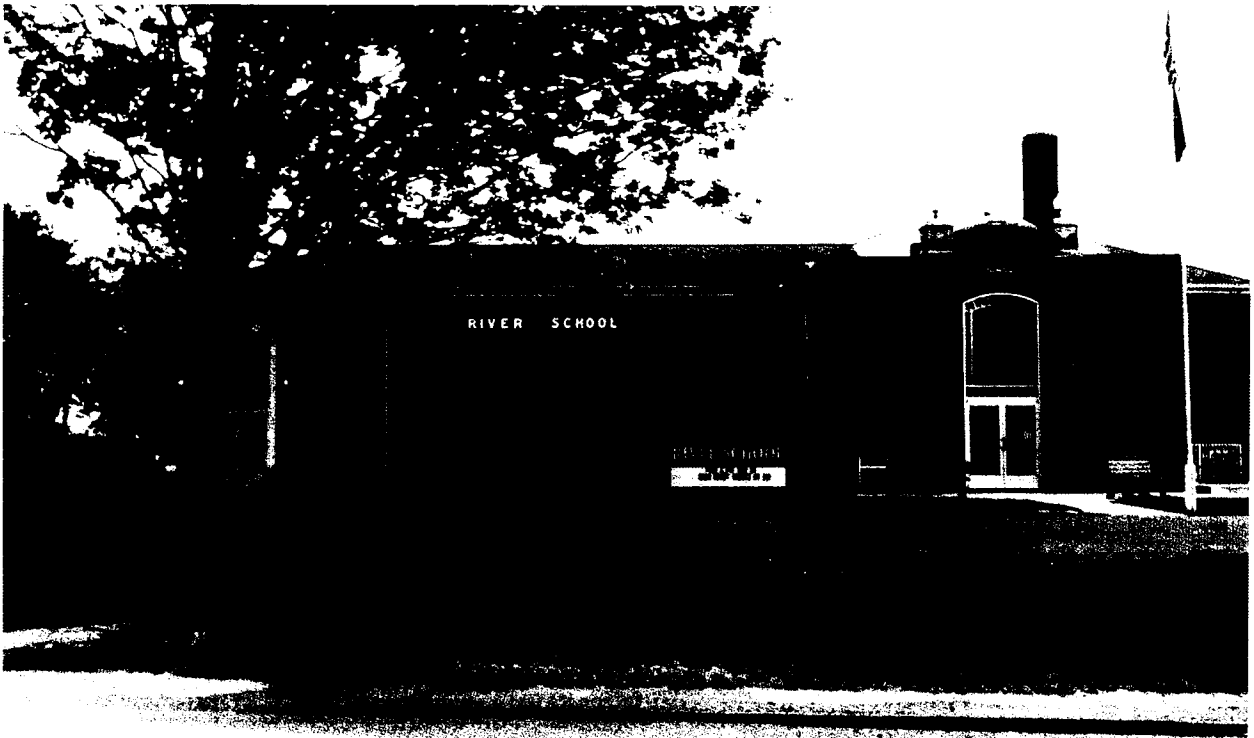


**SODUS TOWNSHIP SCHOOL DISTRICT #5  
RIVER SCHOOL  
4439 RIVER RD  
SODUS, MI 49126  
(269) 925 6757  
WWW.RIVERSCHOOLK8.ORG**

**2024-25  
ENROLLMENT PAPERWORK  
KINDERGARTEN**



**M River School, Sodus Township #5**  
**4439 River Road Sodus, Michigan 49126**  
**Phone (269) 925-6757 Fax (269) 925-3144**

**Kindergarten**

**Parent  
Check-Off**

**School  
Check-Off**

\_\_\_\_\_

\_\_\_\_\_

**Enrollment Form**

\_\_\_\_\_

\_\_\_\_\_

**Authorization to Release School Records** (parent signatures)

\_\_\_\_\_

\_\_\_\_\_

**School of Choice Form**

\_\_\_\_\_

\_\_\_\_\_

**Special Education / IEP** (Administration to confirm with previous school)

\_\_\_\_\_

\_\_\_\_\_

**Residency Information Form**

\_\_\_\_\_

\_\_\_\_\_

**Proof of Residence (Must Have One of the Following)**

- Purchase Agreement
- Current Lease/Rental Agreement
- Current Property Tax Notice

**Must Have One of the Following**

- Current Utility Bill
- Voter's Registration Card
- Other \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Birth Certificate (Certified Copy)**

\_\_\_\_\_

\_\_\_\_\_

**Immunization Record** (completed by doctor or BCHD)

\_\_\_\_\_

\_\_\_\_\_

**Health Appraisal Form** (completed by doctor )

\_\_\_\_\_

\_\_\_\_\_

**Vision/Hearing Form** (completed by doctor or BCHD)

\_\_\_\_\_

\_\_\_\_\_

**Custody Papers** (applicable only if the child is not living with a parent  
Named on the Certified Birth Certificate)

- Guardianship
- Court Placement
- Limited Guardianship

**ENROLLMENT/STUDENT INFORMATION SHEET**

**2024-2025**

**GRADE:** \_\_\_\_\_ **Teacher** \_\_\_\_\_

**Date Enrolled** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Birthdate** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Male** \_\_\_\_ **Female** \_\_\_\_  
Month Day Year Month Day Year

**Location of Birth** \_\_\_\_\_  
City and State

**Student's Name** \_\_\_\_\_ **Phone #** \_\_\_\_\_  
Last First Middle

**Students Address:** \_\_\_\_\_

**Guardian Name (s):** \_\_\_\_\_

**Street Address:** \_\_\_\_\_

**Home Phone #:** \_\_\_\_\_

**\*\*\*Must have valid email address and phone number for one parent at all times\***

**Male Guardian/Parent**

**Female Guardian/Parent**

**Cell Phone #** \_\_\_\_\_

**Cell Phone #** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Work Phone #** \_\_\_\_\_

**Work Phone #** \_\_\_\_\_

**Emergency Contact :** (Please List Someone Other Than Yourself)

**Contact Name:** \_\_\_\_\_ **Phone #** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Contact Name:** \_\_\_\_\_ **Phone #** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Ethnic Code:** Please check all that apply:  Hispanic (1)  White/not hispanic origin (2)  
 Black/not hispanic origin (3)  Asian or Pacific Islander(4)  Amer. Indian/Alaskan (5)

**Is your child's native tongue a language other than English?**  Yes  No

If yes, then what language? \_\_\_\_\_

Is the primary language at home English  Yes  No

**School Last Attended** \_\_\_\_\_

**Address** \_\_\_\_\_ **City/State/Zip** \_\_\_\_\_

**School Phone # ( )** \_\_\_\_\_

Indicate any Special Services Your Child Received at Previous School:

**Speech** \_\_\_\_ **Reading Recovery** \_\_\_\_ **Title I** \_\_\_\_ **504 Plan** \_\_\_\_ **ELS** \_\_\_\_

**Special Education** \_\_\_\_ **Do you have current documentation of services?** Yes  No

**Parent Signature** \_\_\_\_\_

**Rights and Privacy Act**

**STUDENT MEDICAL INFORMATION**

Please check all that apply:

\_\_\_\_ allergies

\_\_\_\_ ADD/ADHD

\_\_\_\_ heart murmur

<input type="checkbox"/> animal*	<input type="checkbox"/> diabetes	<input type="checkbox"/> other heart problems*
<input type="checkbox"/> bee sting*	<input type="checkbox"/> insulin dependent	<input type="checkbox"/> hemophilia
<input type="checkbox"/> environmental*	<input type="checkbox"/> epilepsy	<input type="checkbox"/> other known conditions*
<input type="checkbox"/> food*	<input type="checkbox"/> hay fever	<input type="checkbox"/> non known
<input type="checkbox"/> medication*	<input type="checkbox"/> headaches	<input type="checkbox"/> other*
<input type="checkbox"/> hearing impaired	<input type="checkbox"/> asthma	

**\*\*Additional comments\*\***

Physical limitations: \_\_\_\_\_

**Medication**

I affirm, that as the parent/legal guardian, all information provided above is true and accurate. I understand any false information provided by me, may subject me to legal penalties for perjury. I further authorize River School./Sodus Twp. #5 to share any and all of the aforementioned information with appropriate school staff, for the purpose of providing a safe and healthy environment for my child.

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

Indicate any medication that your child takes and how often it is to be taken.

***If it is to be taken at school, please request an authorization forms.***

**Medication:** \_\_\_\_\_

**Dosage:** \_\_\_\_\_

**How Often:** \_\_\_\_\_

**With whom does child reside:** Please check one:

<input type="checkbox"/> Both Parents	<input type="checkbox"/> Father/Stepmother
<input type="checkbox"/> Father only	<input type="checkbox"/> Mother/Stepfather
<input type="checkbox"/> Mother only	<input type="checkbox"/> Legal guardian
<input type="checkbox"/> Court placed	<input type="checkbox"/> Relative
<input type="checkbox"/> Foster home	<input type="checkbox"/> Other: _____

**DO NOT RELEASE MY CHILD TO:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address if Known: \_\_\_\_\_

Comments: \_\_\_\_\_

Other children who reside in the home: \_\_\_\_\_ Natural Step/half

Name: \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

**OFFICE USE ONLY** Updated information \_\_\_\_ Student Number \_\_\_\_\_ Entry Date \_\_\_\_\_

Birth Certificate \_\_\_Y\_\_\_N Immunization Record \_\_\_Y\_\_\_N

Student Records Requested \_\_\_\_/\_\_\_\_/\_\_\_\_ Received \_\_\_\_/\_\_\_\_/\_\_\_\_

In compliance with the Federal Statute "Family Educational Rights and privacy Act of 1974, Section 99.34 which reads as follows: Schools may send a students educational record to officials of other school systems in which the student seeks or intends to enroll, upon condition that the student's parents be notified of the transfer, receive a copy of the record, if desired and have an opportunity to challenge the content of the record. I affirm that as the parent/legal guardian, all information provided is true and accurate, and that my child and I reside at the above listed address. I understand any false information provided by me, might subject me to legal penalties for perjury. Having read the privacy Act statement above, please send the educational records for this student."



**RIVER SCHOOL**

Sodus Township School District #5 4439 River Rd., Sodus, MI 49126  
Phone 269 925 6757 Fax: 269 925 3144

**Record Release Form 2024-2025**

CHILD'S NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

TELEPHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

PARENT/GUARDIAN \_\_\_\_\_

CHILD'S PRESENT DISTRICT: \_\_\_\_\_

CHILD'S PRESENT SCHOOL \_\_\_\_\_

GRADE LEVEL: 2022-23 \_\_\_\_\_

*According to the final Regulations-Family Educational Rights and Privacy Act (Buckley Amendment), It is no longer necessary to obtain written consent to release records. This information can be found in the Federal Register Vol 41, No 118, dated June 17, 1976*

# RIVER SCHOOL

4439 River Road

Sodus, MI 49126

Phone (269) 925-6757 Fax (269) 925-3144

Email: [llausch@riverschoolk8.org](mailto:llausch@riverschoolk8.org) Home Page: [www.riverschoolk8.org](http://www.riverschoolk8.org)

To: \_\_\_\_\_ Date: \_\_\_\_\_

School: \_\_\_\_\_ Fax: \_\_\_\_\_

From: \_\_\_\_\_

## **Subject: Schools of Choice Application**

The student referenced below has applied for admission to River School under the Schools of Choice Option. We are requesting information in order to evaluate this application as provided for under Section 105 and 105C of the State School Aid Act. Enclosed is a parental release for this information. Your prompt assistance with this form is appreciated, as the student cannot enroll without this information.

Student Name: \_\_\_\_\_ Grade Entering: \_\_\_\_\_

Birth date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_

Has this student ever been expelled? Yes/No

Has this student been suspended during the preceding two years? Yes/No

Does this student have an IEP placement? Yes/No

If yes, who is the contact person for further information?

Name	Phone
------	-------

Person completing this form:

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please send completed form to Carol Quattrin, River School, Sodus Township School District #5, 4439 River Rd., Sodus, MI 49126 or fax to 269-925-3144. Thank you for your assistance

**RESIDENCY INFORMATION FORM**

This questionnaire is in compliance with the McKinney-Vento Act, U.S.C. 42 & 11431 et seq. Your answers will help determine if the student meets eligibility requirements for services under the McKinney-Vento Act.

Student \_\_\_\_\_ Parent/Guardian \_\_\_\_\_

School \_\_\_\_\_ Phone/Pager \_\_\_\_\_

Age \_\_\_\_\_ Grade \_\_\_\_\_ D.O.B. \_\_\_\_\_

Address \_\_\_\_\_

Zip Code \_\_\_\_\_ Is this address Temporary or Permanent? (circle one)

Please choose which of the following situations the student currently resides in (you can choose more than one):

- \_\_\_\_\_ House or apartment with parent or guardian (rent or own)
- \_\_\_\_\_ Motel, car, or campsite
- \_\_\_\_\_ Shelter or other temporary housing
- \_\_\_\_\_ With friends or family members (other than or in addition to parent/guardian)

If you are living in shared housing, please check all of the following reasons that apply:

- \_\_\_\_\_ Loss of housing
- \_\_\_\_\_ Economic situation
- \_\_\_\_\_ Temporarily waiting for house or apartment
- \_\_\_\_\_ Provide care for a family member
- \_\_\_\_\_ Living with boyfriend/girlfriend
- \_\_\_\_\_ Loss of equipment
- \_\_\_\_\_ Parent/Guardian is deployed
- \_\_\_\_\_ Other (Please explain)

Are you a student under the age of 18 and living apart from your parents or guardians? Yes No

**Residency and Educational Rights**

Students without fixed, regular, and adequate living situations have the following rights:

- 1) Immediate enrollment in the school they last attended or the local school where they are currently staying even if they do not have all the documents normally required at the time of enrollment without fear of being separated or treated differently due to their housing situations:
- 2) Transportation to the school of origin for the regular school day;
- 3) Access to free meals, Title I and other educational programs, and transportation to extra-curricular activities to the same extent that it is offered to other students.

Any question about these rights can be directed to the local McKinney-Vento Liaison at 269 925 6757 or the State Coordinator.

By signing below, I acknowledge that I have received and understand the above rights.

\_\_\_\_\_  
Signature of Parent/Guardian/Unattached Youth

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of McKinney-Vento Liaison

\_\_\_\_\_  
Date

### HEALTH APPRAISAL

**Dear Parent or Guardian:** The following information is requested so that the school can work with the parent to meet the physical, intellectual and emotional needs of the child. Fill out the information requested in Section I. Section III may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse and dentist (**BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION**).

**PERSONAL**

CHILD'S NAME (Last, First, Middle)	(City)	(ZIP Code)	DATE OF BIRTH (mm/dd/yy) / /
ADDRESS (Number & Street)		MI	TODAY'S DATE (mm/dd/yy) / /
PARENT/GUARDIAN (Last, First, Middle)			HOME TELEPHONE NUMBER { }
ADDRESS (Number & Street)		MI	WORK TELEPHONE NUMBER { }

#### SECTION I - HEALTH HISTORY

<p><b>Yes No Res # Is your child having any of the problems listed below?</b></p> <p>h h h 1 Allergies or Reactions (for example, food, medication or other)</p> <p>h h h 2 Hay Fever, Asthma, or Wheezing</p> <p>h h h 3 Eczema or Frequent Skin Rashes</p> <p>h h h 4 Convulsions/Seizures</p> <p>h h h 5 Heart Trouble</p> <p>h h h 6 Diabetes</p> <p>h h h 7 Frequent Colds, Sore Throats, Earaches (4 or more per year)</p> <p>h h h 8 Trouble with Passing Urine or Bowel Movements</p> <p>h h h 9 Shortness of Breath</p> <p>h h h 10 Speech Problems</p> <p>h h h 11 Menstrual Problems</p> <p>h h h 12 Dental Problems: Date of Last Exam / /</p> <p>h h h Other (please describe):</p> <p>h h Does your child take any medication(s) regularly?</p> <p>Reason for Medication</p> <p>Parent/Guardian Signature _____ Date / /</p>	<p><b>Birth History:</b></p> <p>Are there any current or past diagnosis(es) h Yes h No</p> <p>If yes, please describe:</p> <p>If yes, list medications:</p> <p>Was the health history reviewed by a health professional?</p> <p>h Yes h No Examiner's Initials:</p>
--	---

#### SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

##### Tests and Measurements

No	Yes	Was child tested for:	Test results:	No	Ref	Un	No	Yes	Was child tested for:	Test results:	No	Ref	Un
h	h	VISION	Visual Acuity Muscle Imbalance Other: Date: / /				h	h	HEIGHT & WEIGHT	Height Weight Other:			
h	h	HEARING	Audiometer Other: Date: / /				h	h	HEMOGLOBIN / HEMATOCRIT				
h	h	URINALYSIS	Sugar Albumin Microscopic: Date: / /				h	h	TUBERCULIN	Type Date: / / Neg: h Pps: h mm			
		BLOOD LEAD LEVEL	Level: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>						NOTE: Blood lead level required for all children enrolled in Medicaid must be tested at the same intervals as listed above.				
<p>Examinations and Measurements</p> <p>Basic Findings Deviating from Normal: _____</p> <p>Date: / /</p>													



<b>SECTION III - IMMUNIZATIONS</b>					
Statements such as 'UP-TO-DATE' or 'COMPLETE' will not be accepted. Admission to school may be derived on the basis of this information.					
VACCINES (Circle Type)	DATE ADMINISTERED MMDD/YYYY		VACCINES (Circle Type)	DATE ADMINISTERED MMDD/YYYY	
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)	1	2
	2			2	3
DTaP/DTaP/DT/d	1	4	Influenza (IV/LAIV)	1	3
	2	5	2	4	
	3	6	Meningococcal (MCV4 / MPSV4)	1	2
Tdap	1		Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
Haemophilus influenzae type b (HIB)	1	3	2		
	2	4	OTHER Vaccines	Type of Vaccine(s)	Date of Vaccine(s)
Polio (IPV/OPV)	1	3	Specify Date &	1	
	2	4	Type	2	
Pneumococcal Conjugate (PCV7/PCV13)	1	3	3		
	2	4	Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable		
Rotavirus (RV1/RV5)	1	3	*NOTE: According to Public Act 368 of 1978, any child enrolling in a Michigan school for the first time must be adequately immunized, vision tested and hearing tested. Exemptions to these requirements are granted for medical, religious and other objections, provided that the waiver forms are properly prepared, signed and delivered to school administrators. Forms for these exemptions are available at your provider office for medical waiver forms and through your local health department for nonmedical waiver forms.		
	2				
Measles, Mumps, Rubella (MMR)	1	2	Parent/Guardian refused immunizations: <input type="checkbox"/>		
Varicella (Chickenpox)	1	2	I certify that the immunization dates are true to the best of my knowledge.		
History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, date _____			Health Professional's Signature _____ Title _____ Date _____		

		<b>SECTION IV - RECOMMENDATIONS</b> (Required for Child Care and Head Start/Early Head Start)	
h	h	Is there any defect of vision, hearing or other condition for which the school could help by seating or other actions? If yes, please explain.	
h	h	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): <input type="checkbox"/> Classroom <input type="checkbox"/> Playground <input type="checkbox"/> Gymnasium <input type="checkbox"/> Swimming Pool <input type="checkbox"/> Competitive Sports <input type="checkbox"/> Other _____	
Other Recommendations _____			

<b>SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)</b>		
I have examined _____	s teeth. As a result of this examination, my recommendation for treatment is _____	child's name _____
Dentist's Signature _____ Date _____		

<b>PHYSICIAN'S SIGNATURE</b>			
Examiner's Signature _____	Date _____	Examiner's Name (Print or Type) _____	Degree or License _____
Number & Street _____	City, ZIP Code _____	Telephone _____	

**Early On** - Hearing and Vision Status; Diagnosis; Health Status  
**Child Care Licensing** - Physical Exam, Restrictions, Immunizations  
**Head Start/Early Head Start** - Determination that child is up-to-date on a schedule of age-appropriate preventive and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-child care visit required by EPSDT and the latest immunizations schedule recommended by the Centers for Disease Control and Prevention, State, tribal, and local authorities. An EPSDT well-child exam includes height, weight, and blood tests for anemia at regular intervals based on age  
 \*\*\*\*\*  
 Developed in Cooperation with the Department of Health and Human Services, Education, Michigan American Association of Pediatrics, Early Childhood Investment Corporation, Child Care Licensing, Head Start, Michigan State Medical Society, Michigan Association of Osteopathic Physicians and Surgeons.

**River School, Sodus Township #5**  
**4439 River Road Sodus, Michigan 49126**  
**Phone (269) 925-6757 Fax (269) 925-3144**

**IMMUNIZATION REQUIREMENTS**

State law requires that each student entering school be current with immunizations on the first day of school. Please provide your child's immunization record when you complete this enrollment packet. A copy of your child's record will be made and the original returned to you.

Because of changes in the immunization laws, please check to see that your child is up-to-date on all immunizations. **Your child will not be allowed to enter school without being current on all immunizations.**

DPT	4 doses required. If the last dose was not given on or after the 4 <sup>th</sup> birthday, a booster dose is required. Most children will have 5 doses.
Tetanus	A tetanus booster is required 5 years after initial series is complete. Then every 10 yrs booster
Polio	3 doses are required. If the last dose was not given on or after the 4 <sup>th</sup> birthday, a booster dose is required. Most children will have 5 doses
MMR	2 doses are required
Hepatitis B	3 doses are required
Varicella	2 doses of varicella (Var) vaccine or history of chickenpox disease. (Required for all children entering kindergarten, all 6 <sup>th</sup> grade students, and all children Changing school district)
HIB	4 doses are required

Required for all children 11-18 years of age who are changing school districts or who are enrolled in 6<sup>th</sup> grade:

+1 dose of meningococcal (MCV4 or MPSV4) vaccine.

+1 dose of tetanus/diphtheria/acellular pertussis (Tdap) vaccine

(If 5 years have passed since last dose of tetanus/diphtheria vaccine – DtaP or DT)

You are eligible for vaccines at the Health Department if your health insurance doesn't cover vaccines. You may call the Berrien County Health Department main phone number at 926-7122 for other times and locations in Berrien County.

If immunizations are against your belief, please contact the Office at 269 925 6757

**Health Department Immunization Clinic**

**Berrien County Health Department**

**Benton Harbor, MI 49023**

**(269) 927 5638**

**River School, Sodus Township #5**  
**4439 River Rd, Sodus, Michigan 49126**  
**Phone (269) 925-6757 Fax (269) 925-3144**

## **TO SECURE A CERTIFIED BIRTH CERTIFICATE FOR YOUR CHILD**

If your child was born in Berrien County:

- Go to Berrien County Administration Building at 701 Main St., St. Joseph (Clerk of the Circuit Court – Vital Records Division)
- The cost is \$13.00 (subject to change).
- Additional copies of the same record, ordered at the same time are \$4.00 each.
- Phone number: 269-983-7111, ext. 8233
- Hours: Hours may vary. Please refer to the website to for current hours.

If your child was born outside of Berrien County or in another state:

- Contact the courthouse in the county/state in which your child was born.
- You may find links for each state at [www.cdc.gov/nchs/w2w.htm](http://www.cdc.gov/nchs/w2w.htm)
- The cost may vary from state to state.
- Start the process as soon as possible. If you are dealing with a large city, such as Chicago, it can take quite a while to get your document.

## **TO SECURE A MICHIGAN DRIVER'S LICENSE OR STICKER FOR YOUR CURRENT MICHIGAN DRIVER'S LICENSE, AND TO SECURE A VOTER'S REGISTRATION CARD**

- Go to the NW Berrien County PLUS office, located at 1960 Mall Place, Benton Harbor (Secretary of State's Office near Meijer and Lowe's), or go online at [www.michigan.gov/SOS](http://www.michigan.gov/SOS) and click on "Driver's License" or "How Do I" to find out how.
- If you are new to the state, a Michigan license costs \$25.00 (subject to change).
- If you have a current license, but have changed addresses, you can get a sticker for the back of your license (online or in person) with your new address at no cost.
- You can also get a voter's card or update your current voter's card with your new address at no cost.
- PLUS office phone number: 888-767-6424.
- PLUS office hours: Hours may vary. Please refer to the website to for current hours.

**River School, Sodus Township #5**

**4439 River Road Sodus, Michigan 49126**

**Phone (269) 925-6757 Fax (269) 925-3144**

**Kindergarten Readiness Skills**

Here are several kindergarten readiness skills to focus on as you work with your child. Do not be over concerned if he or she does not have them all down before the first day of kindergarten. These are skills we will continue to work on throughout the year. Try the activities listed in the skill areas your child may need to work on before school starts in the fall. Use the Help Us To Know Your child Questionnaire as a guide to the areas needing work.

**Writing**

\*Help our child practice writing letters, especially the letters in his or her name.

\*Teach your child how to write his or her name with an uppercase first letter and the remaining letters in lowercase.

\*Write in shaving cream in the bathtub, salt or sugar in a cake pan, or in finger paint to make practicing more fun and multisensory.

\*Let your child see that written words are a part of daily life. Make grocery lists together, or write notes to relatives and friends. Point out the different ways that you use writing in your daily routine.

\*Let your child use school tools such as pencils, markers, crayons, and scissors. Gather and organize these materials, along with some paper, in a box that your child can decorate and have access to.

**Letter Recognition**

\*Play games to help your child recognize some letters of the alphabet.

\*Play hide and seek with refrigerator and alphabet magnets.

\*Use ABC flashcards to play go fish.

\*Make a name card for your child. Display the card in a special place, and talk about the names of the letters.

**Beginning Sounds**

\*Make your child aware of the sound that each letter makes.

\*Find items around the house that begin with the same sound and identify the letter that makes each sound.

\*Overemphasize the first sound in words to help your child hear the individual sounds in words.

**Number Recognition and Counting**

\*Count throughout the day (for example, the crackers she is eating for snack or the socks you take out of the dryer.)

\*Point out numbers you see in your environment and have your child name them (for example, the numbers of food boxes, toys, houses, or street signs).

\*Use number words, point out numbers, and involve your child in counting activities as you go through your day.

**Shapes and Colors**

\*If your child is having trouble recognizing certain colors, you might add a little food coloring to cookie dough, milk, or vanilla pudding to emphasize those colors.

\*Help your child recognize shapes by showing her how to draw them on paper and cut them out.

\*Play games in which your child finds objects of particular colors and shapes around the house or in the neighborhood as you drive.