Jump Start Registration

Please complete both sides & return to the school where your child will attend kindergarten. See school directory for address. 💻email jumpstart@seattleschools.org ✉ 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** ☐**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 or Child care name Address City

Indicate the number of hours each day your child is/was in preschool:

Mon_____ **Tue**_____ **Wed**_____ **Thu** _____ **Fri** _____ **Sat** _____ **Sun**_____

Emergency Contacts (In addition to those listed above, please note people who would be willing to pick up your child in an emergency, if we could not 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 of Jump Start 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: _____
      _____
   c. ☐ Individualized Education Plan (IEP)? Yes ☐ No ☐ 504? ☐ Yes ☐ No ☐ Please note any supports staff can provide in the next section (#7) below.

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

7. Medications taken at school (daily, emergency, etc.)		**Treatments performed at school** (such as tube feedings, suctioning, toileting, VNS stimulator, etc.)	
Time	**Medication, dose & route**	**Time**	**Treatment**
Specific supports we can provide for your child:			

Parent Signature: _____ Phone(s): _____ Date: _____

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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 and we will assist you.