



PORTER CONSOLIDATED SCHOOLS
P. O. BOX 120 ~ PORTER, OKLAHOMA 74454
Elementary Principal: Chris Sherwood
E-mail: csherwood@porter.k12.ok.us
Telephone 918-483-5231 Fax 918-483-2310



Dear Parents,

We are happy to admit your child to our Pre-Kindergarten. We know the experiences and learnings he/she will receive will give him/her a good start on his/her school career.

During the summer, try to acquaint your child with the idea of being away from you for progressively longer periods of time.

SCREENING

In order to enroll your child in Pre-Kindergarten, we will hold a Screening day on April 11. On this day your child will receive a visual, hearing and a developmental screening. Parents should bring their child to the lower elementary brick building at their scheduled appointment time. Attached you will find enrollment papers. Please, bring these forms, filled out, with you to your child's screening. A birth certificate and immunization record are required for pre-enrollment. A CDIB card is required for children of Native American descent.

IMMUNIZATIONS

The following immunizations are required for children entering Pre-Kindergarten.

- 4 doses of DTP
- 3 doses of Polio
- 1 dose of MMR
- 3 doses of Hep B
- 2 doses of Hep A
- 1 dose of Varicella

PRE-KINDERGARTEN SCHEDULE

Pre-Kindergarten will begin in August. Several days prior to the opening of school, letters will be sent indicating your child's Pre-Kindergarten teacher. Porter Elementary's Pre-Kindergarten is a full day program. School begins at 7:45a.m. and dismisses at 3:00 p.m. Students that do not appear for class by the third day of school may lose their place in the program, unless a parent or guardian has contacted the school and made arrangements to start at a later date.

PORTER CONSOLIDATED SCHOOLS

P. O. BOX 120
Porter, Oklahoma 74454

Charles McMahan, Superintendent
(918) 483-2401

Chris Sherwood, Elementary Principal
(918) 483-5231

PERMISSION FOR EVALUATION FORM TO
GIVE PUPIL INDIVIDUAL TESTS

Name of Student _____ School _____
Grade _____ Teacher _____ Birthdate _____ Age _____

Dear Parents:

We request your permission to give _____ the individualized visual and auditory test to determine if they have any difficulties in these areas, and the Oklahoma Proficiency to determine your child's appropriate grade level.

Chris Sherwood
Elementary Principal

Please sign below:

_____ has my permission to take the tests referred to above.

Date

Signature of Parent or Guardian

Telephone

Address

Pre-K Student Enrollment Information
Porter Consolidated School
School Year 2019-2020

Student's legal name _____ / _____
(As shown on birth certificate)(Legal Last) (First) (Middle) (Nickname) (Last name if different from legal)

Grade: _____ Bus No. _____ Gender: ___M___F Birthdate _____ Place of birth _____

Physical address _____ City _____ Zip _____ County _____

Mailing address _____ City _____ Zip _____ County _____

Parent/Guardian home phone _____ Who has legal custody? _____

Student Social Security # _____ Parent/Guardian's E-Mail _____

Ethnic Origin (circle one) Alaskan or American Indian White or Other Hispanic Black Asian or Pacific Island

Name and address of last school attended _____

Is a language other than English spoken in your home? ___Yes___No What language? _____

If yes, (please check one): This language is spoken: ___More often than English___ ___Less often than English___

Name(s) & grades of other children currently in Porter Consolidated Schools _____

Student resides with: Mother/Father Mother Father Mother/Step Father Father/Step Mother Grandparent Other

Parent/Guardian 1 _____ Relationship _____
(Residing in the home) Last First Middle

Employer _____ Work Phone _____ Cell Phone _____

Parent/Guardian 2 _____ Relationship _____

Employer _____ Work Phone _____ Cell Phone _____

Emergency Contact _____ Relationship _____ Daytime Phone _____

Is this person allowed to pick up your child in the event you can not be reached? ___Yes___ ___No___

Does this person reside in the same house with you? ___Yes___ ___No___

Emergency Contact _____ Relationship _____ Daytime Phone _____

Is this person allowed to pick up your child in the event you can not be reached? ___Yes___ ___No___

Does this person reside in the same house with you? ___Yes___ ___No___

Name of physician _____ Phone _____

In case of serious accident or illness when guardian cannot be contacted, do we have permission to take your child to a doctor or hospital? ___Yes___ ___No___

Has student been in any kind of special needs class? ___Yes___ ___No___ If yes, please specify: _____

List any health problems _____

List any learning problems _____

Parent/Guardian Signature _____ Date _____

Pre-K Pre-enrollment
Porter Consolidated School

- My child will receive screenings at the school including, but not limited to, height/weight, visual acuity, hearing, speech, mental health assessment, and any other test deemed necessary.
- My child shall receive personal safety information as part of their curriculum.
- I also understand that the school is required by Oklahoma Law to report injuries or behavior which may be suspicious of child abuse or neglect to DHS. It is our goal to work with families to provide safety to all our children.
- If my child is to be absent, I will contact the school and I will keep all emergency numbers current and on file at the school.
- My child has my permission to accompany the school on field trips. I will be notified ahead of time of any trips away from the school.
- My child will be introduced to computers with access to the internet. The school has a block installed to websites children should not have access to.
- My child may be photographed and/or videotaped by the school.

Photographed: Please circle one. YES or NO

Permission to use name and/or photograph on school web page. YES NO

Parts of the discipline policy incorporate corporal punishment. Corporal punishment consists of paddling. This will be administered by the policy.

_____ I will support the discipline policy of corporal punishment.

_____ I disagree with corporal punishment and do not want my child to receive swats. I will be notified and will pick up my child at school and suspension will be evoked.

Child's Name

Parent/Guardian's Name

Date

This agreement is valid for one year from the date signed by the parent/guardian.

Information shared with Porter Consolidated Staff will be kept strictly confidential unless its release is authorized in writing. These forms will be maintained in locked files.

_____ Initials

Porter Consolidated Schools

Residency Form

This form is intended to address the requirements of the McKinney-Ventro Act (Title X, Part C of the No Child Left Behind Act). The questions below will assist in determining if the student meets the eligibility criteria for services provided under the McKinney-Ventro Act.

School: _____

Name of Student: _____ Male Female

Birth Date: _____ Age: _____ Grade: _____
Month/Day/Year

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Name of Parent(s)/Legal Guardian(s) or person acting as Guardian: _____

Check one: Parent Legal Guardian Acting as Guardian Other

Signature of person checked above: _____

Is the student currently sharing housing? Yes: _____ No: _____
 If checked yes, please complete #1 and #2

(1.) Presently, where is the student living? Check all that apply:

<input type="checkbox"/> in a shelter	<input type="checkbox"/> in foster care
<input type="checkbox"/> with relatives or other due to lack of housing	<input type="checkbox"/> in a motel, car or campsite
<input type="checkbox"/> with more than one family in a house or apartment	<input type="checkbox"/> youth not living with parent/guardian
<input type="checkbox"/> with friends or family member (other than parent)	<input type="checkbox"/> in an abandoned building

(2.) The student lives with:

<input type="checkbox"/> 1 parent	<input type="checkbox"/> a relative, friend(s) or other adult(s)
<input type="checkbox"/> 2 parents	<input type="checkbox"/> alone with no adults
<input type="checkbox"/> 1 parent & another adult	<input type="checkbox"/> an adult that is not the parent or legal guardian

If the student has siblings attending Porter Consolidated Schools, please write their name(s), age(s), and grade level(s) on the line(s) below.

Name: _____ Age: _____ Grade: _____

Name: _____ Age: _____ Grade: _____

Name: _____ Age: _____ Grade: _____

Pre-Kindergarten/Head Start Pre-Enrollment
Public School
2019-2020

Child: _____ Birthdate: _____ Social Security No. _____
Address: _____ Phone: _____

Parent/Guardian #1: Name: _____ Birthdate: _____
Social Security #: _____
Lives with family? Y N Provide Financial Support? Y N Employment status: F P U
Highest grade completed? _____ Teen Parent? Y N

Parent/Guardian #1: Name: _____ Birthdate: _____
Social Security #: _____
Lives with family? Y N Provide Financial Support? Y N Employment status: F P U
Highest grade completed? _____ Teen Parent? Y N

Anyone Disabled? Y N Rent?/Own? Veteran? Y N Citizen? Y N

Other Adults in the home: Relationship to child: _____

Name: _____ Birthdate: _____ Social Security #: _____

Other children in the home:

Name: _____ Birthdate: _____ S.S. #: _____ Gender: M F

Name: _____ Birthdate: _____ S.S. #: _____ Gender: M F

Name: _____ Birthdate: _____ S.S. #: _____ Gender: M F

Name: _____ Birthdate: _____ S.S. #: _____ Gender: M F

Medicaid Eligibility: On? Y N Eligible? Y N Potentially Eligible? Y N
Health insurance/Medicaid number: _____

Food Stamps? Y N Number: _____

TANF: Y N SSI: Y N WIC: Y N Number: _____

Are all contact ok to release to? Y N

Child's Doctor: _____ Phone: _____

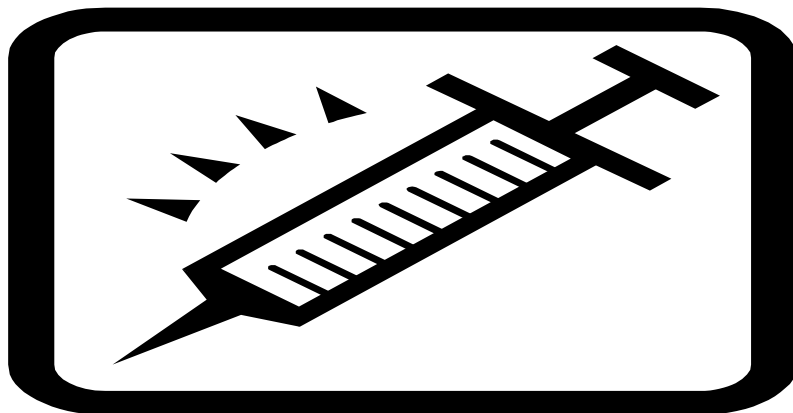
Child's Dentist: _____ Phone: _____

Parent Signature _____ Date _____

IMMUNIZATIONS

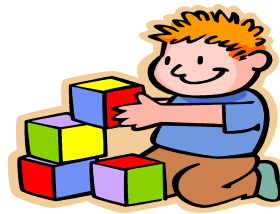
Before a child can enter Pre-School, he/she must have an up-to-date immunization record on file with the school. The following is a list of the current immunization requirements for the fall 2019-2020 school year.

- 4 doses of Diphtheria, Tetanus, and Pertussis
- 3 doses of oral Polio
- 1 doses of Measles, Mumps, and Rubella
- 3 doses of Hepatitis B vaccine
- 2 doses of Hepatitis A vaccine
- 1 dose of Varicella



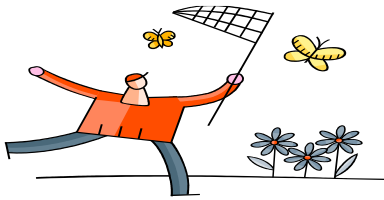
Just Playing

When I'm building in the block room,
Please don't say I'm "Just Playing".
For, you see, I'm learning as I play,
About balance and shapes.
Who knows, I may be an architect someday.



When I'm getting all dressed up,
Setting the table, caring for the babies,
Don't get the idea I'm "Just playing".
I may be a mother or father someday.

When you see me up to my elbows in paint,
Or standing at an easel, or molding and shaping clay,
Please don't let me hear you say, He is "Just Playing".
For, you see, I'm learning as I play.
I'm expressing myself and being creative.
I may an artist or an inventor someday.



When you see me combing the bushes for bugs,
Or packing my pockets with choice things I find,
Don't pass it off as "Just playing".
For, you see, I'm learning as I play.
I may be a scientist someday.

When you see me engrossed in a puzzle or some "plaything" at school,
Please don't feel the time is wasted in "Play".
For you see, I'm learning as I play.
I'm learning to solve problems and concentrate.
I may be in business someday.



When you see me learning to skip, hop, run, and
move my body,
Please don't say I'm "Just Playing".
For you see, I'm learning as I play.
I'm learning how my body works.
I may be a doctor, nurse or athlete someday.

When you ask me what I've done at school today,
And I say, "Just Played".
Please don't misunderstand me.
For, you see, I'm learning as I play.
I'm learning to enjoy and be successful in my work.
I'm preparing for tomorrow.
Today, I am a child, and my work is play.



PARENT QUESTIONNAIRE

Child's Name _____ Birthdate _____ Age _____ Sex _____
 Parent(s)/Guardian(s) _____ Home Phone _____
 _____ Work Phone _____
 Address _____
 Person completing form _____ Relationship to child _____

In an effort to become knowledgeable about and better acquainted with your child, the teacher would appreciate knowing the information requested below. The information is confidential and only used to help plan an appropriate educational program for your child. If for some reason you are unable to answer a question or do not wish to provide the information please leave it blank.

Family Information

Child lives with: _____ Father _____ Mother _____ Both _____ Other
 How many other children in the family? _____ Older _____ Younger
 Other adults living in the household? _____
 What language(s) other than English are spoken in the home? _____

Previous Group Experience

Please indicate any group experiences your child has had, how often attended and for how long.

_____	Preschool	_____	Sunday School
_____	Mother's Day Out	_____	Head Start
_____	Day Care	_____	Other

Describe what your child liked best about the program.

Describe what your child liked least about the program.

Your child's teacher in the other program. _____

Do we have permission to contact the person for further information about your child's experience in that program? _____ Yes _____ No

Parent/Guardian Signature _____

Medical History

Was your child premature Yes No

Were there any complications or concerns at birth
If yes, please explain. Yes No

Has your child been hospitalized for any reason?
If yes, please explain. Yes No

Has your child had frequent Cold, Ear Infections, Tonsillitis, Stomach aches?

Does your child take medication regularly? Yes No
If yes, what medication?

Does your child have any allergies you are aware of? Yes No
 Hay Fever Asthma Food Other

Do you know the cause of allergy? Yes No

What, if any, childhood illnesses has your child had?
 Chicken Pox Measles Mumps Scarlet Fever Diabetes Hepatitis

Does your child have any sleeping problems you are aware of? Yes No

Does your child have any eye or vision problems you are aware of? Yes No

Does your child sit close to the television screen? Yes No

Does your child hold pictures very close? Yes No

Has your child had an eye exam? Yes No

Does your child have any hearing problems you are aware of? Yes No

Does your child often repeat sounds or words? Yes No

Does your child turn the radio, recorder or television at a high volume? Yes No

Does your child say, "What?" frequently? Yes No

Does your child speak louder than most children? Yes No

Has your child had a hearing exam? Yes No

Developmental Information

Approximate age your child began walking _____

Approximate age your child began saying words _____

Is your child's speech usually understood by others? Yes No

Is your child hesitant or afraid to speak? Yes No

Does your child tell others his or her own first and last name? Yes No

Does your child dress his or herself? Yes No

Does your child take care of toileting needs? Yes No

Does your child wash his or her hands? Yes No

Does your child separate from parent(s) without undue stress? Yes No

Is your child easily upset? Yes No

Does your child have frequent temper tantrums? Yes No

Does your child play with other children his or her age? Yes No

Is your child able to share objects with others for a short time? Yes No

Does your child understand acceptable and unacceptable behavior? Yes No

Does your child usually follow simple instructions? Yes No

Does your child have any fears? Yes No

Can your child ask for help when needed? Yes No

Please feel free to share any other information you feel would be helpful as we plan a successful school experience for your child.

Porter Elementary School

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION DURING SCHOOL DAY

Dear Parent or Guardian:

Medication will be given to a student only with the written permission of the student's parent or person having legal custody. Prescription medicine must be in a currently dated prescription vial or properly labeled container which currently states the name of the patient, the name of the physician, dosage, and directions for administering the medication including date and time. Non-prescription (OTC) medicines must be in properly labeled containers with written authorization and instructions for administration.

Oklahoma law provides that the school nurse, administration or other designated school employee shall not be liable to the student or parent or guardian of the student for civil damages for any personal injuries to the student which result from acts of omissions of the school nurse, administrator or other designated school employee in administering any medicine pursuant to the provisions of the law except for acts or omissions constituting gross, willful or wanton negligence.

TO BE COMPLETED BY PARENT OR GUARDIAN

School Year _____

I request the school nurse, a school administrator or other designated school employee, to administer the following medication to my child.

Student's Name _____ Birth Date _____

Home Address _____ Telephone _____

School _____ Grade _____

Name of Medication _____

Purpose of Medication _____

Possible Side Effects _____

Dosage: Amount to be given _____ Time to be given _____

Dates Medicine if to be given _____

Parent's Signature _____ Date _____

Relationship _____

Pre-Kindergarten
Porter Elementary
2019-2020
Supply List

- Backpack (large enough to carry folder)
- Zipper CLEAR Pencil Pouch for binder
- 1 - 1 inch 3 ring HARD binder with pockets
- 1 box of JUMBO Crayola crayons (please no Rose Art)
- 1 roll of paper towels
- 4 boxes of 24 count Crayola Crayons
- 1 box of broad tip Crayola markers (please no Rose Art)
- 1 box of Kleenex
- 1 bottle of Elmer's Glue
- 1 box of Play Dough (please no Rose Art)
- 1 roll of paper towels
- 1 bottle of hand sanitizer
- 1 box of Zip Lock sandwich bags
- 1 container of Clorox Wipes
- 1 container of baby wipes

INFORMATION SHEET

PRIMARY ADULT

(Name)

(Home Phone and Cell Phone Number)

(Social Security Number)

(Income)

U.S. Citizen Yes ___ No ___

Disabled Yes ___ No ___

Home: Own ___ Rent ___ Shelter ___ Homeless ___ Other ___

ADULT #2

(Name)

(Home Phone and Cell Phone Number)

(Social Security Number)

(Income)

U.S. Citizen Yes ___ No ___

Disabled Yes ___ No ___

Food Stamps Yes ___ No ___

CHILD #1

(Name)

(Home Phone and Cell Phone Number)

(Social Security Number)

(Income)

U.S. Citizen Yes ___ No ___

Disabled Yes ___ No ___

CHILD #2

(Name)

(Home Phone and Cell Phone Number)

(Social Security Number)

(Income)

U.S. Citizen Yes ___ No ___

Disabled Yes ___ No ___

CHILD #3

(Name)

(Home Phone and Cell Phone Number)

(Social Security Number)

(Income)

U.S. Citizen Yes ___ No ___

Disabled Yes ___ No ___

CHILD #4

(Name)

(Home Phone and Cell Phone Number)

(Social Security Number)

(Income)

U.S. Citizen Yes ___ No ___

Disabled Yes ___ No ___

CHILD #5

(Name)

(Home Phone and Cell Phone Number)

(Social Security Number)

(Income)

U.S. Citizen Yes ___ No ___

Disabled Yes ___ No ___

CHILD #6

(Name)

(Home Phone and Cell Phone Number)

(Social Security Number)

(Income)

U.S. Citizen Yes ___ No ___

Disabled Yes ___ No ___

Initial Enrollment Prior Participation Form Student Information

The following information should be completed by the parent or guardian of the student. This information is collected on a student's initial enrollment into a school district. Please print legibly.

Student Legal Name: _____
First Last

Student Date of Birth: _____
Month Day Year

Student Gender – Please Circle one: Male Female

Did the student participate in any of the following programs? Please indicate by checking YES or NO for each statement.

PROGRAM	YES	NO
A childcare program that is licensed pursuant to the tiered licensing system established by the Department of Human Services (a DHS licensed childcare program)		
The Sooner Start program operated by the State department of Education		
The Oklahoma Parents as Teachers (OPAT) program operated by the state department of Education		
The Children First program operated by the State Department of Health		
Any child abuse prevention program operated by the State department of Health		
Any federally funded Head Start program		

AUTHORIZATION FOR EMERGENCY CARE TO MINORS

I/We the undersigned, parent(s) or legal guardian of the minor(s) listed below:

_____ /_/_/____ (Minor's name) Birthdate _____ /_/_/____ (Minor's name) Birthdate

_____ /_/_/____ (Minor's name) Birthdate _____ /_/_/____ (Minor's name) Birthdate

Do hereby authorize treatment and transportation to the nearest hospital by Muskogee County Emergency Medical Services rendered to said minor(s) under the general, specific or special consent of:

(Name of adult person(s) or school who is temporary custodian of minor)

It is understood that this authorization is given in advance of any specific diagnosis or treatment being required, but is given to encourage those who have temporary custody of the minor to exercise their best judgment as to the requirements of such medical treatment and ambulance transportation. This authorization also will allow the above designated person(s) or school to withdraw their consent for medical treatment and/or transport via ambulance should the above designated determine in their opinion the services of Muskogee County EMS/other EMS agency are not needed. This authorization shall remain in effect unless revoked in writing and delivered to said person or school entrusted with the custody, care and control of said minor child or children.

Father	Date	Mother	Date
Legal Guardian	Date	Witness (non-custodian)	Date