Welcome new East Aurora families!

This packet contains your child's registration materials for the 2018-2019 school year. Please complete all enclosed forms and bring them to Kindergarten Registration.

Students can be registered at the following schools

BENAVIDES STEAM ACADEMY	March 17, 2018	9:00 am-12:00 pm
HERMES & BEAUPRE	March 20. 2018	3:30 pm-7:30 pm
BARDWELL & KRUG	March 21, 2018	3:30 pm-7:30 pm
ALLEN & JOHNSON	March 22, 2018	3:30 pm-7:30 pm
BENAVIDES STEAM ACADEMY	March 23, 2018	8:30 am-11:00 am
OAK PARK & O'DONNELL	April 3, 2018	3:30 pm-7:30 pm
GATES & BRADY	April 4, 2018	3:30 pm-7:30 pm
DIETERICH & ROLLINS	April 5, 2018	3:30 pm-7:30 pm
EARLY CHILDHOOD CENTER	April 6, 2018	9:00 am-2:00 pm
BENAVIDES STEAM ACADEMY	April 7, 2018	9:00 am-12:00 pm

What to bring to the Kindergarten registration:

- **Birth Certificate** – Original or certified copy
- **Parent/guardian's driver's license or photo ID**
- **Affidavit of guardianship –** If you are not the student's parent/legal guardian and have assumed responsibility for a student.
- **Proof of address –** You must provide **three (3)** documents in parent/guardian's name. Example: Mortgage/Lease, current utility bill, medical card, car/health insurance card, etc.

If you are experiencing a temporary housing or lack of housing situation, please contact the Welcome Center at (630) 299-7302.

What to do if you missed Kindergarten Registration:

- **After April 7** come to the Welcome Center at:
  1480 Reckinger Rd., Aurora, IL 60505
  - Registration walk-in hours: Monday – Thursday, 9 a.m. to 2 p.m.
  - By appointment only after 2 p.m.
- **Bring the required documents listed above to the Welcome Center.**

Please contact the Welcome Center with any questions at (630) 299-7302.

Thank you,
East Aurora Centralized Registration

STUDENT ENROLLMENT FORM

Student ID #_____

Student Information **School**_____ **Grade** _____ **Gender** ☐ **M** ☐ **F**

Name _____ **Birthdate** _____
(First name) (Middle) (Last name) (Suffix)

Birth city, state, country_____ **Mother's maiden name** _____

Last school attended:_____**Has the student ever attended District 131?** ☐ **Yes** ☐ **No**

Has your child received any special education IEP services or medical 504 plans? ☐ Yes ☐ No

Parent/Guardian Household Information **Household Phone Number:**_____

Student lives with: ☐ **Both parents** ☐ **Mother only** ☐ **Father only** ☐ **Legal guardian**
☐ **Mother/stepfather** ☐ **Father/stepmother** ☐ **Foster parent** ☐ **Self**

Address: _____**Apt.**_____**City**_____ **Zip Code**_____

Guardian #1 Name_____ Relationship to student _____

Cell phone _____Work phone _____Email_____

Preferred Language: ☐ English ☐ Spanish

Guardian #2 Name_____ Relationship to student _____

Cell phone _____Work phone _____Email_____

Preferred Language: ☐ English ☐ Spanish

Siblings (*Students who live in the main household and attend an East Aurora school*)

Name_____**Birthdate**_____**School**_____

Name_____**Birthdate**_____**School**_____

Name_____**Birthdate**_____**School**_____

Name_____**Birthdate**_____**School**_____

Secondary Household Information (*parent/guardian who doesn't live in primary household listed above*)

Guardian name_____ **Relationship to student** _____

Cell phone _____**Work phone** _____**Email**_____

Address _____**Apt.**_____**City**_____**State**_____**Zip Code**_____

Do you want this person to be an Emergency Contact and have access to the Student Portal or receive District mail? ☐ **Yes**☐ **No**

Emergency Contact (*other than parents or guardians*)

Name_____**Relationship**_____ **Phone** _____

Name_____**Relationship**_____ **Phone** _____

Name_____**Relationship**_____ **Phone** _____

Military Part A (optional): Is either parent/guardian in the armed forces? ☐ Yes ☐ No If yes, answer Part B
Military Part B: Is either parent/guardian currently deployed to active duty or will be in the next 12 months? ☐ Yes ☐ No

All information on this form is correct to the best of my knowledge. Knowingly falsifying any information on this form is a Class C Misdemeanor.

Parent/guardian signature_____Date_____

OFFICE USE ONLY					
☐ Birth Certificate	☐ Address Verification	☐ Boundary Verification	☐ Health Survey	☐ Home Language Survey	Date Entered US
Date Emailed	Docs Uploaded	Records Req. Sent	Packet Flagged Date	IC Updated	

U.S. DEPARTMENT OF EDUCATION RACE AND ETHNICITY DATA STANDARDS

Student name _____

This form is to be filled out by the student's parents or guardians, and both questions must be answered. **Part A** asks about the student's ethnicity and **Part B** asks about the student's race. If you decline to respond to either question, the District is required to provide the missing information by observer identification.

Part A. Is this student Hispanic/Latino? CHOOSE ONE

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

The question above is about ethnicity, not race. No matter which answer you selected, continue and respond to the question below by marking one or more boxes to indicate what you consider the student's race to be.

Part B. What is the student's race? CHOOSE ONE OR MORE

☐ **American Indian/Alaska Native**
A person having family origins from:
- Mexico
- Puerto Rico
- South America
- Central America
- North America
- Tribal Affiliation

☐ **Asian**
A person having family origins from:
- Far East
- Asia/India
- Cambodia, Philipines, Pakistan
- China, Japan, Korea, Thailand, Vietnam

☐ **Black/African-American**
A person having family origins from:
- Black racial groups of Africa

☐ **Hawaii Native/Pacific Islander**
A person having family origins from:
- Hawaii
- Guam
- Samoa
- Pacific Islands

☐ **White**
A person having family origins from:
- Europe
- Middle East/North Africa

Parent/guardian signature _____**Date**:_____

_____ Observer identification initials

HEALTH REQUIREMENTS NOTICE

Student Services | 1480 Reckinger Road | Aurora, IL 60505
(630) 299-7902 | info@d131.org | www.d131.org/studentservices.asp

To ensure good health for all students, the State of Illinois has mandated certain health requirements for school entrance and grade progression. This means that students will not be able to attend school until these items are presented to the school. The following is a list of these requirements.

1. **Pre-School:** Must present new child health examination on the appropriate state form and proof of updated immunizations. It is recommended that children be screened for lead and TB. Please have your health care provider review your immunization records to ensure that they met current requirements for school attendance.
2. **Kindergarten**: Must present new child health examination physical and comprehensive eye exam on appropriate state forms. Proof of updated immunizations. It is recommended that children be screened for lead and TB. Please have your health care provider review your immunizations records to ensure that they are current.
3. **First Grade**: If the student cannot submit documentation of the child health examination, proof of immunizations or comprehensive eye exam in the prior school year, the child health examination along with proof of immunizations and comprehensive eye examination are required for school attendance for this school year.
4. **Sixth Grade**: Proof of New child health examination on the appropriate state form and proof of updated immunizations. Please have your health care provider review your immunization records to ensure that they meet current requirements.
5. **Ninth Grade**: New physical on the appropriate state form and proof of updated immunizations to records to ensure that they meet requirements.
6. **Twelfth Grade**: Must show proof of 2 doses of meningococcal vaccine (one dose being at or after the age of 16).
7. **In-State Transfer Student**: Must present proof of child health examination and updated immunizations upon enrollment
8. **Out of State Transfer**: Must present proof of required state of Illinois child health examination upon enrollment. Must present proof of updated immunizations within 30 days of registration.
9. **Dental Examination**: Required for all students entering kindergarten, second, and sixth grade prior to May 15th of the academic year.
10. **Vision Examination**: Required of all students entering kindergarten or enrolling in an Illinois public school for the first time.

Students participating in sports need to have a yearly sports physical (IHSA forms are available from the coach, school nurse or your doctor). The sports physical is **not** acceptable as the required child health examination form required for enrollment.

We ask that you please take care of this as soon as possible and return the information to school so that your child's education will not be interrupted. If you have any questions, please phone your school for information. Thank you for your cooperation with this important matter.

If you need resources, please contact your student's school nurse.

ANNUAL STUDENT HEALTH INFORMATION SURVEY

School Name:_____

Student Name:	ID:	DOB: Age: Grade:	Gender: ☐ M ☐ F
Parent/Guardian: (person completing this form)		Home Phone: Cell Phone:	Date:

Does your child have any of the following conditions?	YES	NO	If Yes, please explain and include date:
Allergies:	☐	☐	☐food ☐environmental ☐insect ☐medication ☐other
Bee Sting Allergy ☐ Breathing Difficulty ☐ Rash ☐ Swelling (sting site only) ☐ Itching ☐ Swelling (all over body) ☐ Swelling (face only)	☐	☐	☐ Anaphylaxis Action Plan provided to health office ☐ Epinephrine Auto-Injector (EPI-PEN)Required May self-carry ☐No ☐Yes
Food Allergy Type: _____ ☐ Breathing Difficulty ☐ Rash ☐ Swelling (all over body) ☐ Itching ☐ Swelling (face only)	☐	☐	☐ Epinephrine Auto-Injector (EPI-PEN)Required May self-carry ☐No ☐Yes ☐ Food Allergy Action Plan provided to health office ☐ Physician Statement for Food Substitution provided to health office
Asthma Does student carry inhaler with him/her: ☐No ☐Yes	☐	☐	☐ Inhaler provided to health office ☐ Asthma Care Plan provided to health office
Diabetes	☐	☐	☐ Diabetic Care Plan provided to health office
Convulsion/Seizure Disorder Date of Last Seizure: _____	☐	☐	☐ Seizure Care Plan provided to health office
Vision problem or condition	☐	☐	☐ Glasses ☐ Contacts
Hearing problem or condition	☐	☐	☐ Hearing aid ☐ Cochlear implant

CHECK ALL THAT APPLY TO YOUR CHILD:

☐ ADHD
☐ Asthma/trouble breathing
☐ Autism/Asperger
☐ Diabetes
☐ GI Conditions (ulcer, reflux, IBS)
☐ Headaches/migraines
☐ Heart Conditions
☐ High Blood Pressure
☐ Single Organ (☐kidney, ☐testicle)
☐ Skin Condition: _____
☐ Urinary Condition
☐ Mental Health Condition (depression, eating disorder, anxiety, OCD, ODD, etc.)

CURRENT MEDICATIONS	YES	NO	Please list name, dose, time(s)
Given at school	☐	☐	
Taken at home	☐	☐	
ASSISTIVE EQUIPMENT	**YES**	**NO**	**Please check all that apply**
During or outside of school	☐	☐	☐Crutches ☐Walker ☐Wheelchair ☐AFOs ☐Other:
TREATMENTS	**YES**	**NO**	
During or outside of school	☐	☐	☐insulin/blood glucose monitoring ☐inhaler/nebulizer/peak flow monitoring ☐special diet

Is your child currently under medical treatment/care for a long-term or chronic condition? ☐No ☐Yes
If YES, please explain: _____

Does your child have any special needs or necessary precautions while in school? ☐No ☐Yes
If yes, please explain: _____

HEALTH INFORMATION MAY BE SHARED WITH APPROPRIATE SCHOOL PERSONNEL

_____ _____ _____
Parent/guardian signature Relationship to student Date

State of Illinois
Certificate of Child Health Examination

Student's Name Last First Middle	**Birth Date** Month/Day/Year	**Sex**	**Race/Ethnicity**	**School /Grade Level/ID#**
Address Street City Zip Code	Parent/Guardian	Telephone # Home		Work

IMMUNIZATIONS: **To be completed by health care provider. The mo/da/yr for *every* dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.**

REQUIRED Vaccine / Dose	**DOSE 1** MO DA YR	**DOSE 2** MO DA YR	**DOSE 3** MO DA YR	**DOSE 4** MO DA YR	**DOSE 5** MO DA YR	**DOSE 6** MO DA YR
DTP or **DTaP**						
Tdap; **Td** or Pediatric **DT (**Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles Mumps. Rubella				**Comments:**		
Varicella (Chickenpox)						
Meningococcal conjugate (MCV4)						
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.
If adding dates to the above immunization history section, put your initials by date(s) and sign here.

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.
***MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.
Date of Disease **Signature** **Title**

3. Laboratory Evidence of Immunity (check one) ☐Measles* ☐Mumps ☐Rubella ☐Varicella Attach copy of lab result.**

*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.
**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____
Physician Statements of Immunity MUST be submitted to IDPH for review.

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and *Maintained* by the School Authority.

Last	First	Middle	Birth Date (Month/Day/ Year)	Sex	School	Grade Level/ ID

HEALTH HISTORY **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

ALLERGIES (Food, drug, insect, other)	Yes No	List:		**MEDICATION** (Prescribed or taken on a regular basis.)	Yes No	**List:**	
Diagnosis of asthma? Child wakes during night coughing?	Yes No Yes No			Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No		
Birth defects?	Yes No			Hospitalizations? When? What for?	Yes No		
Developmental delay?	Yes No						
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No			Surgery? (List all.) When? What for?	Yes No		
Diabetes?	Yes No			Serious injury or illness?	Yes No		
Head injury/Concussion/Passed out?	Yes No			TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.	
Seizures? What are they like?	Yes No			TB disease (past or present)?	Yes* No		
Heart problem/Shortness of breath?	Yes No			Tobacco use (type, frequency)?	Yes No		
Heart murmur/High blood pressure?	Yes No			Alcohol/Drug use?	Yes No		
Dizziness or chest pain with exercise?	Yes No			Family history of sudden death before age 50? (Cause?)	Yes No		
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Dental ☐ Braces ☐ Bridge ☐ Plate Other			
Ear/Hearing problems?	Yes No			Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature** **Date**			
Bone/Joint problem/injury/scoliosis?	Yes No						

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE if < 2-3 years old **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING **(NOT REQUIRED FOR DAY CARE)** **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐
Ethnic Minority Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE: Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** **Result**

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

No test needed ☐ **Test performed ☐** **Skin Test: Date Read / / Result: Positive ☐ Negative ☐ mm_____**
Blood Test: Date Reported / / Result: Positive ☐ Negative ☐ Value

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	**Normal**	**Comments/Follow-up/Needs**		**Normal**	**Comments/Follow-up/Needs**
Skin			**Endocrine**		
Ears		Screening Result:	**Gastrointestinal**		
Eyes		Screening Result:	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ☐ No ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)
PHYSICAL EDUCATION Yes ☐ No ☐ Modified ☐ **INTERSCHOLASTIC SPORTS Yes ☐ No ☐ Modified ☐**

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

State of Illinois
Illinois Department of Public Health

PROOF OF SCHOOL DENTAL EXAMINATION FORM

To be completed by the parent (please print):

Student's Name: Last First Middle			Birth Date: (Month/Day/Year) / /
Address: Street City ZIP Code			Telephone:
Name of School:		Grade Level:	Gender: ☐ Male ☐ Female
Parent or Guardian:		Address (of parent/guardian):	

To be completed by dentist:

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present**

☐ Yes ☐ No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

☐ Yes ☐ No **Untreated Caries —** At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

☐ Yes ☐ No **Soft Tissue Pathology**

☐ Yes ☐ No **Malocclusion**

Treatment Needs (check all that apply)

☐ **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

☐ **Restorative Care** — amalgams, composites, crowns, etc.

☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis

☐ **Other** — periodontal, orthodontic

Please note _____

Signature of Dentist _____ Date of Exam _____

Address _____ Telephone _____
Street City ZIP Code

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.idph.state.il.us

IOCI 0600-10 Printed by Authority of the State of Illinois

State of Illinois
Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides eye examinations be submitted to the school no later than October 15 of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

Student Name _____
(Last) (First) (Middle Initial)

Birth Date _____ Gender _____ Grade _____
(Month/Day/Year)

Parent or Guardian _____
(Last) (First)

Phone _____
(Area Code)

Address _____
(Number) (Street) (City) (ZIP Code)

County _____

To Be Completed By Examining Doctor

Case History

Date of exam _____

Ocular history: ❑ Normal or Positive for _____

Medical history: ❑ Normal or Positive for _____

Drug allergies: ❑ NKDA or Allergic to _____

Other information _____

Examination

	Distance			**Near**
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation? ❑ Yes ❑ No

	Normal	Abnormal	Not Able to Assess	Comments
External exam (lids, lashes, cornea, etc.)	❑	❑	❑	_____
Internal exam (vitreous, lens, fundus, etc.)	❑	❑	❑	_____
Pupillary reflex (pupils)	❑	❑	❑	_____
Binocular function (stereopsis)	❑	❑	❑	_____
Accommodation and vergence	❑	❑	❑	_____
Color vision	❑	❑	❑	_____
Glaucoma evaluation	❑	❑	❑	_____
Oculomotor assessment	❑	❑	❑	_____
Other _____	❑	❑	❑	_____

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

Diagnosis

❑ Normal ❑ Myopia ❑ Hyperopia ❑ Astigmatism ❑ Strabismus ❑ Amblyopia

Other _____

Continued on back

State of Illinois
Eye Examination Report

Recommendations

1. Corrective lenses: ❑ No ❑ Yes, glasses or contacts should be worn for:
   ❑ Constant wear ❑ Near vision ❑ Far vision
   ❑ May be removed for physical education

2. Preferential seating recommended: ❑ No ❑ Yes

   Comments _____

   _____

3. Recommend re-examination: ❑ 3 months ❑ 6 months ❑ 12 months

   ❑ Other _____

4. _____

5. _____

Print name _____ License Number _____

Optometrist or physician (such as an ophthalmologist) who provided the eye examination ❑ MD ❑ OD ❑ DO

Address _____

_____

Phone _____

Consent of Parent or Guardian

I agree to release the above information on my child or ward to appropriate school or health authorities.

_____
(Parent or Guardian's Signature)

_____
(Date)

Signature _____ Date _____

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Printed by Authority of the State of Illinois
6/09

IOCI1271-09

FIELD TRIP, MEDICAL RELEASE, PESTICIDE NOTIFICATION FORM

Student name _____ **Grade** _____

AUTHORIZATION FOR FIELD TRIPS

Classrooms today extend beyond the physical building. Teachers recognize the values of taking students on field trips or excursions. Among other educational benefits, children get to see and hear things which cannot be brought into the classroom. On some field trips, children take school buses. On others, they walk or use other means of transportation.

If you sign the space below, your child will be allowed to join in these field trips during the current school year. However, he/she will still be given information to take home before each field trip – by note, by a school's monthly calendar, or by some other means – to let you know the place to be visited and the date of the field trip. At that time, you may refuse to give your permission for your child to go on a specific field trip. You should know that East Aurora School District 131 is not necessarily responsible for every injury sustained by a pupil.

I have read the above information and consent to my child being taken on field trips during the school year and give my permission for my child to receive emergency medical treatment in the event I cannot be reached.

Signature of parent/guardian _____ **Date**_____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

I, as parent or legal guardian of student whose name is listed on this page, hereby authorize and consent to emergency medical treatment for my child. Specifically, I authorize East Aurora School District 131 employees and agents to administer any emergency medical treatment necessary for the health and welfare of my child, and/or to arrange for emergency medical treatment by a health care provider. In addition, I authorize the health care provider to provide emergency treatment that he/she deems appropriate to treat any injury sustained by my child.

I agree to hold harmless and indemnify East Aurora School District 131, its Board of Education, and the Board's members, employees and agents, from and against any and all claims, demands, injuries, damages or causes of action, including reasonable attorneys' fees and costs in the defense thereof, resulting from or arising out of the provision of emergency medical treatment by school personnel or a health care provider.

Signature of parent/guardian _____ **Date**_____

AUTHORIZATION TO RELEASE HEALTH RECORDS TO DISTRICT

I hereby authorize my child's health care provider and previous school to release my child's most recent physical and immunization information to East Aurora School District 131 for completion of student health records. This authorization is valid while the student is enrolled in East Aurora School District 131.

Signature of parent/guardian _____ **Date**_____

PESTICIDE NOTIFICATION REQUEST

East Aurora School District 131 practices Integrated Pest Management, a program that combines preventive techniques, non-chemical pest control methods, and the appropriate use of pesticides with a preference for products that are the least harmful to human health and the environment. The term "pesticide" includes insecticides, herbicides, rodenticides, and fungicides. If you have any questions or comments, please contact, Buildings and Grounds, at (630) 299-8379.

The District has established a registry of people who wish to be notified **prior** to pesticide applications. To be included in the registry, check YES.

☐ **Yes, I would like to be notified two days before the use of pesticides at the school**.

☐ **No, I do <u>NOT</u> need to be notified before the use of pesticides at the school.**

I understand if there is a threat to health or property that requires immediate treatment, notification can be sent as soon as practical.

Signature of parent/guardian _____ **Date**_____

STUDENT/PARENT AGREEMENT AND PERMISSION FOR INTERNET ACCESS

All use of the Internet must be consistent with the District's goal of promoting educational excellence by facilitating resource sharing, innovation, and communication. This Agreement Form does not attempt to state all required or proscribed behavior by users. However, some specific examples are provided. **Students will be subject to loss of privileges, disciplinary action, and/or appropriate legal action for any violation of this Agreement or Board Policy 6:235, or for any inappropriate use of the Internet or network.** The signatures below are legally binding and indicate that the student and the student's parent/guardian have read this Agreement carefully and understand its significance.

By signing this document, guardians and students indicate they understand and will abide by the Agreement and Permission for Internet Access. They further understand that if the student commits any violation, the student's access privileges may be revoked, and the student will be subject to disciplinary action and/or appropriate legal action. In consideration for using the District's Internet connection and having access to public networks, guardians and students hereby release East Aurora School District 131 and its Board of Education members, employees, and agents from any claims and damages arising from use of, or inability to use, the Internet.

Although East Aurora School District 131 provides and operates a technology protection measure (filtering) with respect to any of its computers with Internet access, by signing this document guardians and students recognize that it is impossible to fully eliminate or restrict access to all controversial or inappropriate material. Parents and students also understand that the District cannot guarantee that "filtering" software will be totally effective or that a student will not have access to materials that may be defamatory, inaccurate, offensive, or otherwise inappropriate in the school setting. Guardians and students will hold harmless East Aurora School District 131, its employees, agents, and Board of Education members, for any harm caused by materials or software obtained via the network. Guardians accept full responsibility for supervision if and when my child's use is not in a school setting. The undersigned have discussed the terms of this Agreement.

Students will not be allowed to use the District's internet until signed permission is given to school.

SELECT ONE:

☐ We request that the student be allowed access to the District's Internet.

☐ We do NOT wish the student to have access to the District's Internet

Date _____ **Student ID** _____

Student name (Please print): _____

Guardian name (Please print): _____

Guardian signature _____

School Service Center | 417 Fifth Street | Aurora, IL 60505
(630) 299-5554 | lmorales@d131.org | www.d131.org

NOTIFICATION OF RECEIVING AUTOMATICALLY DIALED CALLS

East Aurora School District 131 values regular communication with parents and guardians so that families can stay involved in the educational life of their students. The District regularly shares important information through brief phone messages and/or emails. These messages often include information about: emergency closings, schedule changes, upcoming events, grades, important deadlines, and student activities. These calls are an important part of staying informed about your student's school life, and ensuring they have a successful educational experience.

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Parents or guardians who do not wish to receive automatically dialed phone calls from their student's school or East Aurora School District 131, must notify the District by **August 15**. Removing your phone number from the automatic dialing means you will not receive emergency calls, including information about school closings or safety issues at the school.

All requests to exclude students can be mailed to:

Lisa Morales
East Aurora School District 131
417 Fifth Street
Aurora, IL 60505

Exclusion requests must include: student's full name, the name of the school they attend, the telephone number that should be excluded, and a parent signature.

School Service Center | 417 Fifth Street | Aurora, IL 60505
(630) 299-5565 | info@d131.org | www.d131.org

PUBLICATION OF STUDENT NAMES/IMAGES
OPT-OUT NOTIFICATION

East Aurora School District 131 draws its strength from the citizens who live and work in the District. The quality of school programs depends on the public understanding what is happening in their schools.

East Aurora School District 131 is proud to highlight the accomplishments, daily work and extracurricular achievements of our students in various internal and external publications. Sharing school news benefits the students, staff, school, the District and our community.

Accordingly, from time to time, your student's name or picture may appear in various publications, including: newsletters, Web sites, newspapers, calendars, communications to parents, textbooks or videos.

The District also issues positive news releases and distributes photos to outside media outlets, which may want to interview, photograph or videotape students under the supervision of District personnel.

The District does not control the publication of students' names or photos in public areas, including outside of schools, Board of Education meetings, extracurricular activities or other areas populated by the general public.

Parents or guardians who do not wish to have their child's name or image identified in publications must notify East Aurora School District 131 in writing by Sept. 15 of the current school year.

All requests to exclude students can be mailed to:

East Aurora School District 131 Communications
417 Fifth Street
Aurora, IL 60505

Or, an exclusion request can be emailed to: info@d131.org.

Exclusion requests must include: student's full name, the name of the school they attend, and a parent signature.

A list of children who cannot be photographed will be maintained at each school.

Exclusion requests will NOT remove your student from having their photo and name published in a yearbook, or having their picture taken at extracurricular events outside the school day.

OFFICE USE ONLY

Attending School | Student District ID # | First Name Initial/Last Name_____ | Screen ☐

East Aurora Schools

District 131

Administrative Service Center
231 E. Indian Trail • Aurora, Illinois 60505 • Telephone (630) 299-7255 • Fax (630) 299-7287

Home Language Survey

The Illinois School Code requires that each school district administers a Home Language Survey to every student entering the district's schools. This information is used to report to the state the number of students whose families speak a language other than English. It also helps to identify the need for English Language Learning services in the schools. Please note: If the answer to either question 1 or 2 (or both) is yes, the law requires the school to assess your child's English language proficiency. Your cooperation in helping us meet this important legal requirement is appreciated.

Student First Name _____ Student Last Name_____

Grade _____ Country of Birth _____ Birthdate (month/day/year) _____

1. Does anyone living in your home speak a language other than English?

   ☐ Yes (What language? _____) ☐ No

2. Does your child speak a language other than English?

   ☐ Yes (What language? _____) ☐ No

If you answered *yes* to either or both questions 1 and 2, please answer all of the questions in the box below.

If you answered *no* to BOTH questions 1 and 2, please skip the questions in the box and only fill out the information at the bottom of this page.

Please mark (✓) English, Spanish or Other Language(s) for each question.	**English**	**Spanish**	**Other Language(s)**
What language did your child learn when he or she first began to talk?			
What language does the family speak at home most of the time?			
What language does the parent(s) speak to his/her child most of the time?			
What language does the child speak to his/her parent(s) most of the time?			
What language does the child hear and understand in the home?			
What language does the child speak to his/her siblings most of the time?			
What language does the child speak to his/her friends most of the time?			
Has your child ever been in a Bilingual or ELL/ESL program? ☐ Yes – What grade (s)? _____ Where? What school/city? _____ ☐ No			

Print First and Last Name of Person Completing Survey _____

Person Completing Survey: ☐ Mother ☐ Father ☐ Legal Guardian

_____ _____ _____

Parent/Guardian Signature | Phone Number | Date