WELCOME TO

THREE RIVERS ELEMENTARY

2023 -2024 REGISTRATION

THREE RIVERS USES AN ONLINE REGISTRATION PROCESS.

WWW.TAYLOR-OH.FINALFORMS.COM/STUDENTS

This packet includes all the forms that need to be completed in order for your child to be enrolled for the 2023 – 2024 school year. In addition to this packet, parents/guardians are required to present their photo ID, custody documentation (if applicable) and the student's original birth certificate.

When all online and paper forms are completed, please call our school office @ (513) 467-3210 to schedule an appointment to enroll your child.

Three Rivers Elementary
Kindergarten Enrollment Checklist
2023 - 2024

****ALL ONLINE FORMS AND ALL OTHER REQUIRED DOCUMENTS MUST BE RECEIVED BEFORE A STUDENT IS ELIGIBLE FOR ENROLLMENT**

Student Name: _____

Grade: _____

Student ID: _____

- **___ Final Forms Completed**
  Yes ___ No ___
- **___ Original Birth Certificate**
- **___ Parent Photo ID**
- **___ Custody Documents – if applicable**
- **___ Affidavit of Current Residence – will need to be notarized**
- **___ Affidavit of Landlord (if renting or currently in residence not owned) – will need to be notarized**
- **___ Affidavit of Prior Residence (if residence has changed in the last 12 months) – will need to be notarized**
- **___ Proof of Residence – utility bill, tax bill, lease/rental agreement with name and current address**
- **___ Immunization Record**
- **___ Health History**

THREE RIVERS LOCAL SCHOOL DISTRICT

Dr. Mark Ault, Superintendent 401 N. Miami Avneue • Cleves, Ohio 45002
513-941-6400 Fax 513-941-1102

AFFIDAVIT OF CURRENT RESIDENCY

(Must be signed by parent and submitted to registrar with parent's photo ID)

****NOTICE****

In accordance with the Ohio Revised Code as noted below, submitting a false statement on this form for the purpose of enrolling a child without tuition is a criminal offense ***and may be punishable as a felony*** according to the amount of tuition owed.

ORC 2913.02 Theft by Deception
ORC 2921.13 Falsification

Student name: _____

Parent name(s): _____

Parent current home address: _____
Street Address

_____
City, State, Zip

Parent contact numbers: _____
Home phone Cell phone

Please mark the following statements as True or False:

TRUE	FALSE	
_____	_____	The above address is where I eat and sleep overnight a majority of the time.
_____	_____	The above address is where my child(ren) eat and sleep overnight a majority of the time.
_____	_____	The above address is the center of our family activities and recreation time.
_____	_____	There is no other address where my child(ren) sleep overnight on a regular basis.

TRUE	FALSE	
_____	_____	I do not rent or lease a house, condominium or apartment outside the Three Rivers Local School District.
_____	_____	I am not provided with living space outside the Three Rivers Local School District by a friend, relative or government agency.

If you marked "False" on any of the previous statements, please explain below:

I, hereby, swear or affirm that all of the above information is true to the best of my knowledge and belief.

_____
Parent Signature

STATE OF OHIO)
S.S.
COUNTY OF HAMILTON)

Subscribed and sworn to before me, a Notary Public, on the _____ day of _____, 2 _____.

_____
Notary Public

_____ Date Commission Expires

THREE RIVERS LOCAL SCHOOL DISTRICT

Dr. Mark Ault, Superintendent 401 N. Miami Avenue • Cleves, Ohio 45002
513-941-6400 Fax 513-941-1102

AFFIDAVIT OF PRIOR RESIDENCY (PARENT)

****NOTICE****

In accordance with the Ohio Revised Code as noted below, submitting a false statement on this form for the purpose of enrolling a child without tuition is a criminal offense ***and may be punishable as a felony*** according to the amount of tuition owed.

ORC 2913.02 Theft by Deception
ORC 2921.13 Falsification

Student name: _____

My prior residence was as follows:

_____ _____
Street Address City, State, Zip

I , _____, no longer live at the above listed residence.
Parent Name

I moved from that residence on _____.
Date

I, hereby, swear or affirm that all of the above information is true to the best of my knowledge and belief.

_____
Parent Signature

STATE OF OHIO)
S.S.
COUNTY OF HAMILTON)

Subscribed and sworn to before me, a Notary Public, on the _____ day of _____, 2 _____.

_____
Notary Public

_____
Date Commission Expires

THREE RIVERS LOCAL SCHOOL DISTRICT

Dr. Mark Ault, Superintendent
401 N. Miami Avenue ▯Cleves, Ohio 45002
mault@trlsd.org
513-941-6400 Fax 513-941-1102

AFFIDAVIT OF LANDLORD

****NOTICE****

In accordance with the Ohio Revised Code as noted below, submitting a false statement on this form for the purpose of enrolling a child without tuition is a criminal offense ***and may be punishable as a felony*** according to the amount of tuition owed.

ORC 2913.02 Theft by Deception
ORC 2921.13 Falsification

Landlord must attach copy of current mortgage agreement, deed, or most recent property tax bill (with address listed) for landlord's property. Financial information is not necessary. Hamilton County Auditor website printouts are not acceptable.

I, _____, am the owner of the residential property located at

_____ _____.
Street Address City, State, Zip

My contact numbers are: _____ _____.
Home number Cell Number

I (we) also swear that the following is a true and accurate list of the persons (adults and children) who rent space from me (us) or are living free of charge at the above address:

_____ _____
_____ _____
_____ _____
_____ _____

I, hereby, swear or affirm that all of the above information is true to the best of my knowledge and belief.

_____
Landlord Signature

STATE OF OHIO)
S.S.
COUNTY OF HAMILTON)

Subscribed and sworn to before me, a Notary Public, on the _____ day of _____, 2 _____.

_____
Notary Public

_____
Date Commission Expires

OHIO SCHOOL HEALTH HISTORY

Instructions:

1. A parent or guardian must complete pages 1-3.

2. A physician must fill out and sign pages 4-5.

3. The oral assessment on page 6 is optional, but highly recommended.

4. Please document on the health history form and inform the health aide if your child has any health problems, allergies, or will be taking medication at school. If your child has an allergy, please have your physician document the prescribed treatment on the Physical Assessment form or appropriate medication form. Please inform the health aide if your child takes medication at home.

5. Vision and Hearing Screenings of Kindergarten students will be done next fall. Parents will be notified by a written referral if your child will need further medical evaluation.

If you have any questions, please contact the health aide at 467-3210 or 824-7549.

Thank you.

Immunization records for Kindergarten must include the following:

-DPT (minimum of 4)-5 doses if 4th dose given prior to 4th birthday
-Polio Vaccine (minimum of 3)-4 doses if 3rd doses of either OPV or IPV given prior to 4th birthday
-MMR-2 doses required
-Hepatitis B-(3 shot series)-must show evidence of having received 1 3 dose series or proof that the Hepatitis B Series is in progress.
-Varicella-(Chickenpox vaccine)-2 doses required

Immunization Records for Pre-School must include the following:

-DPT-(minimum of 4)
-Polio Vaccine-(minimum of 3)
-MMR-1 dose required
-Hepatitis B-(3 shot series)
-Varicella-(Chickenpox vaccine)-1 dose required

Ohio School Health History

To be used for Pre-and Elementary School

School _____

Enrolled _____

Child's Name	Gender ☐ Male ☐ Female	Age	Birthdate

Name of child's parent/legal guardian/s? _____

Parent/Guardian address _____

Home Phone number _____

Ethnicity

☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian American ☐ Other

Social Service History

Mark the box if you have contact with any of the following agencies:

☐ Child/Protective Services If yes, Case worker's name _____

☐ Legal/Court System

☐ Family Counseling Services

☐ Mental Health Provider

☐ Other: _____

Mark the box if you or your child receive any of the following medical assistance:

☐ SSI, Disability ☐ Healthy Start ☐ Insurance (Blue Cross/Blue Shield, HMO)

☐ LEAP ☐ Medicaid/CHIP ☐ Other

Family History

Please list the first and last name of all the child's family members including parents and siblings.

Name	Birthdate	Gender	Health Concerns	Is the child in school?	If so, where?

Perinatal History

Did the mother have any unusual physical or emotional illness during this pregnancy? ☐ Yes ☐ No

If yes, explain briefly _____

How old was the mother when the child was born? _____

What was the infant's birth weight? _____ lbs. _____ oz. ☐ Full term ☐ Early ☐ Late

Did the infant have any sickness or problems? ☐ Yes ☐ No

If yes, explain briefly _____

Developmental History

Please give the approximate age at which this child:

Walked alone _____ Spoke in sentences _____

Toilet trained _____ Dressed self _____

How does this child's development compare to other children, such as his/her siblings or playmates?

□ About the same □ Delayed □Advanced

Allergies

Please list and describe allergies and reactions

Medications/Drugs
Foods/plants/animals/other
Recommended treatment if allergy is severe

Injuries, Illnesses and Hospitalizations

Please list any severe injuries, illnesses and hospitalizations including inpatient and outpatient surgical procedures

Injuries/Illness/Hospitalizations	Age	If hospitalized, please explain

Does your child always wear a seatbelt while riding in automobiles? □ Yes □ No

Does the student wear a helmet when bicycling, skating/rollerblading or riding a motorcycle? □ Yes □ No

Medication Information

Please describe any medications that your child takes daily and/ or frequently.

Medication	What is the medication taken for?	How often is the medication taken? What time is the medication administered?

Health Conditions

Please check any medical conditions that the child currently has or has had in the past.

- ☐ Abnormal spinal curvature (Scoliosis)
- ☐ Allergies/hayfever
- ☐ Anemia
- ☐ Anaphylactic reaction
- ☐ Asthma or wheezing
- ☐ Attention deficit disorder (ADD)
- ☐ Behavior problem
- ☐ Birth or congenital malformation
- ☐ Cancer type_____
- ☐ Chickenpox when _____
- ☐ Chronic Diarrhea or constipation
- ☐ Chronic ear infections
- ☐ Concern about relation with siblings or friends
- ☐ Cystic Fibrosis
- ☐ Diabetes
- ☐ Eczema/Chronic skin conditions
- ☐ Emotional Problems
- ☐ Eye problems, poor vision
- ☐ Frequent headaches
- ☐ Frequent sore throats
- ☐ Heart disease type_____
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ HIV positive
- ☐ Hyperactivity
- ☐ Juvenile Arthritis
- ☐ Kidney disease type_____
- ☐ Measles (10 day)
- ☐ Meningitis or Encephalitis
- ☐ Mumps
- ☐ Mutism
- ☐ Near-drowning/Near-suffocation
- ☐ Nervous twitches or tics
- ☐ Poisoning
- ☐ Rheumatic fever
- ☐ Seizure disorder/Epilepsy
- ☐ Sickle Cell Disease
- ☐ Speech difficulties
- ☐ Stool soiling
- ☐ Toothaches or dental problems
- ☐ Tourette's Syndrome
- ☐ Urinary tract infections
- ☐ Wetting during the day or night

Behavioral History

The child is usually: ☐ very active ☐ normally active ☐ rather inactive

Has your child ever been violent or acted out in the following manner towards adults or children:

☐ hitting ☐ kicking ☐ biting ☐ fighting ☐ scratching

Do you have any concern about how your child gets along with other children?

_____

_____

Please add any comments or concerns you have about your child's health, development, behavior, family or home life that you would like the school to be aware of.

_____

_____

Is the student enrolled in a special education course? ☐ Yes ☐ No
If yes, please list _____

Verification completed by: _____ Date _____

Ohio School Health History

Physical Assessment

School _____

Enrolled _____

Child's Name	Gender	Age	Birthdate
	☐ Male ☐ Female		
Ethnicity ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian American ☐ Other			

Objective Data

Height	Weight	B.P.

Immunizations

Type	Date Mo/Day/Yr					
DTaP DPT or DT						5th dose required if 4th dose given before age 4
DT/Td						
POLIO					4th dose required if 3rd dose given before age 4	
MMR				2nd dose required for K		
HEPATITIS B				3 doses required for K		
VARICELLA			1 dose required for K			
HIB (prior to age 5 only)					0-14 months; 3-4 doses 15-59 months: 1 dose	
TUBERCULIN TEST						
ROTAVIRUS (given @ 2-4-6 mo, not after 12 months)						
OTHER						

Screening Tests

Vision Date	**Hearing** Date
Distance Acuity Right_____ Left_____	Pure tone testing:
Muscle Balance ☐Pass ☐Fail ☐Not Done	Right ear ☐Pass ☐Fail ☐Not Done
Farsightedness ☐Pass ☐Fail ☐Not Done	Left ear ☐Pass ☐Fail ☐Not Done
Color ☐Pass ☐Fail ☐Not Done	Child wears hearing aid? ☐Yes ☐No
Child wears glasses? ☐Yes ☐No	Testing with hearing aid? ☐Yes ☐No
Tested with glasses? ☐Yes ☐No	Referral made? ☐Yes ☐No
Referral made? ☐Yes ☐No	Other test (specify) _____
Specify Test/Equipment	

Speech Assessment Date

☐ Child has no discernible speech problem

☐ Child has possible problem with: ☐ Articulation ☐ Rhythm ☐ Voice ☐Language

Speech evaluation is recommended: ☐Yes ☐ No

Laboratory Tests

☐Hemoglobin/Hematocrit	☐Urine Protein	☐Urine blood	☐Urine glucose
☐Other _____			

Physical Examination

Date of Examination:_____

☐ This child is essentially within normal limits.

☐ This child is not within normal limits.
Explain:

Does this child have any physical, developmental or behavioral problems? Suggest special programs, placement or attention that the school can provide.

Activities & Limitations
Can the child participate fully in the following activities:

Classroom and academic activities	☐Yes	☐No
Physical education classes	☐Yes	☐No
Competitive athletics	☐Yes	☐No
Contact and collision sports	☐Yes	☐No

Specify any limitations:

Is this child on any medications? ☐Yes ☐No
Explain:

Examiner's Signature _____ Date Signed_____

Examiner's Printed Name _____

Address _____

_____

Phone _____

Ohio School Health History

Oral Assessment

School _____

Enrolled _____

Child's Name	Gender	Age	Birthdate
	☐ Male ☐ Female		

The following services have been performed:

☐ Examination by dentist
☐ Dental sealants
☐ Oral Prophylaxis (cleaning)
☐ Orthodontic assessment
☐ Radiographs
☐ Diagnosis
☐ Oral screening
☐ Fluoride Application
☐ Prescription for fluoride supplements

The following oral hygiene instruction was provided:

☐ Toothbrushing
☐ Flossing
☐ Diet counseling related to dental health
☐ Home/school use of fluoride mouthrinse

The following statements are applicable:

- ☐ No apparent care needed at this time.
- ☐ All necessary preventive services have been performed. (Fluoride treatment, prophylaxis)
- ☐ No restorative services are required at this time.
- ☐ Further treatment is indicated. (See comments)
- ☐ Further appointments have been arranged. (ex. Orthodontic, restorative)

Comments:

Examiner's Signature _____ Date Signed _____

Examiner's Printed Name _____

Address _____

_____

Phone _____