Lutheran Central School
Kindergarten Packet

The following forms need to be completed and returned to the LC office.

_____ Registration Form (Form attached and must be signed by parent along with the $150 Registration/Technology Fee)

_____ Tuition Payment Agreement Form (required)

_____ Birth Certificate (Need a copy of child's birth certificate.)

_____ Immunization Record (Need a copy of original immunization records. Please see the attached Indiana State Department of Health School Immunization Requirements.)

_____ Physical Exam (Form attached. Needs to be filled out and signed by child's doctor.)

_____ Dental Exam (on bottom of Physical Exam form. Needs to be filled out and signed by child's dentist.)

_____ Vision Exam (Form attached. Needs to be filled out and signed by child's eye doctor.)

_____ Health History Update (Form attached. Needs to be filled out and signed by child's parent.)

_____ Chirp Form (Form attached. Needs to be filled out and signed by child's parent.)

_____ Home Language Survey (Form attached. Needs to be filled out and signed by child's parent.)

Lutheran Central School

415 N. Elm Street, Brownstown, Indiana 47220
812-358-2512

Date of Registration _____

INSTRUCTIONS: PLEASE ANSWER ALL QUESTIONS BELOW, SIGN, AND RETURN THIS REGISTRATION FORM ALONG WITH THE **$150.00 REGISTRATION/TECHNOLOGY FEE** TO THE LUTHERAN CENTRAL SCHOOL OFFICE. CHECKS MAY BE MADE PAYABLE TO LUTHERAN CENTRAL SCHOOL.

Appreciating the educational advantages offered by a Christian school, I/we hereby request that our child be enrolled as a pupil of Lutheran Central School.

Child's Name: _____ M ____ F ____ Age _____
First Middle Last

Street Address: _____ City _____ Zip _____

Home Phone: _____ Parent Email Address: _____

Parent Email Address: _____

Entering Grade: _____ Ethnicity: _____ Date of Birth: _____

Date of Baptism: _____ Church where baptized: _____

Father

Name: _____ Cell Phone: _____ Work Phone: _____

Place of employment/Occupation: _____

Home Address of Father (if different): _____

Present Church Home: _____ Active: _____ Inactive: _____

Mother

Name: _____ Cell Phone: _____ Work Phone: _____

Place of employment/Occupation: _____

Home Address of Mother (if different): _____

Present Church Home: _____ Active: _____ Inactive: _____

Emergency Contact Information

Name: _____ Cell Phone: _____ Home Phone: _____

Relationship to Student: _____

Name: _____ Cell Phone: _____ Home Phone: _____

Relationship to Student: _____

Brothers and Sisters Please give name and birth date of each brother/sister of child being registered.

Name	**Date of birth**
_____	_____
_____	_____

Please review any special needs that your child may have, including diet, behavior, medication, and any other needs that are pertinent to your child's health and academic success. All information is confidential.

_____

_____

_____

Is your child on any form of medication? Yes _____ No _____

If yes, name of medication _____ Reason for medication _____

Your reasons for wishing to register your child at Lutheran Central School: _____

_____

_____

Answer the following questions only if your child is being transferred from another school.

School from which you intend to transfer: _____

Address of school (street, city, state, zip): _____

Grade last completed _____ When completed? Mo. _____ Yr. _____

In which grade do you wish your child to be enrolled in Lutheran Central: _____

Has your child repeated a Grade? Yes _____ No _____ (If yes, please explain below) _____

_____

_____

Estimate of work that your child is now doing (circle one):

Excellent Good Average Poor Failing

STUDENT LIVES WITH:

_____ Both parents _____ Mother & Stepfather _____ Father

_____ Mother _____ Father & Stepmother _____ Grandparents

_____ Guardian

If parents are divorced, custody was granted to: _____ joint _____ mother _____ father
(you may be asked to provide documentation)

Tuition and Scholarship Information

2025-2026 Tuition $9,200 (Tuition: reflects total costs before member discounts, School Choice Scholarship, SGO Scholarship, and Internal Financial Assistance is applied.)

☐ YES **I plan to submit our 2024-1040 Tax forms and other required forms to be considered for School Choice and**

☐ NO **other scholarship/financial aid assistance**

(FAMILIES SELECTING NO WILL BE RESPONSIBLE FOR $2,500 TUITION CONTRIBUTION PER STUDENT)

- **If No is selected, I understand that I will contribute $2,500 per student attending Lutheran Central toward the cost to educate.**
- **If Yes is selected, please continue with Tuition selection below**

ALL families that submit required forms for financial aid will be **REQUIRED TO SELECT ONE** of the options below to invest in their students' education at Lutheran Central for the 2025-2026 School Year.

☐ Tier 1..... $_____

In grateful response for the educational and spiritual opportunities my child receives at Lutheran Central, our family elects to contribute the above amount (over $850) toward the cost to educate our student.

☐ Tier 2.....$850.00

In grateful response for the educational and spiritual opportunities my child receives at Lutheran Central, our family elects to contribute $850 toward the cost to educate our student.

☐ Tier 3.....$600.00

In grateful response for the educational and spiritual opportunities my child receives at Lutheran Central, our family elects to contribute $600 toward the cost to educate our student.

☐ Tier 4.....$350.00

In grateful response for the educational and spiritual opportunities my child receives at Lutheran Central, our family elects to contribute $350 toward the cost to educate our student.

PLEASE SELECT PAYMENT SCHEDULE FOR TUITION. CHECKS MAY BE MADE PAYABLE TO LUTHERAN CENTRAL.

_____ full payment
_____ we will pay in **TWO** installments on August 15, 2025 and January 15, 2026
_____ we will be paying in **FOUR** installments August 15, 2025, October 15, 2025, January 15, 2026, and March 15, 2026
_____ we will be paying in **TEN** installments August 15, 2025, September 15, 2025, October 15, 2025, November 15, 2025, December 15, 2025, January 15, 2026, February 15, 2026, March 15, 2026, April 15, 2026, and May 15, 2026

The Mission of Lutheran Central School is to share the Good News of Jesus Christ, teach children, and assist parents in training children to be witnessing Christians and productive citizens.

We will provide Christian training based on Scripture and the Lutheran Doctrine of the Lutheran Church, Missouri Synod. As parents, if you are not a member of the Lutheran Church-Missouri Synod, it is required that you sign an agreement that you understand that Lutheran Doctrine will be taught to all students.

Lutheran Central School admits students of any race, color, national and ethnic origin to all rights, privileges, programs, and activities generally accorded or made available to students at the school. It does not discriminate on the basis of race, color, national and ethnic origin in administration of its educational policies or athletic and other school-administered programs.

Signature of Parent: _____ Date_____

LUTHERAN CENTRAL SCHOOL – Tuition Payment Agreement Form

Lutheran Central has established a policy regarding delinquent payments. **If your family has not made a payment by the due date of the payment plan you selected on your registration form, we will need to use an automatic payment method for tuition payments for the 2025-26 school year.** Please sign and return this form to the LC office.

You will not be considered enrolled until this form has been received.

PAYMENT DEDUCTION DATES

According to your registration form you chose the following payment plan option:

☐ Two Installments **AUTOMATICALLY DEDUCTED** on August 15, 2025 and January 15, 2026 if payment has not been received by this date.

☐ Four Installments **AUTOMATICALLY DEDUCTED** on August 15, 2025, October 15, 2025, January 15, 2026, and March 15, 2026 if payment has not been received by this date.

☐ Monthly Installments **AUTOMATICALLY DEDUCTED** on August 15, 2025, September 15, 2025, October 15, 2025, November 15, 2025, December 15, 2025, January 15, 2026, February 15, 2026, March 15, 2026, April 15, 2026, and May 15, 2026 if payment has not been received by this date.

☐ I DO NOT WANT MY TUITION AUTOMATICALLY DEDUCTED. **This will ONLY be done if my payments are delinquent. I understand that I must complete the payment information below for delinquent payments.**

PAYMENT INFORMATION

Please select one of the following options:

☐ **ACH (Automatic Checking Account deduction):**

_____
Bank Name

_____
9-digit Routing Number

_____
Account Number

☐ **Credit Card Information (If using Debit Card, please use ACH)**

_____
Name on Card

_____
Card Number

_____ _____
Expiration date CVC number

I authorize Lutheran Central School to debit or charge m payments via ACH or credit card as outlined above. I further agree Lutheran Central School may process these payments as though I personally signed or initiated the debit or charge.

Name	Student(s)	
Address		
City	State	Zip
Email		
Authorizing Signature	Date	

Required and Recommended School Immunizations, Indiana 2025-2026

Indiana Department of Health

Updated 11.12.2024

Grade	Required		Recommended
Pre-K	3 Hepatitis B 4 DTaP (Diphtheria, Tetanus and Pertussis) 3 Polio	1 Varicella (Chickenpox) 1 MMR (Measles, Mumps and Rubella) 2 Hepatitis A	Annual influenza COVID-19Haemophilus influenza B Pneumococcal conjugate
K-5	3 Hepatitis B 5 DTaP 4 Polio	2 Varicella 2 MMR 2 Hepatitis A	Annual influenza COVID-19
6-11	3 Hepatitis B 5 DTaP 4 Polio 2 Varicella	2 MMR 2 Hepatitis A 1 MCV4 (Meningococcal) 1 Tdap (Tetanus, Diphtheria and Pertussis)	Annual influenza 2 or 3 HPV (Human papillomavirus) COVID-19
12	3 Hepatitis B 5 DTaP 4 Polio 2 Varicella	2 MMR 2 Hepatitis A 2 MCV4 1 Tdap	Annual influenza 2 or 3 HPV 2 MenB (Meningococcal) COVID-19

HepB: The minimum age for the third dose of Hepatitis B is 24 weeks of age.

DTaP: Four doses of DTaP/DTP/DT are acceptable if fourth dose was administered on or after the fourth birthday.

Polio*: Three doses of Polio are acceptable for all grade levels if the third dose was given on or after the fourth birthday and at least six months after the previous dose.
*For students in grades K-12, the final dose must be administered on or after the fourth birthday and be administered at least six months after the previous dose.

Varicella: Physician documentation of disease history, including month and year, is proof of immunity for children entering preschool through 12th grade. Parent report of disease history is not acceptable.

Tdap: There is no minimum interval from the last Td dose.

MCV4: Individuals who receive their first dose on or after their 16th birthday only need one dose of MCV4.

Hepatitis A: The minimum interval between first and second dose is six calendar months. Two doses are required for all grade levels.

For additional immunization information, visit: **in.gov/health/immunization**
or call **1 (800) 701-0704** during normal business hours.

SCHOOL HEALTH EXAMINATION FORM
Lutheran Central School

Child's Name: _____ Date of Birth: _____

Guardian's Name: _____

PHYSICAL EXAMINATION
(Code: No Defect - 0 Defect - note)
To be completed by Physician

Height _____ Weight _____

Head _____

Eyes _____

Ears _____

Nose _____

Throat _____

Heart _____ B/P _____

Lungs _____

Abdomen _____

Posture _____

Serious Illnesses/Injuries/Operations _____

_____

Allergies _____

Is there any condition which should be considered in planning this child's program? _____

_____

Date of Exam _____

Provider Signature _____

RECORD OF IMMUNIZATIONS
(Official CHIRP copy acceptable)

Dtap,Dt,Td 1. _____ 2. _____ 3. _____ 4. _____ 5. _____

IPV 1. _____ 2. _____ 3. _____ 4. _____

MMR 1. _____ 2. _____

Varicella 1. _____ 2. _____

Hep B 1. _____ 2. _____ 3. _____ 4. _____

Hepatitis A 1. _____ 2. _____

DENTAL EXAMINATION
(CODE: No Defect-0 Defect-Note)

TEETH: Cavaties _____
Malocculsions _____

PRESENT STATUS: Restorations _____
Appointments Scheduled _____

RECOMMENDATIONS: _____

_____

_____

Date of Exam _____ Provider Signature _____

STUDENT VISION REPORT FORM

Student's Name: _____ Date of Birth _____

Guardian's Name _____

Summary of Findings

1. Visual Acuity — Pass — Fail

	Distance		Near	
Unaided	R. eye 20/	L. eye 20/	R. eye 20/	L. eye 20/
Corrected	R. eye 20/	L. eye 20/	R. eye 20/	L. eye 20/

Remarks: _____

2. Refractive Error — Pass — Fail
Remarks: _____

3. Ocular Health — Pass — Fail
Remarks: _____

4. Eye Muscle Balance — Pass — Fail
Remarks: _____

5. Binocular Depth Perception — Pass — Fail
Remarks: _____

6. Accommodation (Focusing Ability) — Pass — Fail
Remarks: _____

7. Color Perception — Pass — Fail
Remarks: _____

8. Other

Analysis of Vision and Eye Health: _____

_____

Recommendations: _____No Treatment Indicated _____ Glasses/Contacts Lenses Prescribed
_____ Present Prescription Satisfactory _____ Vision Therapy Prescribed
Other _____

Purpose of Glasses/Contact Lenses If Prescribed: _____
Should be worn: a. Constant Wear b. Desk work only c. Far vision only

Recommendations to Classroom Teacher: _____

_____

Re-Examination advised in _____

I, being licensed to practice optometry and/or ophthalmology, certify that this student's vision and eye health have been examined by me and:

_____1. Is sufficient to enter Kindergarten
_____2. Appropriate treatment has been recommended for deficiencies

Date of Exam: _____ _____M.D./O.D.

LUTHERAN CENTRAL SAINTS
415 North Elm Street
Brownstown, IN 47220
(812) 358-2512

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

Physician's Name:_____ Phone Number:_____

Please circle any that apply to your student and explain below.

Allergies:
Bees/Insects
Latex
Food
Medication
Seasonal/Environmental
***Epi Pen? (with nurse/with student)**

Behavioral/Psychological:
ADD/ADHD
Anxiety or Depression
Autism
Conduct Disorder
PTSD
Other:

Vision:
Wears Glasses
Wears Contacts
Blindness
Color Blindness
Other:

Bowel/Digestive:
Irritable Bowel Syndrome
Crohn's Disease
Bowel Incontinence

Cardiovascular:
High Blood Pressure
Heart Murmur
*Any Restrictions?

Endocrine:
Type 1 Diabetes
Type 2 Diabetes
Other:

Hearing:
Hearing Impairment
Wears Hearing Aids

Musculoskeletal:
History of Fractures
Other:

Neurological:
Migraine
Headaches
History of Concussion
Seizure Disorder

Respiratory:
Asthma/Reactive Airway
***Inhaler? (with nurse/with student)**

Urinary:
Urinary Incontinence
History of Urinary Infections

Blood:
Anemia
Hemophilia
Sickle Cell Anemia

Explain any circled concerns:_____

_____

_____

Medications(list ALL medications taken- at home and/or at school): _____

_____

The school will act based on information provided here. It is expected that this form is accurate, complete and any changes will be reported as soon as possible. I give permission for this information to be shared with school staff on a need to know basis. The information provided will be treated as confidential and protected. I understand that in the event of reasonable attempts to contact myself or my child's emergency contacts have been unsuccessful, I give my consent for emergency medical treatment deemed necessary. I understand that I am financially responsible for any medical care or transportation costs. I release and agree to hold the Board of Trustees, its officials and it's employees harmless from all liability for damages or injuries. I also consent to the release of any additional medical information to the school nursing staff.

Parent/Guardian's Signature: _____ Date:_____

Lutheran Central School
415 N Elm. St
Brownstown, IN 47220

I, _____, give Lutheran Central School, permission to release the following immunization and demographic information concerning my child, _____, to the Indiana State Department of Health's secure website CHIRP- Children and Hoosiers Immunization Registry Program. The CHIRP database is a valuable tool to securely store your child's immunization information for life and only authorized personnel can access this information. Having this information stored in one place makes it easier to apply to colleges and universities. It also helps prevent duplication of vaccine administration. Your child's immunization history may already be entered on the CHIRP database if he/she received immunization at a local health department or through a participating physician's office. To enter your child's immunization history on the CHIRP database we need the following information for your child.

Name:_____ Date of Birth:_____

Address:_____

Phone number:_____ Grade:_____

I understand that the information in the registry may be used to verify that my child has received proper and age appropriate immunizations and to inform me of my child's immunization status or that an immunization is due according to the ACIP recommended immunization schedule.

I understand that my child's information may be available to authorized personnel only of an immunization data registry of another state, a healthcare provider, a local health department, an elementary or secondary school, a child care center, the Office of Medicaid policy and planning, a licensed child placing agency, and a college or university. I also understand that other entities may be added to this list through amendment to I.C. 16-38-5-3.

I hereby consent to the release of such information.

_____ _____
Signature Date

_____
Printed name of Parent or Guardian

Indiana Department of Education

Dr. Katie Jenner, Secretary of Education

Home Language Survey (HLS)

The Civil Rights Act of 1964, Title VI, Language Minority Compliance Procedures, requires school districts and charter schools to determine the language(s) spoken in each student's home in order to identify their specific language needs. This information is essential in order for schools to provide meaningful instruction for all students as outlined Plyler v. Doe, 457 U.S. 202 (1982).

The purpose of this survey is to determine the primary or home language of the student. The HLS must be given to all students enrolled in the school district / charter school. The HLS is administered one time, upon initial enrollment in Indiana, and remains in the student's cumulative file.

Please note that the answers to the survey below are student-specific. If a language other than English is recorded for ANY of the survey questions below, the WIDA Screener will be administered to determine whether or not the student will qualify for additional English language development support.

Please answer the following questions regarding the language spoken by the student:

1. What is the native language of the **student**? _____

2. What language(s) is spoken most often by the **student**? _____

3. What language(s) is spoken by the **student** in the home? _____

Student Name:_____ **Grade:**_____

Parent/Guardian Name:_____

Parent/Guardian Signature:_____ **Date:**_____

By signing here, you certify that responses to the three questions above are specific to your student. You understand that if a language other than English has been identified, your student will be tested to determine if they qualify for English language development services, to help them become fluent in English. If entered into the English language development program, your student will be entitled to services as an English learner and will be tested annually to determine their English language proficiency.

For School Use Only:

School personnel who administered and explained the HLS and the placement of a student into an English language development program if a language other than English was indicated:

Name:_____ Date:_____