Montezuma Community Schools
504 N 4th Street
Montezuma, IA 50171
Phone: 641.623.5121 Fax: 641.623.5733

Begindergarten/Kindergarten checklist:

Required:

____Copy of Birth Certificate

____Physical (recommended yearly)

____Dental Screening

____Completed Immunizations

____Lead Testing (Before age 5)

____Vision Screening (kindergarten only)

____Home Language Survey (fill out one time only)

____Signed Release of Medical Information (fill out one time only)

____Completed Kindergarten Survey

Optional:

____Copy of Social Security Card

____Backpack Program

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Release of Medical Information:

I certify that Montezuma School District can share all information regarding the health records of ________________________ with the following person.

______________________________ ___________________________________

______________________________ ___________________________________

______________________________ ___________________________________

____
Parent Signature/Date

Proof of Insurance

_______________________________ is covered by health insurance. Yes or No
(Student Name)

Our insurance carrier is: ____

____
Parent Signature/Date

MONTEZUMA BEGINDERGARTEN/KINDERGARTEN 2021-2022 PRE- REGISTRATION FORM

WE WILL STILL NEED YOU TO ATTEND THE 2021-22 FALL REGISTRATION

Gender	Last Name	First Name	Middle Name	Birthdate	Grad e	SS Number	*Race Ethnicity

*Please state one of the following: 1=American Indian, 2=Asian, 3=Hispanic, 4=Black, 5=White

Parents/Guardian Name Primary Contact		Secondary Contact: Name, address, phone numbers
Address City/St/Zip		Children live with (circle one) Mother Father Both
Home Phone		Are there any legal restrictions concerning non-custodial parent? Yes_____ No_____ If yes, please provide legal documentation on restrictions.
Cell Phone #1		EMAIL:
Cell Phone #2		
Work Phone #1 Work Phone #2		

Kindergarten Survey for the Department of Education

Please put a check in front of the statement that best tells about your child and fill in the blanks. Thank you.

_____ My child ____________________ did not attend a preschool.

_____ My child ____________________ attended preschool at __________________________________ for one year.

_____ My child ___________________ attended preschool at ______________________________ for two years.

Other: Please explain

____ ___________________

(Parent Signature) (Date)

Montezuma Community School District

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. Is your child's first-learned or home language anything other than English? ❑ Yes ❑ No

If you responded "Yes" to question number 5 above, please answer the following questions:

6. What language did your child learn when he/she first began to talk? ______________

7. What language does your child most frequently speak at home? ______________

8. What language do you most frequently speak to your child? (Father) ______________
   (Mother) ______________

9. Please describe the language understood by your child. (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	

COONCLB-B1 (Rev. 04/13 - IA)

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249995

Montezuma Community School District

Student Race and Ethnicity Reporting

Student Name: ______________________ Date Form Completed: ____________

Date of Birth: ______________________ ❑ Male ❑ Female

Person Completing This Form: ❑ Parent/Guardian ❑ Student ❑ Other: ____________

The U.S. Department of Education has implemented new standards for school districts to report student race and ethnicity. Your answers to the following will be held strictly confidential and data will be used only in the aggregate.

1. Is your child of Hispanic, Latino, or Spanish ethnicity: ❑ Yes ❑ No
   Includes persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin.

If you answered "**Yes**" to question #1, you may also check one or more of the racial categories in question #2. If you answered "**No**", please check one or more of the following racial categories.

2. Racial Categories:

❑ American Indian or Alaska Native
Origins in any of the original peoples of North, Central, and South America who maintain a tribal affiliation or community attachment.

❑ Asian
Origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent for example Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, Philippine Islands, Thailand, and Vietnam.

❑ Black or African American
Origins in any of the black racial groups of Africa

❑ Native Hawaiian or Other Pacific Islander
Origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

❑ White
Origins in any of the original peoples of Europe, the Middle East, or North Africa.

Please complete the entire form and return it to:

Name: MONTEZUMA COMMUNITY SCHOOL Phone Number: 641-623-5121

Address: 504 North 4th St., Box 580 MONTEZUMA, IOWA 50171-0580 City: ________ State: ________ Zip: ________

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Kindergarten Requirements

The following information is required for students entering Kindergarten at Montezuma Community School.

CERTIFICATE OF IMMUNIZATION

PLEASE NOTE Immunization requirements are not delayed or suspended due to the COVID-19 pandemic.

An up-to-date immunization record is required by the state. Please talk to your child's physician or the local public health office if you need to make an appointment for your child to receive required immunizations. Iowa law requires that every child have a completed immunization record on file by the first day of school. If immunizations are in process, your child will receive a provisional status allowing 60 days for completion. At the end of 60 days, the student will be excluded from school until immunizations are completed. The Public Health Department audits all immunization records.

Kindergarten Requirements:

5 doses of DTP (1 dose must be after age 4)
4 doses of polio (1 dose must be after age 4)
2 doses of MMR (after 12 months of age)
3 doses of Hepatitis B
2 doses of Varicella (after 12 months of age)

PHYSICAL EXAMINATION FORM

Please fill out this form to identify health concerns that may impact your student. The back side is to be completed by a physician prior to the first day of school. A blood lead screen is also required, as well as a copy of the results be brought to the school. It is important to inform the school of any health issues/concerns regarding your child that may affect school performance. Examples include: asthma, ADD/ADHD, allergies (environmental, medication, or food) diabetes, seizures, surgical history and potential physical restrictions.

OVER-THE-COUNTER AUTHORIZATION

A release for the dispensing of over-the-counter (OTC) medications must be filled out every year. If not completed, a one-time over the phone approval will be allowed. After that, no OTC medication will be given unless a release is signed.

MEDICATION ADMINISTRATION AUTHORIZATION

If medications are needed at school for a long-term diagnosis or an acute illness, a medication release form is needed for each medication. The school nurse or a staff member who has successfully completed a medication administration course will administer medicine. **Any medication prescribed to be given once daily up to three times a day or for morning or evening should be given at home.** Medication is required to be brought in its original container with prescription label attached and may only be transported to and from school by a responsible adult.

DENTAL SCREEN

All children enrolling in Kindergarten must present documentation of a dental screening upon enrollment. The required *Certificate of Dental Screening* is enclosed in this packet.

VISION

All children entering Kindergarten and 3rd grade are required to have a vision screen and results must be submitted by the school to the Iowa Department of Public Health no later than 6 months after the start of the school year. Please have your child's healthcare provider note vision screen dates and results on their physical form. We will also partner with the local Lion's Club and Kid Sight to screen early elementary students during the year.

HEARING SCREENING

Hearing screens will be conducted annually by AEA on students in Kindergarten, 1st, 2nd, and 5th grades. New students, special education students due for 3-year evaluations, and students with previous known losses will have their hearing screened.

COMMUNICABLE DISEASES

(Examples: chicken pox, impetigo, strep throat, fifth's disease, ringworm, pink eye, mono, etc.) It is important to notify the school of these diagnoses so notification may be sent to the child's class of potential exposure if necessary (no personal identification will be given out). If calling your child out sick, please note if they have a fever, vomiting or diarrhea.

WHEN TO KEEP YOUR CHILD HOME

Please keep the health of others in mind when deciding whether to keep your child home or send them to school. If they have vomited or have had diarrhea within the past 24 hours, have a fever of 100.0 or higher, have an undiagnosed rash, or questionable pink eye, please do not send them to school. Students must be free from vomiting, diarrhea, and fever-free without the use of fever-reducing medication (Tylenol/Motrin) for 24 hours before returning to school. If prescribed an antibiotic, they must be on the antibiotic for 24 hours before returning to school.

EXCLUSION FROM PHYSICAL ACTIVITY

Any illness or injury requiring exclusion of physical activity (PE or recess) will require a signed note from a physician.

Thank you for your participation in helping keep our school a healthy place for all students.

Hannah Dengler, RN
School Nurse

Montezuma Community School
504 N. 4th Street
Montezuma, IA 50171
Phone: 641 623-5121 Fax: 641 623-5733

PARENT PERMISSION TO GIVE "OCCASIONAL" OVER-THE-COUNTER MEDICATION

2021-2022 SCHOOL YEAR

Name of Student: ________________________________ **Grade:** ____________

Allergies: ____

Over-the-counter (OTC) medications are drugs that do not require a prescription and are purchased "over-the counter". This form is required before over-the-counter medications can be administered at school.

PLEASE INITIAL EACH MEDICATION FOR WHICH YOU ARE GIVING PERMISSION

________________**I approve all medications listed below**

________________**I do not want any OTC medications given to my student**

Topical:
______antibiotic ointment (ex. Triple antibiotic ointment)
______Benadryl cream
______eye drops for irritation and allergies (Refresh drops)
______lip products (chap sticks, natural lip emollient)
______sting relief spray (containing benzocaine, lidocaine, and/or ethyl alcohol)

Oral:
______ibuprofen (Advil)
______acetaminophen (Tylenol)
______antacids (Tums)
______antihistamine (Benadryl)
______cough drops (plain or medicated)

THE MEDICATIONS INDICATED ABOVE MAY BE ADMINISTERED TO MY STUDENT

______________________________________ ________________

(SIGNATURE OF PARENT OR GUARDIAN) (DATE)

Montezuma Community School

504 N. 4th Street
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Please check with the school nurse to see which medications are available for students in the school nurse office and which medications you will need to supply. OTC medications will be given at the manufacturer's recommended dosage.

If appropriate, OTC medications brought to school for student use must be in the original manufacturer's container with the label intact or the medication will not be accepted. *For safety purposes, parents are required to bring the medication directly to the nurse.* The medication should be sealed in an envelope in the original manufacturer's container.

The school is not able to supply medication for frequent or daily use. For OTC medications not listed on this form or if medication is to be given on a schedule, please talk to the school nurse. Additional documentation may be required.

This form must be completed yearly.
Prescription medications to be administered at school require a separate form to be filled out, including EPI Pens and Inhalers.

Thank-you,
Hannah Dengler
hdengler@montezuma.k12.ia.us
641-623-5121

MONTEZUMA COMMUNITY SCHOOL DISTRICT
PHYSICAL EXAMINATION FORM FOR PRESCHOOL AND KINDERGARTEN

Date of physical: ______________________ Male ____ Female ____

Child's name: ______________________ Birthdate: ____________

Parent's name: ______________________ Phone: ____________

Parent's address: ______________________________________

Family doctor: ______________________ Phone: ____________

Doctor's address: ______________________________________

Family dentist: ______________________ Phone: ____________

Dentist's address: ______________________________________

List all prescription and over-the-counter medications your child takes regularly and time taken:

____

List any allergies (medication, food, environmental): ______________________

____

Type of reaction: ______________________________

List any dietary restrictions: ______________________________

List any conditions that could affect school work: ______________________

Child's Health History (Circle Yes or No)

Yes	No	ADD/ADHD	Yes	No	Diabetes
Yes	No	Asthma	Yes	No	Hospitalization
Yes	No	Bowel/bladder problems	Yes	No	Eating problems
Yes	No	Kidney/bladder infections	Yes	No	Hearing problems
Yes	No	Heart problems	Yes	No	Hearing aids
Yes	No	Rheumatic fever	Yes	No	Ear infections
Yes	No	Strep throat	Yes	No	Vision problems
Yes	No	Headaches	Yes	No	Eyeglasses
Yes	No	Head injury / concussion	Yes	No	Tuberculosis
Yes	No	Depression / anxiety	Yes	No	Chicken pox
Yes	No	Seizures / epilepsy	Yes	No	Immunizations current?

If yes to any of the above, please explain: ______________________

____

Has your child been seen by a dentist? Yes No If yes, when: ____________

List any operations and major injuries: ______________________

____

To Be Completed By Physician

	Normal	Abnormal Findings
Height/weight		
Blood pressure		
Developmental		
Eyes		
Vision		
Ears		
Hearing		
Nose		
Mouth/throat		
Neck		
Glands		
Heart		
Lungs		
Abdomen		
Neurological		
Musculoskeletal		
Posture		
Nutrition		
Skin		
Genitals		
Urinalysis		
Blood count		
Lead screening (required) if previously screened, send a copy		

Comments: ____

This child is physically able to take part in the regular school program: Yes___ No___

Up-to-date certificate of immunizations attached (required): Yes___ No___

Signature of physician: ______________________________ Date: __________

Iowa Department of Public Health
CERTIFICATE OF VISION SCREENING

RETURN COMPLETED FORM TO CHILD'S SCHOOL.

Student Information (please print)

Student Last Name:	Student First Name:	Birth Date (M/D/YYYY):
Parent/Guardian Telephone Number:	Student Address:	
Zip Code:		

Screening Information (vision screening provider must complete this section *or parents may attach a copy of vision screening results given to them by a provider.*)

Date of Vision Screening: ____________________

Results (visual acuity):

Right Eye__________ Left Eye__________

Overall Result (Please select one):

Pass ○ or Fail ○

Referral to eye health professional (Please select one):

Yes ○ or No ○

Screening Provider: ____________________

Provider Business Name/Source of Screening: (please print) ____________________

Provider Name: (please print) ____________________ Phone: __________

Signature and Credentials of Provider: ____________________ Date: __________

A parent or guardian of a child who is to be enrolled in a public or accredited nonpublic elementary school shall ensure the child is screened for vision impairment at least once before enrollment in Kindergarten and again before enrollment in the 3rd grade.

To be valid, a minimum of one child vision screening shall be performed no earlier than one year prior to the date of enrollment in Kindergarten and no later than six months after the date of the child's enrollment in Kindergarten.

To be valid, a minimum of one child vision screening shall be performed no earlier than one year prior to the date of enrollment in 3rd grade and no later than six months after the date of the child's enrollment in 3rd grade.

RETURN COMPLETED FORM TO CHILD'S SCHOOL.

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
☐ Distance vision only
☐ Near vision only
☐ As needed

TO THE EYE CARE PROFESSIONAL: Please sign and date this card after examination.

Dr. Name: (Please Print) ____

Date________________Signature______________________________________

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):
Parent or Guardian Name:	Telephone (home or mobile):	
Street Address:	City:	County:
Name of Elementary or High School:	Grade Level:	Gender: ☐ Male ☐ Female

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 healthy 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) ______________________ Provider Business 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 onto this form from another health document. 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 Bureau
515-281-3733 • 866-528-4020 • www.idph.state.ia.us/hpcdp/oral_health.asp

A designee of the local board of health or Iowa Department of Public Health may review this certificate for survey purposes.