Jump Start Registration

Please fill out BOTH sides and return to the school where your child is assigned for Kindergarten. See school directory for the school addresses.

School name: _____

Child First Name: _____ **Child Last Name:** _____

What is your child's preferred first name? _____

Date of Birth: _____ | **Early Entrance K:** ☐ | **Gender:** Male ☐ Female ☐ Other ☐

Address: _____ **Zip Code:** _____

Parent Guardian First Name: _____ **Cell Phone:** _____

Parent Guardian Last Name: _____ **Work/Home Phone:** _____

Parent/Guardian E-Mail: _____

Parent Guardian First Name: _____ **Cell Phone:** _____

Parent Guardian Last Name: _____ **Work/Home Phone:** _____

Parent/Guardian E-Mail: _____

Family Primary Language: _____

Is an Interpreter required: Yes ☐ No ☐ **Do you have any other children that attend this school?** Yes ☐ No ☐

If yes, please list your other children names, grade and date of birth.

_____

Emergency Contacts: List others you authorize to pick up your child in an emergency.

Name: _____ **Relationship:** _____

Cell Phone: _____ **Work/Home Phone:** _____

Name: _____ **Relationship:** _____

Cell Phone: _____ **Work/Home Phone:** _____

Photo/Video Permission: Do you give permission for your child to be included in photos or videos during Jump Start for school use only? Yes ☐ No ☐

In case Jump Start cannot be held at school it will be held online: **Do you have:**

Internet access at home: Yes ☐ No ☐ | Computer, Laptop or Ipad: Yes ☐ No ☐ | Smart Phone: Yes ☐ No ☐

Health Information

☐ **My student has no known health concerns**

☐ **Allergy/Anaphylaxis**: Please attach the child's individualized health plan (IHP) for this allergy.

What is the student allergic to: _____

Yes ☐ No ☐ Does the student have an epinephrine auto injector rescue prescription?

☐ **Asthma with rescue medication** (for example: rescue inhaler)

Yes ☐ No ☐ Does child use rescue inhaler routinely for asthma symptoms?

Yes ☐ No ☐ Has your child been hospitalized for asthma in the past year?

Yes ☐ No ☐ Has your child used steroids (prednisone) for asthma symptoms in the past year?

☐ **Seizure Disorder:** Please attach the student's individualized health plan (IHP) for seizures.

Yes ☐ No ☐ My student needs emergency medication for seizures.

Medication: _____

☐ **Diabetes**: Please attach student's individualized health plan (IHP) for diabetes.

My student has: insulin pump ☐ insulin pen ☐ injected insulin ☐

☐ If child has any other health issues, please indicate issue or treatment needed:

_____

My child has an Individual Health Plan (IHP): ☐ **My child's condition is life-threatening:** ☐

My child currently takes the following medication(s): _____

_____

and/or needs these treatments: (tube feeding, suctioning, toileting and etc:) _____

_____

Before Jump Start: If your child has a serious health concern requiring medication at school, send your school the Individual Health Plan (IHP) & an Authorization for Medication. Call (206) 252-0750 (SPS Health Services) for help or questions. Without these, an adult family member will need to stay onsite at Jump Start in case of an emergency.

Behavior and Learning

What will help your child feel comfortable participating at school?

_____

What can staff do to help your child make friends and enjoy Jump Start?

_____

Does your child have a: Individualized Education Plan (IEP): Yes ☐ No ☐ 504 Plan: Yes ☐ No ☐

Before Jump Start: If you have concerns about your child, or your child has an IEP or 504, we'd like to talk with you to plan together. Please call your school to speak with the Jump Start Lead or Principal.

Parent Signature _____ Date : _____

Parent Signature _____ Date : _____

Questions? jumpstart@seattleschools.org - (206) 252-0127 - MS 31-588, PO Box 34165 Seattle WA 98124