

Southwest Valley Schools

Corning Campus

Ph. 641-322-4242

904 8th Street
Corning, IA 50841

FAX: 641-322-4243

Chris Fenster, Superintendent

Jennifer Bissell, High School Principal
Allison Thomas, Elementary Principal

Jodi Lyddon, Board Secretary
Allen Naugle, Athletic Director

Dear Parents,

The following checklist has been compiled to assist you in getting your child ready for school in the fall. The items listed below are required by the Iowa Department of Public Health and need to be completed and returned to the school by August 2023.

___ 1. Health Information Form

___ 2. Physical (mandatory)

___ 3. Complete Immunization information (including dates and sources of immunizations)

___ 4. Dental screening - a valid screening must have been performed after the age of 3 AND the Certificate of Dental Screening is the only acceptable form

___ 5. Vision screening - a valid screening must have been performed within 1 year of enrollment

___ 6. Special forms to be completed by your child's healthcare provider are required if your child has food allergies, requires a special diet, requires an epipen, and/or uses an inhaler. Please ask the school nurse for any forms your child may require.

I encourage you to make your appointments at your healthcare provider, dentist, and eye doctor early because it may take time to get an appointment.

Sincerely,

Lindsey Hogan, RN, BSN
Southwest Valley Schools, East Campus

Health Information

(to be completed by parent/guardian)



Student's Name _____

Date of Birth _____

Because we want your child to have the best/most complete health care, you may assist us by answering the following questions:

Physician _____ Physician's Phone _____

Physician's Address _____

Dentist _____ Dentist Phone _____

Allergies (List all food, medicine, environmental, seasonal, etc) _____

Does your child require medication at school? If so, please list _____

Does your child require medication at home? If so, please list _____

Does your child have any of the following? (please circle)

Vision Problems Hearing Problems Corrective Lenses Ear Tubes Hearing Aids

List any diseases, operations, or injuries in the past year _____

Does your child require any special services at school? Are there any known physical conditions or limitations that the school should be aware of? If so, please explain _____

Please share the above health information with my child's teacher and any other person within the school district who has direct contact with my child.

Parent Signature _____ Date _____



Preschool/Kindergarten Physical Form

Corning Elementary
1012 10th Street
Corning, IA 50841
641.322.4020



Student's Name _____

Birthdate _____

Parent's Name _____ Phone Number _____

Family Physician _____ Physician Phone _____

Information to be completed by the physician/health care provider:

Height (inches) _____ Weight (lbs) _____

Lead Test Date / Result _____

Does the child have any allergies? Yes No Please Explain _____

Does the child have chronic illness? Yes No Please Explain _____

Does the child have ear tubes? Yes No

Has the child had chickenpox? Yes No Disease Date _____

Are the child's immunizations up-to-date? Yes No If no, please explain _____

Does the physical exam reveal any abnormalities or limitations? Yes No

Please Explain _____

Is the child on any medications? Yes No

Please list medications & times given: _____

Are there any restrictions, accommodations and/or recommendations to help this child to be successful in the school environment?

Physician/Health Care Provider Signature _____ Date _____



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: <input type="checkbox"/> Male <input type="checkbox"/> 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 decay¹ or a white spot lesion² is suspected in one or more teeth, or gum infection³ is suspected.
- Requires Urgent Dental Care** – obvious tooth decay¹ 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 • <http://idph.iowa.gov/ohds/oral-health-center>
A designee of the local board of health or Iowa Department of Public Health may review this certificate for survey purposes.

**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):	Referral to eye health professional (Please select one):
Pass or Fail	Yes or No
<input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>

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.

Dear Corning Preschool Parents,

Welcome to the beginning of a new school year! For some of you, this is a normal routine as you have been through the process with other children. However, for some it is a new experience. Through this letter, I hope to inform you of a few details that are very important to our classroom. Also, I want to introduce myself and open up an avenue for communication.

First of all, my name is Christy Ayers, and I am the preschool teacher at Corning Community School's Preschool (CCSP). I have taught preschool here at Corning for 15 years. I am originally from Sidney, IA and attend college at Northwest Missouri State University where I received my degree in elementary education and special education. I went onto the University of Northern Iowa and received my preschool endorsement along with my Master's degree. We also have a para educator who work in the preschool classroom, Deanna Anderson has been helping in my classroom for 2 years, and we will also have a one-on-one para.

Secondly, I would like to express a couple reminders so that everyone is on the same page:

- **Supplies:** 1-2pocket folder (solid color), 3 boxes of Kleenex, 2 Clorox wipes, and 1 spare set of clothes (long pants, shirt, underwear, and socks.)
We will be spending time running and playing outside and ask that your child have/wear appropriate running shoes. These do not need to be a separate pair of gym shoes, but we do **not** recommend that children wear flip flops or other shoes that may fall off easily to school.
- **Morning Routine:** The students eating breakfast will be allowed into the building at 8:00 am. If you are dropping your child off and would like to walk him/her to the line, we ask that you find a parking space rather than remaining in the drive through line. Staff will be present to supervise students outside. Children can be dropped off between 8:00 and 8:20 if attending the morning class.
- **Handbook:** Please read the enclosed handbook and discuss the necessary portions with your child. Then sign and return the form on the first page as soon as you can.
- **Phone calls:** If your child is ill, transportation changes, or any other issue arises, call Dawn Shuler in the elementary office (322-4020) to leave a message for the preschool staff.
- **Afternoon Routine:** If you are bringing your child to school for our afternoon session please note that it starts at 12:30. Please escort your child into the building and check in with the office. For dismissal at 3:15 car riders start to be picked up, please stay in the line of cars and once you pass the solid yellow line on the pavement staff will walk your child out to your car. At 3:20 walkers are dismissed and at 3:25 the bus riders will be dismissed.

Finally, I hope that this letter gives you and your child a better idea what to expect in our classroom. Fostering communication and input from families is very important, and I hope that we are able to develop that type of relationship this year. I look forward to working with you as we begin our wonderful year!

Sincerely,
Christy Ayers

Dear Parents,

We need to ask permission for students to have sunscreen or insect repellent applied when the weather and environment for outdoor play require these measures. Please mark your preferences below and return the form with your child's enrollment packet.

Thanks!

Mrs. Ayers

Child's name _____

_____ I **GIVE** my permission for sunscreen greater than SPF 15 to be applied to protect my child.

_____ I **DO NOT GIVE** my permission for sunscreen greater than SPF 15 to be applied to protect my child.

_____ I **GIVE** my permission for insect repellent containing DEET to be applied to protect my child.

_____ I **DO NOT GIVE** my permission for insect repellent containing DEET to be applied to protect my child.

Parent Signature

Date

Preschool Goal Sheet

Child's Name _____

Please mark what specific goals you would like your child to work on this year at preschool.

	EDUCATION
	Match/Name Colors
	Match/Name Shapes
	Names body parts
	Counts
	Sorts objects
	Recognize numbers 1-10
	LANGUAGE
	Speaks clearly
	Expresses needs/wants appropriately
	States first and last name
	Recognizes/prints name
	Follows directions
	Recognize alphabet: sounds/formation
	NUTRITION
	Tries a variety of foods
	Uses manners at the table
	Pours liquids
	Uses utensils correctly
	Serves self
	Remains at table

	MENTAL/SOCIAL
	Shares with others
	Takes turns
	Uses words not actions (hit, kick, etc.)
	Stay with an activity for 4-10 minutes
	Follow classroom rules
	Helps with clean up
	Use an inside voice
	PHYSICAL
	Use bathroom independently
	Use Kleenex when needed
	Dresses self
	Washes hands-before meal/snack
	Holds a pencil/crayon correctly
	Use glue appropriately
	Hold scissors correctly
	OTHER

Parent comments:



Photo Release Form

Please be advised that your child may be photographed or videotaped at various school sponsored events. If you would like your child's photo to appear on our class and or school Facebook pages please sign and return this form.

Please sign and return this form.

_____ **Yes**, I give permission for my child's photograph and or video to be posted on our class or school Facebook pages.

_____ **No**, my child's photograph and or video may not be posted on our class or school Facebook pages.

Signature

Date



Consent and Release of Information

MATURA Action Corporation

Child's Name:		Age:	Date of Birth:
Address:		Cell Phone:	Other Phone:
<input type="checkbox"/> Male	Race:	<input type="checkbox"/> White	<input type="checkbox"/> Hispanic
<input type="checkbox"/> Female		<input type="checkbox"/> Black	<input type="checkbox"/> Asian/Pacific Islander
		<input type="checkbox"/> Native American	<input type="checkbox"/> Undetermined/Unknown
Child's Physician:		Child's Dentist:	
If applicable, child's Medicaid ID number:			

- YES**, I give permission for my child to receive a dental screening and fluoride varnish application.
- NO**, I do not give permission for my child to receive a dental screening and fluoride varnish application.

Please answer the following questions:

1. Has your child seen a dentist within the past 12 months? Yes No
2. My child's most recent dental visit was within the past: (please check one)
 - 6 months 1 year 3 years 5 years has never seen a dentist
3. How do you pay for your child's dental care? (please check one)
 - Self Medicaid/Title XIX *hawk-i* Private dental insurance Other
4. List any concerns you have about your child's mouth or teeth: _____
5. Has your child seen a physician within the past 12 months? Yes No
6. Is your child currently taking any medications? Yes No Explain: _____
7. Does your child have any allergies? Yes No Explain: _____
8. Are your child's immunizations up to date? Yes No Explain: _____
9. How do you pay for your child's medical care?
 - Self Medicaid/Title XIX *hawk-i* Private medical insurance Other

I consent to MATURA Action Corporation use of email and texting to send me scheduling and child health services information.
 Yes No Email address: _____

- I was offered a Notice of Privacy Practices.
- I understand that this consent for services is valid for one (1) year unless withdrawn in writing by parent, guardian or client (if of legal age).
- I understand that the services that will be received do not take the place of regular dental checkups at a dental office.
- I understand that these services are provided under the Iowa Department of Public Health, Maternal and Child & Adolescent Health Program.
- I understand records created and maintained as part of this program are the property of the Iowa Department of Public Health.
- I understand that the information from these records may be shared with the Iowa Department of Public Health and its agents and Title V contractors, Iowa Medicaid Enterprise, or designee for audit and quality improvement purposes or other legally authorized purposes.

 Parent/Guardian Signature

 Date

I voluntarily authorize MATURA Action Corporation to release, obtain, or exchange information manually and/or via an electronic platform maintained by TAVHealth with the following Title V MCAH agencies, Preschools, Physicians, dentists, Head Start. This release does not authorize disclosure of material protected by federal and/or state law applicable to substance abuse, mental health and/or AIDS-related information.

 Parent/Guardian Signature

 Date

Corning Preschool
Release of Health Information

Student's Name _____

Any health information concerning my child may be shared with the following staff:

Ayers, Christy - Teacher
Stewart, Krist - Para
Hogan, Lindsey - Nurse
Rhamy, Katie – Sub Nurse
Rhamy, Marci – Sub Nurse
Thomas, Allison – Principal
Shuler, Dawn - Secretary

Parent Signature _____ Date _____

Photography Permission Slip

Name of Child

Participant: _____

Name of Parent or Guardian

(Releaser): _____

Name of Teacher: _____

This teacher is seeking or has earned a grant through **DonorsChoose.org**, a nonprofit organization serving public school students. At our website, www.DonorsChoose.org, teachers can request resources and experiences for their students, and individual donors can choose a request they want to fund. This teacher has taken the initiative to seek funding for an activity.

As a result, this teacher's class may receive resources for one or more requested student activities. In this event, we may show photographs of the activities taking place on our website at www.DonorsChoose.org, to the donor(s) who funded the request(s) as well as other visitors to our site. To help generate donor interest for this teacher's project(s), we may also display a picture featuring this teacher's class on our website for potential donors to view. In addition, we may allow our donors to display all photographs on their websites and social media channels and to otherwise use the photographs on their websites and social media channels and to otherwise use the photographs for publicity and promotional purposes.

With your signature below, you consent as follows:

- I am the legal parent or guardian (releaser) of the child participant named above. I hereby give permission for the participant to be photographed (with or without other classmates).
- I understand, agree, and give permission for DonorsChoose.org to display the photographs on the DonorsChoose.org website.
- I understand, agree, and give permission for DonorsChoose.org, its partners, and its donors to otherwise use photographs for promotional purposes.

Signature of Parent or Guardian (Releaser): _____

Date: _____

PLEASE RETURN THE COMPLETED, SIGNED FORM TO THE TEACHER AS SOON AS POSSIBLE. THANK YOU.

Dear Parents,

We would like to administer the BRIGANCE Early Childhood Screening at the beginning of the school year. This assessment will help to identify possible learning delays and giftedness. The information provided also shows the child's strengths and needs in language, motor, self-help, social-emotional, and cognitive skills. (Description from the Brigance curriculum).

Many of the skills shown in this assessment will help the teachers plan and individualize instruction for all preschool students. However, we would like to ask your permission to do the assessment and share information within our CCSP planning team. We will also make you aware of the results and how they could affect education.

Please feel free to keep the top half of this page and return the permission form below.

Thank you very much!

Sincerely,

Mrs. Ayers

Child's Name: _____ Date: _____

_____ I give permission for the BRIGANCE screening to be done with my child.

_____ I **do not** give permission for the BRIGANCE screening to be done with my child.

Parent's Signature: _____

Parent Request for Preschool

Student Name: _____

Child care provider: _____

We offer both a morning and afternoon session. These are mostly determined by bus route and trying to keep students from the same day care provider in the same session. We do our best to honor parent requests to the extent possible. Once the placements are determined, you will receive notice this summer as to which program your child will be attending. To help us in making the schedules, please provide this information:

1. Would you prefer morning or afternoon?
2. Where would your child be picked up in the mornings if they would attend the AM session?
3. Where would your child need to be dropped off or picked up at noon?
4. Where would your child be dropped off after school if in the PM session?

Note:

Morning session 8:15-11:15

Afternoon session 12:30-3:30