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

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 dose 1 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**

<table>
<thead>
<tr>
<th>FIRST NAME:</th>
<th>MIDDLE NAME:</th>
<th>LAST NAME:</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Address:</th>
<th>Address:</th>
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<tbody>
<tr>
<td>City:</td>
<td>City:</td>
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<tr>
<td>State:</td>
<td>State:</td>
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<tr>
<td>Zip Code:</td>
<td>Zip Code:</td>
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</tbody>
</table>

Mailing Address is same as Physical/911 Address

**Parent/Guardian Contact Information**

<table>
<thead>
<tr>
<th>Parent/Guardian 1</th>
<th>Parent/Guardian 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Name:</td>
</tr>
<tr>
<td>Relationship to Student:</td>
<td>Relationship to Student:</td>
</tr>
<tr>
<td>Language of Correspondence:</td>
<td>Language of Correspondence:</td>
</tr>
<tr>
<td>Mailing Address:</td>
<td>Mailing Address:</td>
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<tr>
<td>City:</td>
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<td>State:</td>
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<td>Zip Code:</td>
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<td>Email:</td>
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<td>Home Phone:</td>
<td>Home Phone:</td>
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<td>Cell Phone:</td>
<td>Cell Phone:</td>
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<td>Work Phone:</td>
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<td>*Alert Phone:</td>
<td>*Alert Phone:</td>
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<tr>
<td>Employer:</td>
<td>Employer:</td>
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</table>

- [ ] Student Primarily Resides with this Guardian.

**OFFICE USE ONLY**

<table>
<thead>
<tr>
<th>Entry Date:</th>
<th>Meal ST:</th>
<th>ESL:</th>
<th>IMM:</th>
<th>Residency:</th>
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<tr>
<td>Entry Code:</td>
<td>M/V Act:</td>
<td>SP:</td>
<td>GT:</td>
<td>Choice LEA:</td>
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<tr>
<td>Curriculum:</td>
<td>504:</td>
<td>MIG:</td>
<td>Homeroom:</td>
<td>P/T ADM %:</td>
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</table>
ADDITIONAL STUDENT INFORMATION

City of Birth: ____________________________ State of Birth: ____________ Birth Country: ____________________________

TRAVEL INFORMATION

<table>
<thead>
<tr>
<th>Travel To School (Please check one)</th>
<th>Travel From School (Please check one)</th>
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<tbody>
<tr>
<td><strong><strong>Bus (Bus Number</strong></strong>_____)</td>
<td><strong><strong>Bus (Bus Number</strong></strong>_____)</td>
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<tr>
<td>____Drives Self</td>
<td>____Drives Self</td>
</tr>
<tr>
<td>____Parent/Guardian (includes walkers, child care vans, etc.)</td>
<td>____Parent/Guardian (includes walkers, child care vans, etc.)</td>
</tr>
<tr>
<td>____District Paid Transportation</td>
<td>____District Paid Transportation</td>
</tr>
</tbody>
</table>

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

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


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: ____________________________ State: ____________ Zip Code: ____________

Parent Primarily Resides with this Guardian.

Emergency Information

<p>| Emergency Contact Information (Contacts Other Than Guardians to be Called in Case of an Emergency) |
|-----------------------------------------------|-------------------------------------------------|-----------------------------------|-------------------|</p>
<table>
<thead>
<tr>
<th>Contact Order</th>
<th>Name</th>
<th>Relationship to Child</th>
<th>Phone #</th>
<th>Phone Type (ex: Home, Cell, Work)</th>
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<tbody>
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<td>5</td>
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</tbody>
</table>

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 ____________

Kindergarten Registration Packet Pg. 4
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 ___________________________________ Phone # ___________________________________

NAME ___________________________________ 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 ____________________

Kindergarten Registration Packet  Pg. 6
NOTE: To be completed by the parent/guardian of the Kindergarten student prior to the physical examination/nursing assessment (please print).

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

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

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:

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Description</th>
</tr>
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<tbody>
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</tbody>
</table>

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

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

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</table>

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___________________________

Physician, Nurse or School Health Professional

Phone_______________________

Date Signed__________________

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

<table>
<thead>
<tr>
<th>Student Name:</th>
<th>Grade:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>School:</td>
<td>Student State ID #:</td>
<td>Gender:</td>
</tr>
<tr>
<td>___________</td>
<td>__________</td>
<td>_______</td>
</tr>
</tbody>
</table>

Parent/Guardian Name: __________
Parent/Guardian Signature: __________

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### 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? __________

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### 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? __________

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### 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.

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Note to district: This form is available in multiple languages on [http://www.arkansased.gov/divisions/learning-services/english-learners](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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