KINDERGARTEN ENROLLMENT REQUIREMENTS

2015-2016

PARENT CHECKLIST

☐ Immunizations Record

- **Preferred document: West Virginia State Immunization Certificate,** available at your doctor's office or Health Department.
- **Before being admitted to school, each child shall show proof that he/she has received the immunization requirements.**

☐ Physical Exam (Health Check)

- A Physical completed by your child's doctor is known as a Health Check.

☐ Dental Exam

- Due before the beginning of school.

☐ State Certified Birth Certificate

- This is a birth certificate obtained from the state registrar's office from the state in which your child was born.
- **WE CANNOT ACCEPT A HOSPITAL OR COUNTY COPY OF A CHILD'S BIRTH. IT IS AGAINST THE LAW.**
- **We are required by law to contact the State Police if a certified birth certificate is not presented within three weeks of enrollment.**
- Online forms and ordering can be found at the following website:
  http://www.wvdhhr.org/bph/hsc/vital/birthcert.asp

If you have questions, please contact one of the following:

Jana Miller	Barbour County Schools	304-457-3030
Teresa Childers	Barbour County Schools	304-457-3030
Principal of your home school		

Home School: _____

BARBOUR COUNTY SCHOOLS
105 SOUTH RAILROAD STREET
PHILIPPI, WV 26416

ENROLLMENT & WVEIS STUDENT DATA COLLECTION FORM

STUDENT NUMBER_____

(PLEASE PRINT) STUDENT INFORMATION

Student Name_____Sex _____
Last First Middle M or F

Class_____ Social Security No._____ / _____ / _____

Birth date [MM/DD/YY] _____ / _____ / _____ Birth place [city, state] _____ , _____

Phone (_____) _____ Unlisted _____
Y or N

Year of Graduation _____

Immigration Information: AGE _____ **Born outside United States:** _____ **Yes** _____ **No**

Number of Years Child has attended public school? _____
("State" refers to the 50 states, the District of Columbia, and the Commonwealth of Puerto Rico.)

Native Language _____
(Language spoken in the home) EN=English
SP=Spanish FR=French AS=S. E. Asian
GR=German IT=Italian PO=Polish

Ethnic Group _____
A=Asian or Pacific Islander, B = Black, Non-Hispanic
JA=Japanese H=Hispanic W=White
OT=Other 1+American Indian or Alaskan Native

Transportation_____
01=Bus Student 02=Non-Bus Student

(PLEASE PRINT) PARENT / GUARDIAN INFORMATION

Parent / Guardian_____
Last First Middle

Spouse _____
Last First Middle

Home Address_____

Mailing Address (if different) _____

Employer _____ Phone (_____) _____

Spouse Employer _____ Phone (_____) _____

STUDENT RESIDES WITH _____

NAMES OF OTHER CHILDREN IN SCHOOL:

NAME	AGE	BIRTH DATE	SCHOOL	GRADE
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

LAST SCHOOL ATTENDED _____ PHONE # _____

IS YOUR CHILD COVERED BY MEDICAID? **YES** **NO**

IF YES: MEDICAID NUMBER_____

IF NO: IS YOUR CHILD COVERED BY ANOTHER INSURANCE? **YES** **NO**

IF YES: INSURANCE COMPANY _____

INSURED NAME _____

SOCIAL SECURITY # _____

POLICY # _____

IF I CANNOT BE CONTACTED, I HEREBY GIVE PERMISSION FOR THIS CHILD TO BE MOVED TO A HOSPITAL OR CLINIC BY AMBULANCE OR CAR, IF NEEDED, AND TREATMENT THAT IS NECESSARY TO BE ADMINISTERED BY A NURSE, A PHYSICIAN, OR THEIR ASSISTANT.

_____

SIGNATURE OF PARENT / GUARDIAN DATE

EMERGENCY INFORMATION – Please identify person other than parent or guardian who could be contacted in case of an emergency.

Contact 1 – Name_____
Last First Middle

Relationship _____ Phone (_____) _____

Address _____

Contact 2 - Name_____
Last First Middle

Relationship _____ Phone (_____) _____

Address _____

Special Instructions:

_____

_____

_____

Vaccine-Preventable Diseases and the Vaccines that Prevent Them

Disease	Vaccine	Disease spread by	Disease symptoms	Disease complications
Chickenpox	Varicella vaccine protects against chickenpox.	Air, direct contact	Rash, tiredness, headache, fever	Infected blisters, bleeding disorders, encephalitis (brain swelling), pneumonia (infection in the lungs)
Diphtheria	DTaP* vaccine protects against diphtheria.	Air, direct contact	Sore throat, mild fever, weakness, swollen glands in neck	Swelling of the heart muscle, heart failure, coma, paralysis, death
Hib	Hib vaccine protects against *Haemophilus influenzae* type b.	Air, direct contact	May be no symptoms unless bacteria enter the blood	Meningitis (infection of the covering around the brain and spinal cord), intellectual disability, epiglottitis (life-threatening infection that can block the windpipe and lead to serious breathing problems), pneumonia (infection in the lungs), death
Hepatitis A	HepA vaccine protects against hepatitis A.	Direct contact, contaminated food or water	May be no symptoms, fever, stomach pain, loss of appetite, fatigue, vomiting, jaundice (yellowing of skin and eyes), dark urine	Liver failure, arthralgia (joint pain), kidney, pancreatic, and blood disorders
Hepatitis B	HepB vaccine protects against hepatitis B.	Contact with blood or body fluids	May be no symptoms, fever, headache, weakness, vomiting, jaundice (yellowing of skin and eyes), joint pain	Chronic liver infection, liver failure, liver cancer
Flu	Flu vaccine protects against influenza.	Air, direct contact	Fever, muscle pain, sore throat, cough, extreme fatigue	Pneumonia (infection in the lungs)
Measles	MMR** vaccine protects against measles.	Air, direct contact	Rash, fever, cough, runny nose, pinkeye	Encephalitis (brain swelling), pneumonia (infection in the lungs), death
Mumps	MMR**vaccine protects against mumps.	Air, direct contact	Swollen salivary glands (under the jaw), fever, headache, tiredness, muscle pain	Meningitis (infection of the covering around the brain and spinal cord) , encephalitis (brain swelling), inflammation of testicles or ovaries, deafness
Pertussis	DTaP* vaccine protects against pertussis (whooping cough).	Air, direct contact	Severe cough, runny nose, apnea (a pause in breathing in infants)	Pneumonia (infection in the lungs), death
Polio	IPV vaccine protects against polio.	Air, direct contact, through the mouth	May be no symptoms, sore throat, fever, nausea, headache	Paralysis, death
Pneumococcal	PCV vaccine protects against pneumococcus.	Air, direct contact	May be no symptoms, pneumonia (infection in the lungs)	Bacteremia (blood infection), meningitis (infection of the covering around the brain and spinal cord), death
Rotavirus	RV vaccine protects against rotavirus.	Through the mouth	Diarrhea, fever, vomiting	Severe diarrhea, dehydration
Rubella	MMR** vaccine protects against rubella.	Air, direct contact	Children infected with rubella virus sometimes have a rash, fever, swollen lymph nodes	Very serious in pregnant women—can lead to miscarriage, stillbirth, premature delivery, birth defects
Tetanus	DTaP* vaccine protects against tetanus.	Exposure through cuts in skin	Stiffness in neck and abdominal muscles, difficulty swallowing, muscle spasms, fever	Broken bones, breathing difficulty, death

* DTaP combines protection against diphtheria, tetanus, and pertussis.
** MMR combines protection against measles, mumps, and rubella.

Last updated January 201 • CS245366-A

2015 Recommended Immunizations for Children from Birth Through 6 Years Old

HepB	HepB			HepB						
		RV	RV	RV						
		DTaP	DTaP	DTaP		DTaP				DTaP
		Hib	Hib	Hib	Hib					
		PCV	PCV	PCV	PCV					
		IPV	IPV		IPV					IPV
					Influenza (Yearly)*					
					MMR					MMR
					Varicella					Varicella
					HepA§					

Is your family growing? To protect your new baby and yourself against whooping cough, get a Tdap vaccine in the third trimester of each pregnancy. Talk to your doctor for more details.

Shaded boxes indicate the vaccine can be given during shown age range.

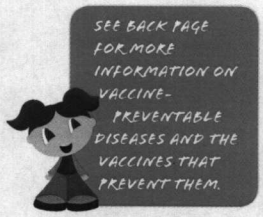
NOTE: If your child misses a shot, you don't need to start over, just go back to your child's doctor for the next shot. Talk with your child's doctor if you have questions about vaccines.

FOOTNOTES:

* Two doses given at least four weeks apart are recommended for children aged 6 months through 8 years of age who are getting a[illegible] flu vaccine for the first time and for some other children in this age group.

§ Two doses of HepA vaccine are needed for lasting protection. The first dose of HepA vaccine should be given between 12 months and 23 months of age. The second dose should be given 6 to 18 months later. HepA vaccination may be given to any child 12 months and older to protect against HepA. Children and adolescents who did not receive the HepA vaccine and are at high-risk, should be vaccinated against HepA.

If your child has any medical conditions that put him at risk for infection or is traveling outside the United States, talk to your child's doctor about additional vaccines that he may need.



For more information, call toll free **1-800-CDC-INFO** (1-800-232-4636) or visit **http://www.cdc.gov/vaccines**

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

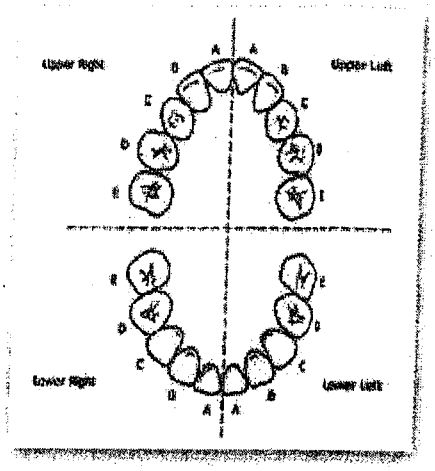
DENTAL EXAMINATION & TREATMENT RECORD

Child's Name:_____ Site:_____
Date of Birth:____/____/_____

Dentist Name:_____ Phone:_____ Fax:_____

Address:_____

Date Services Received:____/____/_____



Services Received:

- ☐ Exam
- ☐ Cleaning
- ☐ Fluoride Treatment
- ☐ X-rays
- ☐ Sealants
- ☐ Fillings
- ☐ Extraction
- ☐ Screening Only
- ☐ Other:_____

Treatment Received at today's visit:

_____
_____
_____
_____
_____
_____

Additional Treatment Needed: ☐ Yes ☐ No
If yes, explain:_____

Treatment is: ☐ Complete ☐ Incomplete

Follow up needed: ☐ Yes ☐ No

Referral Made: ☐ Yes ☐ No
To whom:_____

Additional Information:_____

Next Scheduled appointment:_____/____/_____

_____
Dentist's Signature

____/____/_____
Date

WEST VIRGINIA Department of Health & Human Resources

Application for Certified Copy of West Virginia Birth Certificate

Please complete on-line, print, sign, and mail as instructed below or print except where signature is required.

The following pertains to information that would be found on the certificate being requested.

Name of person on the certificate

_____
First Middle Last

Date of Birth

_____
Month/Day/Year

Mother's Maiden Name

_____
First Middle Last

Sex:

☐ Male ☐ Female

Father's Name

_____
First Middle Last

Place of Birth

City _____ County _____ State _____

Hospital _____

Requestor's Relationship:

Parent/Grandparent ☐ Guardian or agent ☐ Child/Grandchild ☐

Certificate of my own birth ☐ Spouse ☐ Brother/Sister ☐

Making false statements and misuse of vital records will result in criminal and civil penalties pursuant to WV Code §16-5-38.

_____
Signature (Required)

_____
Printed Name (Required)

Requesting _____ copies at $12.00 per copy and enclosing $_____.

Please send check or money order. Please do not send cash.
Make checks payable to: Vital Registration

Send copies to: Print your address below.

_____

_____

_____

_____

_____
City State Zip

( ) _____
Area Code Your daytime telephone number:

_____
E-Mail address

Submit form with check or money order to:

Vital Registration
Room 165
350 Capitol Street
Charleston, WV 25301-3701

Telephone: (304) 558-2931

Last Revised 1/9/09