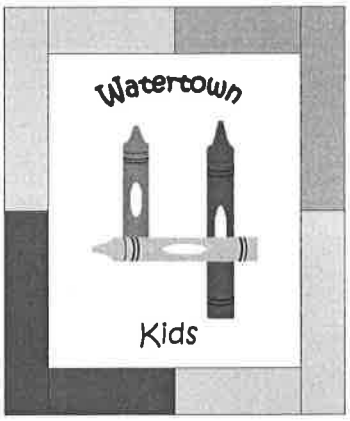

Watertown Unified School District

Watertown 4Kids Office
Schurz Elementary School
1508 Neenah St
Watertown, WI 53094
Phone 920-262-1485
Fax 920-206-7438

Jenny Borst
Director of Elementary Teaching and Learning

Dear Parent/Guardian:

Thank you for your inquiry into the Watertown 4 Kids Program. Watertown 4 Kids is a half-day public school preschool program of preparing four-year-olds for school success. An abundance of research supports the value of four-year-old kindergarten for our children.

The Watertown 4 Kids Program is a collaborative community approach where the preschool programming is conducted in private preschool centers located throughout the Watertown School District. Each of the classrooms has a Wisconsin Department of Public Instruction licensed kindergarten teacher and an adult assistant teacher. The centers for the 2014-2015 school year include Great Expectations Early Learning Center, Gingerbread Preschool, Jefferson County Head Start, Mary Linsmeier Preschool, and St. Bernard's Preschool.

Registration will be Tuesday, January 27 and Wednesday, January 28, 2015 from 10:00 am to 6:00 pm. Registration is located at the Educational Service Center, 111 Dodge St., Watertown, WI 53094. Registrations are accepted for priority placement by first come first serve and **won't** be accepted prior to January 27. If you have a site that you prefer, come early! We will have room for all 4 year olds in the program but have limited class sizes at each site. If you cannot attend registration, please bring packets to 111 Dodge Street after registration dates.

If you are registering for 4 year old kindergarten you will need to show your child's Birth Certificate or Hospital Record at registration for age verification.

To be eligible for 4 year old kindergarten, a child must be 4 years of age on or before September 1, 2015 and your child must be immunized against diphtheria, pertussis, tetanus, polio, measles, mumps, rubella, and hepatitis B. The Hib (Haemophilus influenza B) and PCV (pneumococcal) vaccines are also required for children who attend day care in a licensed center in addition to the 4K program. Your child must be immunized against varicella (chicken pox) if he/she has not had the disease. **Please bring your completed immunization form to registration.**

Fees of $20.00 may be paid at the ESC during registration. You will be notified in the spring by mail of your child's 4K site placement.

When turning in your packet, please make sure you have completed and signed all of the forms enclosed.

We are look forward to seeing you and your child at registration!

Sincerely,
Jenny Borst
Director of Elementary Teaching and Learning

4K PARENT INFORMATION FORM 2015-2016 SCHOOL YEAR – Jenny Borst, Coordinator

Watertown Kids

Section I: Student Information (Legal Name must be used for Students and Parents)

Child's Name: _____ Birthdate: _____
(Last Name) (First Name) (Middle Initial)

School use only:
Birth Certificate Verification _____(initials) _____(date)_____

Other ID_____
Paid:_____Cash _____Check
Check #_____

Name child is to be called at school: _____

Gender: _____ Ethnic: _____ Home Phone: _____ County of Residence: _____

Address: _____City, State & ZIP:_____Township: _____

Birth City: _____**Birth State:** _____**Birth County:** _____ **Birth Country:** _____

Ethnicity: (must choose one) _____Hispanic or Latino _____Not Hispanic or Latino

Federal Race: (must select one or more of the following that apply to this student). Please circle all that apply:

1 - American Indian or Alaskan Native, **2** – Asian, **3** - Black or African American, **4** - Native Hawaiian or Other Pacific Islander, **5** – White

Language Spoken at Home: _____ First Language Learned: _____

Child resides with (mark one): ☐ Both Parents (same household) ☐ Mother only ☐ Father only ☐ Guardian ☐ Foster ☐ Joint Custody

Person completing this Form: _____Father _____Mother _____Step Parent _____Other (_____)

Section II: Guardian Information **Do you have access to the Internet?** _____

FAMILY 1 INFORMATION

Guardian 1 Name: _____ **Relation to Student:** _____

Address: _____ City, State & ZIP: _____

Employer: _____ City, State & ZIP: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Spoken Language: _____

Email address: _____

Guardian 1 Spouse: _____ **Relation to Student:** _____

Employer: _____ City, State & ZIP: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Spoken Language: _____

Email address: _____

FAMILY 2 INFORMATION **Do you have access to the Internet?** _____

Guardian 2 Name: _____ **Relation to Student:** _____

Address: _____ City, State & ZIP: _____

Employer: _____ City, State & ZIP: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Spoken Language: _____

Email address: _____

Guardian 2 Spouse: _____ **Relation to Student:** _____

Employer: _____ City, State & ZIP: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Spoken Language: _____

Email address: _____

Guardian 2 Receives Forms: Yes No Guardian 2 Receives Report Card: Yes No

OVER

Section III Family Information

Sibling's Name	*Sibling's Date of Birth*	*Gender*	*Sibling's School-Grade*

Section IV Busing Information (Rural students only)

☐ Check this box if your student will ride the bus at least once during the school year.

Section V Emergency Information – this should be a person other than parent (Parent/Guardian will be contacted first)

Emergency 1: *Address:* *Phone:*
Work Phone: *Cell Phone:* *Relationship to child:*

Emergency 2: *Address:* *Phone:*
Work Phone: *Cell Phone:* *Relationship to child:*

Emergency 3: *Address:* *Phone:*
Work Phone: *Cell Phone:* *Relationship to child:*

Section VI Physician Information:

Physician/Address: Physician Phone:

General Information:

The following information is to help us understand your child and prepare for his/her entrance into school. If you have questions or reservations about completing any part of it, please feel free to tell us.

My child is currently attending:

_____ Preschool or child care center: _____
(Name of Preschool or Child Care Center)

_____ Licensed family day care

_____ Babysitter

_____ Other peer group experience (i.e. Library hour, Sunday School, YMCA activities)

_____

_____

_____ My child is not attending any of the above.

Comments:

Does your child have a current IEP/disability/or receive therapies? If so explain:

OVER

Site and Time Preference:

Application preference accepted on a first come-first serve basis.
Six sites available: Gingerbread Preschool, Great Expectations, Jefferson County Head Start (qualifying families), Mary Linsmeier Preschool,
St. Bernard's Preschool and St. Henry's Preschool

First Choice of Site_____ AM, PM, or Either? _____

Second Choice of Site_____ AM, PM, or Either?_____

Third Choice of Site_____ AM, PM, or Either?_____

(SPECIAL NOTE: The Watertown School District makes the final decision regarding agency placement.)

Bussing:

If living in a rural location (outside of city limits), do you wish to have bus service for your Child: Yes _____

No_____

If qualified for bussing, do you wish bussing: To School _____ From School_____ Both Ways_____

Before & After School Care:

Do you wish to enroll your child in before or after-school care? Yes_____ No____

(Please note: Parents must contact the child care center for care as the care is provided by the agency...not the school district. It is advised to contact the child care center as soon as you know your location as space is limited. Care is provided on a first come-first serve basis! Parents are responsible for extra childcare costs.)

Please return this form in person on Tuesday, January 27 or Wednesday, January 28, 2015 – 10:00 a.m. to 6:00 p.m.

Watertown Unified School District
Educational Service Center
111 Dodge Street
Watertown, WI 53094

In addition to this packet, please bring copies of the following with your child's registration form:

1. Birth Certificate or a copy, hospital record, or baptismal certificate
2. Immunization Record
3. Registration Fee ($20.00)

Signature of Parent_____Date Signed_____

Revised 11/26/2014

Home Language Survey (Versión en español en el otro lado)

In order to comply with state requirements and to assist the Watertown Unified School District in communicating with the home, please answer the following questions about your child's language. Thank you for your assistance. All your answers are for school purposes only.

PARENT/GUARDIAN HOME LANGUAGE SURVEY

Student's Name	Current Grade	Grade Level Last Completed

Address (city, state, country) of School Last Attended

Watertown School Enrolling In

Relationship of Person Completing Survey

☐ Mother ☐ Father ☐ Guardian ☐ Other: _____

Directions: Check the correct response for each of the following questions.

	English	Spanish	Other Language(s)
1. What language did the child learn when she or he first began to talk?	☐	☐	
2. What language does the family speak at home most of the time?	☐	☐	
3. What language does the parent(s) speak to her/his child most of the time?	☐	☐	
4. What language does the child speak to her/his parent(s) most of the time?	☐	☐	
5. What language does the child hear and understand in the home?	☐	☐	
6. What language does the child speak to her/his brothers/sisters most of the time?	☐	☐	
7. What language does the child speak to her/his friends most of the time?	☐	☐	

	Yes	No	
8. Can an adult family member or extended family member speak English?	☐	☐	
Can they read English?	☐	☐	
9. Do the parents/guardians request oral and/or written communication from the school to be in English?	☐	☐	☐ Oral ☐ Written
		If no, in what language	

SIGNATURE

Signature of Person Completing Survey/Firma de persona completando esta hoja	Date Signed/Fecha
➢	

FOR STAFF COMPLETION
TO BE COMPLETED FOR ALL NEW STUDENTS

ESL File Opened	ESL Test Date	Today's Date	Test
☐ Yes ☐ No			

ESL Evaluator	ESL Level	Placement

Adapted from: *Sample Survey, Institute for Cultural Pluralism*, Lau General Assistance Center, San Diego State University, San Diego, CA 921882 [sic], 1976

HEALTH HISTORY AND EMERGENCY CARE PLAN

Use of form: This form is required for family and group child care centers and day camps to comply with DCF 250.04(6)(a)1. and 250.07(6)(L)5., DCF 251.04(6)(a)6. and 251.07(6)(k)5., and DCF 252.44(6)(g) of the Wisconsin Administrative Codes. Failure to comply may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian should complete this form for placement in the child's file prior to the child's first day of attendance. Information contained on the form shall be shared with any person caring for the child. The department recommends that parents / guardians and center staff periodically review and update the information provided on this form.

CHILD INFORMATION

Name (Last, First, MI)	Address – Home (Street, City, State, Zip Code)	
Telephone Number	Birthdate (mm/dd/yyyy)	Date – First Day of Attendance (mm/dd/yyyy)

PARENT / GUARDIAN INFORMATION

Provide information where the parent(s) / guardian(s) may be reached while the child is in care.

Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular
Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular

PHYSICIAN / MEDICAL FACILITY INFORMATION

Name – Physician	Address – Medical Facility	Telephone Number

SUNSCREEN / INSECT REPELLENT AUTHORIZATION

If provided by the parent, the sunscreen or insect repellent shall be labeled with the child's name. Per DCF 251.07(6)(f)2., authorizations shall be reviewed every 6 months and updated as necessary. Per DCF 250.07(6)(f)2.a., Authorizations shall be reviewed periodically and updated as necessary.

☐ Yes ☐ No I authorize the center to apply sunscreen to my child.	Brand Name	Ingredient Strength
☐ Yes ☐ No I authorize the center to allow my child to self-apply sunscreen.		
☐ Yes ☐ No I authorize the center to apply repellent to my child.	Brand Name	Ingredient Strength
☐ Yes ☐ No I authorize the center to allow my child to self-apply repellent.		

HEALTH HISTORY AND EMERGENCY CARE PLAN

If available, attach any health care plan information from the child's physician, therapist, etc.

1. Check any special medical condition that your child may have.

☐ No specific medical condition
☐ Asthma
☐ Cerebral palsy / motor disorder
☐ Diabetes
☐ Epilepsy / seizure disorder
☐ Gastrointestinal or feeding concerns including special diet and supplements
☐ Any disorder including Cognitively Disabled, LD, ADD, ADHD, or Autism
☐ Other condition(s) requiring special care – Specify.

☐ Milk allergy. If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative.
☐ Food allergies – Specify food(s).

☐ Non-food allergies – Specify.

2. Triggers that may cause problems – Specify.

3. Signs or symptoms to watch for – Specify.

4. Steps the child care provider should follow. If prescription or non-prescription medications are necessary, a copy of the form *Authorization to Administer Medication* should be attached to this form. Note: group child care centers and day camps may use their own form.

5. Identify any child care staff to whom you have given specialized training / instructions to help treat symptoms.
   a.
   b.
   c.

6. When to call parents regarding symptoms or failure to respond to treatment.

7. When to consider that the condition requires emergency medical care or reassessment.

8. Additional information that may be helpful to the child care provider.

SIGNATURE – Parent or Guardian	Date Signed (mm/dd/yyyy)

Review dates: _____ _____ _____ _____ _____

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44192 (Rev. 09/08)

STATE OF WISCONSIN
ss. 252.04,Wis. Stats.

DAY CARE IMMUNIZATION RECORD

COMPLETE AND RETURN TO DAY CARE CENTER . State law requires all children in day care centers to present evidence of immunization against certain diseases within **30 school days (6 calendar weeks) of admission to the day care center.** These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the day care center. See "Waivers" below. If you have any questions on immunizations or how to complete this form, please contact your child's day care provider or your local health department.

STEP 1 PERSONAL DATA — PLEASE PRINT

Child's Name(Last, First, Middle Initial)	Date of Birth (Month/Day/Year)	Area Code/Telephone Number
Name of Parent/Guardian/Legal Custodian (Last, First, Middle Initial)	Address (Street, Apartment number, City, State, Zip)	

STEP 2 IMMUNIZATION HISTORY

List the MONTH, DAY AND YEAR the child received each of the following immunizations. DO NOT USE A (4) OR (X) except to indicate whether the child has had chickenpox. If you do not have an immunization record for this child, contact your doctor or local public health department to obtain the records.

TYPE OF VACCINE	First Dose Month/Day/Year	Second Dose Month/Day/Year	Third Dose Month/Day/Year	Fourth Dose Month/Day/Year	Fifth Dose Month/Day/Year
Diphtheria-Tetanus-Pertussis (Specify DTP, DTaP, or DT)					
Polio					
Hib (Haemophilus *Influenzae* Type B)					
Pneumococcal Conjugate Vaccine (PCV)					
Hepatitis B					
Measles-Mumps-Rubella (MMR)					
Varicella (chickenpox) vaccine Vaccine is required only if the child has not had chickenpox disease.					

Has the child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known.

☐ Yes year _____ (Vaccine is not required)
☐ No or Unsure (Vaccine is required)

STEP 3 REQUIREMENTS

The following are the minimum **required** immunizations for the child's age/grade at entry. All children within the range must meet these requirements at day care entrance. Children who reach a new age/grade level while attending this day care must have their records updated with dates of additional required doses.

AGE LEVELS	NUMBER OF DOSES						
5 months through 15 months	2 DTP/DTaP/DT	2 Polio	2 Hib	2 PCV	2 Hep B		
16 months through 23 months	3 DTP/DTaP/DT	2 Polio	3 Hib[1]	3 PCV[2]	2 Hep B	1 MMR[3]	
2 years through 4 years	4 DTP/DTaP/DT	3 Polio	3 Hib[1]	3 PCV[2]	3 Hep B	1 MMR[3]	1 Varicella
At Kindergarten entrance	4 DTP/DTaP/DT[4]	4 Polio			3 Hep B	2 MMR[3]	2 Varicella

[1]If the child began the Hib series at 12-14 months of age, only 2 doses are required. If the child received one dose of Hib at 15 months of age or after, no additional doses are required. Minimum of one dose must be received after 12 months of age (Note: a dose 4 days or less before the first birthday is also acceptable).

[2]If the child began the PCV series at 12-23 months of age, only 2 doses are required. If the child received the first dose of PCV at 24 months of age or after, no additional doses are required.

[3]MMR vaccine must have been received on or after the first birthday (Note: a dose 4 days or less before the 1st birthday is also acceptable).

[4]Children entering kindergarten must have received one dose after the 4th birthday (either the 3rd, 4th or 5th) to be compliant (Note: a dose 4 days or less before the 4th birthday is also acceptable).

STEP 4 COMPLIANCE DATA AND WAIVERS

IF THE CHILD MEETS ALL REQUIREMENTS (sign at STEP 5 and return this form to the day care center), OR

IF THE CHILD **DOES NOT** MEET ALL REQUIREMENTS (check the appropriate box below, sign and return this form to day care center).

☐ Although the child has not received all required doses of vaccine for his or her age group, at least the first dose of each vaccine has been received. I understand that it is my responsibility to obtain the remaining required doses of vaccines for this child **WITHIN ONE YEAR** and to notify the day care center in writing as each dose is received.

NOTE: Failure to stay on schedule or report immunizations to the day care center may result in court action against the parents and a fine of up to $25.00 per day of violation.

☐ For health reasons this child should not receive the following immunizations _____(List in STEP 2 any immunizations already received)

_____
Physician's Signature Required

☐ For religious reasons this child should not be immunized. (List in STEP 2 any immunizations already received)

☐ For personal conviction reasons this child should not be immunized. (List in STEP 2 any immunizations already received):

STEP 5 SIGNATURE

To the best of my knowledge this form is complete and accurate.

_____ _____
SIGNATURE - Parent, Guardian or Legal Custodian — Date Signed

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
P-44021 (Rev. 07/13)

STATE OF WISCONSIN
s. 252.04, Wis. Stats.

STUDENT IMMUNIZATION LAW
AGE/GRADE REQUIREMENTS
2014 SCHOOL YEAR and Beyond

The following are the minimum required immunizations for each age/grade level. It is not a recommended immunization schedule for infants and preschoolers. For that schedule, contact your doctor or local health department.

Age/Grade	Number of Doses					
Pre K (2 yrs through 4 yrs)	4 DTP/DTaP/DT[2]		3 Polio	3 Hep B	1 MMR[5]	1 Var[6]
Grades K through 5	4 DTP/DTaP/DT/Td[1,2]		4 Polio[4]	3 Hep B	2 MMR[5]	2 Var[6]
Grades 6 through 12	4 DTP/DTaP/DT/Td[2]	1 Tdap[3]	4 Polio[4]	3 Hep B	2 MMR[5]	2 Var[6]

1. DTP/DTaP/DT vaccine for children entering **Kindergarten:** Your child must have received one dose after the 4th birthday (either the 3rd, 4th, or 5th dose) to be compliant. (Note: a dose 4 days or less before the 4th birthday is also acceptable).
2. DTP/DTaP/DT/Td vaccine for all students Pre K through 12: Four doses are required. However, if your child received the 3rd dose after the 4th birthday, further doses are not required. (Note: a dose 4 days or less before the 4th birthday is also acceptable).
3. Tdap means adolescent tetanus, diphtheria and acellular pertussis vaccine. If your child received a dose of a tetanus-containing vaccine, such as Td, within 5 years of entering the grade in which Tdap is required, your child is compliant and a dose of Tdap vaccine is not required.
4. Polio vaccine for students entering grades Kindergarten through 12: Four doses are required. However, if your child received the 3rd dose after the 4th birthday, further doses are not required. (Note: a dose 4 days or less before the 4th birthday is also acceptable).
5. The first dose of MMR vaccine must have been received on or after the first birthday (Note: a dose 4 days or less before the 1st birthday is also acceptable).
6. Var means Varicella (chickenpox) vaccine. A history of chickenpox disease is also acceptable.

Important Immunization Information
Watertown Health Department
515 South First St
Watertown, WI
Phone: 920-262-8090

MONTHLY IMMUNIZATION CLINICS

1st Thursday of the month	time: 10:00-11:00 and 2:30-4:30
3rd Thursday of the month	time: 2:30-4:30

Administration Fee:

City of Watertown Residents $15.00 per visit
Non-city residents $ 20.00 per visit
Medical assistance is available for children under 18 years

****** Current immunization records are required at each visit******

Beginning October 1, 2012, local Health departments will no longer be able to administer state supplied vaccine to children that have private insurance which includes coverage for immunizations. You are encouraged to check your health insurance policy to determine if it covers immunizations and if so, you should seek those services from your physician or clinic.