



# WELCOME TO NORDONIA HILLS CITY SCHOOLS KINDERGARTEN REGISTRATION

9370 Olde Eight Road  
Northfield, OH 44067  
(330) 467-0580  
[www.nordoniaschools.org](http://www.nordoniaschools.org)

*If you have any questions or concerns, please contact:*  
**REGISTRATION**  
(330) 467-0580  
fax (330) 468-0152

*Joe Clark, Ph.D.*  
*Superintendent*

[www.nordoniaschools.org](http://www.nordoniaschools.org)

| Please call for a Registration Appointment |  |
|--|--|
| Date & Time                                |  |
| Location                                   |  |

| Kindergarten Screening Appointment |  |
|------------------------------------|--|
| Date & Time                        |  |
| Location                           |  |

**ITEMS REQUIRED AT YOUR REGISTRATION APPOINTMENT:**

- Parent/Guardian Driver's License/State I.D.
- Original Certified Birth Certificate
- Immunization Records
- Social Security Card
- Custody Papers (certified time-stamped court order, if applicable)
- Proof of Residency (signed Lease/Purchase Agreement or Building Contract or Deed)
- Special Education/Special Needs, I.E.P., E.T.R., M.F.E., 504 Plan (if applicable)
- COMPLETED FORMS**
  - Pupil Registration Record Card
  - Home Language Survey
  - Bus Information Form
  - Authorization for Release of School Records (if applicable)
  - Ohio School Health History  
(Physician's/Dentist's report must be returned by start of school)

**REQUIRED  
SUMMER READING  
Grades K-12  
visit  
[www.nordoniaschools.org](http://www.nordoniaschools.org)  
for more information**



**NORDONIA HILLS CITY SCHOOL DISTRICT  
PUPIL REGISTRATION RECORD**  
Building: LV NF RW LE MS HS (circle one)

|                                |
|--------------------------------|
| For Office Use Only            |
| Entry Grade _____              |
| Student ID# _____              |
| Date Transcript Sent For _____ |

**STUDENT DATA: (TO BE COMPLETED BY THE PARENT/LEGAL GUARDIAN)**

Student Legal Name \_\_\_\_\_ Phone Number w/Area Code \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Place of Birth: City \_\_\_\_\_ State \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_

Information regarding Ethnicity is required by the Ohio Department of Education

Is the Student of Hispanic/Latino Heritage (Circle one) Y N (Below please check all that apply)

Ethnicity: White \_\_\_\_\_ Black \_\_\_\_\_ Asian \_\_\_\_\_ Pacific Islander/Hawaii \_\_\_\_\_ Amer. Indian/Alaskan Native \_\_\_\_\_

Previous School \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Language Spoken by Student: \_\_\_\_\_ Language Spoken by Parent/Legal Guardian(s): \_\_\_\_\_

Does your child have a current IEP? \_\_\_\_\_ 504 plan? \_\_\_\_\_

Does your child attend a special program? \_\_\_\_\_ Title 1 Reading \_\_\_\_\_ Tutoring \_\_\_\_\_ Other \_\_\_\_\_ (please specify)

Has your child ever been retained? \_\_\_\_\_ At what Grade Level? \_\_\_\_\_

**HEALTH DATA: Known or suspected conditions: (please check any that apply)**

|                        |                             |                               |
|------------------------|-----------------------------|-------------------------------|
| Heart Condition _____  | Medication Required? _____  | Name/Type of Medication _____ |
| Seizure Disorder _____ | Medication Required? _____  | Name/Type of Medication _____ |
| Diabetes _____         | Medication Required? _____  | Name/Type of Medication _____ |
| Severe Allergies _____ | Medication Required? _____  | Name/Type of Medication _____ |
| Vision _____           | Glasses: Yes _____ No _____ | Hearing _____                 |
| Other _____            |                             | Aid(s): Yes _____ No _____    |

**FAMILY DATA: (With Whom the Student Resides)**

**Email Address:** \_\_\_\_\_

(Circle one) Father/Legal Guardian, Other: \_\_\_\_\_

(Circle one) Mother/Legal Guardian, Other: \_\_\_\_\_

Name \_\_\_\_\_

Name \_\_\_\_\_

Name of Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Name of Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's Address \_\_\_\_\_

Employer's Address \_\_\_\_\_

Work Phone w/Area Code \_\_\_\_\_

Work Phone w/Area Code \_\_\_\_\_

Mother's Status: (check as many as apply) Married \_\_\_ Single \_\_\_ Widowed \_\_\_ Separated \_\_\_ Divorced \_\_\_ Remarried \_\_\_ Deceased \_\_\_

Father's Status: (check as many as apply) Married \_\_\_ Single \_\_\_ Widowed \_\_\_ Separated \_\_\_ Divorced \_\_\_ Remarried \_\_\_ Deceased \_\_\_

Shared Parenting \_\_\_ If checked, include information for other parent: Name \_\_\_\_\_

Address \_\_\_\_\_ Phone w/Area Code \_\_\_\_\_

Student's Brothers (in district)

Student's Sisters (in district)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(Name) (Birthdate) (School)

(Name) (Birthdate) (School)

State Law requires that school districts have documents on file by the first day of attendance, when a divorce or separation exists.

Check one: Currently in litigation \_\_\_ Finalized Judgement/Journal/Probate Letter \_\_\_

Journal #/ Date \_\_\_\_\_ Custody Papers must be on file with the school by \_\_\_\_\_ the first day of attendance.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_



## AUTHORIZATION FOR RELEASE OF SCHOOL RECORDS

TO: \_\_\_\_\_ Date: \_\_\_\_\_  
(Name of Previous School)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City, State, Zip)

9370 Olde Eight Road  
Northfield, OH 44067

www.nordoniaschools.org \_\_\_\_\_  
(Phone) (Fax)

**THE FOLLOWING STUDENT HAS ENROLLED IN THE NORDONIA HILLS CITY SCHOOL DISTRICT.  
YOU ARE AUTHORIZED TO RELEASE THE RECORDS FOR THE  
FOLLOWING STUDENT.**

\_\_\_\_\_  
Student's Name

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Grade Entering

\_\_\_\_\_  
Date of Birth

**THE RELEASE HAS BEEN GRANTED FOR THE FOLLOWING SPECIFIC RECORDS:  
PLEASE SEND RECORDS TO THE SCHOOL CHECKED BELOW:**

**FOR SPECIAL ED. RECORDS**

**I.E.P. for Special Education**

**Psychological Reports/Multi-Factored Evaluation**

**Nordonia Hills Board of Ed.  
9370 Olde Eight Road  
Northfield, OH 44067  
Phone: 330-468-4600  
Fax: 330-468-0152**

**Academic Records**

- \*Health & Immunization Records (State Law)
- \*Grades-to-Date of Withdrawal (transcript, report cards)
- \*Standardized Achievement Test Scores
- \*Proficiency/Competency Test Scores

**Ledgeview Elementary**  
9130 Shepard Road  
Macedonia, OH 44056  
Phone: 330-467-0583  
Fax: 330-468-4647

**Lee Eaton Elementary**  
115 Ledge Road  
Northfield, OH 44067  
Phone: 330-467-0582  
Fax: 330-468-5218

**Northfield Elementary**  
9374 Olde Eight Road  
Northfield, OH 44067  
Phone: 330-467-2010  
Fax: 330-468-5216

**Nordonia Middle School**  
73 Leonard Avenue  
Northfield, OH 44067  
Phone: 330-467-0584  
Fax: 330-468-6719

**Rushwood Elementary**  
8200 Rushwood Lane  
Sagamore Hills, OH 44067  
Phone: 330-467-0581  
Fax: 330-468-4631

**Nordonia High School**  
8006 South Bedford Road  
Macedonia, OH 44056  
Phone: 330-468-4603  
Fax: 330-908-6038



TO: Parents of children entering Kindergarten

FROM: Ronald G. Hawes, M.D., Medical Director

### **SCHOOL HEALTH RECORDS**

1. Complete the OHIO SCHOOL HEALTH HISTORY. This information will become part of your child's school health record. Some children have special needs or health concerns that the school needs to know about in order to provide accommodations. Please let us know if there are any such concerns for your child.
2. Make sure your child has completed the following IMMUNIZATIONS that are required by current Ohio Law, checking with your health care provider for any changes in that law.

- 5 doses – DPT (DTaP, DT)
- 4 doses – Polio
- 2 doses – MMR (measles, mumps, and rubella)
- 3 doses – Hepatitis B
- 2 doses - Varicella (or proof of disease)

Record all of your child's immunizations by month/day/year on the health history form or attach a copy of the immunization record that clearly has your child's name recorded. In addition to the vaccines required by law, your child may have received Hib (Haemophilus influenzae B) and Prevnar (pneumococcal vaccine).

Immunizations are available at the Summit County Health District (Graham Road Office) by appointment, 330-926-5713; the fee is \$14 per vaccine. No one will be denied immunizations due to inability to pay.

3. Schedule Check-ups with your Physician and Dentist. Ask them to complete the Physician's Report and the Dentist's Report and then return these forms to your child's school.

***Please return the completed health forms to your child's school as soon as possible.***

School health services are provided through the cooperation of your Board of Education and the Summit County Health District. Our goal is to provide services to ensure that children are healthy and able to attend school regularly, so they can take full advantage of the educational programs offered to them.

If you have any questions, or would like information about other services, call the Summit County Health District, (330) 926-5615, or 1-877-687-0002 and ask to speak to a Public Health Nurse.

**IMMUNIZATION REQUIREMENTS  
KINDERGARTEN**

Name of Student \_\_\_\_\_  
School \_\_\_\_\_  
Grade / Teacher \_\_\_\_\_

***Dear Parent/ Guardian:***

According to our records, your child does not meet Ohio minimum immunization requirements for school. If your child has received the required immunizations, please record them on the form below. If your child has not received the immunizations, they may be obtained through your physician or the Summit County Health District.

The immunizations marked below are not complete on your child's record. Please record the **Month/Day/Year** for each vaccine received.

\_\_\_\_\_ DPT, DTaP, DT, Td \_\_\_\_\_  
5 doses required (If 4<sup>th</sup> dose received after 4<sup>th</sup> birthday, 5<sup>th</sup> dose not needed.)

\_\_\_\_\_ Polio (OPV, IPV) \_\_\_\_\_  
4 doses required

\_\_\_\_\_ Measles, Mumps, Rubella (MMR) \_\_\_\_\_  
2 doses required (1<sup>st</sup> dose on or after 1<sup>st</sup> birthday, 2<sup>nd</sup> dose is given at least 28 days after 1<sup>st</sup> dose.)

\_\_\_\_\_ Hepatitis B \_\_\_\_\_  
3 doses required (2<sup>nd</sup> dose must be at least 28 days after the first. The 3<sup>rd</sup> dose must be 2 months after the 2<sup>nd</sup> and at least 4 months after the 1<sup>st</sup> dose and administered at least at six months of age.)

\_\_\_\_\_ Varicella \_\_\_\_\_  
Two doses required. (Or history of chickenpox infection.)

\_\_\_\_\_  
Signature of Parent/Guardian

According to Ohio law, children who do not have required immunizations or an approved exemption **are to be excluded** from school attendance.

Please return the completed form to your **child's school within one week**. If you have any questions, please call the health district, 330-926-5615.

Thank you for your cooperation.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Public Health Nurse / Phone number

**School Health Program**

**SUMMIT COUNTY HEALTH DISTRICT**

**1100 Graham Road Circle  
Stow, Ohio 4424-2992  
(330)-926-5615  
1-877-687-0002**

**School Health Record  
Summit County Health Department**

School \_\_\_\_\_  
Date Enrolled \_\_\_\_\_  
Entering Grade \_\_\_\_\_

|                    |                  |
|--------------------|------------------|
| Child's Name _____ | Birth date _____ |
|--------------------|------------------|

|                       |                         |
|-----------------------|-------------------------|
| Parent/Guardian _____ | Home phone number _____ |
|-----------------------|-------------------------|

**Immunizations:** Ohio Law describes minimum requirements for school entrance. If you have any questions please speak with your school nurse.

| Type:                  | Record Month/Day/Year                  |
|------------------------|--|
| DTaP, DPT, DT          | _____                                  |
| Td, TDaP               | _____                                  |
| Polio, OPV, IPV        | _____                                  |
| MMR                    | _____                                  |
| Hepatitis B            | _____                                  |
| Varivax (chickenpox)   | _____ (date of vaccine or disease)     |
| HIB                    | _____                                  |
| Prevnar (pneumococcal) | _____ Recommended                      |
| TB Test                | _____ Result: Neg. _____ or Pos. _____ |
| Other                  | _____                                  |

**Perinatal History**

Did the mother have any unusual physical or emotional illness while pregnant with this child?  
 Yes     No    If yes, please explain: \_\_\_\_\_

|  |   |  |
|--|---|--|
| How old was the mother when this child was born? _____ | Was this infant:<br><input type="checkbox"/> full term <input type="checkbox"/> early <input type="checkbox"/> late | What was this infant's birth weight? _____ |
|--|---|--|

Did the infant have any sickness or problems while in the nursery?  
 Yes     No    If yes, please explain: \_\_\_\_\_

**Developmental History:**

Please give the approximate age at which this child: walked alone \_\_\_\_\_ was toilet trained \_\_\_\_\_  
 spoke in sentences \_\_\_\_\_ dressed self \_\_\_\_\_

How does this child's development compare to other children, such as his or her brothers/sisters or playmates?  
 About the same \_\_\_\_\_ delayed \_\_\_\_\_ advanced \_\_\_\_\_

**Health Conditions:** Please check any that this child has had.

|  |   |  |
|--|---|--|
| <input type="checkbox"/> Allergies                       | <input type="checkbox"/> Chickenpox when _____      | <input type="checkbox"/> Heart Disease               |
| <input type="checkbox"/> Anaphylactic reaction           | <input type="checkbox"/> Cystic Fibrosis            | <input type="checkbox"/> Hepatitis                   |
| <input type="checkbox"/> Asthma or wheezing              | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Juvenile arthritis          |
| <input type="checkbox"/> Attention Deficit Disorder      | <input type="checkbox"/> Ear problems/ poor hearing | <input type="checkbox"/> Kidney disease              |
| <input type="checkbox"/> Behavioral concerns             | <input type="checkbox"/> Eczema/ skin conditions    | <input type="checkbox"/> Meningitis/ Encephalitis    |
| <input type="checkbox"/> Birth/ congenital malformations | <input type="checkbox"/> Emotional concerns         | <input type="checkbox"/> Seizures/ Epilepsy          |
| <input type="checkbox"/> Blood problems                  | <input type="checkbox"/> Eye problems/ poor vision  | <input type="checkbox"/> Speech difficulties         |
| <input type="checkbox"/> Bone/ joint problems            | <input type="checkbox"/> Frequent headaches         | <input type="checkbox"/> Toothaches/ dental problems |
| <input type="checkbox"/> Bowel problems                  | <input type="checkbox"/> Frequent sore throats      | <input type="checkbox"/> Urinary tract infections    |
| <input type="checkbox"/> Cancer                          |   | <input type="checkbox"/> Wetting during day or night |

## School Health Record

**Injuries, Illnesses & Hospitalizations:** Please explain.

|  |
|--|
|  |
|  |
|  |
|  |

**Current Health:** Please tell us about any health conditions your child has currently:

|  |
|--|
|  |
|  |
|  |

### Allergies:

Allergy to:

Reactions / Recommended Treatment if Severe

|  |  |
|--|--|
|  |  |
|  |  |
|  |  |
|  |  |

**Medications:** List medicine your child takes regularly.

Name

Taken for

How often? What time?

| Name | Taken for | How often? What time? |
|------|-----------|-----------------------|
|      |           |                       |
|      |           |                       |
|      |           |                       |

If your child must take medication at school, please request **Medication Authorization forms** to be completed by you and your child's physician.

Does your child need special assistance at school? Explain:

|  |
|--|
|  |
|  |
|  |

Is your child enrolled in a special education class? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Family History** List family members, relationship to student, birth date and significant health concerns.

Name

Relationship

Birth date

Health Concern

| Name | Relationship | Birth date | Health Concern |
|------|--------------|------------|----------------|
| 1.   |              |            |                |
| 2.   |              |            |                |
| 3.   |              |            |                |
| 4.   |              |            |                |
| 5.   |              |            |                |
| 6.   |              |            |                |

Would you like to talk to a nurse about community resources, Healthy Start Insurance, BCMH or SSI?

Yes \_\_\_\_\_ No \_\_\_\_\_

If you have questions about your child's health or community services that may be available to you, call the Summit County Health Department, (330) 926-5615, or 1-877-687-0002 and ask to speak to a Public Health Nurse.



# School Health Record

## Medications:

|   |                   |
|---|-------------------|
| If this child is taking any medication, please list medication and reason for taking: |                   |
| Medication  | Reason for taking |
|   |                   |
|   |                   |
|   |                   |
|   |                   |

## Immunizations: Ohio Law describes minimum requirements for school entrance.

| Type:                 | Record | Month/Day/Year                            |
|-----------------------|--------|---|
| DTaP, DPT, DT         | _____  | _____                                     |
| Td, TDaP              | _____  | _____                                     |
| Polio, OPV, IPV       | _____  | _____                                     |
| MMR                   | _____  | _____                                     |
| Hepatitis B           | _____  | _____                                     |
| Varivax (chickenpox)  | _____  | _____ (date of vaccine or disease)        |
| HIB                   | _____  | _____                                     |
| Pevnar (pneumococcal) | _____  | _____ Recommended.                        |
| TB Test               | _____  | Result: Neg. _____ or Pos. _____ Optional |
| Other                 | _____  |   |

## Please print or stamp:

|               |                    |
|---------------|--------------------|
| Doctor's name | Doctor's signature |
| Address       | Date signed        |
| Phone         |                    |

|              |            |
|--------------|------------|
| Child's Name | Birth date |
|--------------|------------|

|                   |                   |
|-------------------|-------------------|
| Parent / Guardian | Home phone number |
|-------------------|-------------------|

### Dentist's Report

The following services have been performed:

|                                      |   |  |
|--------------------------------------|---|--|
| <input type="checkbox"/> Examination | <input type="checkbox"/> Radiographs      | <input type="checkbox"/> Prescription for fluoride supplements |
| <input type="checkbox"/> Diagnosis   | <input type="checkbox"/> Oral prophylaxis | <input type="checkbox"/> Topical application of fluoride       |

The following oral hygiene instruction was provided:

|   |   |
|---|---|
| <input type="checkbox"/> Tooth brushing | <input type="checkbox"/> Diet counseling reflecting relation of diet to dental health |
| <input type="checkbox"/> Flossing       | <input type="checkbox"/> Home/school use of fluoride mouth rinse                      |

The following statements are applicable:

|  |  |
|--|--|
| <input type="checkbox"/> All necessary services have been performed        | <input type="checkbox"/> Further treatment is indicated          |
| <input type="checkbox"/> No restorative services are required at this time | <input type="checkbox"/> Further appointments have been arranged |

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please Print or Stamp:**

|                |                     |             |
|----------------|---------------------|-------------|
| Dentist's name | Dentist's signature |             |
| Address        |                     | Date signed |
| Phone          |                     |             |

**Nordonia Hills Transportation Dept.**  
7943 South Bedford Road  
Macedonia, OH 44056

**\*\*FORM MUST BE COMPLETED FOR EVERY STUDENT\*\***  
Grade: Kindergarten ALL DAY  
1 2 3 4 5 6 7 8 9 10 11 12 (circle one)  
School: LV NF RW STB LE MS HS *Other* (circle one)  
**ELIGIBLE TO K-8 STUDENTS WHOSE HOME ADDRESS  
IS OVER TWO MILES FROM BUILDING OF ATTENDANCE**

Transportation 330-468-4710 Fax 330-908-1789

**\*\*PLEASE ALLOW TWO WEEKS FOR PROCESSING\*\***

**BUS STOP REQUEST FORM**

\_\_\_\_\_ **New Student** \_\_\_\_\_ **Request change to current stop**

Student Name: \_\_\_\_\_

Parent Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Daytime Telephone: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Cell Phone (optional): \_\_\_\_\_

Please check the appropriate responses regarding transportation for your child.

**Please Note:** *Students are scheduled for one designated pick-up and one designated drop-off location. These locations need to be the same five days per week for the semester.*

**TO SCHOOL**

\_\_\_\_\_ I will drive my child to school. \_\_\_\_\_ Requesting pick-up by the bus.

\_\_\_\_\_ My child will be bused from the following daycare or caregiver: \_\_\_\_\_  
(List name of daycare/person, address, telephone number)

New stop location requested \_\_\_\_\_

**FROM SCHOOL**

\_\_\_\_\_ I will pick up my child from school. \_\_\_\_\_ Requesting drop off by the bus.

\_\_\_\_\_ My child will be bused to the following daycare or caregiver: \_\_\_\_\_  
(List name of daycare/person, address, telephone number)

New stop location requested \_\_\_\_\_

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

After bus stop assignments are made an additional completed form will be requested for any additional changes in pick up or drop off location. This form can be obtained from your school office or at [www.nordoniaschools.org](http://www.nordoniaschools.org).

**IMPORTANT DAY CARE INFORMATION**

For your planning purposes, school bus transportation is provided to/from the following school/day care centers:

|   |  |  |  |  |
|---|--|--|--|--|
| <b><u>Ledgeview</u></b><br>Kindercare<br>YMCA<br>Goddard School | <b><u>Northfield</u></b><br>First Class<br>Kindercare<br>NF Presbyterian<br>Nordonia Hills | <b><u>Rushwood</u></b><br>First Class<br>NF Presbyterian | <b><u>Lee Eaton</u></b><br>First Class<br>Nordonia Hills | <b><u>St. Barnabas</u></b><br>First Class<br>Kindercare<br>NF Presbyterian |
|---|--|--|--|--|

|                          |                        |                             |
|--------------------------|------------------------|-----------------------------|
| CTD:                     | <b>OFFICE USE ONLY</b> |                             |
| REMOVE FROM AM ROUTE     |                        |                             |
| REMOVE FROM PM ROUTE     |                        | Central Reg. Approval _____ |
| ADD TO:                  | EFFECTIVE DATE: _____  | Expected Start Date _____   |
| AM ROUTE / PM ROUTE      |                        |                             |
| NEW STOP / EXISTING STOP |                        |                             |
| FAX TO SCHOOL            |                        |                             |