



# Jump Start Registration

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For questions and more information about this document, please contact the following:

Mary Fickes  
Early Learning Coordinator  
[mpfickes@seattleschools.org](mailto:mpfickes@seattleschools.org)

Jump Start Registration Form in English.

We can help you in your language!

¡Podemos brindarle asistencia en español!

Waxaan kugu caawin karnaa Luqadaada Somaaliga ah!

Chúng tôi có thể giúp quý vị bằng tiếng Việt!

我們能以你的語言 幫助你!

በቋንቋዎች ለንግዳዎች ዝግጁ ነን!

Matutulungan ka namin sa Tagalog!

ብቋንቋኹም ከንሕግዘኩም ንኸእል ኢና!

Afaan kessaniin isin gargaaruu ni dandeenya!

بإمكاننا تقديم المساعدة لك بلغتك!

☎ (206) 743-3550

✉ [languages@seattleschools.org](mailto:languages@seattleschools.org)

🌐 [www.seattleschools.org/languages](http://www.seattleschools.org/languages)



# Jump Start Registration

Please complete both sides **return to the school where your child will attend kindergarten.** Or you can send to Mary Fickes: [mpfickes@seattleschools.org](mailto:mpfickes@seattleschools.org) or mail to: MS 31-588, Seattle Schools – PO Box 34165 - Seattle, WA 98124

**School name:** \_\_\_\_\_

**Child's full name:** \_\_\_\_\_

**Name child likes to be called:** \_\_\_\_\_

**Child's Date of Birth:** \_\_\_\_\_ **Gender:** M  F Yes  Other

**Address and Zip Code:** \_\_\_\_\_

**Parent/Guardian name:** \_\_\_\_\_

**Cell phone:** \_\_\_\_\_ **Work or home phone:** \_\_\_\_\_

**Preferred Email:** \_\_\_\_\_

**Parent/Guardian name:** \_\_\_\_\_

**Cell phone:** \_\_\_\_\_ **Work or home phone:** \_\_\_\_\_

**Family's primary language:** \_\_\_\_\_

**Will child need interpretation?**  Yes  No

**Does your child have any siblings at school?**  Yes  No  
If yes, please list their name(s), grade(s) and teacher(s)

\_\_\_\_\_

**Did your child attend preschool or childcare before Kindergarten?**  Yes  No

If yes, where? \_\_\_\_\_

Preschool/childcare name                      Address                      City

**Circle days each week your child is/was in preschool:** Mon   Tue   Wed   Thu   Fri   Sat   Sun  
**Number (#) of hours each day:**    \_\_\_   \_\_\_   \_\_\_   \_\_\_   \_\_\_   \_\_\_   \_\_\_

**Emergency Contacts** (In addition to those listed above, please note people who could pick up your child in an emergency, if the school cannot reach you first.)

**1. Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Cell phone:** \_\_\_\_\_ **Work or home phone:** \_\_\_\_\_

**2. Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Cell phone:** \_\_\_\_\_ **Work or home phone:** \_\_\_\_\_

**Photo/Video Permission:** Do you give your permission for your child to be included in photos/videos from Jump Start week, for school use only?  Yes  No

# Health and Development Information

1.  Allergy/Anaphylaxis – Please attach the student’s individualized health plan (IHP) for their allergy.
  - a. What is the student allergic to? \_\_\_\_\_
  - b. Yes  No  Does the student have an epinephrine auto injector rescue prescription?
2.  Asthma with rescue medication (for example: rescue inhaler)
  - a. Yes  No  Does child use rescue inhaler routinely for asthma symptoms?
  - b. Yes  No  Has your child been hospitalized for asthma in the past year?
  - c. Yes  No  Has your child used steroids (prednisone) for asthma symptoms in the past year?
3.  Seizure Disorder – Please attach the student’s individualized health plan (IHP) for seizures.
  - a. Yes  No  My student needs emergency medication for seizures.  
Medication: \_\_\_\_\_
4.  Diabetes – Please attach student’s individualized health plan (IHP) for diabetes.
  - a. My student has:  insulin pump  insulin pen  injected insulin
5.  Other Health, Developmental or Behavioral information: \_\_\_\_\_  
\_\_\_\_\_
  - a. IHP in place? Yes  No  Life threatening? Yes  No
  - b. Medications or treatments needed: \_\_\_\_\_  
\_\_\_\_\_
6.  Individualized Education Plan (IEP)? Yes  No  504?  Yes  No   
Please note any supports staff can provide for your child in section #8 below.
7.  **My student has no known health concerns**

8. Medications taken at school (daily, emergency)		Treatments performed at school (tube feedings, suctioning, toileting, VNS stimulator, etc.)	
Time	Medication, dose & route	Time	Treatment
<b>Specific supports we can provide for your child:</b>			

Parent Signature: \_\_\_\_\_ Phone(s): \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Phone(s): \_\_\_\_\_ Date: \_\_\_\_\_

**Important:** If your child has a serious health concern requiring medication at school, we will need a written [Individual Health Plan](#) (IHP) and an [Authorization for Medication](#) on file at school prior to Jump Start. Without these, an adult family member will need to remain on-site during Jump Start in case of an emergency. Please call (206) 252-0750 (SPS Health Services) if your child needs an Individual Health Plan. We will assist you.