SHERIDAN SCHOOL DISTRICT
DISTRICT ADMINISTRATION
400 NORTH ROCK STREET | SHERIDAN, AR 72150 | 870.942.3135 | WWW.SHERIDANSCHOOLS.ORG

Dear Parents,

Sheridan School District is looking forward to meeting its new kindergarten students and their parents. We are excited about making your child's experience in school a happy one. Kindergarten registration for the 2018-19 school year will be held from 10 a.m. to 6 p.m. on March 26 and March 29 at both Sheridan Elementary and East End Elementary.

Please bring your child to registration. We will conduct a short kindergarten screening at this time. Also, parents are asked to bring the following information about the child at the time of registration:

- ☐ Birth certificate or another form of identification (Child must be 5 years old on or before August 1, 2018.)
- ☐ Identification number (This may be the child's Social Security number or you may request that a school assigned number be used.)
- ☐ Completed immunization record that includes:
- ☐ Proof of residency. Those who do not live in the Sheridan School District may select the School Choice option in order to enroll. The deadline for School Choice applications is May 1, 2018. For more information about School Choice contact Katy Miller at 870-942-3135 or katymiller@sheridanschools.org.
- ☐ Current proof of a physical examination within the past 24 months. The district will also accept this documentation within 90 days after the student is initially enrolled.

The enclosed forms may be completed at home prior to registration.

This is an exciting time! We look forward to working with you to provide a positive and rewarding education for your child in the Sheridan School District. Please let us know if you have any questions about kindergarten or the registration process.

You may come anytime during the hours of registration. However, we are currently setting up appointments to reduce waiting times. To set up an appointment, please contact:

Sheridan Elementary School Office – 870-942-3131
East End Elementary School Office – 501-888-4264

Sincerely,

Dr. Bridget Polk
Assistant Superintendent, Curriculum and Professional Development
Sheridan School District

Inspire. Empower. Serve.

Kindergarten Registration Check List
2018 - 2019

Proof of residency (Property Assessment – If you have questions please call:

- Sheridan Elementary School – Office – 870-942-3131
- East End Elementary School – Office 501-888-4264

Those who do not live in the Sheridan School District may select the School Choice option in order to enroll. The deadline for School Choice applications is May 1, 2018. For more information about School Choice contact Katy Miller at 870-942-3135 or katymiller@sheridanschools.org.

The child entering kindergarten must be 5 years old on or before August 1, 2018. Documentation of student's date of birth including one of the following is required:

- birth certificate
- hospital record
- attested baptism certificate
- passport
- statement from the local registrar or court recorder
- affidavit of the date and place of birth by the child's parents or guardian
- a United States Military Identification

Identification number (This may be the child's Social Security number or you may request that a school assigned number be used.)

Student General Information Form (front and back)

Completed immunization record that includes: 4 doses of Diphtheria, Tetanus, Pertussis with 1 dose on or after the 4th birthday, 3 doses of Polio with 1 dose on or after the 4th birthday, 2 doses MMR (measles, mumps, rubella) with dose 2 on or after the 1st birthday, 3 doses of Hepatitis B, 1 dose of Hepatitis A on or after the 1st birthday, and 2 doses of Varicella (chickenpox) with dose1 on or after the 1st birthday and dose 2 at least 28 days after dose 1.

Health Services Form

Health History Form (front and back)

Physical Assessment Form - Current proof of a physical examination within the past 24 months. The district will also accept this documentation within 90 days after the student is initially enrolled.

Home Language Form

Custody Paperwork (if applicable)

GENERAL STUDENT INFORMATION

FIRST NAME:	**MIDDLE NAME:**	**LAST NAME:**

Birthdate:______________________ Gender: Female Male

Nickname:______________________________ Grade:___________

SSN (Optional):_____________________ Hispanic/Latino Ethnicity: Yes No

RACE Please answer the following in accordance with standards issued by the US Department of Education.

PRIMARY RACE (Please select only **ONE**).

☐ **American Indian or Alaska Native** (A person having origins in any of the original peoples of North and South America, including Central America, and who maintains tribal affiliation or community attachment)

☐ **Asian** (A person having origins in any of the original peoples of Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand and Vietnam)

☐ **Black or African American** (A person having origins in any of the black racial groups of Africa)

☐ **Native Hawaiian or Other Pacific Islander** (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands)

☐ **White** (A person having origins in any of the original peoples of Europe, Middle East or North Africa)

ADDITIONAL RACES (check all that apply):

_____American Indian/Alaska Native _____Asian _____Black

_____Native Hawaiian/Other Pacific Islander _____White

Language Spoken At Home:______________________ Student Email Address:____

Student Physical/911 Address	**Student Mailing Address**
	☐ Mailing Address is same as Physical/911 Address
Address:____	Address:____
City:____	City:____
State:__________ Zip Code:__________________	State:__________ Zip Code:__________________

Student Home Phone:______________________ Student Cell Phone:______________________

PARENT/GUARDIAN CONTACT INFORMATION

Parent/Guardian 1	**Parent/Guardian 2**
Name:____	Name:____
Relationship to Student:__________________________________	Relationship to Student:__________________________________
Language of Correspondence:________________________________	Language of Correspondence:________________________________
Mailing Address:____	Mailing Address:____
City:____	City:____
State:__________ Zip Code:__________________	State:__________ Zip Code:__________________
Email:____	Email:____
Home Phone:________________ Cell Phone:__________________	Home Phone:________________ Cell Phone:__________________
Work Phone:________________ *Alert Phone:________________	Work Phone:________________ *Alert Phone:________________
*Alert Phone is used by the district's automated phone message system.	*Alert Phone is used by the district's automated phone message system.
Employer:____	Employer:____
☐ Student Primarily Resides with this Guardian.	☐ Student Primarily Resides with this Guardian.

OFFICE USE ONLY

Entry Date:________________	Meal ST:_________________	ESL:________	IMMG:________	Residency:________
Entry Code:________________	M/V Act:_________________	SP:_________	GT:______________	Choice LEA:________
Curriculum:________________	504:____________________	MIG:________	Homeroom:___________	P/T ADM %:________

ADDITIONAL STUDENT INFORMATION

City of Birth:________________________________ State of Birth:______________ Birth Country:____________________________

TRAVEL INFORMATION

Travel To School (Please check one)

____Bus (Bus Number_________)
____Drives Self
____Parent/Guardian (includes walkers, child care vans, etc.)
____District Paid Transportation

Travel From School (Please check one)

____Bus (Bus Number_________)
____Drives Self
____Parent/Guardian (includes walkers, child care vans, etc.)
____District Paid Transportation

Distance From Home to School (Miles) One Way:__________________

Pre-School Participation:

A - ARKANSAS BETTER CHANCE
E - EVEN START
EC - EARLY CHILDHOOD
H - HEADSTART
NA - NOT APPLICABLE
C - 21st CENTURY COMMUNITY LEARNING CENTER
O - OTHER
P - PRIVATE PRE-SCHOOL
PS - PUBLIC SCHOOL PRE-SCHOOL

Birth Certificate #:_____________________________ Resident County:______________________________

Is this child a dependent of an active or reserve member of a branch of the United States Armed Services? Yes No

If this child resides in a household with an active or reserve member of a branch of the United States Armed Services, please select the branch below.

____ Active Duty – US Army
____ Active Duty – US Air Force
____ Active Duty – US Navy
____ Active Duty – US Marines
____ Active Duty – US Coast Guard
____ Reserves – US Army
____ Reserves – US Air Force
____ Reserves – US Navy
____ Reserves – US Marines
____ National Guard – US Army
____ National Guard – US Air Force
____ Parents serve in multiple branches

Is this student a twin (or a triplet, quadruplet, etc.)? Yes No

ADDITIONAL CONTACT INFORMATION

Additional Guardian Contact

Name:____ Email:____

Relationship to Student:____ Home Phone:________________ Cell Phone:__________________

Language of Correspondence:_____________________________________ Work Phone:________________ *Alert Phone:________________

Mailing Address:____ *Alert Phone is used by the district's automated phone message system.

City:____ Employer:____

State:__________ Zip Code:__________________ ☐ Student Primarily Resides with this Guardian.

Emergency Information

Emergency Contact Information (Contacts Other Than Guardians to be Called in Case of an Emergency)

Contact Order	**Name**	**Relationship to Child**	**Phone #**	**Phone Type (ex: Home, Cell, Work)**
1				
2				
3				
4				
5				

Physician:____ Physician:____

Physician Phone:____ Physician Phone:____

Please list any medical concerns and/or medications for this child:____

____

Last School Attended:____ Phone #:__________________

Address:____

Has this child been expelled from school in any other school district or is the child a party to an expulsion proceeding? Yes No

Has this child been retained? Yes No

Has this child met the requirements of the Arkansas State Health laws necessary to enter school? Yes No

Please list the names of anyone who IS NOT ALLOWED to check out/pick up this child from school: ______________________________________

______________________________________ ______________________________________ ______________________________________

____ __________________

Parent/Guardian Signature Date

Sheridan School District
Sheridan, Arkansas
Immunization Verification

I understand that ______________________________________ is being enrolled in the Sheridan School District on a conditional basis pending the receipt of records from the school that he/she last attended. The law of the State of Arkansas allows a provisional admittance of 30 days from the date of enrollment in order for the student to produce documentation of the required immunization. If records from that school do not include satisfactory evidence of immunizations required by the State of Arkansas, the student may be suspended from school until an immunization program is started.

Below is a listing of the immunizations required by the State of Arkansas in order to enroll in a public school. My signature below indicates that I agree to begin an immunization program if immunizations are incomplete.

Parent Signature: ____ Date: ___________

Printed Name: ____

Pre-Kindergarten Requirements:

- 5 DTaP with 5th dose after 4th birthday OR 4 doses with last dose after 4th birthday
- 4 Polio with last dose after 4th birthday and a minimum interval of 6 months between 3rd and 4th dose
- 1 MMR
- 3 Hepatitis B given at correct intervals
- 1 Varicella – chicken pox (dose must be after 1st birthday) (2nd dose required before student enters Kindergarten)
- HIB 3-4 doses with last dose on/after 1st birthday OR 1 dose on/after 15 months of age if no prior (not required on/after 5th birthday)
- 3-4 Pneumococcal with last dose on/after 1st birthday OR 1 dose on/after 24 months of age if no prior doses OR 2 doses on/after 1st birthday (not required on/after 5th birthday)
- 2 Hepatitis A with one dose on or after 1st birthday and at least 6 months from first dose

Kindergarten Requirements:

- 4 DTaP (with at least one dose on/after 4th birthday)
- 3 Polio (with at least one dose after 4th birthday and a minimum interval of 6 months between 3rd and 4th dose)
- 2 MMR (First dose on/after 1st birthday and 2nd dose at least 28 days after 1st dose)
- 3 Hepatitis B given at correct intervals
- 2 Varicella – chicken pox (with dose 1 on or after 1st birthday and dose 2 at least 28 days after dose 1st dose ***or*** A medical professional history of disease may be accepted in lieu of receiving vaccine)
- 1 Hepatitis A (1 dose on or after 1st birthday)

1st Through 12th Grade Requirements:

- 4 DTaP (with at least one dose after 4th birthday)
- 1 Tdap at age 11 years or older by September 1st of each year
- 3 Polio (with at least one dose after 4th birthday with a minimum interval of 6 months between the 3rd and 4th dose)
- 2 MMR (First dose on/after 1st birthday and 2nd dose at least 28 days after 1st dose)
- 3 Hepatitis B given at correct intervals
- ***All 7th grade***: required to have one MCV4 (Meningococcal) vaccine - 2nd dose at age 16 years ***or*** if first dose is administered at age 16 years or older, no second dose required ***or*** 1 dose if not vaccinated prior to age 16 years
- 2 Varicella – chicken pox – (dose must be on/after 1st birthday and 2nd dose at least 28 days after 1st dose) ***or*** A medical professional history of disease may be accepted in lieu of receiving vaccine.
- ***All 1st grade:*** *required to have one Hep A given on or after the 1st birthday*

Health Services Form **Sheridan School District School Year 2018-2019**

This form is to be completed by the student's parent or guardian and returned to school immediately. This information will assist us in updating the student's health record.

Date_________________ Grade_____________ Home Room Teacher ____

Student's Name____ Date of Birth _______________________

Address ______________________________________City: _________________________________ Zip______________________

Parent or Guardian's Name____

Father's Work #: ______________________ **Mother's Work #:**__________________________________
Cell #: ________________________ **Cell #:**____________________________________
Home #: ______________________ **Home #:**__________________________________

List name and grades of siblings in school__________________________________, ______________________________________,

_________________________, _______________________________, ____

Person to contact in case of emergency if parent or guardian is UNAVAILABLE:

NAME ___________________________________ NAME ___________________________________
Phone # ___________________________________ Phone # ___________________________________

Does the student have any health problems that might interfere with normal school activities including participation in physical education class?
No__________ Yes __________ Describe ____

Does the student have any other health problems that the school nurse and teacher should know about such as diabetes, asthma, allergies, hearing, vision, epilepsy, heart condition, etc?
No__________ Yes___________ Describe ____

If a medical condition exists, does the **condition require** the development of an Individual Health Care Plan for your child?
No __________Yes __________

List allergies: ____
List any allergies to medications: ____
List any prescription medications to be given on a daily basis *at school*: ____

Circle the following first aid treatments that may be used on your child:

Calamine Caladryl Peroxide Bactine Neosporin Hydrocortisone Cream

IN CASE OF EXTREME EMERGENCY, I AUTHORIZE THE SCHOOL TO ARRANGE FOR AMBULANCE OR EMERGENCY SERVICE AT MY EXPENSE, TO THE NEAREST HOSPITAL OR DOCTOR OF MY CHOICE, OR THE NEAREST HOSPITAL TO THE SCHOOL.

____ ______________________________
Parent Signature Date

FAMILY PHYSICIAN____________________________________ PHONE NUMBER ___________________________________
HOSPITAL CHOICE_____________________________________ ADDRESS____

*Bus Rider*________ *Bus Number* ________ *Car Rider* ________ *Walker* ________

This medical information will be shared in confidence with individuals responsible for student care while the student is at school or at school functions.

Parent/Guardian Signature____ Date____________________

ARKANSAS DEPARTMENT OF EDUCATION
HEALTH HISTORY
DEVELOPED BY A COMMITTEE OF THE ARKANSAS HEALTH CARE ACCESS COUNCIL

NOTE: To be completed by the parent/guardian of the Kindergarten student prior to the physical examination/nursing assessment (please print).

Student Name (Last, First, Middle)	Birth Date (MO./DAY/YR.) / /	School	Medicaid Number Medicaid Physician
Parent/Guardian Name (Male)	Phone	Parent/Guardian Name (Female)	Phone
Physician Name and Address (If no regular physician, write "None")	Phone		
Dentist Name and Address (If no regular dentist, write "None")	Phone		
Other source(s) from which the student receives health care (If none, write "None")	Phone		
Name and address of private health insurance carrier:			

To be completed by parent/guardian (please circle one):

	Question		
1.	Does your child pay attention when being read to?	Yes	No
2.	Can your child play quietly alone for over a ½ hour?	Yes	No
3.	Does your child mind adults and follow instructions?	Yes	No
4.	Does your child speak clearly enough for other to understand?	Yes	No
5.	Does your child have any speech problems (stammering, delayed	Yes	No
6.	Does your child object to being left with a sitter	Yes	No
7.	Can your child dress without help?	Yes	No
8.	Does your child ever wet or soil him/herself during the day	Yes	No
9.	Do you have any concerns about your child's general health (eating and sleeping habits, bowel or bladder, posture, teeth, skin, weight, etc.)?	Yes	No

10. Does your child have any eye problems (difficulty seeing, crossed eyes, frequently reddened or watery eyes, wear glasses or contact lenses)?	Yes	No
11. Does your child have any ear or hearing problems (frequent earaches, difficulty hearing, draining ear, use a hearing aid, etc.)?	Yes	No
12. Does your child have any allergies (foods, insects, drugs, pollens, etc.)?	Yes	No
13. Does your child have any specific sickness which might in your opinion affect his school performance or program?	Yes	No
a) Has your child received any medical or other evaluation, the findings of which could help school personnel in meeting his/her health or educational needs?	Yes	No
b) Does this problem require any health care in the school?	Yes	No
c) Does your child take medications?	Yes	No
14. Do you have any concerns about your child's developmental behavior or emotional well being of which the school should be aware?	Yes	No

If you answered **YES** to any of the preceding questions, please describe the problem or concern you have below:

Question Number	Description

Information on this form may be shared with appropriate personnel for health and educational purposes.

Parent's Signature______________________________________ Date______________________________

KINDERGARTEN PHYSICAL ASSESSMENT

To be Completed by Physician, Nurse or School Health Professional

REQUIRED

	NL	ABNL	Comments
B/P:____________________ WT:________HT:________			
SKIN: Color, Rash, Swelling, Hair, Nails			
EYES: Conjunctiva, Cornea, Pupils, Extraocular Movement.			
EARS: Pinnae, Canals, Tympanic Membrane, Appearance, Mobility			
NOSE: Nares, Turbinates			
MOUTH: Tongue, Teeth, Oral Mucosa, Tonsils, Pharynx			
NECK: Thyroid, Range of Motion			
NODES: Cervical, Axilary, Inguinal, Other			
HEART: Rate, Rhythm, S1, S2, Murmur, Femoral Pulses			
LUNGS: Rate, Auscultation, Percussion			
ABDOMEN: Contour, Palpation of liver, Spleen, Kidneys, Mass: Tenderness			
GENITO-URINARY: Female external, Male Penis, Meatus, Testes, Hernia			
MUSCULOSKELETAL: Range of Motion, Tenderness, Edema, Clubbing Spine (Curvature).			
NEUROLOGICAL: Gait, Cerebullar Function, Motor System (Strength, Tone): Cranial Nerves (Gross)			
DEVELOPMENTAL			
Gross Motor			
Fine Motor			
Social			
Speech/Language			

SUPPLEMENTAL (optional)

	Date	NL	Comments
Hemoglobin			
Hematocrit			
Urinalysis			
Other			

Medications_________________________________

____

____

Diet Restrictions_____________________________

____

____

Special Equipment____________________________

____

____

Allergies____________________________________

____

____

General comments/Recommendations____________

____

____

____

____

____

____

I have performed a physical assessment on this child on the date indicated, and have arranged for any follow-up that was or is needed.

Signature__________________________Phone______________________Date Signed_________________Date of Exam________________

Physician, Nurse or School Health Professional

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Arkansas Department of Education (ADE)
Home Language Usage Survey

The Home Language Usage Survey is completed by *all* students initially enrolling in Arkansas schools.

Student Name:		**Grade:**	**Date:**
School:	**Student State ID #:**	**Gender:**	**Date of Birth:**
Parent/Guardian Name:		Parent/Guardian Signature:	

Right to Translation and Interpretation Services Indicate your language preference so we can provide an interpreter or translated documents, free of charge, when you need them.	All parents have the right to information about their child's education in a language they understand. 1. a) In what language do you prefer to receive written communication from the school? ________________________________ b) In what language would you prefer to communicate with school staff when speaking? ________________________________
Eligibility for Language Development Support Information about the student's language usage helps us identify students who may qualify for extended support to develop the language skills necessary for success in school. Testing may be necessary to determine if language supports are needed.	2. What language(s) is (are) spoken in your home? ________________________________ 3. What language did your child learn first? ________________________________ 4. What language does your child use most often at home? ________________________________ 5. What language does your family speak most often at home? ________________________________ 6. What language do adults speak most often with each other at home? ________________________________
Prior Education Your responses about your child's birth country and previous education give us information about the knowledge and skills your child is bringing to school. ***This form is not used to identify students' immigration status.***	7. Where was your child born? __________________ 8. When did your child first attend a school in the United States (this includes all US territories)? (**Kindergarten – 12th grade**) ______________________ Month Day Year

Thank you for providing the information needed on the Home Language Survey. Contact your child's school if you have further questions about this form or about services available at your child's school.

Note to district: *This form is available in multiple languages on http://www.arkansased.gov/divisions/learning-services/english-learners A response that includes a language other than English to questions #1-6 indicates English language proficiency screening is needed.*

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