Kindergarten and New First Grade Student Registration
Lake Villa School District #41
2011-2012 School Year

Welcome to the Lake Villa School District 41 Kindergarten and New First Grade Student Registration. The 2011-2012 School Year will be exciting for your family. Our school district has four neighborhood schools, B. J. Hooper, J. J. Pleviak, Olive C. Martin, and William L. Thompson, each housing students in kindergarten through sixth grade.

At registration we would like to emphasize a few points:

- **Physical and Immunization Records** for all Kindergarten and New First Grade students need to be completed and returned to the office prior to the first day of school.
- The Dental Exam is a requirement for all Kindergarten students. The completed **Dental Form** should be returned to the office prior to the first day of school.
- The Vision Exam is a requirement for all Kindergarten and New First Grade students. The completed **Vision Form** should be returned to the office prior to the first day of school.
- You must present the original, government issued, **Certified Birth Certificate** from the county in which your child was born (the hospital certificate is not acceptable.)
- **Proof of residency** is a requirement.
  One of the following documents must be presented:
  Gas, Electric or Water bill (dated within the last 30 days for service at the legal address including the portion showing the service address.)
  Current Property Tax bill
  Current Signed Lease agreement
  Please Note: A Driver's License or any other utility bills will not be accepted as proof of residency. If one of the required documents is unavailable, the parent/guardian must contact Mr. Alex Barbour at 847-356-2385 to establish residency.
- You will be notified during the summer as to whether your child will be in morning or afternoon kindergarten along with your child's bus assignment.
- Kindergarten classes start August 24th. First through sixth graders will be starting class on August 23rd.
- Only completed registration packets will be accepted. A completed registration includes the forms, Birth Certificate, proof of residency and payment.
  For Kindergarten and New First Grade students, you must register in person.
  There are three payment options available:
  1.) Payment in Full of the $145 registration fee (Check, Cash, Visa or MasterCard)
  2.) Payment Plan Form completed
  3.) Registration Fee Waiver Application Form completed
  (**Note:** The Payment Plan Form and the Registration Fee Waiver Application Form are separate from The Free/Reduced Lunch Application Form.)

Note: There is a $50 discount per student if payment is made prior to May 6, 2011 or a $20 discount per student if payment is made prior to June 10, 2011

Kindergarten and First Grade is an exciting time for students and parents. We look forward to working with you and your child. Please contact your school if you have any questions.

The Lake Villa School District 41 Staff

LAKE VILLA SCHOOL DISTRICT #41 REGISTRATION AND TRANSPORTATION FORM

School ___________________

STUDENT INFORMATION

Last Name_____________________________First Name __________________________Middle Name ____________________

Gender __________ Grade Level ___________Entry Date _________________Preferred Name _______________________

Is this student Hispanic/Latino? (Choose only one.) _____ No, not Hispanic/Latino _____Yes, Hispanic/Latino

What is the student's race? (Choose one or more.) ______American Indian/Alaska Native ______Asian
______Black or African American ______Native Hawaiian or Other Pacific Islander ______White

High School District: (Please check your Property Tax bill) Circle one: Grayslake Grant Lakes Community

Birth Date: _ _ /_ _ /_ _ _ _ Place of Birth ____
Month Day Year City State Country

Medicaid Number ___________________________

Does your child receive any Special Education Services? ____

FAMILY INFORMATION

Child resides with: ____Parents _____ Mother _____Father _____Other ____

Mailings should be addressed to: ______ Parents ______Mother ______Father ________Other ________________________

Please explain any legal custodial restrictions: **____**
Please attach any legal documents that are in effect for the current school year.

Father	**Mother**
Last Name _______________________________________	**Last Name** ____
First Name, Middle I. ______________________________	**First Name, Middle I.** _______________________________
Address ____	**Address** ____
Town, Zip ____	**Town, Zip** ____
Primary/ALERTNOW **Phone** ________________________**(hm.) (cell)**	**Primary/ALERT**NOW **Phone** ________________________**(hm.) (cell)**
Secondary Phone __________________________________ **(hm.) (cell)**	**Secondary Phone** __________________________________**(hm.) (cell)**
Work Phone _______________________________________	**Work Phone** ______________________________________
Occupation _______________________________________	**Occupation** ______________________________________
Employer ____	**Employer** ____
E-Mail Address ____________________________________	**E-Mail Address** ___________________________________

Brother/Sister (Indicate siblings in District 41 and ages) ____

Other members of the household ____

TRANSPORTATION INFORMATION IF DIFFERENT THAN HOME

My child is bused to/from the following care provider who lives within my neighborhood school boundaries.
Otherwise, children may only ride on their assigned bus.

Name _______________________________________First Name ________________________Phone ____________________________

Address ____

TURN OVER

Student's Name:____

Home Language Survey

The state requires the district to collect a Home Language Survey for every new student. This information is used to count the students whose families speak a language other than English at home. It also helps to identify the students who need to be assessed for English language proficiency.

1. Is a language other than English spoken in your home?
   Yes ____ No ____ What language? ________________________

2. Does your child speak a language other than English?
   Yes ____ No ____ What language? ________________________

If the answer to either question is yes, the law requires the school to assess your child's English language proficiency.

PARENTAL PERMISSION FOR FIELD TRIPS FOR SCHOOL YEAR

I understand that during the course of the school year my child may, from time to time, take field trips from school. I further understand that I will be notified in advance through notes from the teacher as to the date and activities of such field trips. If I have questions regarding a specific field trip, I will contact the classroom teacher. I understand that most field trips use buses for transportation.

SCHOOL NEWSLETTER, WEB PAGE, NEWSPAPERS

_______ I give permission to have photos of my child in the newsletters, newspapers, and web page.
_______ I do not give permission to have photos of my child in the newsletters, newspaper and web page.

STUDENT REQUEST FOR LOAN OF TEXTBOOKS

I hereby request the loan of secular textbooks in accordance with Public Act 79-961 of 1975. I understand that this request will remain valid so long as I am enrolled in Lake Villa District #41and that I may at any time withdraw this request.

EMERGENCY NUMBERS: Please list responsible persons who may be called in the event of an emergency or illness who could come to pick up your child when you cannot be reached.

Name ____ **Relationship** ________________________

Phone Numbers: (H) _________________________ **(W)** ______________________ **(Cell)** ______________________________

Name ____ **Relationship** ________________________

Phone Numbers: (H) _________________________ **(W)** ______________________**(Cell)** ______________________________

Doctor's Name: ___________________________ **Phone:** ______________________ **Hospital of Choice:** __________________________

PLEASE COMPLETE THE FOLLOWING MEDICAL INFORMATION ABOUT YOUR CHILD:

ALLERGIES: ____________________________________Describe reactions: ____

List any operations, injuries, hospitalizations, with dates: ____

List any prescription medications your child takes at home:____

Does your child require medication/limited physical activity at school? (Forms from Doctor must be provided) _______________________

MEDICAL HISTORY (Please check the ones that apply to your child)

Asthma _____ Seizures _____ Diabetes _____ Bleeding _____ Cancer _____ Hearing _____ Speech _____ Fainting _____ Headaches _____
Color Blindness _____ Wears Glasses/Contacts _____ Nose Bleeds _____ Heart Disease _____ Kidney Disease ______ Bone Disease ______

If it is necessary to transport a child for emergency services, we would use only the hospitals serviced by the Lake Villa Rescue Squad. Please provide additional information pertinent to the emergency care of this child, religious or constitutional rights that would affect health care, and special health problems or concerns.

EMERGENCY AUTHORIZATION

In case my child becomes ill or is injured at school and needs emergency medical care and it is not possible to contact me, the school may authorize treatment. I agree to assume the responsibility of any expenses incurred in the handling of his/her emergency care.

Your signature at the bottom of this page indicates your acceptance/understanding of this registration and transportation form.

____ ____________________

Signature of Parent or Guardian Date

LAKE VILLA COMMUNITY CONSOLIDATED SCHOOL DISTRICT #41

131 McKinley Avenue Lake Villa, Illinois 60046-8986 www.district41.org Phone: 847/356-2385 Fax: 847/356-2670

PHYSICAL AND IMMUNIZATION REQUIREMENTS

Students entering **Early Childhood**, **Kindergarten or New First**, **Sixth** and **Ninth** grades in the state of Illinois are required by law to have a **physical exam** and **proof of immunizations** on file with the school they are attending. The physical exam must be dated within one year of the start of the school year. **Out of state transfer students** must have an Illinois physical within one month of start date.

NOTE: IMMUNIZATIONS MUST BE SIGNED ON PHYSICAL EXAM FORM AS SPECIFIED.
In the event the immunizations are not signed, the student must have another series of immunizations.
Dates must include the day and month as well as year.

PLEASE NOTE – The state of Illinois requires that the health care provider fill out the Diabetes Screening and Lead Risk Questionnaire sections on the physical exam form. Any physical exams turned in without those sections filled out will not be accepted.

Please send a completed physical form along with all necessary immunization records. State law and District #41 policy requires us to EXCLUDE students who do not fulfill these requirements.

Religious objections or medical exemptions on file with the school will be the only exceptions to the immunization requirements.

The Lake County Department of Health holds several immunization clinics throughout the area. Please call (847) 377-8470 for the exact times and locations. Call (847) 984-5100 for physical exam information.

Required immunizations are:

DPT	4 or more with the last one on/after the 4th birthday
MMR	On/after the 1st birthday
Measles Booster or 2nd MMR	No less than 4 weeks after the first dose
Polio	3 or more with the last one on/after the 4th birthday
Hepatitis B Series	Students entering the Early Childhood Program, 5th Grade
Hib Series	Children entering the Early Childhood Program are required to have had the Hib series in infancy or one dose between 15-59 months of age.
Varicella	Children entering Early Childhood Program, Kindergarten or New First Grade for first time on or after July 1, 2002
Lead Screening (Age 6 & Under)	Required part of each health examination to be filled out by health care provider. A Lead Assessment Questionnaire must be completed by parent/guardian upon entry to Early Childhood, Kindergarten or New First Grade
Diabetes Screening	Required part of each health examination and health care provider shall document results on the Certificate of Child Health Examination form
Health History	Must be completed and signed by parent/guardian

PLEASE MAKE APPOINTMENTS FOR PHYSICAL EXAMS AND IMMUNIZATIONS EARLY!
CHILDREN WILL BE SUBJECT TO EXCLUSION IF ALL REQUIREMENTS ARE NOT MET.
You may turn in completed physical forms to the school office before school begins. The school offices are open 2 weeks prior to the start of the school year.

Please keep a copy of the medical and immunization form for your records.

STATE OF ILLINOIS
DEPARTMENT OF HUMAN SERVICES
CERTIFICATE OF CHILD HEALTH EXAMINATION

Please Print

Student's Name Last First Middle	**Birth Date** Month/Day/ Year	**Sex**	**School**	**Grade Level /ID#**
Address Street City ZIP code	Parent/ Guardian	Telephone # Home	Work	

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

VACCINE/DOSE	1 MO	DA	YR	2 MO	DA	YR	3 MO	DA	YR	4 MO	DA	YR	5 MO	DA	YR	6 MO	DA	YR
Diphtheria, Tetanus and Pertussis (DTP or DTaP)																		
Diphtheria and Tetanus (Pediatric DT or Td)																		
Inactivated Polio (IPV)																		
Oral Polio (OPV)																		
Haemophilus influenzae type b (Hib)																		
Hepatitis B (HB)																		
Varicella (Chickenpox)										Comments								
Combined Measles, Mumps and Rubella (MMR)																		
Measles (Rubeola)																		
Rubella (3-day measles)																		
Mumps																		
Pneumococcal (not required for school entry) Check specific type (PCV7, PPV23)	☐PCV7 ☐PPV23			☐PCV7 ☐PPV23			☐PCV7 ☐PPV23			☐PCV7 ☐PPV23			☐PCV7 ☐PPV23			☐PCV7 ☐PPV23		
Other (Specify hepatitis A, meningococcal, etc.)																		

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.

Signature **Title** **Date**

Signature
(If adding dates to the above immunization history section, put your initials by date(s) and sign here.) **Title** **Date**

Signature
(If adding dates to the above immunization history section, put your initials by date(s) and sign here.) **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. **Clinical diagnosis is acceptable if verified by physician.** *(All <u>measles</u> cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

***MEASLES (Rubeola)** MO DA YR **MUMPS** MO DA YR **VARICELLA** MO DA YR **Physician's Signature**

2. **History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.**
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease **Signature** **Title** **Date**

3. **Laboratory confirmation (check one)** ☐ **Measles** ☐ **Mumps** ☐ **Rubella** ☐ **Hepatitis B** ☐ **Varicella**
Lab Results **Date** MO DA YR **(Attach copy of lab report, if available.)**

VISION AND HEARING SCREENING DATA

Pre-school – annually beginning at age 3; School age – during school year at required grade levels

Date																					Code: P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/ Contacts
Age/Grade																					
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	
Vision																					
Hearing																					

Printed by Authority of the State of Illinois

(Complete Both Sides)

IL444-4737 (R-01-05)

Student's Name (Last / First / Middle)	**Birth Date** (Month/Day/ Year)	**Sex**	**School**	**Grade Level/ ID #**

HEALTH HISTORY **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

ALLERGIES (Food, drug, insect, other)			**MEDICATION** (List all prescribed or taken on a regular basis.)		
Diagnosis of asthma? Child wakes during the night coughing	Yes No Yes No	Indicate Severity	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No	
Birth defects?	Yes No		Hospitalizations? When? What for?	Yes No	
Developmental delay?	Yes No				
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No		Surgery? (List all.) When? What for?	Yes No	
Diabetes?	Yes No		Serious injury or illness?	Yes No	
Head injury/Concussion/Passed out?	Yes No		TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.
Seizures? What are they like?	Yes No		TB disease (past or present)?	Yes* No	
Heart problem/Shortness of breath?	Yes No		Tobacco use (type, frequency)?	Yes No	
Heart murmur/High blood pressure?	Yes No		Alcohol/Drug use?	Yes No	
Dizziness or chest pain with exercise?	Yes No		Family history of sudden death before age 50? (Cause?)	Yes No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _______ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Dental ☐Braces ☐Bridge ☐Plate Other Other concerns?		
Ear/Hearing problems?	Yes No		Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature** **Date**		
Bone/Joint problem/injury/scoliosis?	Yes No				

Entire section below to be completed by MD/DO/APN/PA (*INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES)

PHYSICAL EXAMINATION REQUIREMENTS **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING **BMI>85% age/sex** Yes ☐ No ☐ And any two of the following: **Family History** Yes ☐ No ☐ **Ethnic Minority** Yes ☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes ☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE* Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.
Blood Test Indicated? Yes ☐ No ☐ **Blood Test Date** **Blood Test Result** (Blood test required in Chicago and other high risk zip codes.)

TB SKIN TEST Recommended only for children in high-risk groups including children who are immunosuppressed due to HIV infection or other conditions, recent immigrants from high prevalence countries, or those exposed to adults in high-risk categories. See CDC guidelines. **Date Read** / / **Result** **mm**

LAB TESTS *INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES	Date	Results		Date	Results
Hemoglobin * or Hematocrit *			Sickle Cell * (as indicated)		
Urinalysis			Other		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin			Endocrine		
Ears			Gastrointestinal		
Eyes Normal Yes☐ No☐ Objective screening Yes☐ No☐ Result_____________ Amblyopia Yes☐ No☐ Referred to Opthalmologist/Optometrist Yes☐ No☐			Genito-Urinary		LMP
			Neurological		
Nose			Musculoskeletal		
Throat			Spinal examination		
Mouth/Dental			Nutritional status		
Cardiovascular/HTN			Mental Health		
Respiratory					

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ☐ **No** ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in **(If No or Modified,please attach explanation.)**
PHYSICAL EDUCATION **Yes** ☐ **No** ☐ **Modified** ☐ **INTERSCHOLASTIC SPORTS** (for one year) **Yes** ☐ **No** ☐ **Limited** ☐

Physician/Advanced Practice Nurse/Physician Assistant performing examination

Print Name **Signature** **Date**

Address **Phone**

(Complete both sides)

Illinois Department of Public Health

Childhood Lead Risk Assessment Questionnaire

ALL CHILDREN 6 MONTHS THROUGH 6 YEARS OF AGE MUST BE ASSESSED FOR LEAD POISONING (410 ILCS 45/6.2)

Name ____________________________ Today's Date __________________________________

Age _____________ Birthdate ________________ ZIP Code _________________

Respond to the following questions by circling the appropriate answer.	RESPONSE		
1. Is this child eligible for or enrolled in Medicaid, Head Start, All Kids or WIC?	Yes	No	Don't Know
2. Does this child have a sibling with a blood lead level of10 mcg/dL or higher?	Yes	No	Don't Know
3. Does this child live in or regularly visit a home built before 1978?	Yes	No	Don't Know
4. In the past year, has this child been exposed to repairs, repainting or renovation of a home built before 1978?	Yes	No	Don't Know
5. Is this child a refugee or an adoptee from any foreign country?	Yes	No	Don't Know
6. Has this child ever been to Mexico, Central or South America, Asian countries (i.e., China or India), or any country where exposure to lead from certain items could have occurred (for example, cosmetics, home remedies, folk medicines or glazed pottery)?	Yes	No	Don't Know
7. Does this child live with someone who has a job or a hobby that may involve lead (for example, jewelry making, building renovation or repair, bridge construction, plumbing, furniture refinishing, or work with automobile batteries or radiators, lead solder, leaded glass, lead shots, bullets or lead fishing sinkers)?	Yes	No	Don't Know
8. At any time, has this child lived near a factory where lead is used (for example, a lead smelter or a paint factory)?	Yes	No	Don't Know
9. Does this child reside in a high-risk ZIP code area?	Yes	No	Don't Know

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A blood lead test should be performed on children:
- with any "Yes" or "Don't Know" response
- living in a high-risk ZIP code area

All Medicaid-eligible children should have a blood lead test at 12 months of age and at 24 months of age. If a Medicaid-eligible child between 36 months and 72 months of age has not been previously tested, a blood lead test should be performed.

If there is any "Yes" or "Don't Know" response; **and**
- there has been no change in the child's living conditions; **and**
- the child has proof of two consecutive blood lead test results (documented below) that are each less than 10 mcg/dL (with one test at age 2 or older), a blood lead test is not needed at this time.

Test 1: Blood Lead Result_____mcg/dL Date _______ Test 2: Blood Lead Result_____mcg/dL Date ______

If responses to all the questions are "NO," re-evaluate at every well child visit or more often if deemed necessary.

_______________________________________ _______________________________________

Signature of Doctor/Nurse Date

Illinois Lead Program
866-909-3572 or 217-782-3517
TTY (hearing impaired use only) 800-547-0466

Illinois Department of Public Health
Guidelines for Blood Lead Screening and Lead Risk Assessment

- **Blood lead screening** is defined as obtaining a blood lead test. **Lead risk assessment** is defined as evaluation of potential for exposures to lead based on questionnaire responses.

- **It is always appropriate to obtain a diagnostic blood lead test when a child is symptomatic or potential exposure to lead has been identified, regardless of child's age.**

- Illinois has defined ZIP code areas at high risk and low risk for lead exposure based on housing age and poverty rates. Review the list of ZIP codes and determine status of ZIP codes in your area.

- In Illinois, all children from **low-income families** (i.e., Medicaid-eligible children) should receive a blood lead test at ages 12 and 24 months, even if they live in a low-risk ZIP code area. If the child is 3 through 6 years old and has not been tested, a blood lead test is required.

Childhood Lead Risk Assessment Questionnaire

- Complete the Childhood Lead Risk Assessment Questionnaire during a health care visit at ages 12 and 24 months.
    - If responses to all the questions are "NO," re-evaluate at every well child visit or more often if deemed necessary.
    - If any response is "YES" or "DON'T KNOW," obtain a blood lead test

- Consider evaluating children before 12 months of age, depending on the area.

- If the child is age 3-6 years ***and***
    1) there is any "YES" or "DON"T KNOW" ***and***
    2) has had two successive blood lead test results that were each less than < 10 mcg/dL with one of these tests at age 2 years or older ***and***
    3) risks of exposure to lead have not changed, **further blood lead tests are not necessary.**

- If the child is 1) 3-6 years, ***and*** 2) all answers to the Childhood Lead Risk Assessment Questionnaire are "NO," ***and*** 3) risks of exposure to lead have not changed, a blood lead test is not necessary.

- If the child is 3-6 years of age and risks of exposures to lead have increased, obtain a blood lead test.

- Continue to use the Childhood Lead Risk Assessment Questionnaire through age 6.

For children living in Chicago:

- A blood lead test for children age 3 and younger should be obtained at 6, 12, 18, 24 and 36 months **OR** at 9, 15, 24 and 36 months.

- Children 4 through 6 years of age with prior blood lead levels <10 mcg/dL should have an annual risk assessment. A blood lead test should be performed if risk increases or if the child exhibits persistent oral behaviors.

Illinois Lead Program
866-909-3572 or 217-782-3517
TTY (hearing impaired use only) 800-547-0466

High-Risk ZIP Codes for Pediatric Blood Lead Poisoning

Adams
62301
62320
62324
62339
62346
62348
62349
62365
62567
62570

Alexander
62914
62988

Bond
62273

Boone
61038

Brown
62353
62375
62378

Bureau
61312
61314
61315
61322
61323
61328
61329
61330
61337
61338
61344
61345
61346
61349
61359
61361
61362
61368
61374
61376
61379

Calhoun
62006
62013
62036
62070

Carroll
61014
61051
61053
61074
61078

Cass
62611
62618
62627
62691

Champaign
61815
61816
61845
61849
61851
61852
61862
61872

Christian
62083
62510
62517
62540
62546
62555
62556
62557

Clark
62420
62442
62474
62477
62478

Clay
62824
62879

Clinton
62219

Coles
61931
61938
61943
62469

Cook
All Chicago ZIP Codes
60043
60104
60153
60201
60202
60301
60302
60304
60305
60402
60406
60456
60501
60513
60534
60546
60804

Crawford
62433
62449
62451

Cumberland
62428

DeWitt
61727
61735
61749
61750
61777
61778
61882

DeKalb
60111
60129
60146
60550

Douglas
61930
61941
61942

DuPage
60519

Edgar
61917
61924
61932
61933
61940
61944
61949

Edwards
62476
62806
62815
62818

Effingham
None

Fayette
62458
62880
62885

Ford
60919
60933
60936
60946
60952
60957
60959
60962
61773

Franklin
62812
62819
62822
62825
62874
62884
62891
62896
62983
62999

Fulton
61415
61427
61431
61432
61441
61477
61482
61484
61501
61519
61520
61524
61531
61542
61543
61544
61563

Gallatin
62934

Greene
62016
62027
62044
62050
62054
62078
62081
62082
62092

Grundy
60437
60474

Hamilton
62817
62828
62829
62859

Hancock
61450
62311
62313
62316
62318
62321
62330
62334
62336
62354
62367
62373
62379
62380

Hardin
62919
62982

Henderson
61418
61425
61454
61460
61469
61471
61480

Henry
61234
61235
61238
61274
61413
61419
61434
61443
61468
61490

Iroquois
60911
60912
60924
60926
60930
60931
60938
60945
60951
60953
60955
60966
60967
60968
60973

Jackson
62927
62940
62950

Jasper
62432
62434
62459
62475
62480

Jefferson
62883

Jersey
62030
62063

Jo Daviess
61028
61075
61085
61087

Johnson
62908
62923

Kane
60120
60505

Kankakee
60901
60910
60917
60954
60969

Kendall
None

Knox
61401
61410
61414
61436
61439
61458
61467
61474
61485
61489
61572

Lake
60040

LaSalle
60470
60518
60531
61301
61316
61321
61325
61332
61334
61342
61348
61354
61358
61364
61370
61372

Lawrence
62439
62460
62466

Lee
60553
61006
61031
61042
61310
61318
61324
61331
61353
61378

Livingston
60420
60460
60920
60921
60929
60934
61311
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61333
61740
61741
61743
61769
61775

Logan
62512
62518
62519
62548
62543
62635
62643
62666
62671

Macon
62514
62521
62522
62523
62526
62537
62551

Macoupin
62009
62033
62069
62085
62088
62093
62626
62630
62640
62649
62672
62674
62685
62686
62690

Madison
62002
62048
62058
62060
62084
62090
62095

Marion
None

Marshall
61369
61377
61424
61537
61541

Mason
62617
62633
62644
62655
62664
62682

Massac
62953

McDonough
61411
61416
61420
61422
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61440
61470
61475
62374

McHenry
60034

McLean
61701
61720
61722
61724
61728
61730
61731
61737
61770

Menard
62642
62673
62688

Mercer
61231
61260
61263
61276
61465
61466
61476
61486

Monroe
None

Montgomery
62015
62019
62032
62049
62051
62056
62075
62077
62089
62091
62094
62538

Morgan
62601
62628
62631
62692
62695

Moultrie
61937

Ogle
61007
61030
61047
61049
61054
61064
61091

Peoria
61451
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61602
61603
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61606

Perry
62832
62997

Piatt
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61929
61936

Pike
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62340
62343
62345
62352
62355
62356
62357
62361
62362
62363
62366
62370

Pope
None

Pulaski
62956
62963
62964
62976
62992

Putnam
61336
61340
61363

Randolph
62217
62242
62272

Richland
62419
62425

Rock Island
61201
61236
61239
61259
61265
61279

St. Clair
62201
62203
62204
62205
62220
62289

Saline
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62946

Sangamon
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62689
62703

Schuyler
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62319
62344
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62639

Scott
62621
62663
62694

Shelby
62438
62534
62553

Stark
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61479
61483
61491

Stephenson
61018
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61062
61067
61089

Tazewell
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61721
61734

Union
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Vermilion
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Wabash
62410
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Warren
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61462
61473
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Washington
62214
62803

Wayne
62446
62823
62843
62886

White
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62821
62835
62844
62887

Whiteside
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61243
61251
61261
61270
61277
61283

Will
60432
60433
60436

Williamson
62921
62948
62949
62951

Winnebago
61077
61101
61102
61103
61104

Woodford
61516
61545
61570
61760
61771

State of Illinois
Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides eye examinations be submitted to the school no later than October 15 of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

Student Name ____
(Last) (First) (Middle Initial)

Birth Date ____________________ Gender ______ Grade _____
(Month/Day/Year)

Parent or Guardian ____
(Last) (First)

Phone ______________________________
(Area Code)

Address ____
(Number) (Street) (City) (ZIP Code)

County ____

To Be Completed By Examining Doctor

Case History

Date of exam ________________

Ocular history: ❑ Normal or Positive for ______________________________

Medical history: ❑ Normal or Positive for ______________________________

Drug allergies: ❑ NKDA or Allergic to ______________________________

Other information ____

Examination

	Distance			**Near**
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation? ❑ Yes ❑ No

	Normal	Abnormal	Not Able to Assess	Comments
External exam (lids, lashes, cornea, etc.)	❑	❑	❑	__________
Internal exam (vitreous, lens, fundus, etc.)	❑	❑	❑	__________
Pupillary reflex (pupils)	❑	❑	❑	__________
Binocular function (stereopsis)	❑	❑	❑	__________
Accommodation and vergence	❑	❑	❑	__________
Color vision	❑	❑	❑	__________
Glaucoma evaluation	❑	❑	❑	__________
Oculomotor assessment	❑	❑	❑	__________
Other ________________________	❑	❑	❑	__________

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

Diagnosis

❑ Normal ❑ Myopia ❑ Hyperopia ❑ Astigmatism ❑ Strabismus ❑ Amblyopia

Other ____

Continued on back

State of Illinois
Eye Examination Report

Recommendations

1. Corrective lenses: ❑ No ❑ Yes, glasses or contacts should be worn for:
   ❑ Constant wear ❑ Near vision ❑ Far vision
   ❑ May be removed for physical education

2. Preferential seating recommended: ❑ No ❑ Yes
   Comments ____
   ____

3. Recommend re-examination: ❑ 3 months ❑ 6 months ❑ 12 months
   ❑ Other ____________________

4. ____

5. ____

Print name ______________________________
Optometrist or physician (such as an ophthalmologist) who provided the eye examination ❑ MD ❑ OD ❑ DO

License Number ______________________________

Address ______________________________
____

Phone ______________________________

Consent of Parent or Guardian
I agree to release the above information on my child or ward to appropriate school or health authorities.

____
(Parent or Guardian's Signature)

____
(Date)

Signature ______________________________ Date ____________

(Source: Amended at 32 Ill. Reg. _________, effective ___________)

Printed by Authority of the State of Illinois
6/09

IOCI1271-09

State of Illinois
Illinois Department of Public Health

PROOF OF SCHOOL DENTAL EXAMINATION FORM

To be completed by the parent (please print):

Student's Name: Last First Middle		Birth Date: (Month/Day/Year) / /
Address: Street City ZIP Code		Telephone:
Name of School:	Grade Level:	Gender: ☐ Male ☐ Female
Parent or Guardian:	Address (of parent/guardian):	

To be completed by dentist:

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present**

☐ Yes ☐ No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

☐ Yes ☐ No **Untreated Caries —** At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

☐ Yes ☐ No **Soft Tissue Pathology**

☐ Yes ☐ No **Malocclusion**

Treatment Needs (check all that apply)

☐ **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

☐ **Restorative Care** — amalgams, composites, crowns, etc.

☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis

☐ **Other** — periodontal, orthodontic

Please note ____________________

Signature of Dentist ____________________ Date of Exam ____________________

Address ____________________ Telephone ____________________
Street City ZIP Code

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.idph.state.il.us

IOCI 0600-10 Printed by Authority of the State of Illinois

131 McKinley Avenue Lake Villa, Illinois 60046-8986 www.district41.org Phone: 847/356-2385 Fax: 847/356-2670

Administrative Procedures

ADMINISTRATION OF MEDICATION TO STUDENTS

I. Authorization For the Administration of Medication and Emergency Medical Assistance

A. School employees shall not administer to a student or supervise a student's self-administration of prescription or over-the-counter medication in non-emergency situations unless the following authorizations have been obtained:

1. A written order from the student's physician, dentist or other person legally authorized to prescribe medication. The written order shall contain:

a. the student's name
b. date of birth
c. licensed prescriber's name, signature, and phone number
d. name of medication
e. dosage of medication
f. route of administration of medication
g. frequency and time of administration of medication
h. date of prescription and order
i. discontinuation date
j. diagnosis requiring medication
k. intended effect of medication
l. possible side effects
m. other medications the student is receiving; and

2. A written request and waiver of liability from the parent/guardians requesting the administration of medication by school employees.

3. Self-administration by a student of prescribed asthma medication requires that the parent/guardian of the student provide the school with written authorization for the self-administration.

B. Emergency medical assistance shall be provided, during school hours or at school sponsored activities, to all students whose parent/guardian have signed a written authorization for the provision of such assistance.

C. Authorizations required by this section shall be placed in the student's cumulative file, with a copy to the school nurse.

II. Administration of Medication

When the conditions contained in Section A of these Rules and Regulations are satisfied, medication shall be administered to students in the following manner:

A. Prescription medications shall be brought to school in the original container which shall display:
   1. the student's name
   2. prescription number
   3. medication name, dosage, route or administration and other required directions
   4. licensed prescriber's name
   5. date and refill instructions
   6. pharmacy name, address, and phone number
   7. name or initials of pharmacist

B. Over-the-counter medications shall be brought to school in their unopened original container with the seal unbroken and the student's name affixed to the container. Cough drops, vitamins, lozenges, gums, and any other item that could be considered a medication and can be purchased at a retail store, must be brought to the school office. Parent/guardian permission will still be required. A decision as to whether or not the item is a medication and may be taken in school will be made by the school nurse or his/her designee.

C. All medications shall be stored in a separate locked or secure area. Medications requiring refrigeration shall be refrigerated in a secure area. Medications and/or over-the-counter medications may not be kept in lockers, or in the student's possession. Exceptions to this are asthma inhalers or epinephrine auto-injectors.

D. The principal shall designate the employee or employees authorized to dispense the medication including employees who are required to administer medication in an emergency situation. Teachers or other non-administrative school employees, except school nurses, who may be certificated or non-certificated registered professional nurses, shall not be required to administer medication to students. However, such employees may be so designed if they agree or volunteer to administer the medication. When necessary, the school nurse shall instruct these employees concerning the manner in which the medication shall be administered, the circumstances requiring the administration of medication and the possible side effects.

E. Each dose of medication shall be documented for the student's health records. Documentation shall include date, time, dosage and route and signature or initials of the person administering the medication. In the event the medication is not administered as ordered, the reasons therefore shall be entered in the record.

F. When requested by the student's physician, the medication's effectiveness and side effects shall be assessed and documented. Parent/guardian is responsible for refilling medication. Any and all changes for medication administration must be in writing.

III. Discretionary Administration of Medication

If a parent/guardian consents to the administration of medication on a discretionary basis, the school nurse shall provide the necessary information and instructions for the administration of the medication including detailing any side effects to the designated personnel. The administration of medication on a discretionary basis shall be done only by the school nurse, who may be a certificated or a non-certificated registered professional nurse or a previously designated and instructed employee after consultation with and approval of the school nurse.

IV. Emergency Medical Treatment

School personnel shall render emergency medical assistance to any student whose parent/guardian have authorized such assistance when paramedical personnel or licensed physicians are not available or have not arrived and such assistance is necessary to protect the student's health, safety or welfare. The school personnel providing emergency medical assistance shall attempt to contact the principal as soon as possible and contact a licensed physician or certified paramedical personnel to provide or assist in providing emergency medical assistance.

V. Self-Administration of Medication

If a parent/guardian requests assistance from school personnel in a student's self-administration of medication, the procedures set forth in these Rules and Regulations concerning the administration of medication by school personnel shall be followed.

VI. Disposal of Medication

The parent/guardian of a student will be responsible at the end of the treatment regime for removing from the school any unused medication which was prescribed for their child. If the parent/guardian does not pick up the medication by the end of the school year, the school nurse will dispose of the medication and document that the medication was disregarded. Medications will be discarded in the presence of a witness.

VII. Dissemination of the Policy

A copy of these rules and regulations and medication form shall be distributed to the parent/guardian of each student prior to the beginning of each school year or within 15 days after starting classes for a student who transfers into the school during a school year. A copy of the policy and these rules and regulations shall also be printed in each student handbook. In addition, the policy, rules and regulations and medication form will be posted on the District website.

Revised: December 15, 2010
Reference: Policy #7:270 Administering Medicines to Students

131 McKinley Avenue Lake Villa, Illinois 60046-8986 www.district41.org Phone: 847/356-2385 Fax: 847/356-2670

Students

Administering Medicines to Students

Students should not take medication during school hours or during school-related activities unless it is necessary for a student's health and well-being. When a student's licensed health care provider and parent(s)/guardian(s) believe that it is necessary for the student to take a medication during school hours or school-related activities, the parent/guardian must request that the school dispense the medication to the child and otherwise follow the District's procedures on dispensing medication.

No School District employee shall administer to any student, or supervise a student's self-administration of, any prescription or non-prescription medication until a completed and signed "School Medication Authorization Form" is submitted by the student's parent(s)/guardian(s). No student shall possess or consume any prescription or non-prescription medication on school grounds or at a school-related function other than as provided for in this policy and its implementing procedures. A student may possess an epinephrine auto-injector (EpiPen®) and/or medication prescribed for asthma for immediate use at the student's discretion, provided the student's parent(s)/guardian(s) have completed and signed a "School Medication Authorization Form." The School District shall incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-administration of medication or epinephrine auto-injector or the storage of any medication by school personnel. A student's parent/guardian must indemnify and hold harmless the School District and its employees and agents, against any claims, except a claim based on willful and wanton conduct, arising out of a student's self-administration of an epinephrine auto-injector and/or medication, or the storage of any medication by school personnel.

Nothing in this policy shall prohibit any school employee from providing emergency assistance to students, including administering medication.

The Building Principal shall include this policy in the Student Handbook and shall provide a copy to the parent(s)/guardian(s) of students.

LEGAL REF.: 105 ILCS 5/10-20.14b, 5/10-22.21b, and 5/22-30.

ADOPTED: February 14, 2007

REQUEST FOR THE ADMINISTRATION OF MEDICINE

MEDICATIONS CANNOT BE ADMINISTERED AT SCHOOL WITHOUT A DOCTORS WRITTEN ORDER AND A WRITTEN REQUEST FROM THE PARENT/GUARDIAN

Name of Student ________________________________Date of Birth ____________________

Address ______________________________________Emergency Phone ________________

School____ Grade ________________________

Part I – Physician's Statement

1. Name/type of medication____
2. Dosage/amount to be given ____
3. Route of administration ____
4. Frequency and time of administration ____________________________________
5. Duration (week, month, indefinite, etc.) _________________________________
6. Diagnosis, Intended Effect and Anticipated Reaction to medication (Symptoms, side effects, etc.)
   ____
   ____
   ____
7. Other medication child is receiving _____________________________________
8. Other requirements ____
9. Must this medication be administered during the school day in order to allow the student to attend school? ____

____
Physician's Signature   Date signed

____   (_________)________________________
Address   Telephone

Part II B Parent's/Guardian's Request/Approval

I hereby request and grant permission for Lake Villa School District #41 school personnel to administer _________________________ or supervise the self-administration of _______________________ medication to my daughter/son ______________, according to the above instructions. I understand that this administration or supervision may be performed by an individual other than a certificated and registered school nurse, and I specifically consent to this. I further waive any claims against District #41, members of the Board of Education, its employees, and agents arising out of the administration of said medication and agree to hold harmless and indemnify the District, the members of the Board of Education, its employees and agents, either jointly or severally, from and against any and all liability, claims demands, damages, or causes of action or injuries, costs and expenses, including attorney's fees, resulting from or arising out of the administration of medication.

_________________________________(____)_______________________   ____________________
Signed   Telephone   Date

SELF ADMINISTRATION OF ASTHMA MEDICATION BY STUDENT

The responsibility for administering medication rests with the student's parent/guardian. Written authorization from the parent/guardian and a written statement from the student's physician, physician assistant, or advanced practice registered nurse is required.

The medication will remain in the possession of the student at all times.

The child will be responsible for taking the medication at the prescribed time.

The classroom teacher will give the child the opportunity to take the medication.

After reading the above guidelines for Self Administration of Medication, I am requesting that my child be allowed to self administer his/her own medication.

_______________________________________ _______________________________

Parent/Guardian Signature Date

Student Name __________________________________ Birth Date _________________

School _______________________ Grade _________Teacher/Nurse _______________

Name of Medication_________________________ Dose ____________ Time________

Reason for Medication ____

Side Effects or Special Instructions ____

____

Physician's Printed Name _____________________________________

Physician's Signature ____

Physician's Phone ____

Date ____________________________________

March, 2007

LAKE VILLA SCHOOL DISTRICT #41

ADMINISTRATION OF ASTHMA INHALER OR EPINEPHRINE AUTO-INJECTOR PARENT/GUARDIAN AUTHORIZATION AND RELEASE FORM (2011-2012 School Year)

Name of Student______________________________Date of Birth___________________________

School_______________________________________Grade_________________________________

I request that my student be allowed to carry his/her _______ asthma inhaler or _______ epinephrine auto-injector and self-administer as needed while at school or during school-sponsored activities. I have attached the following information to this form:

_____ **For asthma inhalers:** The prescription label, which contains the name of the medication, prescribed dosage, and time at which or circumstances under which the medication is to be administered. (*Note: A health care provider's signature is not required for students who require asthma inhalers while at school or during school-sponsored activities.)*

_____ **For epinephrine auto-injectors:** A written statement authorizing use, signed by the student's physician, a physician's assistant, or advanced practice registered nurse having such authority delegated by a supervising/collaborating physician. This statement must include the name and purpose of the epinephrine auto-injector, the prescribed dosage, and the time or times at which or the special circumstances under which the epinephrine auto-injector is to be administered.

Authorization, Waiver, and Indemnification

I hereby consent to and authorize Lake Villa School District #41 to:

_____ Administer medication to my student while at school or during school-sponsored activities according to the above instructions. I hereby confirm my primary responsibility to administer medication to my student. However, in the event that I am unable to do so, I hereby authorize Lake Villa School District #41 and its employees and agents, on my behalf and stead, to administer or to attempt to administer to my student lawfully prescribed medication in the manner described above. I ACKNOWLEDGE THAT IT MAY BE NECESSARY FOR THE ADMINISTRATION OF MEDICATION TO MY STUDENT TO BE PERFORMED BY AN INDIVIDUAL OTHER THAN A SCHOOL NURSE AND SPECIFICALLY CONSENT TO SUCH PRACTICES. I waive any claims against the School District, members of the Board of Education, its employees, and agents arising out of the administration of said medication, and agree to release, hold harmless, and indemnify the School District, the members of the Board of Education, its employees and agents, either jointly or severally, from and against any and all liability, claims, demands, damages, or causes of action or injuries, costs, and expenses, including attorneys' fees, resulting from or arising out of the administration of medication or storage of any medication by school personnel.

_____ Permit my student's possession and self-administration of asthma medication or use of epinephrine auto-injector while at school or during school-sponsored activities according to the above instructions. I waive any claims against the School District, members of the Board of Education, its employees, and agents arising out of the self-administration of said asthma medication or use of said epinephrine auto-injector, and agree to hold harmless and indemnify the School District, the members of the Board of Education, its employees and agents, either jointly or severally, from and against any and all liability, claims, demands, damages, or causes of action or injuries, costs, and expenses, including attorneys' fees, resulting from or arising out of the self-administration of asthma medication or use of epinephrine auto-injector. I also acknowledge that the School District, members of the Board of Education, its employees, and agents shall incur no liability, except for willful and wanton conduct, as a result of any injury arising from my student's self-administration of asthma medication or use of epinephrine auto-injector, regardless of whether the self-administration of an asthma inhaler or epinephrine auto-injector was authorized by the parent/guardian or healthcare provider.

This Parent/Guardian Authorization and Release Form and attached documentation shall be valid only for the school year in which they are submitted. A new form and supporting documentation must be submitted to the District each subsequent school year.

Parent/Guardian printed name: ____

Parent/Guardian signature: ____________________________ **Date:** ________________

Parent/Guardian telephone numbers:

Home: ____

Work: ____

Cell: ____

Lake Villa School District #41 Supply List
2011-2012

Teachers may request additional items as the need arises.
Items not on the list should not be brought to school unless requested by the teacher.

KINDERGARTEN

Qty	*Description*
4	24 count Crayola Crayons (not Jumbo)
1	Prang or Crayola Watercolor set: 8 colors
1	12 pack #2 pencils (sharpened)
1	Set Crayola Classic True Colors Markers, thick washable
1	Box Kleenex tissues-girls
1	Box of Zip-Lock quart bags-girls
1	Box of Zip-Lock gallon bags-boys
1	Roll of paper towels-boys
10	Glue sticks
1	Pair Fiskars for Kids blunt scissors
2	Pocket Folders
1	Container of baby wipes
1	Large backpack that holds folder (without wheels)
2	Low odor Dry Erase Markers (black & blue)
1	School glue bottle 8 oz.

NOTES FOR ALL GRADES:

***K-2 Please do not label supplies.**
All supplies are community property & are not returned to the individual students.

***K-6 No backpacks or gym shoes with wheels.**

LAKE VILLA SCHOOL DISTRICT #41

2011/2012 SCHOOL CALENDAR

The following calendar has been adopted on February 14, 2011 by the Board of Education for the 2011/2012 school year.

August	Monday - 22nd Tuesday - 23rd Wednesday - 24th	Teachers' Institute - No School First Day of Classes - Half Day - Grades 1 - 8 First Day of Classes for Early Childhood and Kindergarten
September	Monday - 5th	Labor Day - No School
October	Friday - 7th Monday - 10th	Teachers' Institute - No School Columbus Day - No School
November	Friday - 11th Friday - 18th Monday - 21st Tuesday - 22nd Wednesday - 23rd Thursday - 24th Friday - 25th	First Trimester Grading Period Ends Report Cards Sent Home Parent/Teacher Conferences - No School Teachers' Institute/Parent/Teacher Conferences - No School No School - Non Attendance Day Thanksgiving Day - No School No School - Non Attendance Day
December	**WINTER BREAK - December 23 to January 6**	
January	Monday - 9th Monday - 16th	School Resumes Martin Luther King's Birthday - No School
February	Friday - 17th Monday - 20th	Teachers' Institute - No School Presidents' Day - No School
March	Friday - 2nd Friday - 9th Thursday - 15th Friday - 16th	Second Trimester Grading Period Ends Report Cards Sent Home **Early Release**/Evening Parent/Teacher Conferences No School - Non Attendance Day
	SPRING BREAK - March 26 to March 30	
April	Friday - 6th	No School - Non Attendance Day
May	Friday - 18th Monday - 28th	Half Day Teachers' Institute - Half Day of School - No Early Childhood or Kindergarten 8th Grade Graduation – Time and Location to be determined Memorial Day - No School
June	Tuesday - 5th	Last Day of School if we do not take any emergency days - Half Day of School No Early Childhood or Kindergarten Classes Third Trimester Grading Period Ends Report Cards Sent Home

The calendar will include an early release day every Friday throughout the school year.

Starting and dismissal times for the school year are listed on the back.

FOLLOWING ARE THE STARTING AND DISMISSAL TIMES FOR THE 2011/2012 SCHOOL YEAR:

REGULAR CLASS DAYS:

Pleviak School - 8:45 a.m. to 3:25 p.m.
8:45 a.m. to 11:35 a.m. - AM Kindergarten
12:35 p.m. to 3:25 p.m. - PM Kindergarten

Thompson School - 8:45 a.m. to 3:25 p.m.
8:45 a.m. to 11:35 a.m. - AM Kindergarten
12:35 p.m. to 3:25 p.m. - PM Kindergarten
8:50 a.m. to 11:30 a.m. - AM Early Childhood

Hooper School - 8:15 a.m. to 2:55 p.m.
8:15 a.m. to 11:05 a.m. - AM Kindergarten
12:05 p.m. to 2:55 p.m. - PM Kindergarten
8:20 a.m. to 11:00 a.m. - AM Early Childhood
12:00 noon to 2:40 p.m.- PM Early Childhood

Martin School - 8:15 a.m. to 2:55 p.m.
8:15 a.m. to 11:05 a.m. - AM Kindergarten
12:05 p.m. to 2:55 p.m. - PM Kindergarten

Palombi Middle School - 7:42 a.m. to 2:27 p.m.

HALF DAY OF CLASSES DATES AND TIMES:

August 23, 2011
May 18, 2012
June 5, 2012

Pleviak and Thompson Schools - 8:45 a.m. to 11:45 a.m.
Hooper and Martin Schools - 8:15 a.m. to 11:15 a.m.
Palombi Middle School - 7:42 a.m. to 10:40 a.m.

No Early Childhood or Kindergarten Classes

EARLY DISMISSAL DATES AND TIMES:

August 26, 2011	November 18, 2011	March 2, 2012
September 2, 2011	December 2, 2011	March 9, 2012
September 9, 2011	December 9, 2011	March 15, 2012
September 16, 2011	December 16, 2011	March 23, 2012
September 23, 2011	January 6, 2012	April 13, 2012
September 30, 2011	January 13, 2012	April 20, 2012
October 14, 2011	January 20, 2012	April 27, 2012
October 21, 2011	January 27, 2012	May 4, 2012
October 28, 2011	February 3, 2012	May 11, 2012
November 4, 2011	February 10, 2012	May 25, 2012
November 11, 2011	February 24, 2012	June 1, 2012

Pleviak School -
8:45 a.m. to 2:25 p.m.
8:45 a.m. to 11:05 a.m. - AM Kindergarten
12:05 p.m. to 2:25 p.m. - PM Kindergarten

Thompson School -
8:45 a.m. to 2:25 p.m.
8:45 a.m. to 11:05 a.m. - AM Kindergarten
12:05 p.m. to 2:25 p.m. - PM Kindergarten
8:50 a.m. to 10:55 a.m. - AM Early Childhood

Palombi Middle School -
7:42 a.m. to 1:27 p.m.

Martin School -
8:15 a.m. to 1:55 p.m.
8:15 a.m. to 10:35 a.m. - AM Kindergarten
11:35 a.m. to 1:55 p.m. - PM Kindergarten

Hooper School -
8:15 a.m. to 1:55 p.m.
8:15 a.m. to 10:35 a.m. - AM Kindergarten
11:35 a.m. to 1:55 p.m. - PM Kindergarten
8:20 a.m. to 10:25 a.m. - AM Early Childhood
11:25 a.m. to 1:30 p.m. - PM Early Childhood