



# 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