

TRILLIUM CREEK PRIMARY SCHOOL

It will be a wonderful year of learning and growing experiences. The checklist below includes items you will need to enroll your child. Please make sure all your forms are included.

Registration Checklist

- ___ Registration Form (two pages; be sure to sign and date)
- ___ Copy of Certified Birth Certificate
- ___ Immunization Form (this is our Oregon form that needs to be completed)
- ___ Authorization for Exchange of confidential Information (Record Release)
- ___ TCPS Student Information Sheet

West Linn - Wilsonville School District #3Jt Registration Form

Name: _____
(Last Name then First Name)

Teacher/Counselor: _____

Last Name: _____ First Name: _____
 Middle Name: _____ Preferred Name: _____
 Grade Level: _____ Date of Birth: _____
 Gender: _____ Male _____ Female _____
 Birthplace: _____
 Ethnicity: Hispanic/Latino? _____ Yes _____ No _____ Asian
 Race (check all that apply): _____ Amer Indian/Alaskan Native _____
 (You must select at least one.) _____ Black or African American _____
 _____ White _____ Native Hawaii/Pac Islander _____

Other Emergency Contacts: The parties (include the Day Care Provider, if appropriate) listed below are authorized to pick up this child from school and to make decisions regarding cases of emergency, serious illness, or accident.

Name	Primary Phone/Work Phone/Other Phone	Relationship
_____	_____ / _____ / _____	_____
_____	_____ / _____ / _____	_____
_____	_____ / _____ / _____	_____

Student Cell Phone/Texting: Schools may begin contacting students via cell phone or text messaging. Please provide the following information if your student has a cell phone or text messaging device.

Cell Number: _____ Service Provider: _____
 I do NOT approve of the school using my child's cell phone or text messaging for communications. _____

Siblings: Please list the names, ages, grades, and schools of any siblings:

Name	Age	Grade	School
_____	_____	_____	_____
_____	_____	_____	_____

Parent/Guardian Info: *The address provided must be the student's primary residence.*

Relationship: Mother / Father / Other (Please Specify): _____
 Last Name: _____ First Name: _____
 Home Address: _____ City/Zip: _____
 Mailing Addr: _____ County: _____
 Email: _____

Previous School(s) (Name, Location, & Dates): _____

Initial to Confirm the Above Address is the Student's Residence:

Home Phone: _____ Work Phone: _____
 Home Phone Unlisted? _____ Yes _____ No _____
 Cell Phone: _____ Employer: _____
 Occupation: _____
Additional Parent/Guardian (at same address):
 Relationship: Mother / Father / Other (Please Specify): _____
 Last Name: _____ First Name: _____
 Work Phone: _____ Employer: _____
 Cell Phone: _____ Occupation: _____
 Email: _____

Medical Conditions: Please check all conditions that apply and elaborate below:

Life-Threatening Allergies	Heart disease	Orthopedic problems
Asthma	Kidney disease	Hearing problems
Seizure disorder	Diabetes	Vision problems

Details/Other Health Concerns: _____

Extra Mailing Information:
 Under certain circumstances, the district is willing to send second mailings, for example, to non-custodial parents. If a second mailing is desired, please provide the information below:

Last Name: _____ First Name: _____
 Relationship: _____ Email: _____
 Home Address: _____ City/Zip: _____
 Mailing Addr: _____
 Home Phone: _____ Work Phone: _____
 Home Phone Unlisted? _____ Yes _____ No _____
 Other Phone: _____ Employer: _____
 Describe the circumstances that you believe warrant a second mailing: _____

Medications Taken/Dosage: _____

 District Nursing Staff will be in touch regarding specifics of these situations.

Permission Denials: (Initial each item for which you deny permission):
 I do not approve of my child being photographed or videotaped for educational purposes, including usage of such on the school or district website. _____
 I do not want any of my family's contact information disclosed by the school district. This means that school directories will not include my family's address, phone number, or email. _____
 I do not want any other information about my child or my family to appear in any school publication. I understand that this means that my child will not be included in yearbooks, sports rosters, playbills, and other activity-related publications. _____
 (For HS Age Student) I do not approve of my student being included in data sent to the military for recruiting purposes. _____

Legal/Custody Documents:
 Please list the names of anyone who has legal guardianship of this child: _____

 Are there legal documents concerning the custody of this child? _____ Yes _____ No _____
 If Yes, you will need to provide copies of the documents when submitting this form.

Medications Taken/Dosage: _____

 District Nursing Staff will be in touch regarding specifics of these situations.

Permission Denials: (Initial each item for which you deny permission):
 I do not approve of my child being photographed or videotaped for educational purposes, including usage of such on the school or district website. _____
 I do not want any of my family's contact information disclosed by the school district. This means that school directories will not include my family's address, phone number, or email. _____
 I do not want any other information about my child or my family to appear in any school publication. I understand that this means that my child will not be included in yearbooks, sports rosters, playbills, and other activity-related publications. _____
 (For HS Age Student) I do not approve of my student being included in data sent to the military for recruiting purposes. _____

West Linn - Wilsonville School District #3Jt
Registration Form

For Office Use Only:

Teacher/Counselor: _____

Name: _____
(Last Name then First Name)

Bus Information (If Known):
Morning Bus _____ Afternoon Bus: _____

Special Services (please check any areas in which your child has received special services in the last year):

_____ Title I _____ Gifted Education _____ Special Education (IEP)
_____ ESL (English as a Second Language) _____ 504 Plan _____ Other: _____

Emergency Early Closure Plan (For Primary School Children Only) - If school should close early, what should your child do (*Please choose ONLY two*):

_____ Take the bus home and can get into the house. _____ Take the bus and stay with _____
_____ Will be picked up by _____ Is to walk home and can get in the house.
_____ Is to take the bus to _____ day care.
_____ Alternate Plan: _____

Language Survey:

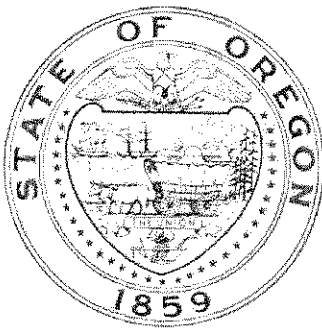
What language did the student learn first? _____ What language(s) are spoken at home? _____
What is the student's primary language? _____
Have you moved during the past three years for the purpose of obtaining seasonal or temporary employment in agriculture, forestry, or fishing? Yes _____ No _____
Has this student ever missed more than 3 months of school? Yes _____ No _____
If yes, when? _____

Complete these questions only if English is not the only language listed above.

Father's Native Language _____ Mother's Native Language _____
What language is most often used by adults in the family? _____
What language does the student use to communicate with the adults at home? _____
What language does the student use most often to communicate with friends? _____

All information provided on both sides of this form is accurate to the best of my knowledge.

Parent/Guardian Signature: _____ Date: _____



Oregon Certificate of Immunization Status Oregon Health Authority, Immunization Program

Oregon law requires proof of immunization be provided or an exemption be signed prior to a child's attendance at school, preschool, child care or home day care. This information is being collected on behalf of the Oregon Health Authority, Immunization Program and may be released to the Authority or the local public health department by the school or children's facility upon request of the Authority. Please list immunizations in the order they were received.

Child's Last Name <i>Apellido</i>	First <i>Primer Nombre</i>	Middle Initial <i>Segundo Nombre</i>	Birthdate <i>Fecha de Nacimiento</i>
Mailing Address <i>Dirección</i>	City <i>Ciudad</i>	State <i>Estado</i>	Zip Code <i>Código Postal</i>
Parents' or Guardians' Names <i>Nombre de los padres o guardian</i>		Home Telephone Number <i>Número de Teléfono</i>	

Complete for all
 Up-to-date
 medical
 non-medical

Vaccines	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Diphtheria/Tetanus/Pertussis (DTaP, Tdap, Td)	(mm/dd/yy)	(mm/dd/yy)	(mm/dd/yy)	(mm/dd/yy)	(mm/dd/yy)
Booster Dose Tdap					
Polio (IPV or OPV)					
Varicella (Chickenpox) [VZV or VAR] <input type="checkbox"/> Check here if child has had chickenpox disease _____ (mm/dd/yy)					
Measles/Mumps/Rubella (MMR) <i>or</i> Measles vaccine only Mumps vaccine only Rubella vaccine only					
Hepatitis B (Hep B)					
Hepatitis A (Hep A)					
Haemophilus Influenzae Type B (Hib) (Only children less than 5 years)					

I certify that the above information is an accurate record of this child's immunization history.

Signature* _____ Date _____

Update Signature _____ Date _____

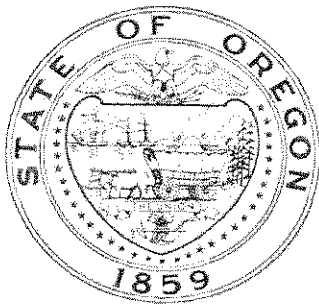
Update Signature _____ Date _____

Update Signature _____ Date _____

For school/facility use only
School/facility Name
Student ID Number
Grade

*Parent, guardian, student at least 15 years of age, medical provider or county health department staff person may sign to verify vaccinations received.

Continued On Reverse Side



Oregon Certificate of Immunization Status, Page 2
Oregon Health Authority, Immunization Program

<i>Child's Last Name</i> <i>Apellido</i>	<i>First</i> <i>Primer Nombre</i>	<i>Middle Initial</i> <i>Segundo Nombre</i>	<i>Birthdate</i> <i>Fecha de Nacimiento</i>
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	Recommended Vaccines	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5
Recommended Vaccines	Pneumococcal (PCV) (Only in children less than 5 years)					
	Meningococcal (MCV4, MPSV4)					
	Human Papilloma Virus (HPV) (9 years or older)					
	Influenza (Flu)					
	Other Vaccine Please specify:					
	Other Vaccine Please specify:					

For medical exemptions:

Please submit a **letter** signed by a licensed physician stating:

- Child's name
- Birth date
- Medical condition that contraindicates vaccine
- List of vaccines contraindicated
- Approximate time until condition resolves, if applicable
- Physician's signature and date
- Physician's contact information, including phone number

For Immunity Documentation (history of disease or positive titer): Please submit a **letter** signed by a licensed physician stating:

- Child's name and birth date
- Diagnosis or lab report
- Physician's signature and date

Nonmedical Exemption:

I have received information regarding the benefits and risks of immunizations. I understand that my child may be excluded from school or child care attendance if there is a case of disease that could be prevented by vaccine. I have attached the required document from (check one):

- A health care practitioner
- The vaccine educational module approved by the Oregon Health Authority

I understand that I may decline one or more vaccinations for my child and request that my child be exempted from the following required immunizations (check all that apply):

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Diphtheria/ Tetanus/Pertussis | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Varicella | <input type="checkbox"/> Hib |
| <input type="checkbox"/> Measles/Mumps/Rubella | |

Signature of Parent or Guardian _____

Date _____

Optional:

ORS 433.267 states that this document may include the reason for declining the immunization. Immunization is being declined because of:

- Religious belief
- Philosophical belief
- Other

I certify that the above information is an accurate record of this child's immunization history and exemption status.

Signature _____ Date _____

Update Signature _____ Date _____

Update Signature _____ Date _____

Update Signature _____ Date _____

West-Linn Wilsonville School District
West Linn, Oregon 97068

Trillium Creek Primary School

AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION

Student Name: _____

Birthdate: _____ Grade: _____ Date: _____

As parent/guardian of the named student, I hereby authorize the mutual exchange of confidential information between the **WEST LINN – WILSONVILLE SCHOOL DISTRICT**

and/or

Previous School/Practitioner: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Records to be included are:

- ✓ Education Records
- ✓ Behavioral Record
- ✓ IEP
- ✓ Health
- ✓ Transcripts
- ✓ ELL
- ✓ Other _____

Parent/Guardian Signature

Address

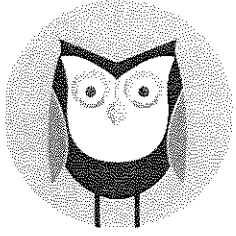
City State Zip Code

Oregon Revised Statutes allow transfer of student progress records without penalty to any other school or educational institution upon receipt of notice of the student enrolling in said institution. (ORS 336.215)

Please send all confidential information to:

Trillium Creek Primary School
1025 SW Rosemont Road
West Linn, Oregon 97068
Phone: 503.673.7950
Fax: 503.905.2010

TCPS Student Information



Welcome to Trillium Creek Primary School! In order to provide a smooth transition, we appreciate your responses to the following questions. This information will be shared with your child's teacher.

Date of Enrollment _____

Child's Name _____ Age _____ Grade _____

Please list the school(s) your child has attended in the past.

Kindergarten

1st Grade

2nd Grade

3rd Grade

4th Grade

5th Grade

1. What are your child's strengths?

2. What language(s) does your child speak? _____

What language(s) is spoken at home and by whom? _____

3. After School my child will:

Walk home _____

Ride bus # _____

Go home with _____

Please fill out other side →

4. In what type of learning environment does your child work best?

5. Please check the following services your child has received:

Gifted Education

Counseling

English as a Second Language

Adaptive PE

Special Education - Individualized Education Plan (IEP) in the following areas:

Speech/Communication

Reading

Behavior

Mathematics

Writing

Other

Other Services (please specify):

6. Please tell us about any learning issues or concerns you feel will be important for your child's teacher or counselor to know?

7. Is there any medical information we need to know about your child such as medication, allergies, glasses, etc?

8. Do you feel that there are any special areas where your child or your family could use assistance?

9. Please answer the following questions to see if you qualify for the Migrant Program

Yes No Are you employed in any type of agricultural (fruits or vegetables, food processing or fishing industry)?

Yes No Did you come to this school district because you needed to seek work agricultural or the fishing industry?

What type of agricultural or fishing work do you do? _____

Yes No Have you worked in the agricultural or fishing industry in the last 5 years?