

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 2022-2023 school year at Wyneken Memorial Lutheran School.

Our registration day will take place on August 4, 2022 and our first day of school will be August 10, 2022. 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 10, 2022.

- 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, 2022.

- 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

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.



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:** _____

KINDERGARTEN IMMUNIZATION CHECKLIST

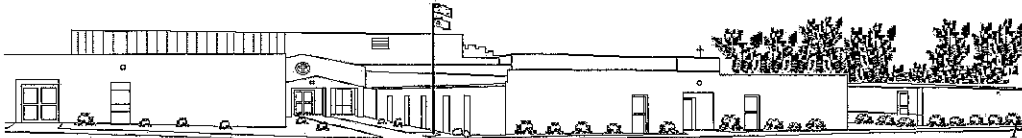
Name _____

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			
Hepatitis-B #1			
Hepatitis-B #2 (1 month after #1)			
Hepatitis-B #3 (6 months after #2)			
MMR #1			
MMR #2			
Varicella #1			
Varicella #2			
Hepatitis-A #1			
Hepatitis-A #2			

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

Physician Signature: _____



Wyneken Memorial Lutheran School

11565 North U.S. 27

Decatur, IN 46733

Phone (260) 639-6177

Fax (260) 639-3050

Principal - Daniel P Bultemeyer

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.

Wyncken 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
11565 N US Hwy 27
Decatur, IN 46733

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.