Clarinda Community School District
Enrollment/ Emergency Form

Student_____ Grade_____ Date of Birth_____ Male/Female_____

Home Phone_____ Address_____City,State,Zip_____

Family Information:

List Name and Relationship to child:	Address	Home Phone	Cell Phone	Employer	Work Phone	Email address	Has contact with student Yes/No
Parent/Guardian Living with Student:							
Spouse of Parent/Guardian Listed Above:							
AND							
Parent/Guardian Not Living with Student:							
Spouse of Parent/Guardian Listed Above:							

Please Mark if student:_____ is Open Enrolled Y/ N **in Special Education** Y/ N **in Band** Y/ N If Y, list instrument _____

Student lives with: __Parent(s) __Caretaker __Legal Guardian **Student lives in:** __Parent home __Relatives/Friends home __Hotel __Other

Contact Information (please list LOCAL contacts):

Child Care_____ Child Care Phone_____

Emergency Contact #1_____ Phone (1) _____ Phone (2) _____

Emergency Contact #2_____ Phone (1) _____ Phone (2) _____

Emergency Contact #3_____ Phone (1) _____ Phone (2) _____

For Residents New to Clarinda: What Brought You to Clarinda: ___Employment ___Relatives ___Other - please list _____

(OVER)

School Medical Registration Form – Health History

Please list a local provider that you prefer in the case of an emergency.

Family Doctor _____ Date of last exam _____ Does student have a current school physical Y/N

Dentist _____ Date of last exam _____

Eye Doctor _____ Date of last exam _____

***In the event of an emergency, 911 will be called and your child will be taken to Clarinda Regional Health Center.**

List other doctors, specialists, counselors (local or out-of-town): _____

Allergies (list allergy and type of reaction): _____

Medications taken routinely: _____

Will your child take medicine at school: Yes/No If yes, what medication? _____

* Note- All medications given at school must be supplied by the parent in the original container and a medication permit form must be completed and signed by the parent.

1. Does your child have health insurance? Yes/No Provider Name: _____
2. Do you have any concerns about your child's general health? (eating, sleeping, weight, etc.) Yes/No
3. Does your child have any chronic illness or medical condition? (seizures, asthma, heart condition, ADHD, etc.) Yes/No
4. Has your child had any serious accidents? (burns, head injury, broken bones, etc.) Yes/No
5. Does your child have any problems with:

Hearing	Yes/No	Vision	Yes/No	Does your child wear glasses?	Yes/No
Speech	Yes/No	Physical Disabilities	Yes/No		

Explain all yes answers in the space provided below:

_____

_____

_____

This form will be added to the students health file and shared with appropriate school staff.

Parent Signature: _____ *Date:* _____

(OVER)

Clarinda School District
Home Language Survey

Date_____School_____Grade_____

Student Name:_____
(last) (first) (middle)

*Place of Birth:_____

Father/Guardian Name: _____

*Employment: _____

Mother/Guardian Name: _____

*Employment: _____

Address: _____

Phone Number : _____(home)_____(work)

1. Was English the first language your son/daughter learned to speak? _____Yes _____No

2. What language do you speak to your son/daughter? (father) _____

(mother) _____

3. What language does your son/daughter speak to you? _____

4. What language does your son/daughter speak to other relatives? _____

5. What language does your son/daughter speak to friends? _____

6. In what language would you prefer to receive

communication from the school? _____

I understand my son/daughter, _____, will receive English language proficient testing. I will be notified if my son/daughter qualifies for English Language Learner (ELL) program services. I understand that at the time I have the right to refuse ELL services for my child. However, I can request services at a later date.

_____ _____
(Parent/Guardian Signature) (Date)

OFFICE USE ONLY: Refer for:

Initial ELL Identification: _____ Initial Migrant Identification: _____

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) _____ 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 Center
515-242-6383 • 866-528-4020 • www.idph.state.ia.us/ohds/OralHealth.aspx
A designee of the local board of health or Iowa Department of Public Health may review this certificate for survey purposes.

School District: Clarinda CSD 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 Address: 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 is the date your family arrived in the city/town? _____
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? (Check all that apply)

   [ ] Agriculture; planting/picking fruits and vegetables
   [ ] Planting, Growing, Detasseling or Farm labor
   [ ] Processing/packing agricultural products
   [ ] Dairy/Poultry/Egg/Livestocks
   [ ] Meatpacking/Meat processing
   [ ] Fishing or fish farms
   [ ] Other (Please specify the 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) or Susan Selby at 515-281-4732 (susan.selby@iowa.gov)

State law requires that the school report specific data to the Department of Education. Please indicate whether or not your child attended preschool prior to attending Kindergarten.

_____ Yes, my child attended preschool. If yes, please list preschool name: _____

_____ No, my child did not attend preschool.

Childs Name: _____Parent Signature: _____

Student Name: _____ **Date:** _____

Is this student Hispanic/Latino? (A person of Cuban, Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race.)

- ☐ **No, not Hispanic/Latino**
- ☐ **Yes, Hispanic/Latino**

The above part of the question is about ethnicity, not race. No matter what you selected above, **please continue to answer the following** by marking one or more boxes to indicate student race.

What is the student's race? (*Choose one or more*)

- ☐ **American Indian or Alaska Native** (A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.)
- ☐ **Asian** (A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)
- ☐ **Black or African American** (A person having origins in any of the black racial groups of Africa.)
- ☐ **Native Hawaiian or Other Pacific Islander** (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)
- ☐ **White** (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

Parent Name (print): _____Parent Signature: _____

**This is a requirement of the Iowa Department of Education.*