LAKOTA LOCAL SCHOOL DISTRICT

5200 C.R. 13
Kansas, OH 44841
Telephone: 419-986-6650 FAX: 419-986-6651

Please complete and return the entire registration packet to Lakota Local School's District Office. Please bring your child's original birth certificate, immunization records, proof of residency, and custody papers (if applicable) at the time of registration. *No student will be enrolled without proper documentation and social security number.*

If you have questions, please feel free to call 419-986-6650.

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For Office Use Only

New Student Checklist

Student _____ Student's Current Grade in 2017-2018 _____

_____Proof of Residence
_____Copy of Birth Certificate
_____Copy of Social Security Card
_____Registration Form
_____Guardianship Papers (if applicable)
_____Ohio School Health History
_____Immunization Record
_____Bus Route Form
_____Release of Records
_____Ohio Health History-Oral (K-only)
_____Ohio Health History-Physical (K-only)
_____Schedule Built
_____Perm Folder
_____Course History Entered

_____Date Entered
_____Date Withdrawn from other school
_____IRN #_____ from other school
_____OGT/OAA Record
_____Writing
_____Science
_____Math
_____Social Studies
_____Reading
_____IEP/ETR
_____Records Received
_____TGRG
_____Honeywell

LAKOTA LOCAL SCHOOL DISTRICT REGISTRATION FORM

(Please Print)

Date_____ Student's Current Grade in 2017-2018_____ Social Security Number _____

Child's name exactly as it appears on birth certificate including the full middle name:

_____

First **Middle** **Last**

City and State that child was born in _____

Child's Birth Date _____ Sex: Male Female

Child's Address_____ P.O. Box_____

City_____ State_____ Zip Code_____ County_____

Father/Guardian's name_____ Mother/Guardian's name_____

(From student's Birth Certificate-Do not list step-parent) ***(From student's Birth Certificate -Do not list step-parent)***

Mother's Maiden Name_____

Father/Guardian's address_____

Mother/Guardian's address_____

Father/Guardian's telephone-Home_____ Mother/Guardian's telephone-Home_____

Cell_____ Work_____ Cell_____ Work_____

Parent's Marital Status: ☐ Never married ☐ Married ☐ Separated ☐ Divorced

Do you have custody papers? ☐ Yes ☐ No ☐ Custody in Process

Parent/Guardian Name(s) with whom the child lives _____

First and last names ***(Do not list step-parents)***

Parent/Guardian Relationship with whom the child lives (Please check one)

_____ Parents _____ Grandparents _____ Guardian

_____ Mother (if student is living with mother only) **_____Father (if student is living with father only)**

_____ Court (if student has been placed by the court)

Ethnicity:

Is the student of Hispanic/Latino heritage? ☐ **Yes** ☐ **No**

Please circle EACH that apply:

A-Asian **B-Black/African American** **I-American Indian or Alaskan Native**

P-Native Hawaiian-Pacific Islander **W-White**

Child's native language_____ **Parent's native language** _____

Is there another language spoken in the home? ☐ **Yes** ☐ **No (If yes, what is the language)?**

_____

Is this student presently under expulsion or suspension? ☐ **Yes** ☐ **No** **(If yes, please provide copies of paperwork)**

Has your child ever been retained? ☐ **Yes** ☐ **No**

Has your child been served by any of the following Programs?

Special Education	☐ **Yes**	☐ **No**
504 Plan	☐ **Yes**	☐ **No**
Speech and Hearing	☐ **Yes**	☐ **No**
Talented and Gifted	☐ **Yes**	☐ **No**
Guidance and Counseling	☐ **Yes**	☐ **No**
Title I Reading	☐ **Yes**	☐ **No**

If yes, please explain:_____

Is there a step-parent (a person to whom you are married) that your child lives with at the child's address?
☐ **Yes** ☐ **No**

If yes, what is the step-parent's name? _____

May we contact you by e-mail? ☐ **Yes** ☐ **No**

If yes, what is your e-mail address:_____

Please list all siblings who attend Lakota Local Schools:

Last Name_____ First Name _____ Current Grade _____
Last Name_____ First Name _____ Current Grade _____
Last Name_____ First Name _____ Current Grade _____

Parent Signature _____ **Date** _____

LAKOTA LOCAL SCHOOLS

CUSTODY STATEMENT

This statement is in regards to my child who is a student at Lakota Local Schools.

_____ Child lives with both parents listed on birth certificate, custody is not applicable.

We are married_____ We are not married_____

_____ Parents are divorced, we have custody papers.

_____ No father is listed on the birth certificate.

_____ I am the child's mother and was not married at the time of the child's birth and so custody is not applicable.

_____ I am the child's father and I have custody papers.

_____ My spouse and I are *not* living together, but there has been no legal action started that could result in custody being awarded to the other spouse.

_____ Separation (divorce, dissolution, etc...) action has been started, but no final decree has been rendered. *I will bring in a copy of the papers once they are complete*.

_____ Child does not live with either parent. I am the child's legal guardian and I have custody papers.

_____ Other _____

Parent/Guardian Name/Signature_____

Student's Name (please print)_____

Date _____

Ohio Department of Health • School and Adolescent Health

Health History

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

Family Health History Please list allergies, heart problems, diabetes, cancer or other serious health conditions.

Father
Mother
Brothers and Sisters

Birth and Developmental History ☐ No unusual birth or developmental history

Did the mother have any unusual physical or emotional illness during this pregnancy? ☐ Yes ☐ No

Was infant born full term? ☐ Yes ☐ No Did the infant have any sickness or problems? ☐ Yes ☐ No

Briefly explain illness or problems.

How does the child's development compare to other children, such as his or her brothers/sisters or playmates?

☐ About the same ☐ Delayed ☐ Advanced

Student Health Conditions

☐ **YES,** my child receives regular medical/health care for the following conditions: ☐ **NO** medical conditions

☐ Allergies	☐ Diabetes	☐ Seizure disorder
☐ Asthma	☐ Depression	☐ Sickle cell anemia
☐ ADD/ADHD	☐ Ear problem/hearing difficulty	☐ Skin conditions
☐ Autism	☐ Emotional concerns	☐ Speech problems
☐ Behavior concerns	☐ Headaches	☐ Traumatic brain injury
☐ Birth/congenital malformations	☐ Heart problems	☐ Vision problems (glasses, contacts)
☐ Bone/muscle/joint problems	☐ Hemophilia	☐ Other_____
☐ Blood problems	☐ Juvenile arthritis	☐ Other_____
☐ Bowel/bladder problems	☐ Lead poisoning	☐ Other_____
☐ Cancer	☐ Migraines	☐ Other_____
☐ Cystic fibrosis	☐ Neuromuscular disorder	☐ Other_____

Please explain any conditions above or any reasons for hospitalizations.

Please indicate any allergies your child may have.

Allergy type	Reaction	School restrictions or recommended actions
☐ Bee/Insect		
☐ Food		
☐ Medication		
☐ Other		

Health History continued

Please list any prescription and over the counter medication that your child takes on a regular basis.

Medication and dose	Time	Reason

Do any health and/or medical conditions require school restrictions, modifications, and/or intervention?

☐ Yes ☐ No If YES, please explain.

Does the student require any special procedures and/or treatments for their health condition(s)?

☐ Yes ☐ No If YES, please explain.

Please indicate any other information about your child's health or development that you think would be helpful for the school to know.

Form completed by **Relationship to student** **Date**

Ohio Department of Health • School and Adolescent Health

Oral Assessment

Student's name	Date of birth
	/ /

The following services have been performed (please check all that apply)

☐ Examination ☐ Fluoride application ☐ Oral prophylaxis (cleaning) ☐ Prescription for fluoride supplement
☐ Orthodontic assessment ☐ Radiographs ☐ Dental sealant ☐ Treatment (restoration, pulp therapy)
☐ Other_____

The following oral hygiene instruction was provided (please check all that apply)

☐ Toothbrushing ☐ Flossing ☐ Dietary counseling ☐ Use of fluoride mouthrinse
☐ Other_____

The following statements are applicable (please check all that apply)

☐ All necessary preventive services have been performed. (Fluoride treatment, prophylaxis)
☐ No restorative services are required at this time.
☐ Further treatment is indicated.(See comments)
☐ Further appointments have been arranged. (Orthodontic, restorative)
☐ Routine recall visits recommended.

Comments

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

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

Bus # _____ Date _____

Time _____ AM

Time _____ PM

LAKOTA LOCAL SCHOOLS
BUS ROUTE CHANGES/ADDITIONS

PS/K _____ Parent's Name _____

Elementary _____ Address _____

MS _____ _____

HS _____ Phone # _____ Cell #_____

Work Phones _____

Alternate Contact Name & Phone #_____

Relationship to the Child _____

Be as specific as possible on the address. Give house number and road number. Below please indicate other information that will be helpful in locating the address. (Road name, name of neighbors, landmarks, etc.) Also, please mark location on the diagram below.

Student(s) name	**Grade**
_____	_____
_____	_____
_____	_____
_____	_____

Map

_____

LAKOTA LOCAL SCHOOLS – IRN #049569

PARENT/GUARDIAN REQUEST FOR RELEASE OF RECORDS

Former School _____
Address _____
_____
Phone # _____
FAX # _____

Student's Name _____ Grade _____

Effective Start Date _____

Specific records to be released:

_____ Transcripts (Includes: academic, attendance, class rank, grades at time of withdrawal and all test scores)
_____ Psychological reports (Released only at request of school psychologist and parent)

_____ Health records **(Please include all immunization records and dates of immunizations)**

_____ IEP/MFE and all testing information

_____ Current/most recent state testing results (OAA, OGT, etc…)

_____ Other (Please specify) _____

The above records are to be released to:

_____ Lakota Elementary School
5200 C.R. 13
Kansas, OH 44841
Phone: (419) 986-6640
FAX: (419) 986-6631

_____ Lakota Middle School
5200 C.R. 13
Kansas, OH 44841
Phone (419) 986-6630
FAX: (419) 986-6631

_____ Lakota High School
5200 C.R. 13
Kansas, OH 44841
Phone (419) 986-6620
FAX: (419) 986-6621

Reason for release: _____

As the parent/guardian, I give permission to release records designated above. I understand that I may have an opportunity to challenge the content of the records and for the actual cost of copying, I may receive a copy of the records released.

_____ _____
Date Parent/Guardian Signature