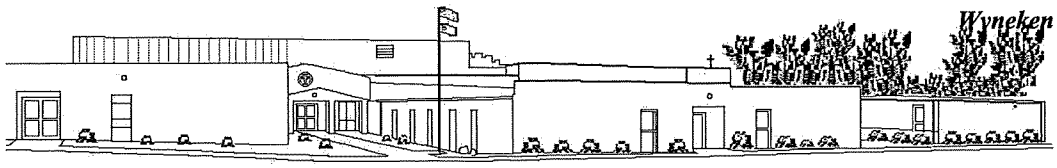

Wyneken Memorial Lutheran School
11565 North U.S. 27
Decatur, IN 46733
Phone (260) 639-6177
Fax (260) 639-3050
Principal – Andrew Gavrun

REACH, TEACH, & SEND IN CHRIST

Dear Wyneken Family,

This informational packet contains the documents that are necessary for children who will be entering Kindergarten for the 2024-2025 school year at *Wyneken Memorial Lutheran School.*

Our registration day will take place on August 1, 2024 and our first day of school will be August 10, 2023. If you have any of your child's Kindergarten documents completed at that time you may bring those forms with you to registration or on the first day of school.

The following documents are to be on file with the school office by August 8, 2024.

1) **COPY OF YOUR CHILD'S BIRTH CERTIFICATE**
2) **IMMUNIZATION RECORDS.**

Copies of the following documents are to be completed and turned in to the school office by September 30, 2024.

1) **VISION EXAM RECORD**
2) **DENTAL EXAM RECORD**
3) **MEDICAL EXAM RECORD**

Thank you for your cooperation with this matter. If you have any questions please call the school office at 260-639-6177.

In His Service,

Mr. Andrew Gavrun, Principal

Indiana Department of Education

Dr. Katie Jenner, Secretary of Education

Home Language Survey (HLS)

The Civil Rights Act of 1964, Title VI, Language Minority Compliance Procedures, requires school districts and charter schools to determine the language(s) spoken in each student's home in order to identify their specific language needs. This information is essential in order for schools to provide meaningful instruction for all students as outlined Plyler v. Doe, 457 U.S. 202 (1982).

The purpose of this survey is to determine the primary or home language of the student. The HLS must be given to all students enrolled in the school district / charter school. The HLS is administered one time, upon initial enrollment in Indiana, and remains in the student's cumulative file.

Please note that the answers to the survey below are student-specific. If a language other than English is recorded for ANY of the survey questions below, the W-APT or WIDA Screener will be administered to determine whether or not the student will qualify for additional English language development support.

Please answer the following questions regarding the language spoken by the student:

1. What is the native language of the **student?** _____

2. What language(s) is spoken most often by the **student?** _____

3. What language(s) is spoken by the **student** in the home? _____

Student Name:_____ **Grade:**_____

Parent/Guardian Name:_____

Parent/Guardian Signature:_____ **Date:**_____

By signing here, you certify that responses to the three questions above are specific to your student. You understand that if a language other than English has been identified, your student will be tested to determine if they qualify for English language development services, to help them become fluent in English. If entered into the English language development program, your student will be entitled to services as an English learner and will be tested annually to determine their English language proficiency.

For School Use Only:

School personnel who administered and explained the HLS and the placement of a student into an English language development program if a language other than English was indicated:

Name:_____ Date:_____

Wyneken Memorial Lutheran School
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Phone 260-639-6177 / FAX 260-639-3050

KINDERGARTEN IMMUNIZATION CHECKLIST

Name _____ **DOB**_____

Immunization Requirements	Has	Needs	Date
DTP, DTaP, or DT #1			
DTP, DTaP, or DT #2			
DTP, DTaP, or DT #3			
DTP, DTaP, or DT #4			
DTP, DTaP, or DT #5			
IPV / OPV #1			
IPV / OPV #2			
IPV / OPV #3			
Hepatitus-B #1			
Hepatitus-B #2 (1 month after #1)			
Hepatitus-B #3 (6 months after #2)			
MMR #1			
MMR #2			
Varicella #1			
Varicella #2			
Hepatitus-A #1			
Hepatitus-A #2			

History of Chicken Pox Disease: Yes / No
Date of Chicken Pox Disease (if applicable) _____

Physician Signature: _____

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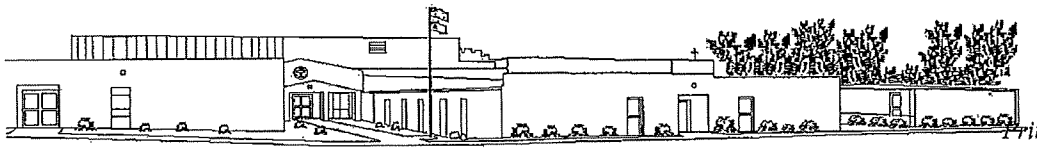

REACH, TEACH, SEND IN CHRIST

WYNEKEN MEMORIAL LUTHERAN SCHOOL
C.H.I.R.P.

I, _____, give *Wyneken Memorial Lutheran School*

permission to release the following information concerning my child

_____ to the Indiana State Department of Health's Children and

Hoosiers Immunization Registry Program (CHIRP):

STUDENTS NAME, ETHNICITY, PARENT/GUARDIAN NAMES, PARENT/GUARDIAN CONTACT NUMBER, ADDRESS, DATE OF BIRTH, IMMUNIZATION DATA

I understand that the information in the registry may be used to verify that my child has received proper immunizations and to inform me or my child of my child's immunization status or that an immunization is due according to recommended immunization schedules.

I understand that my child's information may be available to the immunization data registry of another state, a healthcare provider or a provider's designee, a local health department, an elementary or secondary school, a child care center, the office of Medicaid policy and planning or a contractor of the office of Medicaid policy and planning, a licensed child placing agency, and a college or university. I also understand that other entities may be added to this list through amendment to I.C. 16-38-5-3.

I hereby consent to the release of such information.

_____ _____
Parent/Guardian Signature Date

_____
Printed Name of Parent or Guardian

_____ (____)_____
Address Telephone Number

_____ _____
Child's Name Grade Level

_____
School

Wyneken Memorial Lutheran School admits students of any race, color, national and ethnic origin to all the rights, privileges, programs, and activities generally accorded or made available to students at the school. It does not discriminate on the basis of race, color, national and ethnic origin in administration or its educational policies, scholarship and loan programs, and athletic and other school administered programs.

Wyneken Memorial Lutheran School
11565 N US Hwy 27
Decatur, IN 46733

KINDERGARTEN DENTAL EXAMINATION

Name _____ Date of Birth _____

Address _____ Date _____

Please check the appropriate spaces:

Gingiva: Inflamed ☐ Normal ☐ Other _____

Prophylaxis and Fluoride Treatment: Date of last _____

Caries, Deciduous Teeth: Yes ☐ No ☐

Occlusion: Class I _____ Class II _____ Class III _____

Home Care: Good ☐ Poor ☐

Habits detrimental to oral health: Yes ☐ No ☐

Please specify _____

Encircle abnormalities noticed in oral cavity: Throat, Tongue, Lips, Palate, Missing Teeth,

Abscess, Other (explain) _____

Dentist Signature _____ Date _____

Address _____

TO PARENTS: THIS FORM IS TO BE COMPLETED BY YOUR DENTIST AND RETURNED TO THE SCHOOL NURSE.

Local dentists will provide free dental exams for children entering kindergarten. Please call your dentist and explain that you are making an appointment for a kindergarten exam.

Free dental exams do not include any X-ray or dental work. If the exam indicates a need for these services and the services are performed, parent(s) will be responsible for payment. **IF YOUR CHILD HAS HAD A DENTAL EXAM WITHIN THE LAST YEAR, TAKE THIS FORM TO YOUR DENTIST FOR COMPLETION.**

Wyneken Memorial Lutheran School
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KINDERGARTEN VISION EXAMINATION

The state requires that a modified eye exam be done prior to your child entering kindergarten

Name _____ Date of Birth _____

Address _____ Date _____

1. History (description of past vision and eye health problems plus present observations or complaints relative to vision)

_____

2. Visual Acuity (with/without) Glasses R20/_____ L20/_____

3. Cover Test

	Distance (20 ft)	Near (16")
Esotropia (any)	_____	_____
Exotropia (any)	_____	_____
Esophoria (5 PD or more)	_____	_____
Exophoria (5 PD or more)	_____	_____
Hyperphoria (2 PD or more)	_____	_____

4. Refractive Error

Hyperopia	R_____ L_____	Is it +1.50 DS or more?	R_____ L_____
Myopia	R_____ L_____	Is it -0.50 DS or more?	R_____ L_____
Astigmatism	R_____ L_____	Is it = 1 DC or more?	R_____ L_____
Anisometropia		Is it = 1 DC or more?	_____
		Is it = 1 DS or more?	_____

5. Organic (Pathology of eye and /adnexa)_____

_____

6. Color Vision Pass ☐ Fail ☐

7. If corrective lenses are prescribed, they are for? No Rx at present _____

Constant Wear ☐ Near Vision Only ☐ Other_____

8. Corrected Visual Acuity (if corrective lenses prescribed)

R_____ L_____

9. Special Comments and Recommendations_____

_____

10. Re-examination Advised In

Six (6) months_____ Twelve (12) months_____ Other_____

Doctor Signature _____ Date _____

TO PARENTS: THIS FORM IS TO BE COMPLETED BY YOUR PHYSICIAN AND RETURNED TO THE SCHOOL NURSE.

Wyneken Memorial Lutheran School
11565 N US Hwy 27
Decatur, IN 46733

KINDERGARTEN MEDICAL EXAMINATION

Name _____ Date of Birth _____

Address _____ Date _____

Physician's Examination ☐ Normal ☐ Abnormal

Height _____ Weight _____

B/P _____ Temp _____

HEENT _____ Ears Rt _____ Lt _____

Heart _____ Respiratory _____

Abdomen _____ Neuromuscular System _____

Genitalia & Hernia _____ Skin & Glands _____

Posture & Spine _____ Nutrition _____

Other _____

General Condition Good ☐ Poor ☐

Recommendation & Comments _____

_____

_____

Physician Signature _____ Date _____

Address _____

TO PARENTS: THIS FORM IS TO BE COMPLETED BY YOUR PHYSICIAN AND RETURNED TO THE SCHOOL NURSE.

A physical examination is recommended before enrolling your child in kindergarten. Please contact your physician to schedule your child's physical exam.