WINTHROP HARBOR SCHOOLS

LAKE COUNTY • DISTRICT NO. 1
500 NORTH AVENUE • WINTHROP HARBOR, ILLINOIS 60096
(847) 731-3085 • (847) 731-3156 FACSIMILE

BOARD OF EDUCATION
Rick Lambert, President
Kristin Heiny, Vice-President
Kimberly Young, Secretary
Michelle Good, Treasurer
Gene Ellison
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Patricia Goodwin, M.S.Ed.
Superintendent

Carrie Nottingham, M.S.Ed.
Principal, North Prairie Jr. High

Dear Parents,

Taking advantage of our early registration not only saves you money, but is the quickest and most convenient way to register your child for the upcoming school year. Enclosed in this packet you will find a registration form, residency verification form, health services information and a school calendar.

Please complete the registration forms and return them along with the registration fee of $120.00 **(or $100.00 if registration is completed by May 20, 2016)** and two proofs of residency.

1st Proof of Residency will be a **current utility bill** with the bottom portion still attached.

2nd Proof of Residency will be one of the following: lease agreement, driver's license or state ID, purchase or sales agreement, voter registration, Social Services papers, General Assistance or Aid for Families with Dependent Children (AFDC) or rent receipt including verification of Landlord's address and phone number.

The first day of school is Monday, August 22nd, this is a FULL DAY. All new students must bring a lunch. If you were approved for the lunch program in our district for the 2015-2016 school year, it will remain in effect until October 1, 2016. Applications must be renewed annually, forms will be sent home with every student the first week of school.

Teacher class lists will be posted after 4:00pm on the Friday before the first day of school.

Please call the office if you have any questions regarding the registration process, we look forward to seeing you next year!

Sincerely,

North Prairie Junior High School

WINTHROP HARBOR SCHOOLS

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(847) 731-3085 • (847) 731-3156 FAX

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Patricia Goodwin, M.S.Ed.
Superintendent

Carrie Nottingham, M.S.Ed.
Principal, North Prairie Jr. High

April 6, 2016

NOTICE TO PARENTS OF A STUDENT IN OUT-OF DISTRICT PLACEMENT

Dear Parent,

This letter is to inform you that you are responsible for registering your child as a District 1 student each year, even though he/she is attending an out-of-district school. This is a requirement of the Illinois School Code and is also a Winthrop Harbor School District board policy.

Along with completing all registration requirements, a registration fee of $120.00 per child is required; however, a $20.00 discount is given if the registration process is completed by May 20, 2016. This fee helps offset the expenses associated with your child's tuition, material and equipment costs for his or her placement.

Thank you for your cooperation.

Sincerely,

Patricia Goodwin, M.S.Ed.
Superintendent

Winthrop Harbor Public Schools

Student Registration 2016-2017

STUDENT INFORMATION please print

Name ______________________ Birthdate ____________ Male ____ Female ____

Address ______________________ Grade ____________

Student Lives With ______________________ Home/Main Phone ____________

Student has siblings(s) at Westfield ____ North Prairie ____

PARENT/GUARDIAN please print

Mother/Guardian ______________________ Day Phone ____________

Address ______________________

Work Place ______________________ Work Phone ____________

Cell Phone ______________________ E-mail ____________

Father/Guardian ______________________ Day Phone ____________

Address ______________________

Work Place ______________________ Work Phone ____________

Cell Phone ______________________ E-mail ____________

EMERGENCY CONTACTS (*People,* ***other than parents,*** *who can pick up your child.)*

Name ______________________ Relationship to student ____________

Home Phone ____________ Work Phone ____________ Cell Phone ____________

Name ______________________ Relationship to student ____________

Home Phone ____________ Work Phone ____________ Cell Phone ____________

Name ______________________ Relationship to student ____________

Home Phone ____________ Work Phone ____________ Cell Phone ____________

FEES

___ Registration Fee $120.00.

OR

____ Early Registration

(if paid before May 20th) $100.00

METHOD OF PAYMENT

Check No. ____________ Cash: Receipt No. ____________

Credit Card: ___Visa ___Mastercard ___Discover

Cardholders Name: ______________________

Card No : ______________________

Expiration Date: ____________ Security Code ____________

Signature ______________________

For Office Use Only: Total Paid ____________ Date Paid ____________ Received by ____________

WINTHROP HARBOR SCHOOLS

DISTRICT NUMBER ONE - LAKE COUNTY
500 NORTH AVENUE, WINTHROP HARBOR, ILLINOIS 60096
PHONE: 847.731.3085 ♦ FAX: 847.731.3156

RESIDENCY VERIFICATION

Student's Name ____

State law requires that all students attending District #1 schools be bona fide residents of the district. Generally, to be a bona fide resident, a student must be living with a parent or legal guardian who resides within our district and possesses appropriate custody documents. At the time a student is registered, parents or guardians will be required to provide at least two documents showing proof of residency.

Registration of a student who is not a resident is a fraudulent act. Any student found to have been fraudulently registered would be dropped from the district rolls immediately. Parents or guardians making a fraudulent registration will be charged 100% of the per capita tuition for the current school year, plus any court costs. This will be determined per day for the time the child attended. The tuition was $10,251.66 for the 2015/16 school year.

Sources of verification required for Proof of Residency are as follows:

1. Current utility bill with bottom portion still attached (cell phone bills _not_ accepted) or deposit receipt indicating address and date

2. Plus one of the following documents:

   ( ) Lease agreement
   ( ) Driver's License or State identification with current address
   ( ) Purchase or Sales Agreement
   ( ) Voter registration
   ( ) Social Services Papers – Social Security, General Assistance or Aid
   ( ) for Families with Dependent Children (AFDC)
   ( ) Rent receipt including verification of landlord's address and phone number
   ( ) Affidavit

______________________________ (Signature of Parent or Guardian)

______________________________ (Date)

______________________________ (Address – City, State and Zip)

Approved by: ______________________________

______________________________ (Date)

Health Services Information

Kindergarten and Sixth Grade Physical Examinations and Immunizations

Physical examinations and up-to-date immunizations are due on or before the first day of school, which is **Monday, August 22, 2016.** Only examinations dated after January 1, 2016 will be accepted. You can get these forms when you register your student. To avoid the late summer rush, we strongly encourage you to make a doctor's appointment now, and have these forms **completed during the summer**. You may mail them to the District Office or bring them to your child's school.

Kindergarten, Second and Sixth Grade Dental Examinations

All Kindergarten, Second grade, and Sixth grade students must have an oral health examination by a licensed dentist. Students will need to have a *Proof of School Dental Examination Form* submitted verifying that a dental exam was performed within 18 months prior to May 15, of the school year. This form is available at each school, and will be sent home in the registration packets. Following your child's exam, please have your dentist complete and sign the form required by the state and return it to the Health Office at your child's school. PLEASE make certain your child's name is on the form.

Vision Examinations

Illinois law requires proof of an eye examination for all children enrolling in Kindergarten and children enrolling for the first time in an Illinois school. A licensed eye care professional will be required to perform the exam. If your child's physician is also certified in eye care, ONLY then will that exam be accepted. This form is available in the school office, as well as in the kindergarten and new student registration packets.

Proof must be received no later than October 15th in order to be compliant with state requirements

Administration of Medication

You must complete the *School Medication Authorization Form* if your child has been prescribed a medication that must be administered during school hours. Please see your school health aide.

* 6th Grade students must have Tdap vaccine.

If you have any questions, please contact one of the following School Health Aides:

Westfield School: Cheri Zeis at 847-872-5438
North Prairie Junior High School: Alice Smith at 847-731-3089

State of Illinois
Certificate of Child Health Examination

Student's Name Last First Middle	Birth Date Month/Day/Year	Sex	Race/Ethnicity	School /Grade Level/ID#
Address Street City Zip Code	Parent/Guardian		Telephone # Home	Work

IMMUNIZATIONS: To be completed by health care provider. The mo/da/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
DTP or DTaP																		
Tdap; Td or Pediatric DT (Check specific type)	☐Tdap☐Td☐DT			☐Tdap☐Td☐DT			☐Tdap☐Td☐DT			☐Tdap☐Td☐DT			☐Tdap☐Td☐DT			☐Tdap☐Td☐DT		
Polio (Check specific type)	☐ IPV ☐ OPV			☐ IPV ☐ OPV			☐ IPV ☐ OPV			☐ IPV ☐ OPV			☐ IPV ☐ OPV			☐ IPV ☐ OPV		
Hib Haemophilus influenza type b																		
Pneumococcal Conjugate																		
Hepatitis B																		
MMR Measles Mumps. Rubella										Comments:								
Varicella (Chickenpox)																		
Meningococcal conjugate (MCV4)																		
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose																		
Hepatitis A																		
HPV																		
Influenza																		
Other: Specify Immunization Administered/Dates																		

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
Signature	Title	Date

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.
*MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.
Date of Disease **Signature** **Title**

3. Laboratory Evidence of Immunity (check one) ☐Measles* ☐Mumps** ☐Rubella ☐Varicella **Attach copy of lab result.**

*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.
**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: ______________________
Physician Statements of Immunity MUST be submitted to IDPH for review.

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and *Maintained* by the School Authority.

Last	First	Middle	Birth Date Month/Day/ Year	Sex	School	Grade Level/ ID

HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)	Yes No	List:	MEDICATION (Prescribed or taken on a regular basis.)	Yes No	List:
Diagnosis of asthma?	Yes No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No	
Child wakes during night coughing?	Yes No				
Birth defects?	Yes No		Hospitalizations? When? What for?	Yes No	
Developmental delay?	Yes No				
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No		Surgery? (List all.) When? What for?	Yes No	
Diabetes?	Yes No		Serious injury or illness?	Yes No	
Head injury/Concussion/Passed out?	Yes No		TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.
Seizures? What are they like?	Yes No		TB disease (past or present)?	Yes* No	
Heart problem/Shortness of breath?	Yes No		Tobacco use (type, frequency)?	Yes No	
Heart murmur/High blood pressure?	Yes No		Alcohol/Drug use?	Yes No	
Dizziness or chest pain with exercise?	Yes No		Family history of sudden death before age 50? (Cause?)	Yes No	

Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)

Dental ☐ Braces ☐ Bridge ☐ Plate Other

Ear/Hearing problems?	Yes No	
Bone/Joint problem/injury/scoliosis?	Yes No	

Information may be shared with appropriate personnel for health and educational purposes.
Parent/Guardian Signature   Date

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE if < 2-3 years old **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐ **Ethnic Minority** Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE: Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)
Questionnaire Administered? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** **Result**

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.
No test needed ☐ **Test performed** ☐ **Skin Test: Date Read** / / **Result: Positive** ☐ **Negative** ☐ **mm**_________
Blood Test: Date Reported / / **Result: Positive** ☐ **Negative** ☐ **Value**

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin			**Endocrine**		
Ears		Screening Result:	**Gastrointestinal**		
Eyes		Screening Result:	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

NEEDS/MODIFICATIONS required in the school setting   **DIETARY** Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ☐ No ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)
PHYSICAL EDUCATION Yes ☐ No ☐ Modified ☐ **INTERSCHOLASTIC SPORTS** Yes ☐ No ☐ Modified ☐

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

State of Illinois
Illinois Department of Public Health

PROOF OF SCHOOL DENTAL EXAMINATION FORM

To be completed by the parent (please print):

Student's Name: Last First Middle		Birth Date: (Month/Day/Year) / /
Address: Street City ZIP Code		Telephone:
Name of School:	Grade Level:	Gender: ☐ Male ☐ Female
Parent or Guardian:	Address (of parent/guardian):	

To be completed by dentist:

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present**

☐ 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 1st 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 **Soft Tissue Pathology**

☐ Yes ☐ No **Malocclusion**

Treatment Needs (check all that apply)

☐ **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

☐ **Restorative Care** — amalgams, composites, crowns, etc.

☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis

☐ **Other** — periodontal, orthodontic

Please note ______________________________

Signature of Dentist ______________________ Date of Exam ______________

Address ______________________ Telephone ______________
Street City ZIP Code

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.idph.state.il.us

Printed by Authority of the State of Illinois

Illinois Department of Public Health
VISION EXAMINATION REPORT

White – Doctor's Referral
Canary – File

Date ____________

Name ____________ Birth Date ____________ Sex ________ Grade ________

Parent or Guardian ____________ Phone ____________

Address ____________ County ____________

Testing Location ____________ Testing Agency ____________ Tester ____________

TO BE COMPLETED FOLLOWING SCREENING

TEST GIVEN

1. Instrument Used ____________
   - a. ☐ Visual Acuity
   - b. ☐ Plus Sphere
   - c. ☐ Muscle Balance
   - d. ☐ Near and Far Binocular Vision
   - e. ☐ Other: ____________

REASON FOR REFERRAL

1. ☐ Visual Acuity
2. ☐ Plus Sphere
3. ☐ Muscle Balance – Phoria
4. ☐ Near and Far Binocular Vision – Fusion

SYMPTOMS NOTED

1. ☐ Academic Achievement
2. ☐ Observable Signs: ____________

TO THE DOCTOR

CHILD WEARING GLASSES OR UNDER CARE

Children wearing glasses or under care are not screened as part of the routine vision screening program. Observations by screening technicians possibly indicate the following:

☐ Frames broken / too small
☐ Lenses scratched / broken
☐ Two years since last examination
☐ Other: ____________

TO BE COMPLETED BY EXAMINING DOCTOR

DISTANCE

(1) UNCORRECTED VISUAL ACUITY		(2) BEST CORRECTED VISUAL ACUITY	
RIGHT	LEFT	RIGHT	LEFT

(3) Ocularmotor Assessment ____________

(4) Diagnosis ____________

(5) Comments ____________

PLEASE CHECK IF APPROPRIATE:

☐ Treatment recommended
- ☐ Medical
- ☐ Glasses
- ☐ Contact Lenses
- ☐ Other: ____________

☐ Corrective lens prescribed
- ☐ Constant Wear
- ☐ Near Vision only
- ☐ Far Vision only
- ☐ May be removed for physical education

☐ Visual field restriction

☐ Amblyopia exists

☐ Muscle imbalance exists
- ☐ Close work may be difficult or cause fatigue

☐ Preferential seating needed

☐ Re-examination advised
- ☐ Six months
- ☐ Twelve months
- ☐ Other: ____________

IMPORTANT NOTICE

THIS STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 81-174. DISCLOSURE OF THIS INFORMATION IS VOLUNTARY, AND THERE IS NO PENALTY FOR NON-COMPLIANCE. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

CONSENT OF PARENT OR GUARDIAN

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

____
PARENT OR GUARDIAN'S SIGNATURE

Please print or stamp

Doctors Name ____________

Address ____________

City ____________

Date of Examination ____________

____
DOCTOR'S SIGNATURE

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DISTRICT NUMBER ONE – LAKE COUNTY

Westfield School
2309 W. 9th Street
Winthrop Harbor, IL 60096
847/872-5438
847/746-1477 (Fax)

North Prairie Junior High
500 North Avenue
Winthrop Harbor, IL 60096
847/731-3089
847/731-3152 (Fax)

School Medication Authorization

To be completed by the child's parent(s)/guardian(s). A new form must be completed every school year. Keep in the school nurse's office or, in the absence of a school nurse, the Building Principal's office.

Student's Name: ______________________________ Birth Date: __________

Address: ____

Home Phone: __________________ Emergency Phone: __________________

School: ____________________ Grade: ______ Teacher: ______________

To be completed by the student's physician, physician assistant, or advanced practice RN:

Physician's Printed Name: ______________________________

Office Address: ______________________________________

Office Phone: __________________ Emergency Phone: __________________

Medication name: ______________________________________

Purpose: ____

Dosage: ______________________ Frequency: ______________________

Time medication is to be administered or under what circumstances:

____

Prescription date: ________ Order date: ____________ Discontinuation date: ________

Diagnosis requiring medication: ______________________________

Is it necessary for this medication to be administered during the school day ? ☐ Yes ☐ No

Expected side effects, if any: ______________________________

Time interval for re-evaluation: ____________________________

Other medications student is receiving: ______________________

____
Physician's signature Date

For only parents/guardians of students who need to carry asthma medication or an EpiPen®:

I authorize the School District and its employees and agents, to allow my child or ward to possess and use his or her asthma medication and/or epinephrine auto-injector: (1) while in school, (2) while at a school-sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities, such as while in before-school or after-school care on school-operated property. Illinois law requires the School District to inform parent(s)/guardian(s) that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-administration of medication or epinephrine auto-injector (105 ILCS 5/22-30). ***If you agree please initial:***______________________
Parent(s)/guardian(s)

For all parents/guardians:

By signing below, I agree that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the School District and its employees and agents, in my behalf, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described above. **I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse and specifically consent to such practices**, and

I agree to indemnify and hold harmless the School District and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication.

________________________________	________________________________
Parent/Guardian printed name	Parent/Guardian printed name
________________________________	________________________________
Parent/Guardian signature* Date	Parent/Guardian signature* Date

** Both parents and/or guardians, if available, should sign.*

Winthrop Harbor School District

2016-17 Calendar

August

Friday	19	Teacher Institute, No Student Attendance Kindergarten Orientation (3:00-3:45)
Monday	22	First Day for Students (WF 8:00am-2:37pm, NP 7:45am-2:22pm)
Monday	29	Map testing (8/29-9/7)
Wednesday	31	WF Curriculum Night (6:30pm-8:00pm)

September

Thursday	1	NP Curriculum Night (6:30pm-8:00pm)
Friday	2	Half Day for Students (WF 11:30am, NP 11:15am)
Monday	5	Labor Day - No School
Thursday	15	Picture Day
Thursday	22	Progress Reports
Monday	26	Teacher Institute, No Student Attendance

October

Monday	10	Columbus Day - No School
Tuesday	25	End of 1st Quarter
Monday	31	Report Cards

November

Thursday	3	Parent/Teacher Conferences 12:00pm-8:00pm - No Student Attendance
Friday	11	Veteran's Day - No School
Wednesday	23	No School
Thursday	24	Thanksgiving Holiday - No School
Friday	25	No School

December

Thursday	1	Progress Reports
Monday	19	Winter Break (12/19-12/30)

January

Monday	2	School Resumes
Wednesday	4	MAP Testing (1/4-1/12)
Monday	16	Martin Luther King Jr. Holiday - No School (Emergency Day if needed)
Wednesday	18	End of 2nd Quarter
Monday	23	Report Cards
Monday	30	Half Day for Students (WF 11:30am, NP 11:15am) Parent/Teacher Conferences 1:00pm-6:00pm

February

Friday	17	Progress Reports
Monday	20	Presidents' Day - No School (Emergency Day if needed)

March

Monday	6	Casimir Pulaski Day - No School (Emergency Day if needed) PARCC Testing TBD
Friday	17	End of 3rd Quarter
Monday	27	Spring Break (3/27-3/31)

April

Monday	3	School Resumes
Tuesday	4	Report Cards
Friday	14	No student attendance
Friday	28	Progress Reports

May

Monday	8	MAP Testing (5/8-5/16)
Monday	29	Memorial Day - No School
Wednesday	31	8th Grade Graduation 7:00pm

June

Thursday	1	Teacher Institute - No Student Attendance
Friday	2	Last Day of School - Field Day, Early Release (NP 1:15pm, WF 1:30pm)

School Cancellations

For date changes or emergency cancellation information, please check the school website at WHSD1.org, the district Facebook page, or listen to local news sources. School cancellations are posted by 6:30am.

In case an emergency day needs to be taken, the next holiday following the emergency day will be used to replace the missing day. This applies to the following holidays: Martin Luther King Jr. Day, President's Day, and Casimir Pulaski Day.

North Prairie	(847) 731-3089
District Office	(847) 731-3085

	M, T, Th, F	Wed. ONLY
Westfield	8:00 - 2:37	8:00-1:40
North Prairie	7:45 - 2:22	7:45 - 1:25