Early Bird Preschool

Child & Family Information and Registration Form

The information you provide on this form is strictly confidential. This information is important because it helps us to have a picture of the whole child when we are considering referral or placement options. Thank you for your cooperation.

Today's Date:	Form Completed By:	Relationship to Child:
Child's Last Name:	Child's First Name:	Child's Middle Name:
Child's Date of Birth:	☐ Male ☐ Female	Potty Trained? Y N
Mother's Name: Employed At:	Father's Name: Employed At:	☐ Married ☐ Single ☐ Divorced ☐ Widowed
Address:	Phone:	E-mail:
If single or divorced, custody of child: ☐ Mother ☐ Father ☐ Joint	Name(s) of Guardian(s):	Which class do you prefer? ☐ Morning ☐ Afternoon
Do either of the following describe your situation? ☐ Grandparent raising grandchild ☐ Child is in foster care		

Sibling Name:	Birthdate:	Lives with student: Y N	Male Female
Sibling Name:	Birthdate:	Lives with student: Y N	Male Female
Sibling Name:	Birthdate:	Lives with student: Y N	Male Female
Sibling Name:	Birthdate:	Lives with student: Y N	Male Female
Sibling Name:	Birthdate:	Lives with student: Y N	Male Female

Child History

Was your child premature at birth? Y N Child's Birth Weight _____lbs _____oz

Were there any complications or difficulties during pregnancy and/or birth of this child? Y N

Explain:

Was this child exposed to drugs or alcohol before birth? (Including prescription drugs taken by mother during pregnancy?) Y N

Explain:

Did your child have a birth defect, injury, or illness requiring hospitalization before the age of three? Y N

Explain:

Does your child have any special needs? Y N

Explain:

Does your child have an IEP or a diagnosed disability? Y N

Please list any allergies, medications, or medical conditions your child has:

Student Health History — Check all that apply		
Asthma	☐ Diabetes	☐ Cancer
Migraines	☐ Latex Allergy	☐ Seizures
Genetic rder	☐ Visions/Hearing Problems	☐ Bee sting allergy
Blood Disorder	☐ Bladder/Bowel Disorder	Other:

Programs you or your child have used — Check all that apply		
☐ Head Start	☐ DCFS	☐ Bi-County
☐ Parents as Teachers	☐ Early Intervention 0-3	☐ Lee County Health Dept.
☐ Luthern Social Services	☐ Shining Star	☐ WIC

your child ever been enrolled in any of the following: ☐ other preschool ☐ day care center ☐ in home child care

your child ever received a developmental screening before? Y N

s, who did the screening and what was the date?

Family History

Hispanic ☐ Non-Hispanic (if non-Hispanic, choose a race below)

White	☐ Black	☐ Asian
American Indian	☐ Pacific Islander	☐ Multiracial

at language do the parents speak in the home?

there any adults in the home who cannot read? Y N

nyone in the family active duty military? Y N

you receive assistance from any of the following programs?

Free/Reduced Lunch ☐ Public Housing ☐ Child Care Subsidy ☐ WIC ☐ SNAP ☐ TANF ☐ Medicaid

o to all of these, what is approximate gross family income? _____ ☐ per month ☐ per year

hild has older siblings, please indicate school lunch status: ☐ Free ☐ Reduced ☐ Paid

ase indicate any problems er siblings have in school	☐ Chapter 1 ☐ Poor Attendance ☐ School dropout ☐ Poor Grades ☐ Title 1/Poor Reader ☐ Behavior Problems ☐ Other_____

e of Mother when child was born _____ Age of Father when child was born _____

hest level of education Mother has completed:	Highest level of education Father has completed:
Did not finish – Grade completed _____	☐ Did not finish – Grade completed _____
GED	☐ GED
High School Diploma	☐ High School Diploma
Some college studies	☐ Some college studies
College degree	☐ College degree

here family history of: ☐ Life threatening illness ☐ Physical or Sexual Abuse ☐ Mental Illness ☐ Disability

ase specify:

any of the following describe your living situation:

Doubled up with friends or relatives ☐ Living in a shelter, motel, vehicle or campground

Living on the street ☐ Living in an abandoned building, trailer or other inadequate accommodations

d any agency refer you to our program? Y N Name of Agency _____

Early Bird Preschool
Parent Agreement Form

Child's Name _____ Date _____

CIRCLE

Yes / No 1. I permit my child to be screened for normal development in the following areas: hearing, vision, speech, fine & gross motor, social & emotional skills, problem solving skills, and English proficiency (if applicable).

Yes / No 2. I agree to **have a physical exam** completed for my child **before** his/her first day of school along with a copy of his/her up-to-date immunization record. I also agree to **provide a certified copy my child's birth certificate before** his/her first day of school.

Yes / No 3. I agree it is my responsibility as a parent to ensure my child is at school daily and on time unless illness prevents attendance. I also agree to pick up my child at the designated dismissal time. I understand I must call the school to inform them if my child won't be in attendance.

Yes / No 4. I agree to allow the Early Bird Preschool staff to make home visits during the school year, at mutually convenient hours, as required by the state grant. I understand there will be a minimum of one home visit per school year. I understand that either I or Early Bird staff may request a home visit.

Yes / No 5. I give my permission to Early Bird Preschool and/or Dixon Public Schools staff to provide routine preventative health care and emergency first aid to my child.

Yes / No 6. I give my permission to Early Bird Preschool and/or Dixon Public Schools staff to obtain emergency medical treatment for my child in situations that mandate a physician's order only after every effort has been made to obtain consent.

Yes / No 7. I give permission for my child to participate in all supervised Early Bird Preschool Field Trips.

Yes / No 8. I give permission for my child to be observed as part of an early childhood project and/or play based assessment.

Yes / No 9. I agree to volunteer as a classroom helper or (find a substitute volunteer) at least once a month as required by the state grant. I agree to cooperate with all Early Bird Preschool staff while volunteering and understand that I am subject to the personnel standards of conduct outlined in the Personnel Policies for the school district.

Notification for public relations, radio, television, newspapers, websites, etc: Parents must fill out the Dixon Public Schools Authorization Sheet notifying the principal that they **do not** want their child's name or picture released to the media for public recognition of student achievements, class projects, or promotional purposes.

_____ _____

Parent/Legal Guargian Signature Signature of Early Bird Staff

Early Bird Preschool
Emergency Contacts & Child Release Permission Form

'lease list, in order, who should be called if we need to contact you about your child during the day for illness, :tc. (List yourself if the order you want to be notified, if you so desire.)

NAME	RELATIONSHIP	PHONE

give permission for the following person(s) to pick up my child from the Early Bird Preschool site. I understand :hat, without my written permission, no person may leave the site with my child other than an Early Bird or)ixon Public Schools staff member. I understand that should someone not listed try to pick my child up from ;chool, I will be called by a Dixon Public School staff member to get my consent for my child to be released to :hat individual. I further understand that should I not be able to be reached, my child will not be released.

NAME	RELATIONSHIP	PHONE

Revised 1/18

Current Date _____ **DIXON PUBLIC SCHOOLS REGISTRATION INFORMATION**

For Office Staff Only
☐ New Family ☐ Proof of Residency

School _____ Starting Date _____

Student's Last Name _____ Student's First Name _____ Middle Name _____

Birth Date _____ Grade _____ Gender _____

Home Address _____ City _____ Zip Code _____

Home Phone _____ Unlisted? ☐ Cell Phone _____

Ethnicity: ☐ Hispanic OR If Non-Hispanic please choose one of the following: ☐ White ☐ Black or African American ☐ 2 or more races ☐ Asian ☐ American Indian or Alaskan Native ☐ Other Pacific Islander

Are you living with friends or relatives because of your financial situation or are you homeless? ☐ Yes ☐ No

Has this student ever attended Dixon Public Schools? ☐ No If yes, what school _____

IF TRANSFERRING, Name of Previous School _____

Address/City/State _____

HOME LANGUAGE SURVEY:

Is a language other than English spoken in your home? ☐ No ☐ If yes, what language _____

Is this the primary language in the home? ☐ No ☐ Yes

Does your child speak a language other than English? ☐ If yes, what language? _____

**If you answered yes to the above language questions, the law requires to test your child's English Language proficiency. The school will measure your child's listening, speaking, reading, & writing skills.*

Is this child a Foster Child? ☐ Yes Placed by _____ (please supply our office with documentation)

If yes, does the biological parent live in the Dixon School District? ☐ Yes ☐ No

SPECIAL SERVICES:

Is this student receiving Special Education Services or have a current IEP? ☐ Yes ☐ No

Type of Service

Does the child have any known: ☐ Speech/Language Needs ☐ Hearing Problems ☐ Vision Problems ☐ Advanced Skills ☐ Disabilities

Does this student have at least one Parent or Guardian who is an active member of the Army, Navy, Air Force, Marine Corps, or Coast Guard that is full-time in the military service of the United States? ☐ Yes ☐ No

GUARDIAN INFORMATION:

Mother's Last Name _____ First Name _____ ☐ Lives with Student

If you do not live with the student, what is your address? _____

Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

Email address _____ Is this person a CONVICTED CHILD SEX OFFENDER? ☐ Yes ☐ No

Do you have sole custody: ☐ **Yes (If yes, please supply our office with documentation)** ☐ **No** ☐ **Joint Custody?**

Father's Last Name _____ First Name _____ ☐ Lives with Student

If you don't live with the student, what is your address? _____

Home Phone _____ Cell Phone _____

Employer: _____ Work Phone _____

Email address _____ Is this person a CONVICTED CHILD SEX OFFENDER? ☐ Yes ☐ No

Do you have sole custody: ☐ **Yes (If yes, please supply our office with documentation)** ☐ **No** ☐ **Joint Custody?**

Step Mother's Last Name _____ First Name _____ ☐ Lives with Student

Address _____ Employer _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____ Is this person a CONVECTED CHILD SEX OFFENDER? ☐ Yes ☐ No

Step Father's Last Name _____ First Name _____ ☐ Lives with Student

Address _____ Employer _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____ Is this person a CONVECTED CHILD SEX OFFENDER? ☐ Yes ☐ No

Other Legal Guardian's Last Name _____ First Name _____ Lives with Student ☐

Address _____ Employer _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____ Is this person a CONVECTED CHILD SEX OFFENDER? ☐ Yes ☐ No

Emergency Information: **Please list in order, who should be called if we need to contact you about your child during the day for illness, etc…** ***(List yourself in the order you want to be notified, if you so desire)***

1. Name _____ Relationship _____ Home Phone _____
   Alternate Phone _____ Is this person a CONVICTED CHILD SEX OFFENDER? ☐ Yes ☐ No
2. Name _____ Relationship _____ Home Phone _____
   Alternate Phone _____ Is this person a CONVICTED CHILD SEX OFFENDER? ☐ Yes ☐ No
3. Name _____ Relationship _____ Home Phone _____
   Alternate Phone _____ Is this person a CONVICTED CHILD SEX OFFENDER? ☐ Yes ☐ No
4. Name _____ Relationship _____ Home Phone _____
   Alternate Phone _____ Is this person a CONVICTED CHILD SEX OFFENDER? ☐ Yes ☐ No

Physician _____ Office Phone _____

Daycare Provider _____ Phone _____

List Name (s) of other children in your household:

Name _____ Relationship _____ Year Born _____ ☐ Male ☐ Female

Name _____ Relationship _____ Year Born _____ ☐ Male ☐ Female

Name _____ Relationship _____ Year Born _____ ☐ Male ☐ Female

Name _____ Relationship _____ Year Born _____ ☐ Male ☐ Female

Please Sign: _____ **This form can only be signed by a parent or guardian**

DIXON PUBLIC SCHOOLS
AUTHORIZATION SHEET

Rev. July, 2012

STUDENT'S NAME_____ **GRADE**_____
(Please Print)

FIELD TRIPS:

Please allow the above student to participate in scheduled field trips. _____ **Please initial**

HANDBOOK:

I acknowledge that the Student/Parent Handbook is available to view on the DPS Website.

_____ **Please initial**

Notice to Parents Student Pictures/Images/Publications

I give permission for the above student to have their photo printed in a school yearbook and class photo.
Yes ☐ **No** ☐ **Check One**

I grant consent to the Dixon School District to identify a picture of the above student, by full name and/or the school he or she attends, in any school sponsored material, publication, videotape, or web site. This consent is valid for the entire time the above student is enrolled in Dixon Public Schools. I may revoke this consent at any time by notifying the building Principal.
Yes ☐ **No** ☐ **Check One** _____ **Please initial**

INTERNET/ACCELERATED READER: Both you and your child must sign this agreement:

Electronic Network Access Acceptable Use Policy Agreement

I understand and will abide by the Authorization for Electronic Network Access. I further understand that should I commit any violation, my access privileges will be revoked, and school disciplinary action and/or appropriate legal action may be taken. In consideration for using the District's electronic network connection and having access to public networks, I hereby release the District and its School Board members, employees, and agents from any claims and damages arising from my use, or inability to use the district's electronic network access. I acknowledge that I have read and understand the Student's Acceptable Use Policy on the District's Website.

Date _____ **Student Signature** _____

I have read this Authorization for Electronic Network Access. I understand that access is designed for educational purposes and that the District has taken precautions to eliminate controversial material. However, I also recognize it is impossible for the District to restrict access to all controversial and inappropriate materials. I will hold harmless the District, its employees, agents, or Board of Education members, for any harm caused by materials or software obtained via the electronic network. I accept full responsibility for supervision if and when my child's use is not in the school setting. I have discussed the terms of this Authorization with my child. I hereby request that my child be allowed access to the District's electronic network connection. . *The entire Acceptable Use Policy can be viewed on our website under the "Parents" link, Registration Forms. I acknowledge that I have read and understand the Student's Acceptable Use Policy on the District's Website.

Parent/Guardian Signature_____

Dixon Public Schools #170

PARENT MEDICATION CONSENT FORM

Student Name: _____ Grade: _____

I consent for my child to take **Tylenol** at school

☐ Yes ☐ No

I consent for my child to take **Ibuprofen** at school

☐ Yes ☐ No

Concerns you would like us to be aware of (allergies, asthma, health restrictions, etc.)

I would like my child's Emergent (inhaler, epi-pen) medication to be:

☐ Stored in the Nurse's Office ☐ Carried on Self

Name of medication: _____

By Signing Below, I Agree:

1. I hereby authorize Dixon Public Schools and its employees on my behalf to allow my child to self administer medication while under the direct supervision of an employee of Dixon Public Schools. I acknowledge that it may b necessary for the supervision of administration to my child be performed by an individual other than a school nurse, and specifically consent to such practice.

2. To indemnify and hold harmless Dixon Public Schools and its employees against any claims. except a claim based on willful and wanton conduct, arising out of the self administration of medication by the child.

3. Agree that the above information may be shared with appropriate personnel for health and educational purposes.

4. I consent to any x-ray, examination, anesthetic, medical and or surgical diagnosis, medical treatment or hospita care, to be rendered to the minor child under the general or special supervision and on the advise of any physician or surgeon licensed to practice in the State of Illinois when need for such treatment is immediate. This will be used only when reasonable effort to contact me or the emergency contact person(s) is unsuccessful.

_____ _____

Guardian/Parent Signature Date

APPLICATION FOR FREE MILK/MEAL AND REDUCED-PRICE MEALS—Complete One Application per Household Per School District. Instructions on back.

SCHOOL USE ONLY

☐ Check if Error Prone Application

1. All Household Members (Attach another sheet of paper if necessary.)

NAMES OF ALL HOUSEHOLD MEMBERS First, Middle Initial, Last	(for Student only) School Name	(for Student only) Grade	SNAP OR TANF CASE NUMBER Skip to Part 4 if you list a SNAP or TANF case number. At least one SNAP/TANF must be provided below.	Check if Foster Child*
			- -	☐
			- -	☐
			- -	☐
			- -	☐
			- -	☐
			- -	☐

* A foster child is the legal responsibility of a welfare agency or court.

2. Homeless, Migrant, Runaway, or Head Start (Categorically eligible)

☐ Homeless ☐ Migrant ☐ Runaway ☐ Head Start

Signature of Your School Homeless Liaison, Migrant Coordinator, or Head Start Director _____ Date _____

3. Total Household Gross Income (before deductions) You must tell us how much and how often.

A. NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)	GROSS INCOME AND HOW OFTEN IT WAS RECEIVED (Example: $100/month; $100 /twice a month; $100/every other week; $100/week)							
	Earnings From Work (Before Deductions)		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		Worker's Comp., Unemployment, SSI, etc. (All other income)	
	B. Amount	How often?	C. Amount	How often?	D. Amount	How often?	E. Amount	How often?
i.	$		$		$		$	
ii.	$		$		$		$	
iii.	$		$		$		$	
iv.	$		$		$		$	
v.	$		$		$		$	

4. Signature and Social Security Number (Adult must sign)

An adult household member must sign the application. If Part 3 is completed, the adult signing the form must also list the last four digits of his or her social security number or mark the *I do not have a social security number* box.

X X X - X X - _ _ _ _ (Social Security Number) ☐ I do not have a social security number.

I certify (promise) all information on this application is true and all income is reported. I understand the school will get Federal funds based on the information I give. I understand school officials may verify (check) the information. I understand if I purposely give false information, my children may lose meal benefits and I may be prosecuted.

Date | *Printed Name of Adult Household Member* | *Signature of Adult Household Member*

5. Contact Information (Optional)

Work Telephone Number (Include Area Code) | *Home Telephone Number (Include Area Code)* | *Home Address (Number, Street, City, State, Zip Code)*

6. Children's Racial and Ethnic Identities (Optional)

Mark one ethnic identity:
☐ Hispanic/Latino
☐ Not Hispanic/Latino

Mark one or more racial identities:
☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander
☐ White ☐ American Indian or Alaska Native

7. Sharing Application Information With *All Kids*—*All Kids* program is a complete healthcare program for every child in Illinois.

No! I DO NOT want information from my Household Eligibility Application shared with *All Kids*. *Sign here:* _____

– THE FOLLOWING SECTIONS ARE FOR SCHOOL USE ONLY –

INITIAL DETERMINATION

TOTAL INCOME $ _____ Per: ☐ Week ☐ Every 2 Weeks ☐ Twice a Month ☐ Month ☐ Year NUMBER IN HOUSEHOLD: _____ CHANGE IN STATUS: _____ Date _____

LEAs must annualize income only when multiple incomes, at varying frequencies, are reported.
Annual Income Conversion Weekly X 52 Every 2 Weeks X 26 Twice a Month X 24 Once a Month X 12

☐ Free based on:
- ☐ homeless
- ☐ migrant
- ☐ runaway
- ☐ Head Start
- ☐ SNAP or TANF
- ☐ foster child
- ☐ household's income

☐ Reduced based on:
- ☐ household's income

☐ Denied—Reason:
- ☐ Income too high
- ☐ Incomplete application
- ☐ Non-qualifying SNAP/TANF

Signature of Determining Official _____ Date Withdrawn _____ Date: _____

THE FOLLOWING SECTIONS ARE NOT REQUIRED FOR SCHOOLS/DISTRICTS THAT ONLY PARTICIPATE IN ILLINOIS FREE AND/OR SPECIAL MILK PROGRAMS

CONFIRMATION VERIFICATION *(Prior to verification and only for those applications selected for verification.)* Signature of Determining Official _____ Date _____

DIRECT VERIFICATION COMPLETED ☐	INITIAL DETERMINATION	VERIFICATION RESULTS:	REASON FOR CHANGE:	DATE NOTICE OF STATUS CHANGE SENT: _____
DATE VERIFICATION NOTICE SENT: _____	☐ Free based on SNAP/TANF case number	☐ No Change	☐ Income $ _____	
DATE RESPONSE DUE FROM HOUSEHOLD: _____ (recommend 10 calendar days)	☐ Free based on income	☐ Free to Reduced	☐ Household Size: _____	EFFECTIVE DATE OF STATUS CHANGE: _____
	☐ Reduced based on income	☐ Free to Paid	☐ Change in SNAP/TANF	
		☐ Reduced to Free	☐ Did not respond	
		☐ Reduced to Paid	☐ Other: _____	
DATE, METHOD, RESULTS OF FOLLOW-UP* (recommend 3 business days)	☐ Mail ☐ Telephone ☐ Personal Contact Results		Signature of Official _____	Date: _____