



Alice Buzanis, Principal
 Kimberly Easter, Assistant Principal

2016-2017

REGISTRATION PACKET

- ✓ ALL INDIVIDUALS REGISTERING A CHILD TO SHERWOOD SCHOOL MUST BE THE LEGAL GUARDIAN. THE LEGAL GUARDIAN MUST PRESENT A DRIVERS LICENCE OR A STATE IDENTIFICATION WITH THE CURRENT ADDRESS AND A UTILITY BILL. SHERWOOD IS OPEN TO ALL NEIGHBORHOOD CHILDREN.
- ✓ ALL STUDENTS MUST WEAR A UNIFORM EVERYDAY. PRE-K-8TH GRADE STUDENTS BLACK BOTTOMS AND PURPLE TOPS. UNIFORMS AND GYM UNIFORMS CAN BE PURCHASED AT THE SCHOOL.

REGISTRATION CHECKLIST

At the registration meeting with each family:

Complete with the family:

Share with the family:

- ___ School Enrollment Form
- ___ Parent Agreement
- ___ Release Form
- ___ Request for Emergency and Health Information
- ___ Home Language Survey
- ___ Media Consent Form and Release
- ___ Family Partnership Needs Assessment
- ___ Student Medical Information

- ___ Minimum Health Requirements
- ___ Rights of Students in Temporary Living Situations

Give to families to complete and return before the first day of enrollment:

- ___ Dental Form
- ___ Certificate of Child Health Examination

Note: In accordance with the McKinney Vento Homeless Assistance Act, students in a temporary living situation are eligible for immediate enrollment (see Rights of Homeless Students).



CHICAGO
Public Schools

QUESTIONS?

Contact Alice Buzanis, Principal
773.535-0829

Chicago Public Schools School Enrollment Form

School Name Jesse Sherwood Elementary School

<p style="text-align: center;">Student Information</p> <p>Student's siblings' names if currently enrolled in CPS:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Student ID# _____</p>	<p>School Use Only: Prevent duplicate student records. Search in SIM for an existing Student ID before creating a new one.</p>
	<p>Last Name _____ First Name _____ Middle Name _____ Generation (Jr., etc) _____</p> <p>Gender _____ Birth date (mm/dd/yyyy) _____ Registration Grade Level (when first entering CPS) _____</p>	
<p style="text-align: center;">Personal, Immigrant, and Refugee Information</p> <p>To Parent/Guardian:</p> <p><i>CPS is required to keep a count of immigrant students for Federal and State Guidelines in order to determine if additional resources and services for students are needed.</i></p> <p><i>Note that this is not an inquiry on citizenship status, and all information will be kept confidential.</i></p>	<p style="text-align: center;">Y / N _____</p> <p>Birth Certificate on File _____ Birth Verification Type _____</p> <p>* Birth Country _____ Birth State _____ Birth City _____</p> <p>* Complete if student was <u>not</u> born in the United States (US) or one of its Territories:</p> <p style="text-align: center;">Date of first enrollment in any US School: _____</p> <p style="text-align: center;">Full Years completed school in US: _____</p> <p>Student has refugee status: Y / N _____ Country of refugee: _____</p>	<p>School Use Only: Note that "Date of first enrollment in any US School" becomes a required field in SIM if "Birth Country" is <u>not</u> the US or one of its Territories.</p>
<p style="text-align: center;">Student Address/Phone</p> <p>Physical (Home) Address</p> <p>Street Number and Name _____ Apt. _____ City _____ State _____ Zip Code _____</p> <p>Mailing Address (if different than Home)</p> <p>Street Number and Name _____ Apt. _____ City _____ State _____ Zip Code _____</p> <p>Home Phone Number _____</p>		
<p style="text-align: center;">Demographic, Home Language, Parent/Guardian Contacts, Emergency/Health Information</p>	<p>Federal Ethnic and Race Categories: <i>(Enter information into SIM from the Race and Ethnicity Survey form)</i></p> <p>Home Language Survey: <i>(Enter information into SIM from the Home Language Survey form)</i></p> <p>Parent/Guardian Contacts: <i>(Enter information into SIM from the Request for Emergency and Health Information form)</i></p> <p>Emergency/Health Information: <i>(Enter information into SIM from the Request for Emergency and Health Information form)</i></p>	
<p style="text-align: center;">Enrollment</p> <p>Enrollment Status Codes:</p> <p>01 – No Former School</p> <p>02 – Chicago Public School (to incl. Charter/Contract)</p> <p>03 – Chicago Private School</p> <p>04 – IL Public Schl, not Chicago</p> <p>05 – IL Private Schl, not Chicago</p> <p>06 – US Public Schl, not Illinois</p> <p>07 – US Private Schl, not Illinois</p> <p>08 – Not in USA</p>	<p>*School Transferring From <i>(if not a Chicago Public, Charter or Contract School)</i> _____ City and State _____</p> <p>*Is the student in good standing? Y / N _____ <i>(Instructions to school: for out-of-state public school or any private school students, a certification of "good standing" should be received from the Parent/Guardian. Refer to CPS Policy 10-0623-PO1 for more information.)</i></p> <p>Last Chicago Public, Charter, or Contract School Attended _____</p> <p>Is the student receiving any type of Special Education services? Y / N _____ <i>(Instructions to school: if yes, please notify the Case Manager.)</i></p> <p>Student Enrolled by _____ <i>(Print Name and Relationship)</i></p> <p>Signature of Parent/Guardian _____ Date of Enrollment _____</p>	
	<p>School Use Only: Enrollment Status Code <i>(insert a # from the left)</i> _____ Grade Level _____ Homeroom/Division # _____</p>	

PARENT AGREEMENT FORM

CHILD'S NAME: _____ DATE _____

SCHOOL NAME: _____ ROOM _____

I wish to have my child enroll at Jesse Sherwood Elementary School. I take full responsibility for his/her safe transportation to and from school and promise I will make sure he/she wears their uniform everyday. I understand the importance of daily attendance and agree to bring my child to school everyday and to fully participate in the program, including daily outdoor play during recess. Additionally, I will adhere to the school schedule so that my child is dropped off and picked up on time.

I understand that I am expected to communicate with my child's teacher via email or via telephone weekly. I am willing to attend meetings, workshops or conferences at the school as may be requested.

I give my permission for my child to be taken on trips related to the classroom program, including walking trips within the community.

Home Visit Preference

I understand that the relationship between home and school is vital to a child's future success, and recognize that two home visits a year are an integral part of the school program. I prefer to have my child's preschool staff conduct a home visit in the following setting:

_____ My home

_____ Other place of my choice: _____

SIGNATURE OF PARENT/GUARDIAN

**STUDENT
RELEASE FORM**

CHILD'S NAME _____ DATE _____

SCHOOL NAME _____ ROOM _____

PARENT'S NAME _____

The following people have permission to pick up my child from Sherwood:

SIGNATURE OF PARENT _____

NAME _____ RELATIONSHIP TO CHILD _____

PHONE NUMBER _____

NAME _____ RELATIONSHIP TO CHILD _____

PHONE NUMBER _____

NAME _____ RELATIONSHIP TO CHILD _____

PHONE NUMBER _____

NAME _____ RELATIONSHIP TO CHILD _____

PHONE NUMBER _____

Child WILL NOT be released to anyone other than the individuals named above. Changes must be made in WRITING by the legal guardian. Please ask the individual picking up your child to bring identification with a picture.

Request for Emergency and Health Information

School Name: Jesse Sherwood Elementary School

PARENTS/GUARDIANS: The school must have on file emergency information that can be used to contact you. Please print clearly. Whenever there is a change in this information, immediately notify the school in writing.

Student ID# _____ Last Name _____ First Name _____ Middle Name _____ Homeroom # _____

Birth Date (mm/dd/yyyy) _____ Student Home Address _____ Student Home Phone # _____

Confidential Information Box 1	Confidential Information Box 2
<p>Complete this box only if (1) it reflects your child's current living situation; OR (2) it reflects your living situation if you are a youth not living with a Parent or Guardian. (Your answer will help school staff with enrollment and may enable the student to receive additional services.) Check one box:</p> <p><input type="checkbox"/> awaiting foster care placement <input type="checkbox"/> in a car/park/other public place</p> <p><input type="checkbox"/> doubled-up <input type="checkbox"/> in a hotel/motel <input type="checkbox"/> in a shelter <input type="checkbox"/> in transitional housing</p> <p>School Note: If any box is checked, see the CPS Policy 702.5.</p>	<p>Is there a current Order of Protection or No Contact Order which concerns this student? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="background-color: #e0e0e0; padding: 5px;">School Note: If "Yes," follow CPS Policy 704.4 procedures. Enter information in <i>Legal Alert</i> field and update contact information, as needed, in SIM.</p>

Parent/Guardian and Emergency Contact Information: Add extra contacts on the back of this form, if needed.

	Parent/Guardian Contact	Parent/Guardian Contact
Contact Name		
Relationship to Student		
<i>Check all that apply:</i>	<input type="checkbox"/> Lives With <input type="checkbox"/> Gets Mailings <input type="checkbox"/> Emergency <input type="checkbox"/> Permission to Pickup	<input type="checkbox"/> Lives With <input type="checkbox"/> Gets Mailings <input type="checkbox"/> Emergency <input type="checkbox"/> Permission to Pickup
Home Address, if different from student's		
Home Phone Number, if different from student's		
Cell Phone Number		
Email Address		
Name and Address of Employer		
Work Phone Number		
* Communication Language		
<p><small>* CPS communicates via phone calls. Select the language that should be used to communicate with you. Languages available for mass communication at this time are English and Spanish (note: other languages upon availability).</small></p>		

List the name of a relative or neighbor who can also be notified in an emergency and has permission to pick up the student:

Name _____ Home Address _____ Telephone # _____ Relationship _____

Family Doctor's Name, Address, and Phone Number: I authorize you to call my family doctor, if necessary, in an emergency.

Student Health Insurance: (select only one of the three)

- Illinois Medical Card/All Kids: provide student's medical ID # _____ (9-digit number located on back of card)
- No Insurance: are you interested in applying for the Illinois Medical Card/All Kids? Yes No
- Private/Employer Health Insurance: no additional information needed

Children of Military Personnel (optional)

- As the Parent or Guardian, are you a member of a branch of the armed forces of the United States? Yes No
- If yes, are you either deployed to active duty or expect to be deployed to active duty during the school year? Yes No

I certify that the information on this form is correct:

_____ (Parent/Guardian Signature) _____ (Date)



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School: Jesse Sherwood Elementary School Room: _____ Unit: _____ Area: _____

Student Name: _____ Student ID No.: _____

English

1. Is a language other than English spoken in your home?

No Yes _____ (Language)

2. Does the student speak a language other than English?

No Yes _____ (Language)

If the answer to either question is yes, the law requires the school to assess your child's English language proficiency.

IMPACT REGISTRATION PROCESS

(For Office use only)

- The Non-English language identified on either question is the Home Language.
- If two different non-English languages are identified, enter the language identified in question 2 as the Home Language.
- Enter ENGLISH as a Home Language ONLY when both questions are answered no.

Spanish

1. ¿Se habla algún otro lenguaje que no sea inglés en su hogar?

No Sí _____ (Lenguaje)

2. ¿Habla el estudiante un lenguaje que no sea el inglés?

No Sí _____ (Lenguaje)

Si la respuesta a cualquiera de las preguntas es "Sí", la ley requiere que la escuela evalúe la fluidez de su niño en el idioma inglés.

Polish

1. Czy językiem innym niż angielski mówi się w domu?

Nie Tak _____ (język)

2. Czyt uczeń mówi innym językiem niż angielski?

Nie Tak _____ (język)

Jeśli udzielili Państwo twierdzącej odpowiedzi na którekolwiek z powyższych pytań, przepisy wymagają, aby szkoła sprawdziła poziom znajomości języka angielskiego waszego dziecka.

Chinese

1. 在家中是否說英語之外的一種語言
[] 否 [] 是 _____ (語言)

2. 該學生是否會說英語之外的一種語言
[] 否 [] 是 _____ (語言)

如果你在兩個問題中之任一項的答案是“是”，則法律規定校方要測試貴子女的英語通悉度。

Arabic

1 - هل تتكلم في بيتك بلغة أخرى غير اللغة الإنجليزية ؟
لا () نعم () اللغة _____

2 - هل يتكلم طفلك بلغة أخرى غير اللغة الإنجليزية ؟
لا () نعم () اللغة _____

إذا كانت الإجابة نعم علي أي من السؤالين فإن القانون يحتم علي المدرسة تقييم ابنكم للكفاءة في استخدام اللغة الإنجليزية.

Bosnian/Croatian/Serbian

1. Da li se u kući govori na stranom jeziku (različitom od engleskog)?
[] NE [] DA _____ (jezik)

2. Da li učenik govori neki strani jezik (različit od engleskog)?
[] NE [] DA _____ (jezik)

Ukoliko ste na bilo koje od ovih pitanja odgovorili sa "Da", škola će biti zakonski dužna da procijeni nivo znanja engleskog jezika kod vašeg djeteta

Urdu

1 کیا گھر پر انگریزی کے علاوہ کوئی اور زبان بولی جاتی ہے؟

() نہیں () ہاں

2 کیا طالب علم گھر پر انگریزی کے علاوہ کوئی اور زبان بولتا ہے؟

() نہیں () ہاں

اگر دونوں سوالوں میں سے ہر سوال کا جواب ہاں میں ہے تو قانون کے مطابق سکول کے لیے آپ کے بچے کا انگریزی میں مہارت کا اندازہ لگانے کا فیصلہ لازمی ہے۔

Signature of School Official

Date

Signature of Parent/Guardian

Date

Notes:

- If the parent/guardian does not speak English and the school does not have staff who speaks the parent/guardian's language, identify the language spoken by the parent/guardian through any assistance available in the school.
- If exact name of the language cannot be determined, enter "Other" as a temporary entry. The exact language must be determined within two weeks after the enrollment. Assistance from Area Compliance Facilitators is available.
- Questions or concerns, contact your Area Compliance Facilitator.



Media Consent Form and Release

Consent/Release

I hereby consent to have my child photographed, digitally recorded, video taped, audio taped and/or interviewed by the Board of Education of the City of Chicago (the "Board") or the news media when school is in session or when my child is under the supervision of the Board. Further, I consent for these photos, digital recordings, video tapes, audio tapes and/or interviews to be shared with third parties who have received written approval from the Office of Communications. I understand in the course of the above described activities that the Board might like to celebrate my child's accomplishments and work. Therefore, I further consent for the Board's release of information on my child's name, academic/non-academic awards and information concerning my child's participation in school-sponsored activities, organizations and athletics.

I also consent to the Board's use of my child's name, photograph or likeness, voice or creative work(s) on the Internet or on a CD or any other electronic/digital media or print media.

As the child's parent or legal guardian, I agree to release and hold harmless the Board, its members, trustees, agents, officers, contractors, volunteers and employees from and against any and all claims, demands, actions, complaints, suits or other forms of liability that shall arise out of or by reason of, or be caused by the use of my child's name, photograph or likeness, voice or creative work(s), on television, radio or motion pictures, or on the Internet, or on a CD, or any other electronic/digital media or print media.

It is further understood and I do agree that no monies or other consideration in any form, including reimbursement for any expenses incurred by me or my child, will become due to me, my child, our heirs, agents, or assigns at any time because of my child's participation in any of the above activities or the above-described use of my child's name, photograph or likeness, voice or creative work(s).

I understand that I may cancel this release by providing written notice to the principal. I also understand that this release is valid for one school year, including the following summer.

Instructions: Check Box #1 or Box #2

1. I consent as outlined in the above consent/release section.
2. I **DO NOT** consent as outlined in the above consent/release section.

Signature of Parent/Guardian/Student if age 18 or older

Printed Name of Parent/Guardian/Student if age 18 or older

Student's Name

Student ID #

Date

School

I understand that I have the right to inspect and copy my student's records, challenge the contents of such records; and limit my consent to the designated records or designated portions of information within the records.





Family Partnership Needs Assessment

Please check, sign and date one category below:

() Yes, I am interested in developing family goals as part of the Family Partnership Agreement.

I may need information or assistance with: *(please check all that apply)*

___ Basic Life Skills ___ Housing ___ Child Care ___ Legal Assistance

___ Child Development ___ Literacy ___ Mental Health ___ Education

___ Domestic Violence ___ Employment ___ Health/Nutrition ___ Substance Abuse

___ Parent Involvement ___ Other: _____

My personal goal for this year is: (Example: GED; job training; employment)

Steps needed to reach this goal are: _____

I may need assistance to reach this goal: ___ Yes ___ No

If yes, please explain: _____

() No, I am not interested in developing family goals, at this time. I understand that I may choose to develop family goals at anytime during my child’s enrollment.

The process of developing family goals as part of the Family Partnership Agreement has been explained to me.

Parent Signature

Date

Staff Signature

Date

School

Classroom Room

Student Medical Information 2016/2017 School Year

INFORMATION MUST BE UPDATED AND SUBMITTED **ANNUALLY** AT THE BEGINNING OF THE SCHOOL YEAR

PLEASE PRINT ALL INFORMATION and RETURN FORM TO SCHOOL

SCHOOL NAME: _____

Student Name: _____ Date of Birth: _____ Grade: _____

Student ID: _____ Medicaid Number: _____

To ensure the safety of your child during the school day, extracurricular activities, on any field trip, and when being transported by CPS it is important that the school is aware of any health conditions that may impact your child. We are asking you to please complete this form. For confidentiality purposes, this information will only be shared with relevant CPS staff. Thank you for your cooperation in this important matter.

Please check below if applicable:

- Food Allergies: (Type) _____
- Other Allergies: (Type) _____
- Asthma
- Diabetes: Type 1 Type 2
- Seizures
- Other Medical Condition

- My child has **NO** allergies, medical conditions and/or does not take any medications during school hours
- My child has a primary healthcare provider (e.g., Doctor, Nurse Practitioner, Physician Assistant, etc.)

For the medical condition identified above which requires prescribed medication during school hours, please provide written verification from your healthcare provider with diagnosis, type of medication, dosage, and time to be given. An Emergency Action Plan (Allergy, Asthma, or Diabetes) can also be requested from your healthcare provider. Your child may qualify for a **504 Accommodation Plan** due to his/her condition. Please make sure you follow up with your school nurse and/or case manager once you have submitted this form.

Parent Name: (Please Print): _____ Date: _____

Parent Signature: _____

Phone Number: _____ Email: _____



2016-2017 Minimum Health Requirements for Chicago Public Schools

Medical Home

A medical home will allow your child and family to access better healthcare. The medical home is where you can access affordable, quality, culturally sensitive, competent and coordinated healthcare.

Most people who are found eligible for Medicaid must choose a Primary Care Provider (Medical Home). The Illinois Client Enrollment Broker will help you understand your healthcare choices, so that you can choose the best plan for you. <http://illinoisceb.com/>

If you are seeking a provider, you may call 311 or go to: www.cityofchicago.org and type in "Find a Community Health Center" in the Search box

The CPS Children and Family Benefits Unit (CFBU) provides application assistance for CPS families that are eligible for benefit programs such as medical insurance (e.g., All Kids).

For more information, please call: 773-553-KIDS (5437)

For more information regarding health requirements contact your School Nurse.

Evidence shows that healthy students have better attendance and perform better in school academically. The following health requirements apply to all children enrolled in a Chicago Public School. **Children must provide proof of required immunizations and health exams before October 15, 2015, or they will face exclusion from school.**

EXAMINATION REQUIREMENTS

Physical Examination requirements due upon enrollment, or by 10/15/15

Physical Examination must be completed within one year prior to entry to:

- Preschool and kindergarten (physical exam and lead screening through age 6)
- 6th grade and 9th grade (ages 5, 11, 15 for un-graded programs)
- Any student entering CPS for the first time

Vision Examination requirements due upon enrollment, no later than 10/15/15

- Entering the State of Illinois for the first time at any grade level.
- Entering kindergarten

Dental Examination requirements due 5/15/16 for PE, PK, kindergarten, 2nd and 6th grade.

IMMUNIZATION REQUIREMENTS

Diphtheria, Pertussis (Whooping Cough), Tetanus (DTaP & Tdap)

- Four (4) or more doses. The first 3 doses with intervals of 4 weeks apart. The interval between the 3rd and 4th dose is at least 6 months.
- The last dose qualifying as a booster and received on or after the 4th birthday
- One (1) dose of the Tdap vaccine for 6th to 12th grades.

Polio

- Three (3) or more doses of a polio vaccine with intervals of 4 weeks apart.
- The last dose qualifying as a booster and received on or after the 4th birthday

Measles, Mumps, and Rubella

- One (1) dose required for preschool, & a second dose required for all students kindergarten to 12th grade.
- 1st dose received at 12 months or later
- 2nd dose must be administered at least four weeks (28 days) after 1st dose

Hepatitis

- Three (3) doses required for all students.
- 1st dose at birth.
- 2nd dose received no less than 28 days or 4 weeks after 1st dose.
- 3rd dose received no less than 2 months after the 2nd dose and 4 months after the 1st dose.

Varicella (Chicken Pox)

- Two (2) doses of varicella are required for kindergarten, 1st grade, 6th grade, 7th grade, 9th, and 10th grades The first dose on or after the first birthday and the second dose no less than four weeks (28 days) after the first dose.
- One (1) dose required on or after the first birthday for Prek, 2nd, 3rd, 4th, 5th, 8th, 11th, & 12th grades.

Haemophilus Influenzae, Type B (HIB)

- Three (3) doses required for primary series.
- If none received before age 15 months, only one (1) dose required from age 15 months to 59 months of age. Not required age 5 years or older.

Pneumococcal Disease (PCV)

- Four (4) doses required for primary series.
- If none received before age 24 months, only one (1) dose required from age 24 to 59 months of age. Not required age 5 years or older.

New: Meningitis (MCV4)

- One (1) dose of the meningitis vaccine for 6th grade.
- Two (2) doses of the meningitis vaccine for 12th grade.
- If the 1st dose was given at age 16 or older; only one (1) dose will be required for 12th grade.

Students in Temporary Living Situations (STLS) Notice of Rights of Homeless Students

The Board of Education of the City of Chicago (Board) shall provide an educational environment that treats all students attending the Chicago Public Schools (CPS) with dignity and respect. Every student in a temporary living situation shall have equal access to the same free and appropriate educational opportunities as students who are permanently housed. This commitment to the educational rights of students in a temporary living situation, youth, and youth not living with a parent or guardian, applies to all services, programs, and activities provided or made available by the Board.

A student is considered to be in a temporary living situation if he or she lacks a fixed, regular, and adequate nighttime residence and includes children and youth who are:

- sharing the housing of other persons due to loss of housing, economic hardship, or similar reason;
- living in a motel/hotel, trailer park or camping ground, due to lack of alternative, adequate housing;
- living in emergency or transitional shelters;
- abandoned in hospitals;
- awaiting DCFS foster care placement
- living in cars, parks, public spaces, abandoned building, substandard housing, bus or train station, or similar setting; and
- migratory children living in one of the above settings.
- youth not in the custody of a parent/guardian (unaccompanied youth) of any age, in one of the above settings.

All STLS Students Have Rights To:

- **Immediate school enrollment.** *A school must immediately enroll students even if they lack health, immunization or school records, proof of guardianship, or proof of residence. "Enrollment" means enrolled into the school, attending classes and participating fully in school activities.*
- **Enroll In:**
 - the school he/she attended when permanently housed or the school in which he/she was last enrolled (school of origin)
 - any school that permanently housed students living in the same attendance area in which the STLS student or youth is actually living are eligible to attend (attendance area school)
- **Remain** enrolled in his/her selected school for as long as he/she remains in a temporary living situation or, if the student becomes permanently housed, until the end of the academic year.
- **Enroll in** preschool
- **Access** to charter schools, selective enrollment schools, magnet schools, and all other CPS programs in the same manner as students who are permanently housed and assistance with application process will be provided upon request
- **Participate** in tutoring services beyond those provided to all students; school-related activities; and/or receive other support services
- **Receive** free school meals, fee waivers, free uniforms, and low-cost or free medical referrals
- **Transportation services:** If parents/caregivers choose to continue their child's education in the school of origin, CPS will provide transportation to and from the school of origin, and all school-related activities, for as long as the student is in a temporary living situation or, if the student becomes permanently housed, until the end of the academic year.
 - **Eligible students receive CTA transportation cards and adult caregivers of eligible students in grades PK-6 receive CTA transportation cards to accompany the student to/from school. Eligible students in grades PK-6 whose caregiver is unable to accompany them on public transportation due to a hardship may apply for yellow school bus service by submitting documentation or affidavit of their inability to transport the student.** Examples of a "hardship" situation are:
 - Parent/caregiver employment, job training, or education program
 - Parent's/caregiver's mental and/or physical disability
 - Children need to be transported to and from schools at different locations
 - Court order, DCFS, or DCFS contract agent requires activities that do not enable parent/guardian to transport children to and from school
 - Rules of shelter or similar facility will not permit parent/caregiver to leave to transport children to and from school
 - Other good cause why parent/caregiver cannot use public transportation to transport children to and from school

Students who temporarily reside outside of Chicago due to homelessness and attend their CPS school of origin receive transportation assistance as do students experiencing homelessness who live in the City of Chicago but attend a school of origin outside of CPS.

Dispute Resolution: When a school official denies a student in a temporary living situation enrollment or transportation to the school of origin, the parent or student may file a complaint with the CPS STLS Department. The STLS Department will attempt to resolve the dispute in a timely manner. The STLS Department will refer you to free and low-cost legal services to help you, if you wish. During the dispute, the student must be immediately enrolled in the school with participation in school activities and/or provided transportation to the school of origin until the dispute is resolved. Every Chicago Public School, including charter schools, has an STLS Liaison who will assist you in making enrollment decisions, provide notice of the dispute resolution process, if needed assist you in completing the dispute resolution forms and refer you to low-cost legal assistance.

If you have questions about enrollment in school, or want more information about the rights of STLS students in Chicago Public Schools, call the STLS program at (773) 553-2242, fax at (773)553-2182 or email at STLSInformation@cps.edu.



PROOF OF SCHOOL DENTAL EXAMINATION FORM

To be completed by the parent (please print):

Student's Name:	Last	First	Middle	Birth Date: (Month/Day/Year) / /
Address:	Street	City	ZIP Code	Telephone:
Name of School:	Grade Level:		Gender: <input type="radio"/> Male <input type="radio"/> Female	
Parent or Guardian:	Address (of parent/guardian):			

To be completed by dentist:

Oral Health Status (check all that apply)

Yes No **Dental Sealants Present**

Yes No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

Yes No **Untreated Caries** — At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

Yes No **Soft Tissue Pathology**

Yes No **Malocclusion**

Treatment Needs (check all that apply)

Urgent Treatment — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

Restorative Care — amalgams, composites, crowns, etc.

Preventive Care — sealants, fluoride treatment, prophylaxis

Other — periodontal, orthodontic

Please note _____

Signature of Dentist _____

Date of Exam _____

Address _____
Street City ZIP Code

Telephone _____





State of Illinois Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 2/2013



Student's Name				Birth Date	Sex	Race/Ethnicity	School /Grade Level/ID#
Last		First		Middle		Month/Day/Year	
Address				Parent/Guardian		Telephone # Home	
Street		City		Zip Code		Work	

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for every dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

Vaccine / Dose	1 MO DA YR		2 MO DA YR		3 MO DA YR		4 MO DA YR		5 MO DA YR		6 MO DA YR	
DTP or DTaP												
Tdap; Td or Pediatric DT (Check specific type)	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	
Polio (Check specific type)	<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV	
Hib Haemophilus influenza type b												
Hepatitis B (HB)												
Varicella (Chickenpox)												
MMR Combined Measles Mumps. Rubella												
Single Antigen Vaccines	Measles		Rubella		Mumps							
Pneumococcal Conjugate												
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza												

COMMENTS:

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.)

Signature	Title	Date
Signature	Title	Date

ALTERNATIVE PROOF OF IMMUNITY

1. **Clinical diagnosis is acceptable if verified by physician.** *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

***MEASLES (Rubeola)** MO DA YR **MUMPS** MO DA YR **VARICELLA** MO DA YR **Physician's Signature**

2. **History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.**
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease	Signature	Title	Date
------------------------	------------------	--------------	-------------

3. **Laboratory confirmation (check one)** Measles Mumps Rubella Hepatitis B Varicella
Lab Results Date MO DA YR (Attach copy of lab result)

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN													
Date													Code: P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/Contacts
Age/Grade													
	R	L	R	L	R	L	R	L	R	L	R	L	
Vision													
Hearing													

Last	First	Middle	Birth Date Month/Day/Year	Sex	School	Grade Level/ ID
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HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)			MEDICATION (List all prescribed or taken on a regular basis.)		
Diagnosis of asthma?	Yes	No	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No
Child wakes during night coughing?	Yes	No	Hospitalizations? When? What for?	Yes	No
Birth defects?	Yes	No	Surgery? (List all.) When? What for?	Yes	No
Developmental delay?	Yes	No	Serious injury or illness?	Yes	No
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No	TB skin test positive (past/present)?	Yes*	No
Diabetes?	Yes	No	TB disease (past or present)?	Yes*	No
Head injury/Concussion/Passed out?	Yes	No	Tobacco use (type, frequency)?	Yes	No
Seizures? What are they like?	Yes	No	Alcohol/Drug use?	Yes	No
Heart problem/Shortness of breath?	Yes	No	Family history of sudden death before age 50? (Cause?)	Yes	No
Heart murmur/High blood pressure?	Yes	No	Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other		
Dizziness or chest pain with exercise?	Yes	No	Information may be shared with appropriate personnel for health and educational purposes.		
Eye/Vision problems? <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____					
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)					
Ear/Hearing problems?	Yes	No	Parent/Guardian Signature	Date	
Bone/Joint problem/injury/scoliosis?	Yes	No			

PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA
HEAD CIRCUMFERENCE if < 2-3 years old **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI > 85% age/sex** Yes No And any two of the following: **Family History** Yes No
Ethnic Minority Yes No **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes No **At Risk** Yes No

LEAD RISK QUESTIONNAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered? Yes No **Blood Test Indicated?** Yes No **Blood Test Date** **Result**

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. **No test needed** **Test performed**

Skin Test: Date Read / / **Result: Positive** **Negative** **mm** _____

Blood Test: Date Reported / / **Result: Positive** **Negative** **Value** _____

LAB TESTS (Recommended)	Date	Results	Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)	
Urinalysis			Developmental Screening Tool	

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs	Normal	Comments/Follow-up/Needs
Skin			Endocrine	
Ears			Gastrointestinal	
Eyes		Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>	Genito-Urinary	LMP
Nose			Neurological	
Throat			Musculoskeletal	
Mouth/Dental			Spinal Exam	
Cardiovascular/HTN			Nutritional status	
Respiratory		<input type="checkbox"/> Diagnosis of Asthma	Mental Health	
Currently Prescribed Asthma Medication: <input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist) <input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)			Other	

NEEDS/MODIFICATIONS required in the school setting **DIETARY** Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pace maker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
 If you would like to discuss this student's health with school or school health personnel, check title: Nurse Teacher Counselor Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g. ,seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
 Yes No If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in _____ (If No or Modified please attach explanation.)
PHYSICAL EDUCATION Yes No Modified **INTERSCHOLASTIC SPORTS** Yes No Limited

Print Name _____ (MD,DO, APN, PA) **Signature** _____ **Date** _____

Address _____ **Phone** _____

(Complete Both Sides)



VOLUNTEER APPLICATION

Dear Prospective Volunteer,

Thank you for your interest in becoming a CPS Volunteer. While we aim to make this process as straightforward as possible, we also recognize our high level of responsibility for the well-being of our students. As such, we require those who will work most closely with our students to complete background checks and TB tests. The attached form will provide the information we need and will enable us to contact you about volunteer opportunities.

Below is a checklist and description of the documents you must submit:

- Volunteer Interest Form** – Please provide as much information as possible about your interests, preferences, and availability. Submit this form to the school or program where you would like to volunteer.
- Valid government issued photo ID** – Driver’s License, State ID, Foreign Government issued ID
- The following additional documents may be required, depending on the level of student contact, and the amount of time spent volunteering:
 - **Certification of Freedom from Tuberculosis** – *to be completed by a health care provider. (if applicable, document will be provided later)*
 - **Volunteer Fingerprint Background Investigation Authorization & Release Form** - *to be completed and submitted to an Accurate Biometrics site. (if applicable, document will be provided later)*

If you are not arranging your volunteer service directly through a school or program, please submit the *Volunteer Interest Form* and a copy of your photo ID to Volunteer Programs to the Principal, Ms. Buzanis.

Thank you again for your interest in serving the students of Chicago Public Schools. We hope you will find this a satisfying and rewarding experience.



Volunteer Interest Form

Name: _____
 First Middle Last

Address: _____ City, State, Zip: _____

Phone: Day: _____ Evening: _____ Email: _____ @ _____

Are you currently an approved CPS Volunteer? No Yes

Are you currently a CPS Parent? No Yes
(If yes, list student name(s))

Are you volunteering with an organization? No Yes

Education Level: High School/GED Some College/College Graduate

Languages you speak other than English: _____

Assignment Preferences *(if any):*

Grade Level: Elementary School Middle School High School
Neighborhood: 1. _____ 2. _____
School: 1. _____ 2. _____

Availability:

Regular School Year (Sept-June) Program/Short-term Project__
 Summer School (July-Aug) Other _____

Time: (*# hours/week* _____)

Morning (_____ to _____) M T W TH F S
 Afternoon (_____ to _____) M T W TH F S

Day(s)

I am interested in volunteering in:

- | | | |
|---|---|--|
| <input type="checkbox"/> Tutoring | <input type="checkbox"/> Mentoring | <input type="checkbox"/> Competition Judge |
| <input type="checkbox"/> Fine Arts | <input type="checkbox"/> Technology Support | <input type="checkbox"/> Career Activity |
| <input type="checkbox"/> Visual Arts | <input type="checkbox"/> Sports | <input type="checkbox"/> After School Programs |
| <input type="checkbox"/> Classroom Support | <input type="checkbox"/> Student Clubs | <input type="checkbox"/> Fundraising |
| <input type="checkbox"/> Cafeteria/Playground/Hallway | <input type="checkbox"/> Administrative Support | <input type="checkbox"/> Chaperone |
| <input type="checkbox"/> Other: _____ | | |

References *(individuals unrelated to you, who know you well; e.g. employer, pastor, teacher)*

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____

Candidate Signature: _____ **Date:** _____



Jesse Sherwood Elementary School 245 W. 57th St. - Chicago, Illinois 60621
Telephone 773/535-0829 - Fax 773/535-0872

Alice Buzanis
Principal

Kimberly Easter
Assistant Principal

PARENT PORTAL PERMISSION SLIP

I _____
(PARENT NAME)

give my child's school: *JESSE SHERWOOD ELEMENTARY* permission to set up my Parent Portal Account , using my email or cell phone number to receive alerts regarding my SON/DAUGHTER academic status.

Child 1 _____

Child 2 _____

Child 3 _____

Child 4 _____

Child 5 _____

Parent Email Address: _____

Parent Cell Phone Number: _____

User Name and Password will be text or emailed to you as soon as the account is set-up. Thank you so much.

Parent Signature

Date

JESSE SHERWOOD ELEMENTARY SCHOOL
IMPORTANT REMINDERS FOR THE 2016-2017 SCHOOL YEAR
BEGINNING SEPTEMBER 2016

NEW HOURS FOR ALL STUDENTS

9:00 A.M. TO 4:00 P.M.

NEW UNIFORMS FOR ALL STUDENTS

PURPLE TOPS



BLACK BOTTOMS



Gym Uniforms are highly suggested!

ORDER YOURS TODAY!

\$8 shorts.....\$12 sweat pants....\$6.00 t-shirt

\$26 per student for a t-shirt, shorts and sweat pants

\$14 per student for t-shirt and shorts

\$18 for sweat pants and t-shirt

\$10 for Polo Shirts

\$15 for uniform pants

or purchase a purple top and black sweat pants on your own.

Students must wear their gym uniforms on gym day please!

Have a great summer!

Alice Buzanis, Principal

Kimberly Easter, Asst. Principal

Jesse Sherwood Elementary Spirit Wear Order Form

Student Name Room # _____

Parent Phone Number: _____

Parent Name: _____

Student Address: _____

PLEASE INDICATE SIZE, YOUTH OR ADULT BELOW.

<i>ITEM</i>	<i>HOW MANY</i>	<i>YOUTH OR ADULT</i>	<i>SIZE</i>
Gym Mesh Shorts \$8.00	_____	_____	_____
Polo \$10	_____	_____	_____
Hoodie with Zipper \$30	_____	_____	_____
Sweat Pants \$12	_____	_____	_____
T-Shirt \$6.00	_____	_____	_____
Hoodie Pull Over \$25	_____	_____	_____
T-Shirt, Gym Mesh Shorts, Sweat Pants \$26	_____	_____	_____
T-Shirt, Mesh Shorts \$14	_____	_____	_____
Sweat Pants, T-Shirt \$18	_____	_____	_____
Uniform Black Pants \$15	_____	_____	_____

CASH OR MONEYORDER - PAYABLE TO SHERWOOD SCHOOL
Uniform Colors – BLACK BOTTOMS – PURPLE TOPS
NEW HOURS
9 A.M. TO 4 P.M.