

WELLINGTON EXEMPTED VILLAGE SCHOOL DISTRICT

Student Services Department
627 North Main Street
Wellington, Ohio 44090-1315
Office: 440-647-7934
Fax: 440-647-7447

Daniel Rahm
Director of Student Service
drahm@wellingtonvillageschools.org

Pattie Roush
Student Service Coordinator
proush@wellingtonvillageschools.org

Dear Parent or Guardian:

Due to your preschool aged child having an evaluation at the Lorain County Early Learning Center we are asking that you please complete the enclosed preschool registration packet and return it to our office as soon as possible along with a COPY of the following items:

1. CHILD'S BIRTH CERTIFICATE (Upload Here)
2. CHILD'S SOCIAL SECURITY CARD (Upload Here)
3. PARENT'S DRIVER'S LICENSE (if available)
4. 2 FORMS OF PROOF OF RESIDENCE (mail with address / name listed, bill, mortgage statement or lease)

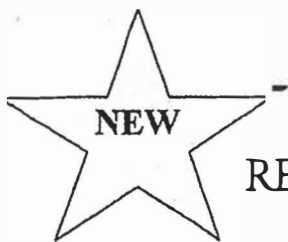
HOW TO RETURN: Mail the forms back to the Wellington Middle School at the cost of the parent/guardian, scan and email them to me at jlorsik@wellingtonvillageschools.org or drop them off at the Wellington Middle School front office in an envelope addressed to the attention of Joslyn Orsik.

Should you have any questions and/or concerns please feel free to contact me at (440) 647-7934.

Sincerely,

Joslyn Orsik

Joslyn Orsik
Student Services Secretary
(440)647-7934
jorsik@wellingtonvillageschools.org



Please complete & return

REGISTRATION FOR PRESCHOOL SERVICES

STUDENT'S LAST NAME: _____

STUDENT'S FIRST NAME: _____

STUDENT'S MIDDLE NAME: _____

GENDER: MALE _____ FEMALE _____

BIRTHDATE: _____

HOME PHONE: _____

ETHNICITY/RACE: _____

ADDRESS: _____

CITY: _____

NOTE: This form should be given to the registrar at the time of referral for pre-registration.

Wellington Exempted Village School District



305 Union Street
Wellington, OH 44090

Date: _____

Grade Assigned: _____

Student ID #: _____

Registration Form

The information supplied on this form is required under Provisions of Ohio Law and the Ohio Department of Education Regulations.

STUDENT DATA:

Name _____ Male _____
Last First Middle Female _____

Street Address _____ Apt# _____

City _____ County _____ Zip _____

Mailing Address _____

(If different from home address)

Home Phone _____ Cell Phone _____ Mother's Maiden Name _____

Birth Date ____/____/____ City/State of Birth _____ SSN ____-____-____

Name of Previous School _____

Address/City/State/Zip _____

Ethnicity/Race Declaration

Is Student Hispanic/Latino (person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race) _____ Yes _____ No

Race (Mark all that apply)

_____ (I) American Indian or Alaskan Native

_____ (A) Asian

_____ (P) Native Hawaiian or other Pacific Islander

_____ (B) Black/African American

_____ (W) White

Military Student Identifier

_____ (*) Not Applicable – Not a Military Student

_____ (A) Active Duty – Student is a dependent of a member of the Active Duty Forces (Army, Navy, AF, USMC, CG).

_____ (B) National Guard – Student is a dependent of a member of the National Guard (Army Nat Guard or Air Nat Guard).

_____ (C) Reserve Duty

Limited English Proficiency _____ Yes _____ No

Brothers/Sisters

1. _____ Age _____ Birth Date ____/____/____

2. _____ Age _____ Birth Date ____/____/____

3. _____ Age _____ Birth Date ____/____/____

4. _____ Age _____ Birth Date ____/____/____

Office Use Only

District IRN 045658

Wellington High School

IRN 061317

McCormick Middle School

IRN 022244

Westwood

IRN 040881

Birth Certificate on File _____

Immunization on File _____

Wellington Exempted Village School District

PARENT DATA:

Student lives with: (check one)

_____ Mother/Father _____ Mother _____ Father _____ Legal Guardian
_____ Mother/Stepfather _____ Father/Stepmother _____ Ward of Court _____ 18 Years Old

IF STUDENT LIVES WITH MOTHER AND FATHER SKIP THIS SECTION:

If divorced is this joint custody? _____ Yes _____ No

If not joint, custody has been granted to _____

***Evidence of application for legal custody/guardianship within one week of enrollment.

Date received: _____

CUSTODY/GUARDIANSHIP DOCUMENTS ARE REQUIRED WITHIN SIXTY (60) DAYS.

Date received: _____

PARENT NAMES:

Mother _____ Cell Phone _____

Place of Employment _____ Work Phone _____

Address if different from student _____

Mother Email _____

Father _____ Cell Phone _____

Place of Employment _____ Work Phone _____

Address if different from student _____

Father Email _____

To the best of my knowledge, all of the above information is true. I certify that the student's name listed on this form is his/her legal name and that I/we have legal custody or are in the process of obtaining legal custody/guardianship. I will notify the school of any changes which will affect this application.

(Signature)

(Date)

SCHOOL USE: Date Records sent for _____ Date Received _____
Withdrawal Date _____ Records Sent _____

*****PLEASE USE BLUE OR BLACK INK ONLY*****

PARENT INFORMATION:

Father's Name _____ **Resides with Child** _____

Street Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone Number _____ **Cell Number** _____ **Email Address** _____

Employer's Name _____ **Work Number** _____

Stepfather's Name (if applicable) _____ **Resides with Child** _____

Street Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone Number _____ **Cell Number** _____ **Email Address** _____

Employer's Name _____ **Work Number** _____

Mother's Name _____ **Resides with Child** _____

Street Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone Number _____ **Cell Number** _____ **Email Address** _____

Employer's Name _____ **Work Number** _____

Stepmother's Name (if applicable) _____ **Resides with Child** _____

Street Address _____ **City** _____ **State** _____ **Zip** _____

Home Phone Number _____ **Cell Number** _____ **Email Address** _____

Employer's Name _____ **Work Number** _____

CUSTODY

Are there any custody issues the school needs to be aware of? _____

If you answered yes, please inform the school in writing.

Are there custody papers on file? _____

Unless a legally stamped custody paper is on file in your child's school and is specific about not involving the other parent in school related matters, both parents have equal rights.

PHONE NUMBER TO BE USED FOR AUTOMATED DISTRICT PHONE CALLS:

Phone Number _____

*****REMEMBER TO KEEP THE SCHOOL INFORMED OF ANY CHANGES THROUGHOUT THE SCHOOL YEAR. *****

*****PLEASE COMPLETE BOTH SIDES*****

Home Language Survey

Date: _____

School District: _____

Name of Student: _____

Family Name

First Name

Middle I

Date of Birth: ____/____/____
Month Day Year

Place of Birth: _____
City State Country

Name of Parent/Guardian: _____

Family Name

First Name

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

For Parents/Guardians:

Please answer the following questions:

1. What language did your son/daughter speak when he/she first learned to talk? _____
2. What language does your son/daughter use most frequently at home? _____
3. What language do you speak most frequently to your son/daughter? _____
4. What language to the adults at home most often speak? _____
5. How long has your son/daughter attended school in the United States? _____

For School District Personnel: (contact EMIS Coordinator for assistance)

Select True for Immigrant Status field in the EMIS FD if student has been attending school < 3 years in the United States.

Enter the language answered for question 1 and 2 into the EMIS GI Native Language and Home Language fields, respectively.

If the answer to any of the first four questions above is a language other than English, begin the process to assess the student's English language proficiency

INITIAL ENGLISH LANGUAGE ASSESSMENT

Communication skill

Proficiency Level

Listening:	____ Beginning	____ Intermediate	____ Advanced	____ Proficient
Speaking:	____ Beginning	____ Intermediate	____ Advanced	____ Proficient
Reading:	____ Beginning	____ Intermediate	____ Advanced	____ Proficient
Writing:	____ Beginning	____ Intermediate	____ Advanced	____ Proficient
*Comprehension	____ Beginning	____ Intermediate	____ Advanced	____ Proficient

(*note: The comprehension score is calculated by averaging the listening and reading scores.)

Assessment instrument(s) used: _____

Student is LEP? ____Yes ____No

If Yes, inform EMIS coordinator of appropriate LEP Code and effective date to enter on EMIS FD LEP field

If student has been in U.S. schools for less than three years, is the student eligible for extended accommodations for statewide academic assessments? ____Yes ____No

STATEMENT OF CUSTODY
(For use ONLY when no custody order exists)

I, _____ hereby state that I am the natural parent of _____. Furthermore, I state that I have full custody rights of said child(ren). I have no written proof of custody for the following reasons:

I was never married to the father/mother of my child(ren), but my name appears on the birth certificate. No custody order exists.

I am still married to the father/mother of my child(ren). We are separated, but not divorced. No custody order exists.

The father/mother of my child(ren) is deceased. My name appears on the birth certificate. No custody order exists.

Other (please specify):

I certify that the above information is true and accurate. Further, I understand that if this information is false, my child(ren) could be withdrawn from school.

I also waive my right to confidentiality of this information and allow the Wellington School District to use any legal means necessary to verify my custodial status.

Signature _____ Date _____

Witness _____ Date _____

Ohio Department of Health • School and Adolescent Health

Health History

Student's name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth / /
----------------	--	---------------------------

Family Health History Please list allergies, heart problems, diabetes, cancer or other serious health conditions.

Father
Mother
Brothers and Sisters

Birth and Developmental History No unusual birth or developmental history

Did the mother have any unusual physical or emotional illness during this pregnancy?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Was infant born full term? Yes No	Did the infant have any sickness or problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Briefly explain illness or problems. _____		
How does the child's development compare to other children, such as his or her brothers/sisters or playmates? About the same Delayed Advanced		

Student Health Conditions

<input type="checkbox"/> YES , my child receives regular medical/health care for the following conditions: <input type="checkbox"/> NO medical conditions		
<input type="checkbox"/> Allergies <input type="checkbox"/> Asthma <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Autism <input type="checkbox"/> Behavior concerns <input type="checkbox"/> Birth/congenital malformations <input type="checkbox"/> Bone/muscle/joint problems <input type="checkbox"/> Blood problems <input type="checkbox"/> Bowel/bladder problems <input type="checkbox"/> Cancer <input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> Diabetes <input type="checkbox"/> Depression <input type="checkbox"/> Ear problem/hearing difficulty <input type="checkbox"/> Emotional concerns <input type="checkbox"/> Headaches <input type="checkbox"/> Heart problems <input type="checkbox"/> Hemophilia <input type="checkbox"/> Juvenile arthritis <input type="checkbox"/> Lead poisoning <input type="checkbox"/> Migraines <input type="checkbox"/> Neuromuscular disorder	<input type="checkbox"/> Seizure disorder <input type="checkbox"/> Sickle cell anemia <input type="checkbox"/> Skin conditions <input type="checkbox"/> Speech problems <input type="checkbox"/> Traumatic brain injury <input type="checkbox"/> Vision problems (glasses, contacts) <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____
Please explain any conditions above or any reasons for hospitalizations. _____		
Please indicate any allergies your child may have.		
Allergy type	Reaction	School restrictions or recommended actions
<input type="checkbox"/> Bee/Insect		
<input type="checkbox"/> Food		
<input type="checkbox"/> Medication		
<input type="checkbox"/> Other		

Health History continued

Please list any prescription and over the counter medication that your child takes on a regular basis.		
Medication and dose	Time	Reason
Do any health and/or medical conditions require school restrictions, modifications, and/or intervention? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please explain.		
Does the student require any special procedures and/or treatments for their health condition(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please explain.		
Please indicate any other information about your child's health or development that you think would be helpful for the school to know.		
Form completed by	Relationship to student	Date / /

WELLINGTON EXEMPTED VILLAGE SCHOOL DISTRICT

Student Services Department
627 North Main Street
Wellington, Ohio 44090-1315
Office: 440-647-7934
Fax: 440-647-7444

Date of Meeting

To the Parent(s) or Guardian(s) of:

Student's First and Last Name

State Law (Ohio Revised Code Section 3323.19) requires a student to have a Comprehensive Eye Examination either prior to or shortly after the start of an individualized education program (IEP). The comprehensive eye exam needs to be performed either by a licensed optometrist or ophthalmologist. If such an examination has been completed for your child within nine months prior to the initial eligibility determination, that exam will meet the requirement. The law further specifies that the parent, not the school district, has full financial responsibility for this examination.

The requirement as defined has been very confusing for parents whose children have just completed a comprehensive multi-factored evaluation. Please understand there is no "consequence" for not completing the eye exam. The special education services to which your child is entitled under his/her IEP will not be withheld, delayed or denied pending completion of the eye examination.

Please feel free to direct any questions to our Director of Student Services at 440-647-7907.

Sincerely,

Daniel Rahm
Director of Student Services
Wellington Exempted Village School District

Eye Specialist Report

(* Return completed report to school health clinic or nurse)

School Screening Information

Child's Name:	Date of Birth:	Date of Referral:
School:	Grade:	
Reason for referral (Test failed or type of symptoms):		
<input type="checkbox"/> Failed Observation <input type="checkbox"/> Failed Distance Visual Acuity: <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Failed Stereopsis <input type="checkbox"/> Unable to screen Circle option selected (Sloan Chart, LEA Symbols Chart 5 or 10 feet, JAEB Screener JVAS) (PASS 2 or Random Dot E)		
Electronic screening:		
without glasses (WA SureSight® / Retinomax)	With glasses (WA SureSight® / Retinomax)	
R_____ L_____	R_____ L_____	

Eye Specialist Findings

Date of Exam: _____	without correction	with current prescription	with new prescription
<input type="checkbox"/> Normal	R_____ L_____	R_____ L_____	R_____ L_____
Summary of vision problem & diagnosis			
<input type="checkbox"/> Hyperopia: Indicate eye? _____		<input type="checkbox"/> Myopia: Indicate eye? _____	
<input type="checkbox"/> Amblyopia: Indicate eye? _____		<input type="checkbox"/> Strabismus: Indicate eye? _____	
<input type="checkbox"/> Esotropia: Indicate eye? _____		<input type="checkbox"/> Astigmatism: Indicate eye? _____	
<input type="checkbox"/> Exotropia: Indicate eye? _____			
<input type="checkbox"/> Other: Explain _____			
Recommendations & Treatment			
Glasses Prescribed: <input type="checkbox"/> No <input type="checkbox"/> Yes ➡ <input type="checkbox"/> Constant Wear <input type="checkbox"/> Near vision only <input type="checkbox"/> Far vision only <input type="checkbox"/> May remove for physical education			
<input type="checkbox"/> Medical/surgical treatment (e.g., patching, Atropine drops, etc.): _____			
<input type="checkbox"/> Contact Lenses _____			
Additional instructions for teachers			
Upon completion of any needed eye care treatment, I expect there will be:			
<input type="checkbox"/> No significant visual problem that may interfere with learning.			
<input type="checkbox"/> Visual problem that may interfere with learning. Explain (see below): _____			
* <input type="checkbox"/> Preferential seating needed <input type="checkbox"/> Visual aids <input type="checkbox"/> Magnifiers <input type="checkbox"/> Assistive technology <input type="checkbox"/> Lighting conditions <input type="checkbox"/> Other: _____			
Is further treatment necessary? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, specify _____			
Do you wish to see this child again? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, specify _____			

Consent of Parent or Guardian

I agree to release the above information on my child or ward to appropriate school or health authorities.

Parent or Guardian Signature_____
DateSend completed report by medical professional to:
(Place school name, address, fax #, etc. here.)_____
Eye Specialist Signature_____
Date_____
Address_____
City_____
State_____
Zip_____
Phone Number

WELLINGTON EXEMPTED VILLAGE SCHOOL DISTRICT

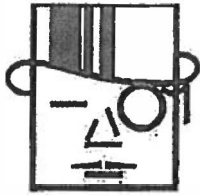
Student Services Department
627 North Main Street
Wellington, Ohio 44090-1315
Office: 440-647-7934
Fax: 440-647-7447

Student Name: _____

Does your child currently receive or has he/she ever received Special Education services?

Yes No Unsure

Parent/Guardian Signature: _____ Date: _____



WELLINGTON EXEMPTED VILLAGE SCHOOL DISTRICT
305 Union Street
Wellington, Ohio 44090

Date _____

Release of Educational Information

To: _____

Attn: _____

Address/Fax/Email: _____

Requesting student information for:

Name: _____
Last First Middle Grade Date of Birth

Please forward the following records:

- _____ State Student ID# (SSID) _____
- _____ Transcript
- _____ Most recent grade card and/or progress report
- _____ Withdrawal grades if student left during school year (% and letter grade)
- _____ Attendance (complete with excused and unexcused days/totals)
- _____ Copy of current schedule
- _____ Immunization/Health records
- _____ Birth certificate
- _____ Social Security Card
- _____ State Testing Scores and other standardized test scores
- _____ Custody papers, if applicable
- _____ IEP/ETR

Release: I hereby give my permission for the release of complete educational information.

Student Signature (if over 18 years of age)

Parent/Guardian Signature

Please forward records to:

☐ Wellington High School
Dawn Wyman – Guid. Secretary
629 North Main St.
Wellington, OH 44090
P – 440-647-7404
F – 440-647-7318

dwyman@wellingtonvillageschools.org

☐ McCormick Middle School
Deb Kimmich – Secretary
627 North Main Street
Wellington, OH 44090
P – 440-647-2342
F – 440-647-7310

dkimmich@wellingtonvillageschools.org

☐ Westwood Elementary School
Jen McCloskey - Secretary
305 Union Street
Wellington, OH 44090
P – 440-647-3636
F – 440-647-1089

jmcloskey@wellingtonvillageschools.org

WELLINGTON EXEMPTED VILLAGE SCHOOL DISTRICT

Student Services Department McCormick Middle School
627 North Main Street
Wellington, Ohio 44090-1315
Office: 440-647-7934
Fax: 440-647-7447

Nancy Nimmo
Director of Student Services
nnimmo@wellingtonvillageschools.org

Special Education Notices to Families

Below is a list of information for students of Wellington and their families of some extra services that are available to students and families in the district.

- **Parent Mentors:**

Family support services are available through Lorain County Educational Services Center. The county offers parent mentor services with staff certified specifically in the area of special education. For more information you can contact the Lorain County Educational Service Center at 440-324-3178 or via the LCESC website at www.loraincountyesc.org.

- **Autism and John Peterson Scholarship Programs:**

Your child may be eligible for a scholarship under the Autism Scholarship Program or the John Peterson Special Needs Scholarship Program to attend special education programs that implement the child's individualized education program and that is operated by an alternative public provider or by a registered private provider. Information on scholarship programs can be found on the Ohio Department of Education (ODE) website at: www.education.ohio.gov.

- **Transition Planning:**

Beginning at age 14, there is now a requirement that your child's Individualized Education Plan include a plan for successful adult living rather than just a statement. Areas addressed in this plan will include education beyond high school, employment, and independent living when appropriate. For additional information on transition plans, contact Wellington Student Services Department office at: 440-647-7934.

- **Child Find:**

Wellington Exempted Village School District can provide information about educational programs and services for children with special needs. For additional information you can contact the Wellington Student Services Department at: 440-647-7934

By signing below I acknowledge that I have received the information above:

Parent/Guardian Signature

Date

**For Students with Disabilities and their Parents:
A Comparison of Rights Under IDEA and Chapter 3323
to the Jon Peterson Special Needs Scholarship Program**

November, 2011

IDEA and Chapter 3323	Peterson Scholarship Program
<p>A public school district must provide a Free Appropriate Public Education (FAPE) to students with disabilities. A Free Appropriate Public Education includes special education and related services that:</p> <ul style="list-style-type: none"> • Are provided at no cost; • Meet the standards of the Ohio Department of Education; • Include an appropriate preschool, elementary, or secondary school education; and • Are provided in conformity with an IEP that meets Ohio's standards for IEPs. <p>Special education is specially designed instruction to meet the needs of a child with a disability.</p> <p>Examples of related services include transportation, speech-language pathology services, audiology services, interpreting services, physical and occupational therapy, recreation, and counseling services.</p>	<p>A child who participates in the Jon Peterson Scholarship Program is a unilaterally privately placed student, and is not entitled to FAPE.</p>
<p>A FAPE must be provided at no cost to the parents.</p>	<p>A participating student receives a scholarship of up to \$20,000 to pay for a special education program at a registered private provider or alternative public provider. If the program costs more than the scholarship, the parents are responsible.</p>
<p>A public school district is required to EVALUATE students with suspected disabilities, including students who attend private programs within the district.</p>	<p>A public school district is required to EVALUATE students with suspected disabilities, including students who attend private programs within the district.</p>
<p>A public school district prepares an initial IEP once a student has been determined eligible under IDEA.</p>	<p>A public school district prepares an initial IEP once a student has been determined eligible under IDEA. A student is not eligible for a scholarship until the</p>