CLINTON ELEMENTARY SCHOOL
20397 E. Mullan Road
PO Box 250
Clinton, MT 59825-250
PH: 406-825-3113 Fax: 406-825-3114

KU5/KINDERGARTEN REGISTRATION FORM

Full Legal Name of Student: _____ **Today's Date:** _____

Preferred Name/Nickname: _____ **Students Date of Birth:** _____

Grade: _____ **Gender:** ☐ Male ☐ Female

Mother's/Guardian's Name: *if guardian, please state relation to student*

_____

Physical Address and/or Mailing Address:

_____

_____

E-mail: _____

Name of Employer: _____

PHONE: Please indicate what numbers to call during school hours. (mark with an X)	
Home:	
Cell:	
Work:	
Legal Guardian Y N	**Lives with** Y N
Receive Mailings Y N	**Auth. to pick up** Y N

Father's/Guardian's Name: *if guardian, please state relation to student*

_____

Physical Address and/or Mailing Address

_____

_____

E-mail: _____

Name of Employer: _____

PHONE: Please indicate what numbers to call during school hours. (mark with an X)	
Home:	
Cell:	
Work:	
Legal Guardian Y N	**Lives with** Y N
Receive Mailings Y N	**Auth. to pick up** Y N

***** PLEASE INFORM THE SCHOOL OF ANY CHANGES THROUGHOUT THE SCHOOL YEAR *****

Siblings *(complete this section only if applicable. Include only siblings who currently attend Clinton School)*

Full name: _____ **Grade:** _____

Full name: _____ **Grade:** _____

Full name: _____ **Grade:** _____

EMERGENCY CONTACTS

Name	Relation to Student	Home Phone; Other Phone	Auth. to pick up Y	N

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Legal bindings: Please list any legal binding information including: restraining orders, custody agreements, parenting plans, etc. that may be pertinent to this student and his/her safety. *(Copy of legal documentation is required)*

_____

_____

Has this student ever received services, or been involved in:

☐ Behavior Management ☐ Counseling ☐ Gifted Program ☐ Reading/Math Tutor

☐ Section 504 ☐ Speech Therapy ☐ Special Education ☐ Title I ☐ ESL

Guidance on Race/Ethnicity Montana Office of Public Instruction (OPI)

In accordance with new standards issued by the U.S. Department of Education (ED), schools across the nation must revise how they collect and report race and ethnicity for students. These revisions will make educational data consistent with the U.S. Census and other national data sets. The change in reporting is intended to make demographic information more accurate and to account for people who identify themselves as being part of more than one race in our diverse American society. This change is not optional for states. State educational agencies, local educational agencies, postsecondary institutions, and other educational institutions and Department grantees are required to report racial and ethnic data to the Department. All must use the categories set forth in the ED's 2007 final guidance starting with information for the 20102011 school year. The new standards make a separate distinction between race and ethnicity. Hispanic/Latino is considered an ethnicity, not a race. In general, the Census Bureau defines ethnicity as the heritage, nationality group, lineage, or country of birth of the person or the person's ancestors. People who identify their ethnicity as Hispanic or Latino may be of any race. Individuals will have the opportunity to select multiple races to more fully describe their heritage. Montana law 20-9-309(2)(g) MCA authorizes the OPI to collect race/ethnicity data. Funding is allocated to districts based in part on reporting student racial/ethnic data. Federal education funds are allocated using aggregate data reported to the U.S. Department of Education (ED). Some state funding, such as the American Indian Achievement Gap Payment, is also tied to demographic data.

Identify the ethnicity and race of the individual by answering **BOTH** questions below:

Part 1.
Is the individual Hispanic or Latino? *(Choose only one)*

☐ No, not Hispanic or Latino

☐ Yes, Hispanic or Latino *(A person of Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race.)*

Part 2.
What is the individual's race? *(Choose one or more races below)*

☐ **American Indian or Alaska Native** *(A person having origins in any of the original peoples of North and South America, including Central America, and who maintains tribal affiliation or community attachment.)*

☐ **Asian** *(A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, Vietnam and Laos.)*

☐ **Black or African American** *(A person having origins in any of the black racial groups of Africa.)*

☐ **Native Hawaiian or Other Pacific Islander** *(A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.)*

☐ **White or Caucasian** *(A person having origins in any of the original peoples of Europe, the Middle East or North Africa.*

Is English the primary language in your home? (circle) **Yes** or **No** – please specify _____

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KU5/Kindergarten Enrollment Questionnaire

At Clinton we believe the first year of school helps to build a solid foundation for a student's future. Please help us best meet your child's social, physical and academic needs by completing the following information.

This information is confidential

It is strictly used to help us become better acquainted with you and your child.

Full Legal Name of Student: _____ **Today's Date:** _____

Preferred Name/Nickname: _____ **Students Date of Birth:** _____

Grade: _____ **Gender:** ☐ Male ☐ Female

Name of person completing questionnaire: _____

FAMILY BACKGROUND

HOUSEHOLD #1:

Child lives with the following **ADULTS:**

NAME	RELATION	OCCUPATION/EMPLOYER
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other Children in the household:

NAME/RELATION	AGE	GENDER	GRADE
_____	_____	M / F	_____
_____	_____	M / F	_____
_____	_____	M / F	_____

HOUSEHOLD #2:

Child lives with the following **ADULTS:**

NAME	RELATION	OCCUPATION/EMPLOYER
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other Children in the household:

NAME/RELATION	AGE	GENDER	GRADE
_____	_____	M / F	_____
_____	_____	M / F	_____
_____	_____	M / F	_____

***If your child shares two households, is there a **legal parenting plan** in place?* ☐ *Yes* ☐ *No (if yes, please provide copy)*

Please list any **special living situations** that may help us better understand your child's daily schedule:

_____

SOCIAL EXPERIENCES

1. During the day, my child currently (check all that apply):

☐ is home with a parent
- ☐ full day
- ☐ half day
- # of days per week: _____

☐ is home with a sitter/nanny
- ☐ full day
- ☐ half day
- # of days per week: _____

☐ attends daycare (Name of daycare and/or provider: _____)
- ☐ full day
- ☐ half day
- # of days per week: _____

☐ attends preschool (Name of facility: _____)
- ☐ full day
- ☐ half day
- # of days per week: _____

2. Has your child ever attended **preschool or a Head Start** program: ☐ Yes ☐ No

Name & location of preschool(s) attended:	Length of Experience: (6 mos, 2 yrs, etc)	Age of attendance:
_____	_____	_____
_____	_____	_____
_____	_____	_____

May we contact the preschool(s) about your child? ☐ Yes ☐ No

3. Has your child previously attended Preschool/Kindergarten? ☐ Yes ☐ No

Name & location of preschool(s) attended:	Length of Experience: (6 mos, 2 yrs, etc)
_____	_____

DEVELOPMENT

(Feel free to add additional comments to your responses):

1. Child's birth weight: _____ Was the birth premature? ☐ Yes ☐ No
   If yes, how many weeks premature? _____
   Were there any complications during the pregnancy or delivery? ☐ Yes ☐ No
   If yes, please explain: _____
2. At approximately what age did you child: Crawl? _____ Walk? _____
3. How often does your child spend time **looking** at books? ☐ Often ☐ Occasionally ☐ Not often
4. Do you read to your child? ☐ Yes ☐ No How often? _____
5. Is your child able to remember children's songs and nursery rhymes? ☐ Yes ☐ No
6. Has anyone in your child's **family** experienced reading difficulties? ☐ Yes ☐ No
   (optional) If yes, please describe: _____

7. Is your child right or left handed? ☐ RIGHT ☐ LEFT ☐ NO DOMINANCE YET

8. Has your child had experience with scissors? ☐ Yes, often ☐ No, not at all ☐ Only a few times

   Does your child use scissors properly?

   Meaning – he/she can cut fairly accurately along curved lines and around shapes (circle, square and triangle) and turn paper fairly effectively with his/her hand to stay on the line.

   ☐ Yes ☐ No

9. **Self-Help skills:** Please check the items below that **your child can do independently** (most of the time, with no help):

   ☐ Buttons ☐ Puts on jacket ☐ Zips ☐ Completely dresses/undresses self ☐ Ties shoes
   ☐ Blows & wipes nose without being told ☐ Uses bathroom (wipes independently)
   ☐ Routinely washes hands after toileting ☐ When asked, cleans up after self (puts toys away, picks up items, cleans up after eating)

   ****These are great skills for your child to practice and have in place prior to starting Kindergarten!****

10. Has your child ever received any services? (counseling, mental health, speech therapy, etc?) ☐ Yes ☐ No

    Service(s) my child **once received,** but is no longer receiving (check all that apply):

    ☐ Counseling ☐ Mental Health therapy ☐ Speech therapy ☐ Occupational therapy
    ☐ Physical therapy ☐ Vision therapy ☐ Foster Care ☐ Other: _____

    Service(s) my child **is currently receiving** (check all that apply):

    ☐ Counseling ☐ Mental Health therapy ☐ Speech therapy ☐ Occupational therapy
    ☐ Physical therapy ☐ Vision therapy ☐ Foster Care ☐ Other: _____

    Names of agencies/providers currently helping child: _____
    _____

SCHOOL ADJUSTMENT

1. My child's attention level (excluding TV time/media time) can be described as:
   ☐ Always on the go
   ☐ Sometimes able to sit for 10 minute stretches
   ☐ Maintains interest in one activity for 20 minutes or more

2. Does your child listen without interrupting while someone else talks? ☐ Yes ☐ No

3. What is your child's regular bedtime? _____

4. How many hours per night does your child typically sleep? _____

5. How many **hours per day** does your child:
   - Play independently (creative play, dramatic play, outside play – NOT including media time)? _____
   - Have access to screen time (tv, movies, computer, tablets, smartphone, video games)? _____
   - Naps? _____ hours

6. What three words best describe your child?

   _____ _____ _____

7. **Parental Concerns:** Please check any areas you are concerned with regarding your child:

☐ **Behavior** ___ tantrums ___ is not able to accept limits ___ is very shy
___ resists or refuses requests ___ easily frustrated ___ hits/shoves/bites
___ has trouble relating to other children ___ other: _____

☐ **Social skills** ___ does not play well with others ___ will not work in a group
___ does not separate from parent easily ___ is left out of peer activities
___ other: _____

☐ **Speech/Language:** ___ speech is unclear or garbled ___ stutters
___ often needs instructions repeated ___ difficulty expressing needs/wants
___ other: _____

☐ **Speech/Language:** ___ toilet difficulties or accidents ___ feeding or dressing issues
___ other: _____

☐ **Attention:** ___ distracted easily ___ short attention span
___ jumps from one thing to another ___ other: _____

☐ **Developmental Delays:** ___ is not learning at average rate ___ delays in developmental milestones
___ other: _____

☐ **Movement:** ___ clumsy ___ difficulty using tools ___ hand/eye coordination
___ poor control of body movement ___ other _____

☐ **Hearing:** ___ trouble hearing ___ asks other to repeat or talk louder ___ favors one ear
___ startles at sudden noises ___ frequent ear infections ___ other: _____

☐ **Vision:** ___ eyes cross or turn out ___ squints ___ rubs eyes ___ eyes quiver
___ tilts or turns head to focus on something ___ other: _____

8. List your child's strengths and/or interests: _____
_____

9. How does your child feel about starting Kindergarten? (excited, nervous, no interested, etc.) _____
_____

10. Is there anything else that you would like to share with us that may affect your child here at school? _____
_____
_____

Thank you so much for your time! We look forward to getting to know your child and working together with you to create a successful Preschool/kindergarten year!

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Please provide a copy of your child(ren)'s most up-to-date immunizations.

These can be obtained for your doctor's office.

AND

A certified copy of their birth certificate

(required prior to first day of classes)

ALSO

Please download the Infinite Campus app.

On your smart phone. Or go to https://mtcloud3.infinitecampus.org/campus/portal/clinton.jsp on your home computer.

This will allow you to keep track of lunch balances, grades, attendance and communicate with your child(ren)'s teacher!

CLINTON ELEMENTARY SCHOOL
School District #32
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CUMULATIVE HEALTH RECORD

Student Name: _____ Sex: _____ Birth Date: _____

Physician: _____ Dentist: _____

Pupil's Health (give approximate age)

Allergy, specify: _____

Under MD treatment? _____

Asthma: _____

Congenital defects (cleft lip, or palate, hip dysplasia)

_____

Diabetes (date of onset): _____

Epilepsy or Seizure Disorder (date of onset)

_____

Significant family history (diabetes, hypertension, etc.)

_____

Ear Infections: _____

Ear Tubes: (year inserted): _____

Heart Condition, specify:

_____

_____

Injuries: _____

Surgery: _____

Other:

_____

_____

_____

Physical restrictions or health problems that may require special seating, bathroom privileges, etc.

_____

Special diet or food restrictions: _____

Current medications (name of medication and how often):

_____

_____

Parent/Nurse/Teacher Comments

_____

_____

_____

_____

_____

Reverse side FOR OFFICE USE ONLY

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Please note: If this sheet was completed recently for new registration, another is not needed. Thank you.

EMERGENCY CONTACT INFORMATION IN CASE OF ILLNESS OR INJURY DURING SCHOOL
This sheet is kept in the student's medical file at school.

Today's Date: _____

Student: _____ **Grade:** _____ **Teacher:** _____

Health Problems/Concerns: _____

Allergies: _____

Mother's Name & Preferred phone: _____

Father's Name & Preferred phone: _____

Mailing Address: _____

E-Mail Address: _____

Alternate contacts if parent(s)/guardian(s) cannot be reached:

Name/Relationship to Student:_____

Phone #:_____

Name/Relationship to Student: _____

Phone #: _____

Name/Relationship to Student: _____

Phone #: _____

Please inform these family members/friends that you have chosen to list them as your alternative contacts. We suggest you choose someone who is local and that may be available when you are not. **A renewal is necessary each year.**

Notes:_____
_____
_____
_____
_____
_____

Thank you,

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HEALTH CONSENT FORM 2024-2025

Please return ASAP.

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A renewal is necessary each year.

If you are new to the school and have already completed this, another is not necessary.

FIRST AID

I hereby voluntarily consent to emergency treatment, first-aid examinations, and minor treatment as may be deemed necessary by school personnel. When unable to contact parent/guardian, I hereby give my permission to the school to authorize treatment needed, until the parent/guardian can be notified. If appropriate and the school is unable to contact the parent, the school may contact the medical provider listed below and follow his/her instructions**. *I am aware that the school stocks epinephrine autoinjector (EpiPen) which may be used in the event of anaphylactic emergency.***

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

In case of an emergency involving my child AND I CANNOT BE REACHED, I understand emergency medical services will be contacted and my child may be transported to the following provider/hospital for emergency medical care:

Preferred Hospital (in case of ambulatory transport): _____

If, for any reason, NEITHER I NOR THE ABOVE LISTED MEDICAL CARE PROVIDERS OR HOSPITAL CANNOT BE REACHED, I understand that appropriate transport and medical care of my child will be arranged to ANY appropriate medical care provider, hospital or medical facility. This authorization does not cover major surgery unless one other doctor/dentist concurs to the need. Nothing in this section shall be construed to impose liability on any school official or school employee, who in good faith, attempts to comply with this section. It is understood that I will be financially responsible for all emergency care. I authorize the school health office staff to contact my child's providers listed above regarding medical management of my child. I understand information on this form will be shared with appropriate personnel on an as-needed basis only.

Parent Signature: _____ Date: _____

HEALTH SCREENING

I also voluntarily consent to preventive health screenings including but not limited to vision, hearing, height and weight.

Yes: _____ No: _____ Exception: _____

Parent Signature: _____ Date: _____

Timber Buckner, Health Aide

CLINTON ELEMENTARY SCHOOL DISTRICT

THE MCKINNEY-VENTO HOMELESS EDUCATION ASSISTANCE PROGRAM

Contact: Amanda Cyr, Special Services Director
20397 E. Mullan Rd · Clinton, MT 59825
(406) 825-3113

STUDENT RESIDENCY QUESTIONNAIRE

Your child may be eligible for educational services through the McKinney-Vento Act.
Eligibility is based on the current primary nighttime residence and can be determined by completing this questionnaire.

Name of Student:_____ Today's Date:_____
(Last, First, Middle)

First Day of Enrollment:_____

Presently, where is the student living? Check one option.

Section A	**Section B**
☐ In a shelter (YWCA Women's Shelter, Union Gospel Mission, Watson's Children's Shelter, etc.) ☐ Sharing housing with another family. **Choose one:** ☐ **Due to loss of housing, economic hardship, other hardship/situation or similar reason** ☐ **By personal choice** ☐ In a motel, car or campsite ☐ In Transitional Housing (YWCA Transitional Housing) **Continue→ If you checked a box in Section A, please complete the rest of this form.**	☐ Choices in Section A do not apply _____ **STOP: If you checked Section B, it is unnecessary to complete the rest of this form.**

In the past 24 months, has your child attended: ☐ 1 School ☐ 2-4 Schools ☐ More than 4 Schools

Student Info: Birth date:_____ Grade:_____
(Month/Day/Year)

☐ Male ☐ Female

Siblings currently enrolled/enrolling at Clinton Elementary:_____

Name of Parent(s)/Guardian(s):_____

Current Address: (City and State):_____

Phone/Message Number: _____ Alternate Phone/Cell:_____