

HEA 4241 8/06