



Learners Today  
Leaders Tomorrow

## Laraway C.C.S.D. 70C REGISTRATION 2026 - 2027

Registration for the 2026-2027 school year will be done at Laraway School. All families must complete registration and prove residency in the main office. **All paperwork/residency documents must be returned at one time.**

- You must complete registration and prove residency in the main office on any of the following dates:  
**Monday, June 1<sup>st</sup> – Wednesday, June 3<sup>rd</sup> between 9a-2p.**  
**Thursday, June 4<sup>th</sup> between 10a-6p.**  
**Tuesday, August 4<sup>th</sup> – between 10a-6p.**
- If your name is **NOT** listed on the current lease or mortgage statement you are required to complete a "Third Party Affidavit" and have it notarized. The form is in this packet. Please remember you **MUST** sign the form in front of a notary.
- **New students must have a Birth Certificate and Health Records on file before registration is complete.**
- Your student will not be registered until registration papers and residency has been approved.

### IMPORTANT NOTES

- Only one parent/no children will be allowed to enter the building to register. Paperwork must be completed in advance or you will be asked to return with a complete packet.
- Download the Laraway School APP and the Powerschool APP (Google Play/ITUNES) prior to attending registration.

**School starts at 8am. Any student arriving after 8:15 must be signed in by an adult**

**\*\*\* \$100.00 late registration fee that cannot be waived, may be charged after August 4<sup>th</sup>, 2026. RETURNING FAMILIES ONLY**

**LARAWAY C.C.S.D. 70C**  
**2026-2027 REGISTRATION INFORMATION**

**All families Pre-k-8<sup>th</sup> grade must register on one of the following dates:**

June 1st – June 3rd 9am – 2pm

June 4th 10am – 6pm

August 4th 10am-6pm

## **Residency:**

Laraway School District requires ALL students to establish residency on a yearly basis.

Only the specific documents listed in each category will be accepted towards proof of residency.

### **Category A – One (1) document required**

Current Mortgage Statement  
Recent Closing Papers –  
HUD I Settlement  
Current Real Estate Tax Bill  
Signed 12-month lease  
Residency Affidavit

### **Category B – Two (2) documents required**

Gas/Electric/Water Bill  
Vehicle Registration  
Public Aid/Medicaid Card  
Bank Statement  
Pay Check Stub

### **Category C – One (1) document required**

**Valid IL Driver's License/State ID with current address**

\*If the parent is not the homeowner, notarized affidavits with supporting documents from Category A (owner), Category B (parent) and Category C (owner and parent) must be provided.

### **Additional Fees:**

Gym Suit (Grades 6-8 only)	\$15.00
Graduation (Grade 8 only)	\$100.00*
Sports	\$20/sport*

(\*) Fee may be paid at a later date, but will not be waived

## **Required documents for students**

### **New Students transferring to Laraway:**

A State of Illinois Transfer form, birth certificate and copy of physical with immunization records are required to enroll. Students transferring from any other State do not need to provide a transfer form, but must provide a physical with immunization record.

### **Kindergarten Students:**

Students must be 5 years of age or older by September 1, 2026 in order to enroll for Kindergarten for the 2026-2027 school year.

An original birth certificate is required of all Kindergarten students upon enrollment. Your child will also need a physical with immunization record, and eye/dental exams.

### **Second Grade Students:**

Dental exam required

### **Sixth Grade Students:**

Dental exam and Physical with immunization record is required.

If you have questions related to the registration/residency of students for the 2026-2027 school year, please contact Laraway @ 815-727-5196.

FOR OFFICE USE ONLY:

STUDENTID# \_\_\_\_\_

TEACHER \_\_\_\_\_

LARAWAY SCHOOL  
DISTRICT 70C  
STUDENT  
REGISTRATION 2026-2027

FOR OFFICE USE ONLY:

DATE ENTERED: \_\_\_\_\_

LOCKER#: \_\_\_\_\_

Child's Name/ Nombre del niño\* \_\_\_\_\_ Nickname/Apodo: \_\_\_\_\_  
(Last/ Apellido) (First/Nombre) (Middle)

\*Full legal name as it appears on the birth record/ \*Nombre legal completo tal como aparece en el acta de nacimiento

Gender/Género: M F Birth Date/Fecha de nacimiento: \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade/Grado: \_\_\_\_\_

Street Address/Dirección: \_\_\_\_\_ P.O. Box #/Apt./#Apartado postal, apartamento \_\_\_\_\_

City/Ciudad: \_\_\_\_\_ State/Estado: \_\_\_\_\_ Zip/Código Postal: \_\_\_\_\_

**Parent/Guardian Information/ Información para padres/tutores**

Child resides with whom: ¿Con quién reside el niño?: \_\_\_\_\_

Are there any parent/guardian custodial concerns the school should be aware of? \_\_\_\_\_ Yes/Si \_\_\_\_\_ No/No  
¿Existe alguna inquietud sobre la custodia de los padres o tutores que la escuela debería conocer?

**If yes, please explain and attach all legal custody documents/En caso afirmativo, explique y adjunte todos los documentos de custodia legal:** \_\_\_\_\_

**1) Parent/Guardian's Contact Information/Información de contacto del padre/tutor:**

Relationship/Relación: \_\_\_\_\_

Name/Nombre: \_\_\_\_\_ Employer/Empleador: \_\_\_\_\_

Home Phone: \_\_\_\_/\_\_\_\_/\_\_\_\_ Cell: \_\_\_\_/\_\_\_\_/\_\_\_\_ Work: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Teléfono de casa: Celular: Trabajo:

Address (if different from student's) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Dirección (si es diferente a la del estudiante) Ciudad Estado Código Postal

**2) Parent/Guardian's Contact Information/Información de contacto del padre/tutor:**

Relationship/Relación: \_\_\_\_\_

Name/Nombre: \_\_\_\_\_ Employer/Empleador: \_\_\_\_\_

Home Phone: \_\_\_\_/\_\_\_\_/\_\_\_\_ Cell: \_\_\_\_/\_\_\_\_/\_\_\_\_ Work: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Teléfono de casa: Celular: Trabajo:

Address (if different from student's) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Dirección (si es diferente a la del estudiante) Ciudad Estado Código Postal

**\*\*Custodial Parent/Guardian Email Address:** \_\_\_\_\_

\*\*Dirección de correo electrónico del padre/tutor con custodia

Parent/Guardian is a member of the U.S. Armed Forces \_\_\_ Yes/Si \_\_\_ No/No  
El padre/tutor es miembro de las Fuerzas Armadas de los EE. UU.

Last School Attended: \_\_\_\_\_ Phone: \_\_\_\_\_  
Última escuela a la que asistió: Teléfono:

Address: \_\_\_\_\_ Transfer Out Date: \_\_\_\_\_  
Dirección: Fecha de transferencia:

Is this child in any Accelerated Classes? \_\_\_ Yes/Si \_\_\_ No/No If yes, which subject(s)?  
¿Está este niño en alguna clase acelerada? Si es así, ¿en qué materia(s)?

Has this child ever been retained? \_\_\_ Yes/Si \_\_\_ No/No If yes, which grade was the child retained in?  
¿Este niño ha sido retenido alguna vez de grado? Si es así, ¿en qué grado fue retenido el niño?

Does this child have an IEP? \_\_\_ Yes/Si \_\_\_ No/No If yes, which type of service is the child receiving?  
¿Tiene este niño un IEP? Si es así, ¿qué tipo de servicio recibe el niño?

Does the child have a 504 plan? \_\_\_ Yes/Si \_\_\_ No/No  
¿Tiene el niño un plan 504?

**Laraway School District 70C  
Residency Verification 2026-2027**

**TO BE COMPLETED BY THE PERSON CLAIMING CUSTODY OF THE STUDENT AND WITH WHOM THE STUDENT LIVES  
WITHIN THE BOUNDARIES OF LARAWAY SCHOOL DISTRICT 70C**

Illinois law provides that the residence of a student is deemed to be the same as the residence of the person who has legal custody of the student and permits only students who are residents of the school district to enroll. The person claiming custody must also reside in the District. To assist the District in determining residency and legal custody, this form must be completed. The district may investigate the residency of any student before or after enrollment and require the involved persons to provide additional information to be considered by The District in determining residency. Enrollment is not completed and attendance will not be permitted, until all residency issues are resolved.

**PLEASE COMPLETE ONE FORM PER FAMILY**

**I. IDENTIFYING INFORMATION (Please Print)**

**Student Name and Grade:**

_____	_____
Student Name	Grade
_____	_____
Student Name	Grade
_____	_____
Student Name	Grade
_____	_____
Student Name	Grade
_____	_____
Student Name	Grade

**Parent / Guardian Proving Residency:**

_____
Name
_____
Street Address
_____
City, State, Zip
_____
Telephone Number
_____
Relationship to Student

**II. RESIDENCY OF PERSON WITH WHOM STUDENT LIVES AND WHO CLAIMS CUSTODY OF THE STUDENT**

As initial proof of residency, the person with whom the student lives within the district and who claims custody of the student must provide at least one document from **Category I**, at least two documents from **Category II**, and one document from **Category III** all of which must be acceptable to the District.

**CATEGORY I – Provide at least one of the following documents.**

- Current Mortgage Statement
- Recent Closing – HUD I Settlement
- Current Real Estate Tax Bill
- Signed Lease
- Residency Affidavits (See Below)

**CATEGORY II – Provide at least two of the following documents.**

- Most Recent Gas / Electric / Water Bill / Phone / Cable
- Vehicle Registration / Vehicle Insurance Card
- Bank Statement / Pay Check Stub
- Public Aid / Medicaid / Food Stamp Card

**CATEGORY III** Current Illinois State ID/ Illinois Driver's License

**III. CUSTODY (Check as many of the following as are applicable) A Separate Affidavit may be required.**

- I am the natural or adoptive parent of the student
- The student lives with me on a full-time basis
- I provide the student with a regular nighttime place to sleep. ("Regular" means virtually full-time, including most weekends, holidays and school vacation periods.)
- I have been appointed a short-term guardian of the student.
- I have a court order giving me custody or guardianship of the student
- I am a foster parent of the student who was placed with me by the Illinois Department of Children and Family Services.

**IV. WARNING AND AFFIRMATION**

Illinois law has made it a crime, punishable by imprisonment and fine, to knowingly or willfully present any false information regarding the residence of a student for purposes of enabling that student to attend on a tuition-free basis when the student is known to be a non-resident of the District. The School District will seek prosecution to the full extent of the law of any person who the District believes has committed any residency-related crime. Additionally, the District may initiate a civil lawsuit.

I affirm that I am a resident of this District and that the information presented in this Affidavit or in connection with any investigation of my residency of the student is true, complete, and accurate.

\_\_\_\_\_  
Signature of Person with Legal Custody of the Student

\_\_\_\_\_  
Date



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Leaders Tomorrow

# LARAWAY C.C.S.D. 70-C

DR. JOSEPH SALMIERI, *Superintendent*

MRS. VALERIE TEEGARDIN, *Administrative Assistant*

1715 ROWELL AVENUE, JOLIET, ILLINOIS 60433

(815) 727-5115 Fax (815) 727-5289

Mr. Aaron Ventsias, Principal  
Mr. Joe Pope, Assistant Principal

Laraway School  
1715 Rowell Avenue  
Joliet, Illinois 60433  
(815) 727-5196

## CONSENT FOR RELEASE OF STUDENT RECORDS

I hereby give my consent to: \_\_\_\_\_  
(School Student is Coming From)

to release the following student/s records:

STUDENT	GRADE	BIRTH DATE
_____	_____	_____
_____	_____	_____
_____	_____	_____

Send Records to: Laraway C.C.S.D.70-C  
1715 Rowell Ave.  
Joliet, IL 60433  
815-727-5196; Fax: 815-727-5289

The Records to be Released are as Follow:

- A. **PERMANENT RECORDS:** Consists of basic identifying information (including students, parents or guardians names and addresses, student's birth date and place); academic transcripts (including grades and grade level achieved); attendance records, **health/immunization records**, and accidents reports.
- B. **TEMPORARY RECORDS:** Consists of all information not required to be in the student permanent records and may include test scores (achievement, aptitude or IQ); honors and awards received; participation in school sponsored organizations; disciplinary information.
- C. **SPECIAL EDUCATION RECORDS:** Consists of IEP'S Multi-Disciplinary Reports, psychological, speech/language report, health history, progress reports, audiological.

The reason for this release is: Relocation \_\_\_\_\_; Other (Specify) \_\_\_\_\_

I understand that I have the right to inspect, copy and challenge the contents of the school records in question prior to the release, and the right to limit any consent for the release of school records to designated records of designated portions of information in the school student records.

\_\_\_\_\_  
(SIGNATURE OF PARENT/GUARDIAN)

\_\_\_\_\_  
DATE

FEDERAL LAW 99 31 No parent signature is required for educational records sent to another educational agency. Records will be sent as indicated above if we do not hear from you within ten (10) school days.



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English

## Home Language Survey

The state requires the district to collect a Home Language Survey for every new student. This information is used to count the students whose families speak a language other than English at home. It also helps to identify the students who need to be assessed for English language proficiency.

Please answer the questions below and return this survey to your child's school.

Student's Name: \_\_\_\_\_

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

Yes \_\_\_\_\_ No \_\_\_\_\_

What language? \_\_\_\_\_

2. Does your child speak a language other than English?

Yes \_\_\_\_\_ No \_\_\_\_\_

What language? \_\_\_\_\_

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

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date



## Important Information Regarding Emergency Asthma Medication (Albuterol) Standing Order

Dear Parent/Guardian,

To ensure the safety and well-being of all students, Laraway School District 70-C maintains a supply of emergency epinephrine auto-injectors and, authorized by Illinois law undesignated (stock) albuterol inhalers. These medications are available to assist students experiencing acute respiratory distress or asthma symptoms while on school grounds, or during school-sponsored activities.

### What is Undesignated/Stock Albuterol?

This is a rescue medication (not a daily maintenance medication) intended for quick relief of asthma symptoms (e.g., wheezing, coughing, severe shortness of breath). This stock medication is not specifically prescribed for your child but is authorized for use under a standing order from a licensed physician.

### How it Works:

If your student shows signs of respiratory distress, a trained school nurse or staff member may administer this medication to your child.

### Important Information for Parents:

1. **Notification:** If this medication is administered to your child, school personnel will notify you as soon as possible, and you will be advised to follow up with a healthcare provider.
2. **Existing Care Plans:** This program does not replace your child's existing Asthma Action Plan. If your child has a known condition, please ensure we have their personalized medication and action plan on file.
3. **Opt-Out Option:** If you **do not** want your child to receive this school-provided, undesignated albuterol, you must check the circle below and sign and date.

If you have any questions, please contact Nurse Stokes at [cstokes@laraway70c.org](mailto:cstokes@laraway70c.org) or 815-727-5196.

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I have read and understand the policy regarding the administration of undesignated asthma medication. I authorize the school to administer this medication to my child, if needed.

Student Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I DO NOT authorize the use of school-provided, undesignated albuterol for my child.

**LARAWAY SCHOOL DISTRICT #70C  
BUS TRANSPORTATION 2026 – 2027**

**\*\*THIS FORM MUST BE FILLED OUT – ONE PER FAMILY\*\***

**\*\*ESTE FORMULARIO DEBE SER COMPLETADO – UNO POR FAMILIA\*\***

Bus transportation is provided to eligible students to and from school. Bus routes are assigned based on your home address. Transportation to or from a childcare provider at a different address (within our district), other than your home address will be considered only if the arrangement is consistent 5 days a week. **STUDENTS MUST TAKE THEIR ASSIGNED BUS ROUTE HOME FROM SCHOOL EVERY DAY.** This form will be kept on file in case someone other than yourself will be at the bus stop or picking your child up from Laraway. Please complete one form per family.

Se proporciona transporte en autobús a los estudiantes elegibles para ir y volver de la escuela. Las rutas de autobús se asignan según su domicilio. **El transporte hacia o desde una guardería en una dirección diferente (dentro de nuestro distrito), que no sea su domicilio, solo se considerará si el acuerdo es constante 5 días a la semana. LOS ESTUDIANTES DEBEN TOMAR LA RUTA DE AUTOBÚS ASIGNADA DE LA ESCUELA A CASA TODOS LOS DÍAS.** Este formulario se guardará en archivo por si alguien más está en la parada de autobús o recogiendo a su hijo/a en Laraway. Por favor, complete un formulario por familia.

**HOME ADDRESS (Direccion):** \_\_\_\_\_

STUDENT NAME \_\_\_\_\_ GRADE \_\_\_\_\_ HEALTH CONCERN \_\_\_\_\_

Nombre del estudiante Grado Preocupación de salud

STUDENT NAME \_\_\_\_\_ GRADE \_\_\_\_\_ HEALTH CONCERN \_\_\_\_\_

Nombre del estudiante Grado Preocupación de salud

STUDENT NAME \_\_\_\_\_ GRADE \_\_\_\_\_ HEALTH CONCERN \_\_\_\_\_

Nombre del estudiante Grado Preocupación de salud

STUDENT NAME \_\_\_\_\_ GRADE \_\_\_\_\_ HEALTH CONCERN \_\_\_\_\_

Nombre del estudiante Grado Preocupación de salud

PARENT / GUARDIAN NAME \_\_\_\_\_ CELL# \_\_\_\_\_ WORK # \_\_\_\_\_ PREFERRED LANGUAGE \_\_\_\_\_

Nombre del Padre/ guardián # Celular # Trabajo Lenguaje preferido

PARENT / GUARDIAN NAME \_\_\_\_\_ CELL# \_\_\_\_\_ WORK # \_\_\_\_\_ PREFERRED LANGUAGE \_\_\_\_\_

Nombre del Padre/ guardián # Celular # Trabajo Lenguaje preferido

**\*\*THOSE PERSONS DESIGNATED TO PICK UP MY STUDENT FROM BUS STOP OR SCHOOL:**

**\*\*AQUELLAS PERSONAS DESIGNADAS PARA RECOGER A MI ESTUDIANTE DE LA PARADA DE AUTOBÚS O DE LA ESCUELA:**

FULL NAME \_\_\_\_\_ (PHONE #) \_\_\_\_\_ RELATIONSHIP TO STUDENT \_\_\_\_\_

Nombre completo (Telefono) Relación con el estudiante

FULL NAME \_\_\_\_\_ (PHONE #) \_\_\_\_\_ RELATIONSHIP TO STUDENT \_\_\_\_\_

Nombre completo (Telefono) Relación con el estudiante

FULL NAME \_\_\_\_\_ (PHONE #) \_\_\_\_\_ RELATIONSHIP TO STUDENT \_\_\_\_\_

Nombre completo (Telefono) Relación con el estudiante

**CONTINUED/ Continua**



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Leaders Tomorrow

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## ONLY FILL OUT IF YOU DO NOT WANT YOUR CHILD PARTICIPATING IN DRILLS

### *Laraway Notice of Safety Drills*

### *Safety Drill Information & Law Enforcement Lockdown Opt-out Request*

Dear Parent(s)/Guardian(s):

On an annual basis, Laraway Community Consolidated School District 70C conducts law enforcement lockdown drills, and fire evacuation drills throughout the school year to keep all students and staff safe.

The School Safety Drill Act requires that within the first 90 days of every academic year, we conduct at least one law enforcement lockdown drill. This drill addresses a school shooting incident and evaluates the preparedness of the school personnel and student for situations involving law enforcement when there is an active threat or an active shooter within a school building. Please be assured that the lockdown drill:

- Does not include any simulation that mimic an actual school shooting incident or active shooter event,
- Is announced in advance to all school personnel and students before it begins,
- Includes content that is age and developmentally appropriate,
- Includes and involves school personnel, including school-based mental health professionals,
- Includes trauma-informed approaches to address the concerns and well being of school personnel, and
- Permits student to ask questions related to it.

This year's **lockdown drill** will take place during the school year. If you do not want your child to participate in the lockdown drill, please complete the following **OPT-out REQUEST**.

I request that the District opt-out my child from the law enforcement lockdown drill. I understand that my child will be provided with alternative safety education and instruction related to an active threat or active shooter event. **I also agree to pick up my student on the day of the lockdown drill for the duration of the drill.** The administration staff will provide the date one week before the drill.

\_\_\_\_\_  
Student (please print)

\_\_\_\_\_  
Parent/Guardian (please print)

\_\_\_\_\_  
Parent/Guardian (signature)

\_\_\_\_\_  
Date

If you have any questions please feel free to contact me.

Sincerely,

*Principal - Aaron Ventsias*

**LARAWAY CCSD 70-C**  
**DEPARTMENT OF MULTILINGUAL SERVICES**

Dr. Joseph Salmieri  
SUPERINTENDENTE  
FAX: (815) 727-5289

1715 ROWELL AVE.  
JOLIET, IL 60433  
(815) 727-5196

Beatriz Martínez  
DEPT. OF  
MULTILINGUAL SERVICES

**Parent Rights to Communication**

**English**

Dear Parent/Guardian:

You will be receiving communication from Laraway C.C.S.D. 70-C throughout the school year in English and your home language indicated on the Home Language Survey. You will be receiving your child's report card three times this school year. The Illinois State Board of Education requires that school districts provide translation of the report card and interpretation of Parent-Teacher conferences, unless you waive your right to translation/interpretation and choose to receive it in English only. Every effort will be made to provide you with written translation, if feasible, in your home language.

**Please feel free to reach out for questions, concerns, or request to waive your right to translation/interpretation and choose to receive it in English only.**

Sincerely,  
Beatriz Martínez  
Department of Multilingual Services

**Derechos de Padres de la comunicación**

**Spanish**

Estimado Padre/Tutor:

Recibirá comunicación de Laraway C.C.S.D. 70-C durante todo el año escolar en inglés y en su idioma del hogar indicado en la Encuesta sobre el idioma materno. Recibirá la boleta de calificaciones de su hijo tres veces este año escolar. La Junta de Educación del Estado de Illinois requiere que los distritos escolares proporcionen traducción de la boleta de calificaciones e interpretación de las conferencias de padres y maestros, a menos que usted renuncie a su derecho a traducción/interpretación y elija recibirlo solo en inglés. Se hará todo lo posible para proporcionarle una traducción escrita, si es posible, en su idioma materno.

**No dude en comunicarse si tiene preguntas, inquietudes o solicitar la renuncia a su derecho a traducción/interpretación y elija recibirlo solo en inglés.**

Atentamente,  
Beatriz Martínez  
Departamento de Servicios Multilingües

**LARAWAY COMMUNITY CONSOLIDATED SCHOOL DISTRICT 70C**

**ONLY COMPLETE THIS FORM IF YOU ARE NOT LISTED ON THE LEASE OR MORTGAGE STATEMENT of YOUR CURRENT RESIDENCE**

**THIS FORM MUST BE SIGNED IN THE PRESENCE OF A NOTARY. DO NOT SIGN IT PRIOR**

**Affidavit of Third-Party Residency**

Only students who are residents of Laraway C.C.S.D. 70C are entitled to attend Laraway C.C.S.D. 70C schools. Minor students are presumed to be residents of the school district in which their natural custodial parent resides.

Please attach copies of proof of address and complete the following affidavit.

I, \_\_\_\_\_;  
*Resident Name(s)*

being duly sworn on oath that the owner/lease of the residence commonly known as

\_\_\_\_\_  
*Address*

that I personally know \_\_\_\_\_;  
*Parent Name(s)*

the parents(s) of \_\_\_\_\_;  
*Student Name(s)*

The parent(s) and child(ren) reside with me at the aforementioned address and have made my residence their permanent home, living there on a permanent, continuous basis; and that they are not living with me for the sole purpose of accessing Laraway C.C.S.D. 70C educational programs or services.

\_\_\_\_\_ I understand that knowingly or willfully providing false information to a school district regarding the residency of a pupil for the purpose of enabling that pupil to attend any school in that district is a Class C misdemeanor. Initial

\_\_\_\_\_ I understand that knowingly enrolling or attempting to enroll a pupil in the school of a school district on a tuition-free basis, when I know that pupil to be nonresident of the school district, unless the nonresident pupil has a lawful right to attend, is a Class C misdemeanor. Initial

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Resident's Signature*

SUBSCRIBED AND SWORN TO  
Before me this \_\_\_\_\_ day  
of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Notary Public



# Certificate of Child Health Examination

<b>Student's Name</b>	<b>Birth Date</b> (Mo/Day/Yr)	<b>Sex</b>	<b>Race/Ethnicity</b>	<b>School/Grade Level/ID#</b>
Last _____ First _____ Middle _____				

Street Address _____	City _____	ZIP Code _____	Parent/Guardian _____	Telephone (home/work) _____
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**HEALTH HISTORY: MUST BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

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

**IMMUNIZATIONS: To be completed by health care provider. The mo/day/yr for every dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.**

REQUIRED Vaccine/Dose	DOSE 1			DOSE 2			DOSE 3			DOSE 4			DOSE 5			DOSE 6		
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR
<b>DTP or DTaP</b>																		
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	<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 Haemophiles Influenza Type B																		
Pneumococcal Conjugate																		
Hepatitis B																		
MMR Measles, Mumps, Rubella																		
Varicella (Chickenpox)																		
Meningococcal Conjugate																		
<b>RECOMMENDED, BUT NOT REQUIRED Vaccine/Dose</b>																		
Hepatitis A																		
HPV																		
Influenza																		
Other: Specify Immunization Administered/Dates																		

**Comments:** \* indicates invalid dose

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 \_\_\_\_\_



# Certificate of Child Health Examination

<b>Student's Name</b>	<b>Birth Date</b> (Mo/Day/Yr)	<b>Sex</b>	<b>Race/Ethnicity</b>	<b>School/Grade Level/ID#</b>
Last                                  First                                  Middle				

Street Address	City	ZIP Code	Parent/Guardian	Telephone (home/work)
----------------	------	----------	-----------------	-----------------------

**HISTORIAL DE SALUD: DEBE SER COMPLETADO Y FIRMADO POR EL PADRE/TUTOR Y VERIFICADO POR EL PROVEEDOR DE ATENCIÓN MÉDICA.**

<b>ALERGIAS</b> (Alimentos, drogas, insectos, otro)	<input type="checkbox"/> Sí <input type="checkbox"/> No	<b>Anote todas las alergias:</b>	<b>MEDICAMENTOS</b> (Recetados o tomados con regularidad)	<input type="checkbox"/> Sí <input type="checkbox"/> No	<b>Anote todos los medicamentos:</b>
¿Tiene diagnóstico de asthma?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Tiene pérdida de funciones en uno de los órganos?(Ojos/Oídos/Riñones/Testículos)	<input type="checkbox"/> Sí <input type="checkbox"/> No	
¿Despierta el niño tosiendo en la noche?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Ha sido hospitalizado? ¿Cuándo? ¿Para qué?	<input type="checkbox"/> Sí <input type="checkbox"/> No	
¿Tiene defectos de nacimiento?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Ha tenido alguna cirugía?(anótelas todas) ¿Cuándo? ¿Para qué?	<input type="checkbox"/> Sí <input type="checkbox"/> No	
¿Tiene retrasos del desarrollo?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Ha tenido heridas graves o enfermedades?	<input type="checkbox"/> Sí <input type="checkbox"/> No	
¿Tiene problemas de la sangre? Hemofilia, Glóbulos Falciformes (Sickle Cell), Otro. Explique.	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Prueba positiva de TB (Pasado o Presente)?	<input type="checkbox"/> Sí* <input type="checkbox"/> No	*Si contestó sí, refiera al departamento de salud local
¿Tiene diabetes?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Enfermedad de TB (Pasado o Presente)?	<input type="checkbox"/> Sí* <input type="checkbox"/> No	
¿Tiene heridas en la cabeza/golpe/desmayo?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Usa tabaco (tipo, frecuencia)?	<input type="checkbox"/> Sí <input type="checkbox"/> No	
¿Tiene convulsiones? Cómo se manifiestan?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Toma alcohol/drogas?	<input type="checkbox"/> Sí <input type="checkbox"/> No	
¿Tiene problemas cardíacos/Dificultad para respirar?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Historial de familiares de muerte repentina antes de los 50 años? ¿Causa?	<input type="checkbox"/> Sí <input type="checkbox"/> No	
¿Tiene soplo en el corazón/presión arterial alta?	<input type="checkbox"/> Sí <input type="checkbox"/> No		<input type="checkbox"/> Dental <input type="checkbox"/> Frenos <input type="checkbox"/> Puente <input type="checkbox"/> Placas <input type="checkbox"/> Otro		
¿Tiene mareos o dolor de pecho al hacer ejercicios?	<input type="checkbox"/> Sí <input type="checkbox"/> No				
¿Problemas con los ojos/visión? _____ <input type="checkbox"/> Lentes <input type="checkbox"/> Lentes de Contacto Último examen _____			<b>Información Adicional:</b>		
¿Otras Preocupaciones? (bizco, párpados caídos, parpadear, dificultad cuando lee) _____			La información en este formulario se puede compartir con el personal apropiado para propósitos de salud y educación.		
¿Tiene problemas de los oídos/no oye bien?	<input type="checkbox"/> Sí <input type="checkbox"/> No		<b>Firma del Padre/ Tutor:</b> _____ <b>Fecha:</b> _____		
¿Tiene problemas de los huesos/articulaciones/heridas/ escoliosis?	<input type="checkbox"/> Sí <input type="checkbox"/> No				

**IMMUNIZATIONS: To be completed by health care provider. The mo/day/yr for every dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.**

REQUIRED Vaccine/Dose	DOSE 1			DOSE 2			DOSE 3			DOSE 4			DOSE 5			DOSE 6		
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR
<b>DTP or DTaP</b>																		
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	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV
<b>Hib Haemophiles Influenza Type B</b>																		
<b>Pneumococcal Conjugate</b>																		
<b>Hepatitis B</b>																		
MMR Measles, Mumps, Rubella																		
Varicella (Chickenpox)																		
<b>Meningococcal Conjugate</b>																		
<b>RECOMMENDED, BUT NOT REQUIRED Vaccine/Dose</b>																		
Hepatitis A																		
HPV																		
Influenza																		
Other: Specify Immunization Administered/Dates																		

**Comments:** \* indicates invalid dose

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 \_\_\_\_\_



# Proof of School Dental Examination Form

Illinois law (Child Health Examination Code, 77 Ill. Adm. Code 665) states all children in kindergarten and the second, sixth, and ninth grades of any public, private, or parochial school shall have a dental examination. The examination must have taken place within 18 months prior to May 15 of the school year. A licensed dentist must complete the examination and sign and date this Proof of School Dental Examination Form. If you are unable to get this required examination for your child, fill out a separate Dental Examination Waiver Form.

This important examination will let you know if there are any dental problems that need attention by a dentist. Children need good oral health to speak with confidence, express themselves, be healthy, and be ready to learn. Poor oral health has been related to lower school performance, poor social relationships, and less success later in life. For this reason, we thank you for making this contribution to the health and well-being of your child.

### To be completed by the parent or guardian (please print):

Student's Name: <i>Last</i> _____ <i>First</i> _____ <i>Middle</i> _____			Birth Date (Month/Day/Year): _____
Address: <i>Street</i> _____		<i>City</i> _____	<i>ZIP Code</i> _____
School: <i>Name</i> _____	<i>ZIP Code</i> _____	Grade Level: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent or Guardian: <i>Last Name</i> _____		<i>First Name</i> _____	
Student's Race/Ethnicity: <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Middle Eastern or North African <input type="checkbox"/> Two or More Races <input type="checkbox"/> Unknown <input type="checkbox"/> Other			

### To be completed by the dentist:

Date of Most Recent Examination: \_\_\_\_\_ (Check all services provided at this examination date)

- Dental Cleaning     Sealant     Fluoride treatment     Silver Diamine Fluoride     Restoration of teeth due to caries

#### Oral Health Status (check all that apply)

- Yes  No Dental Sealants Present on Permanent Molars
- 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 first 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 Urgent Treatment — Abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling.

#### Treatment Needs (check all that apply)

For Head Start Agencies, please also list the appointment date or date of the most recent treatment.

- Restorative Care — amalgams, composites, crowns, etc.    Appointment Date: \_\_\_\_\_
- Preventive Care — sealants, fluoride treatment, prophylaxis    Appointment Date: \_\_\_\_\_
- Pediatric Dentist Referral Recommended    Treatment Completion Date: \_\_\_\_\_

Office Address: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Signature of Dentist: \_\_\_\_\_ License #: \_\_\_\_\_ Date: \_\_\_\_\_

Illinois Department of Public Health, Oral Health Section  
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.dph.illinois.gov



# State of Illinois Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides eye examinations be submitted to the school no later than October 15 of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

Student Name \_\_\_\_\_  
 (Last) (First) (Middle Initial)

Birth Date \_\_\_\_\_ Gender \_\_\_\_\_ Grade \_\_\_\_\_  
 (Month/Day/Year)

Parent or Guardian \_\_\_\_\_  
 (Last) (First)

Phone \_\_\_\_\_  
 (Area Code)

Address \_\_\_\_\_  
 (Number) (Street) (City) (ZIP Code)

County \_\_\_\_\_

### To Be Completed By Examining Doctor

#### Case History

Date of exam \_\_\_\_\_

Ocular history:  Normal or Positive for \_\_\_\_\_

Medical history:  Normal or Positive for \_\_\_\_\_

Drug allergies:  NKDA or Allergic to \_\_\_\_\_

Other information \_\_\_\_\_

#### Examination

	Distance			Near
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation?  Yes  No

	Normal	Abnormal	Not Able to Assess	Comments
External exam (lids, lashes, cornea, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Internal exam (vitreous, lens, fundus, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pupillary reflex (pupils)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Binocular function (stereopsis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Accommodation and vergence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oculomotor assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

#### Diagnosis

Normal  Myopia  Hyperopia  Astigmatism  Strabismus  Amblyopia

Other \_\_\_\_\_



## Estado de Illinois Informe de examen de la vista

La ley de Illinois requiere que la prueba de un examen de la vista realizado por un optometrista o médico (como un oftalmólogo) que realiza exámenes de la vista se presente a la escuela a más tardar el 15 de octubre del año en que se inscribió al niño por primera vez o según lo exija la escuela para otros niños. El examen debe completarse dentro de un año antes del primer día del año escolar en que el niño ingresa al sistema escolar de Illinois por primera vez. El padre de cualquier niño que no pueda obtener un examen debe presentar un formulario de exención a la escuela.

Nombre del estudiante \_\_\_\_\_  
(Último) (Primer) (Iniciar del segundo nombre)

Fecha de nacimiento \_\_\_\_\_ Género \_\_\_\_\_ Calificación \_\_\_\_\_  
(Mes día año)

Padre o guardián \_\_\_\_\_  
(Último) (Primer)

Teléfono \_\_\_\_\_  
(Codigo de AREA)

DIRECCIÓN \_\_\_\_\_  
(Número) (Calle) (Ciudad) (Código postal)

Condado \_\_\_\_\_

Para ser completado por el médico examinador

Historia del caso  
 fecha de examen \_\_\_\_\_

Historia ocular: Normal o Positivo para \_\_\_\_\_

Historial médico: Normal o Positivo para \_\_\_\_\_

Alergias a medicamentos: NKDA o Alérgico a \_\_\_\_\_

Otra información \_\_\_\_\_

**Examen**

	Distancia		Cerca	
	Derecha	Izquierda	Ambos	Ambos
Agudeza visual no corregida	20/	20/	20/	20/
Mejor agudeza visual corregida	20/	Izquierda 20/ 20/	20/	20/

¿Se realizó la refracción con dilatación? Sí No

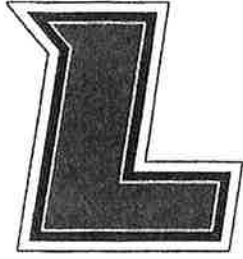
	Normal	Anormal No se puede evaluar	
Examen externo (párpados, pestañas, córnea, etc.)	Examen interno (vitreo, cristalino, fondo de ojo,		Comentarios _____ _____ _____ _____ _____
etc.) Reflejo pupilar (pupilas)	Función binocular (estereopsis)	Acomodación y vergencia	
Visión cromática			
Evaluación de glaucoma			
Evaluación oculomotora			
Otro _____			

NOTA: "No se puede evaluar" se refiere a la incapacidad del niño para completar la prueba, no a la incapacidad del médico para proporcionar la prueba.

**Diagnóstico**

Normal Miopía Hipermetropía Astigmatismo Estrabismo Ambliopía

Otro \_\_\_\_\_



## LARAWAY CCSD 70-C

DR. JOSEPH SALMIERI, Superintendent  
SRA. VALERIE TEEGARDIN, Administrative Assistant  
1715 ROWELL AVENUE, JOLIET, ILLINOIS 60433

(815) 727-5115 Fax (815) 727-5289

Sr. Aaron Ventsias, Principal  
Sr. Joe Pope, Assistant Principal

“Learners Today, Leaders Tomorrow”

Dear Parents/Guardians of Laraway Students,

Our District is participating in a state food program for your students. All breakfast, lunch and snack (Pre-K-1<sup>st</sup> grade) is provided to them free of charge.

In order for these meals to remain free, we must adhere to the state’s nutrition program’s rules.

Please feel free to contact the Food Service Director with any questions you may have.

Houston Cantrell (815)727-5196 ext 2558 o [hcantrell@laraway70c.org](mailto:hcantrell@laraway70c.org)

Houston Cantrell  
Food Service Director

# **STUDENT UNIFORM**

## **UNIFORM APPLIES TO ALL PK-8 STUDENTS**

### **Male Students:**

- Navy blue, black, or khaki/beige slacks;
- Light blue or navy blue button-down or pullover shirt with no logos (short or long sleeves with a collar);
- Blue, black, or white socks;
- Black comfortable shoes (no stripes on gym shoes); Boots allowed in winter but must be changed before start of class.
- Solid navy blue or light blue sweater/sweatshirt only (no logo) must be a light blue shirt or blouse underneath and tucked in.

### **Female Students:**

- Navy blue, black, or khaki/beige skirt or split skirt that is at least finger-tip length or
- Navy blue, black, khaki/beige slacks;
- Light blue or navy-blue blouse or pullover shirt with no logo (short or long sleeves with a collar);
- Solid navy blue or light blue sweater/sweatshirt only (no logo)
- Blue, black or white socks or nylons;
- Black comfortable shoes (no stripes on gym shoes); Boots allowed in winter but must be changed before start of class.

### **All Students:**

When sweaters are worn, there must be a light blue shirt or blouse underneath and tucked in. Sweatshirts may not be turned inside out to hide logos.

### **Additional Information**

- Slacks shall not be a “jean” type, stretchy pant, cargo or a sweatpants style. Denim is not permissible for slacks.
- No stretchy pants, yoga pants, leggings, or jeggings will be permissible.
- Belts must be worn with all slacks having belt loops and must be worn at the waist level.  
Belts must be a dark color.
- Shirts/blouses must be buttoned and must be tucked in at the waist.
- No faded shirts or denim-type shirts.
- Hoods may not be worn during the school day.
- T-shirts/undershirts, or turtlenecks worn beneath shirts/blouses must be solid white.
- No clogs or sandals.
- No boots. If boots are worn to school because of the weather, students must bring the appropriate shoes and change into them while at school.
- Students will be allowed to change into gym shoes for physical education classes or for outside activities. • Black, navy or brown shoelaces only. Shoelaces must be tied.
- When appropriate, navy blue, black, or khaki/beige uniform shorts that are at least finger-tip length may be worn.

## Laraway CCSD 70-C 2026 – 2027 School Calendar

August 3	Teachers May Report to Classrooms
TBA	New Teacher and Teaching Assistants Orientation/Training
August 11*	Board of Education Meeting*
August 17-18	Teacher & Teaching Assistants Institute Day – No School
August 17	Staff ID Pictures – 9am
August 19	Dismissal 1:15pm First Day of School – K-8 <sup>th</sup> grade
August 20	Little Learners Meet & Greet Teacher – 1pm-3pm
August 20-25	Little Learners Family Intake Meetings
August 26	Little Learners – First Day of School (Full Day)
August 26	Open House from 5pm-6:30pm for Little Learners through 8 <sup>th</sup> Grade
September 7	Labor Day – No School
September 11	Friday Set Up for Annual Health Fair & Back to School Picnic
September 12	Saturday - Annual Health Fair & Back to School Picnic - 11:00am-2:00pm
September 15	Board of Education Meeting
TBA	Fall Pictures
September 25	1/2 Day School – Dismissal 11:30am – PM Teacher & Assistants In-service
October 12	Columbus Day – No School
October 20	Board of Education Meeting
October 30	1/2 Day School – Dismissal 11:30am – PM Teacher & Assistants In-service
November 11	Dismissal 1:15pm – PM Teacher In-service
November 17	Board of Education Meeting
November 19	Dismissal 1:15pm – PM Parent Teacher Conferences
November 19	Parent Teacher Conferences – 2pm – 7pm
November 20	1/2 Day School – Dismissal 11:30am – PM Teacher & Assistants In-service
November 23-27	Thanksgiving Holiday – No School
December 15	Board of Education Meeting
December 18	1/2 Day School – Dismissal 11:30am – PM Teacher & Assistants In-service
December 21-January 1	Winter Break – No School
January 4	Teacher & Teaching Assistants Institute Day – No School for Students
January 5	School Resumes after Winter Break
January 18	Martin Luther King's Birthday – No School
January 19	Board of Education Meeting
February 12	1/2 Day School – Dismissal 11:30am – PM Teacher & Assistants In-service
February 15	President's Day – No School
February 16	Board of Education Meeting
March 1	Dismissal 1:15pm – PM Teacher & Assistants In-service
March 16	Board of Education Meeting
March 24	Dismissal 1:15pm – PM Parent Teacher Conferences
March 24	Parent Teacher Conferences – 2pm – 7pm
March 25	1/2 Day School – Dismissal 11:30am – PM Teacher & Assistants In-service
Mach 26	Good Friday – No School
March 29-April 2	Spring Break – No School
April 5	School Resumes after Spring Break
April 20	Board of Education Meeting
May 18	Board of Education Meeting
May 27	Dismissal 1:15pm - Last Day of School if No Emergency Days are Used
May 28	Teacher & Teaching Assistants Institute Day
May 31	Memorial Day – No School
June 1-June 7	Emergency Days (If necessary)
June 15	Board of Education Meeting
TBD	Kindergarten Graduation
TBD	8 <sup>th</sup> Grade Trip
TBD	8 <sup>th</sup> Grade Graduation

*This calendar provides for 176 student attendance days and 4 Teachers' Institute Days.*

November 6 - End of 1<sup>st</sup> Trimester (56 days) February 26 - End of 2<sup>nd</sup> Trimester (62 days) May 27 - End of 3<sup>rd</sup> Trimester (58 days)



# LARAWAY SCHOOL

There's  
an **App**  
for  
that!



Download  
for Free  
Today!



## @ srnv TNFoRMED

Notifications from administrators and teachers make it easy to stay on top of whats going on at school and in the classroom.

## a Qurcr( AND EASY ACCESS TO - GRADES, MENUS & MORE

Quick access to everyth;ng school-related including calendars, directions to events, important documents, menus, grade sys{ems, sports scores, school resources and more!

## Q rnsv school coNTAcR

One click to call, email and submit important forms directly lo us. Subscribe to receive important notifications from groups that are irnportant to you.

## €) EAsY TEAcHER coNTAcR

One click to call, email and visit teacher websites and class resources. Subscribe to receive important notifications from teachers.