



SOUTHWEST VALLEY  
#TWOVESTERRITORY

# Preschool Registration Packet

Please return all completed forms to the elementary office.

- ☐ Student Profile
- ☐ Student Health Information
- ☐ Emergency Information
- ☐ Home Language Survey
- ☐ Student Race & Ethnicity Reporting
- ☐ Releases for Publishing and Social Media
- ☐ District Alerts
- ☐ School Nurse Checklist (Immunizations, Required Screenings, etc)



# Preschool Registration

## Student Profile Page 1 of 2

Registration Date: \_\_\_\_\_ Location of Attendance: ☐ Corning ☐ Villisca

Student Name :

\_\_\_\_\_  
(Last Name) (First Name) (Middle Name)

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ ☐ Male ☐ Female  
(Student must turn 4 prior to September 15)

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Mother's Name: \_\_\_\_\_ ☐ Student Residence

Address: \_\_\_\_\_  
Street City State Zip

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Work Place: \_\_\_\_\_

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Father's Name: \_\_\_\_\_ ☐ Student Residence

Address: \_\_\_\_\_  
Street City State Zip

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Work Place: \_\_\_\_\_

## Student Profile Page 2 of 2

*Optional additional information about step-parents, long-term caregivers, and guardians:*

Guardian's Name: \_\_\_\_\_ ☐ Student Residence

Relationship to Student: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Work Place: \_\_\_\_\_

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Guardian's Name: \_\_\_\_\_ ☐ Student Residence

Relationship to Student: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Work Place: \_\_\_\_\_

Additional helpful information regarding student's living arrangements or life at home:

# Preschool Registration

## Student Health Information Page 1 of 2

Doctor's Name: \_\_\_\_\_

Location: \_\_\_\_\_ Doctor's Phone: \_\_\_\_\_

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Dentist's Name: \_\_\_\_\_

Location: \_\_\_\_\_ Dentist's Phone: \_\_\_\_\_

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Eye Doctor's Name: \_\_\_\_\_

Location: \_\_\_\_\_ Eye Doctor's Phone: \_\_\_\_\_

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List other doctors, specialists, or counselors: \_\_\_\_\_

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Allergies: \_\_\_\_\_

Does your child require access to an EpiPen? ☐ Yes ☐ No

Medications taken routinely: \_\_\_\_\_

Does your child require medication at school? ☐ Yes ☐ No

If yes, what medication? \_\_\_\_\_

\*All medications given at school must be supplied by the parent in the original container.  
Please contact the school nurse to make these arrangements.

# Preschool Registration

## Student Health Information Page 2 of 2

Does your child have visual or hearing problems?

☐

Corrective Lenses

☐

Ear Tubes

☐

Glasses

☐

Hearing Aids

Do you have concerns about your child's general health? (eating, sleeping, weight, etc)

☐

Yes

☐

No

Does your child have any chronic illness or medical conditions? (seizures, asthma, heart condition, ADHD, etc.)

☐

Yes

☐

No

Has your child had any serious accidents? (burns, head injury, broken bones, etc)

☐

Yes

☐

No

Does your child require any special services?

☐

Yes

☐

No

Explain all yes answers:

# Preschool Registration

## Emergency Information Page 1 of 1

In an emergency situation when we cannot reach you at home or at work, please list three LOCAL individuals who have agreed to take responsibility for your child and consented to the release of their address and phone numbers so we may reach them as an alternative.

Child Care: \_\_\_\_\_ Child Care Phone: \_\_\_\_\_

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Emergency Contact #1 \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone (1) \_\_\_\_\_ Phone (2) \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

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Emergency Contact #2 \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone (1) \_\_\_\_\_ Phone (2) \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

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Emergency Contact #3 \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone (1) \_\_\_\_\_ Phone (2) \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

# Preschool Registration

## Home Language Survey Page 1 of 1

In accordance with federal law and required by Iowa code, districts are required to administer this Home Language Survey for all students at the time of enrollment. This form should be completed once, upon enrollment and not each year.

Parents should know that the HLS is used solely to offer appropriate education services, not for determining legal status, for immigration purposes or any other purposes than best serving the student's educational needs.

A complete HLS, signed and dated by the parent must be appropriately filed with the other permanent student enrollment documentation.

Date: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Student Name: \_\_\_\_\_ Sex: ☐ Male ☐ Female

Parent/Guardian Name: \_\_\_\_\_

Phone \_\_\_\_\_

Address: \_\_\_\_\_

1. What is the primary language used regardless of the language spoken by the student?

\_\_\_\_\_

2. What is the language most often spoken by the student?

\_\_\_\_\_

3. What is the language that the student first acquired?

\_\_\_\_\_

# Preschool Registration

## Student Race & Ethnicity Reporting Page 1 of 1

Date: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Student Name: \_\_\_\_\_

Sex: ☐ Male ☐ Female

Parent/Guardian Name: \_\_\_\_\_

1. Is your child Hispanic, Latino, or Spanish ethnicity? ☐ Yes ☐ No  
Includes persons of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin.

If you answered "Yes" to question 1, you may also check one or more of the racial categories in question #2. If you answered "No", please check one or more of the following racial categories.

### 2. Racial Categories

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



# Preschool Registration

## Release for Publishing and Social Media Page 1 of 1

I give permission for my student's name and photo to be published in the following ways:

Description	Student Name	Student Photo	Permission Denied
Local Newspapers (Adams County Free Press, Villisca Review, Red Oak Express, Creston News Advertiser, etc)			
Southwest Valley Publications, Newsletters, etc.			
Southwest Valley's Facebook page as an individual			
Southwest Valley's Facebook page as part of a group			
<i>Corning Elementary Kids Only</i> Preschool Facebook page			

# Preschool Registration

## District Alert System Page 1 of 1

Using our district-wide message alert system, you may opt-in to receive messages regarding school updates about general district announcements, weather-related closings, student safety and emergency updates, etc.

Name: \_\_\_\_\_

☐ Phone Call at this number: \_\_\_\_\_

☐ Text at this number: \_\_\_\_\_

☐ Email at this address: \_\_\_\_\_

Name: \_\_\_\_\_

☐ Phone Call at this number: \_\_\_\_\_

☐ Text at this number: \_\_\_\_\_

☐ Email at this address: \_\_\_\_\_

# Preschool Registration

## School Nurse Checklist Page 1 of 1

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. Physical (mandatory)
- \_\_\_ 2. Complete Immunization information (including dates and sources of immunizations)
- \_\_\_ 3. 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
- \_\_\_ 4. Vision screening - a valid screening must have been performed within 1 year of enrollment
- \_\_\_ 5. 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.

We 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

Darcy Dalton, RN, BSN  
Southwest Valley Schools, West Campus

Corning Elementary  
1012 10th Street  
Corning, IA 50841  
641.322.4020  
Fax: 641.322.4922



**SOUTHWEST VALLEY**  
**#TWOLVESTERRITORY**

Enarson Elementary  
219 Central Ave  
Villisca, IA 50864  
712.826.5982  
Fax: 712.826.4133

## Preschool/Kindergarten Physical Form

**Child Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

Date of Exam: \_\_\_\_\_

Blood Lead Level: \_\_\_\_\_

Please provide a current and up-

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Date of test: \_\_\_\_\_

to date record of immunizations.

B/P: \_\_\_\_\_

Results: \_\_\_\_\_

### Physical Exam

Skin: \_\_\_\_\_

HEENT: \_\_\_\_\_

Teeth/Oral Health: \_\_\_\_\_

Heart: \_\_\_\_\_

Lungs: \_\_\_\_\_

Stomach/Abd: \_\_\_\_\_

Genitalia: \_\_\_\_\_

Extremities/Joints/Muscles/Spine: \_\_\_\_\_

Neuro: \_\_\_\_\_

Psychosocial/Behavioral: \_\_\_\_\_

### Allergies:

### Current Medications:

Environmental: \_\_\_\_\_

\_\_\_\_\_

Medication: \_\_\_\_\_

\_\_\_\_\_

Food: \_\_\_\_\_

\_\_\_\_\_

Insects: \_\_\_\_\_

Any medications need given at school?

EpiPen Needed: \_\_\_\_\_

\_\_\_\_\_

**Dietary Restrictions/Accommodations?**

\_\_\_\_\_

**Health Provider Signature:** \_\_\_\_\_



## 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/YY):
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### 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 health and there is no apparent reason for the child to be seen before the next routine dental checkup.
- ☐ **Requires Dental Care** – tooth decay<sup>1</sup> or a white spot lesion<sup>2</sup> is suspected in one or more teeth, or gum infection<sup>3</sup> is suspected.
- ☐ **Requires Urgent Dental Care** – obvious tooth decay<sup>1</sup> is present in one or more teeth, there is evidence of injury or severe infection, or the child is experiencing pain.

<sup>1</sup> Tooth Decay: A visible cavity or hole in a tooth with brown or black coloration, or a retained root.

<sup>2</sup> 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.

<sup>3</sup> Gum infection: Gum (gingival) tissue is red, bleeding, or swollen.

**Screening Provider** (check **ONE** only): (Ninth grade screening must be provided by DDS/DMD or RDH.)

☐ DDS/DMD   ☐ RDH   ☐ MD/DO   ☐ PA   ☐ RN/ARNP

**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 on this form from another health department. 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 Health and Human Services • Bureau of Oral and Health Delivery Systems  
 1-866-528-4020 • <https://idph.iowa.gov/ohds>

A designee of the local board of health or Iowa Department of Health and Human Services may review this certificate for survey purposes.  
 Updated March 2023





**Iowa Department of Public Health**  
**CERTIFICATE OF VISION SCREENING**  
Pursuant with Iowa Code Chapter 641.52  
**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 testing requirements can be accomplished either through a screening (see below) or with a comprehensive eye exam (see other side). Screening provider must complete this section *or parents may attach a copy of vision screening results given to them by a provider.*

<b>Date of Vision Screening:</b> _____
<b>Result: (Please check):</b> <input type="checkbox"/> Pass or <input type="checkbox"/> Fail
<b>Testing method: (Please check)</b> <input type="checkbox"/> Vision Screening <input type="checkbox"/> Photo Screen <input type="checkbox"/> Other: _____
<b>Visual Acuity: (if available)</b> <input type="checkbox"/> With Correction <input type="checkbox"/> Without Correction
Right Eye _____ Left Eye _____
<b>Referral to eye health professional: (Please check)</b> <input type="checkbox"/> Yes or <input type="checkbox"/> No

Business Name/Source of Screening: (please print name of provider office or if provided by school nurse, name of school)

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 3<sup>rd</sup> 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 3<sup>rd</sup> grade and no later than six months after the date of the child's enrollment in Kindergarten and 3<sup>rd</sup> grade.

**RETURN COMPLETED FORM TO CHILD'S SCHOOL.**