



SHERIDAN
SCHOOL DISTRICT
Inspire. Empower. Serve.

GET READY FOR

2020-2021

PRE-K REGISTRATION

Beginning March 13, 2020
9 AM - 2:30 PM

Sheridan Elementary

Principal Lindsey Bohler

707 Ridge Drive
Sheridan, AR 72150
PH: 870-942-3131

East End Elementary

Principal Vickie Easley

21801 Arch Street
Little Rock, AR 72206
PH: 501-888-4264



www.SheridanSchools.org



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2020-2021 Preschool Registration Packet

Applications will be accepted for all preschool programs in the Sheridan School District beginning **Friday, March 13, 2020**. To be eligible, a child must be 4 years old on or before Aug. 1, 2020.

You may bring your completed application packet and the required documents to the elementary school office from 9 a.m. - 2:30 p.m. on or after March 13, 2020. Please sign in at the elementary school office. **PLEASE** have ALL of the required information with you when you arrive.

Once an application is complete, it will be date and time stamped. The Sheridan School District currently has only 40 seats available at Sheridan Elementary School and 40 seats at East End Elementary School. Once seats are filled, a waiting list will be created based on the time that complete application packets were received.

General Preschool Information

The Sheridan School District Preschool Program offers classrooms at Sheridan Elementary School and East End Elementary School.

Teachers

All classrooms are taught by experienced teachers who are licensed by the Arkansas Department of Education. Each classroom is also served by a highly qualified paraprofessional that has training specifically focused upon the preschool.

Curriculum

All classrooms use curriculum that meets or exceeds the design requirements of the Arkansas Early Childhood Education Framework. This curriculum assists these young children in getting ready for a successful experience in Kindergarten.

Schedule

Preschool classrooms follow the same school calendar and schedule as all other grades in the Sheridan School District. Parents are responsible for transporting their preschooler to and from school. Parents are also required to sign their child in and out of the classroom each day.

Supplies

The Sheridan School District Preschool Program provides ALL students with ALL school supplies, sleeping mats, and a daily snack. If a child does not qualify for the school free/reduced lunch program, parents will be responsible for paying for breakfast and lunch.

Class Size

Each preschool classroom in the Sheridan School District is held to no more than 20 students.

Contact Information

Sheridan School District Central Office

East End Elementary School
Sheridan Elementary School

Dr. Bridget Polk - Assistant Superintendent - 870-942-3135
Kristy Morrison - Administrative Assistant - 870-942-3135
Vickie Easley - Principal - 501-888-4264
Lindsey Bohler - Principal - 870-942-3131

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Child's Name: _____

REQUIRED

- ☐ Sheridan School District Application (pages 5 and 6)
- ☐ ABC Child Application (pages 7-9)
- ☐ ABC Family Eligibility Application (pages 11-15)
- ☐ ABC Well Child Screening Form (pages 17-18)
- ☐ Sheridan School District Health Services Form (pages 19)
- ☐ Sheridan School District Home Language Survey (page 21)
- ☐ Birth Certificate
- ☐ Child's Social Security Number
- ☐ Proof of Residency – must include 2020 personal property assessment and one of the following: utility bill; rent receipt with current date; lease agreement with current date; dated contract for the purchase of home; dated contract for closing on construction of new home.
(Grant County Assessor: 870-942-3711 OR Saline County Assessor: 501-303-5622).
- ☐ Immunization Record
- ☐ Proof of Income (Total Family Income) – may include one of the following:
 - USDA free/reduced lunch application (for public schools only)
 - 30 days of current pay stubs
 - Income Tax Form
 - W2
 - Other _____

If Unemployed:

- ☐ Documentation of unemployment benefits OR
- ☐ Notarized statement signed by the parent stating that there is no earned income (page 23).

OTHER INFORMATION (IF APPLICABLE)

- ☐ Early Childhood Services Form (page 25)
- ☐ Custody Paperwork
- ☐ Current Military Orders (Military Personnel)
- ☐ Foster Child Documentation (Provided by DHHS)

With the signature below, I agree that the above requirements are completed.

Program Staff: _____ **Date:** _____

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GENERAL STUDENT INFORMATION

FIRST NAME:	MIDDLE NAME:	LAST NAME:
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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**

Address: _____ City: _____ State: _____ Zip Code: _____	<input type="checkbox"/> Mailing Address is same as Physical/911 Address Address: _____ City: _____ State: _____ Zip Code: _____
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Student Home Phone: _____

Student Cell Phone: _____

PARENT/GUARDIAN CONTACT INFORMATION**Parent/Guardian 1****Parent/Guardian 2**

Name: _____ Relationship to Student: _____ Language of Correspondence: _____ Mailing Address: _____ City: _____ State: _____ Zip Code: _____ Email: _____ Home Phone: _____ Cell Phone: _____ Work Phone: _____ *Alert Phone: _____ *Alert Phone is used by the district's automated phone message system. Employer: _____ <input type="checkbox"/> Student Primarily Resides with this Guardian.	Name: _____ Relationship to Student: _____ Language of Correspondence: _____ Mailing Address: _____ City: _____ State: _____ Zip Code: _____ Email: _____ Home Phone: _____ Cell Phone: _____ Work Phone: _____ *Alert Phone: _____ *Alert Phone is used by the district's automated phone message system. Employer: _____ <input type="checkbox"/> Student Primarily Resides with this Guardian.
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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)	Travel From School (Please check one)
<input type="checkbox"/> Bus (Bus Number _____)	<input type="checkbox"/> Bus (Bus Number _____)
<input type="checkbox"/> Drives Self	<input type="checkbox"/> Drives Self
<input type="checkbox"/> Parent/Guardian (includes walkers, child care vans, etc.)	<input type="checkbox"/> Parent/Guardian (includes walkers, child care vans, etc.)
<input type="checkbox"/> District Paid Transportation	<input type="checkbox"/> 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.

<input type="checkbox"/> Active Duty – US Army	<input type="checkbox"/> Active Duty – US Air Force	<input type="checkbox"/> Active Duty – US Navy	<input type="checkbox"/> Active Duty – US Marines
<input type="checkbox"/> Active Duty – US Coast Guard	<input type="checkbox"/> Reserves – US Army	<input type="checkbox"/> Reserves – US Air Force	<input type="checkbox"/> Reserves – US Navy
<input type="checkbox"/> Reserves – US Marines	<input type="checkbox"/> National Guard – US Army	<input type="checkbox"/> National Guard – US Air Force	<input type="checkbox"/> 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: _____	<input type="checkbox"/> 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 _____



Arkansas Better Chance Program

P.O. Box 1437, Slot S-160

Little Rock, Arkansas 72203

Child Application							
Agency Sheridan School District				Applicant For		<input type="checkbox"/> Current Year <input type="checkbox"/> Next Year	
Desired Center (Circle One)		East End Elementary		Sheridan Elementary			
First Name		M. Initial		Last Name			
Application Date *mm-dd-yyyy		/ /		Gender		<input type="checkbox"/> Male <input type="checkbox"/> Female	
				*Birth Date mm-dd-yyyy		/ /	
Demographic Information							
*Primary Language		*Other Language					
Speak English at home?		<input type="checkbox"/> Yes <input type="checkbox"/> No		English Skills		<input type="checkbox"/> Very Well <input type="checkbox"/> Well <input type="checkbox"/> Not Well <input type="checkbox"/> Not At All	
*Ethnicity		*Race					
<input type="checkbox"/> Hispanic <input type="checkbox"/> Hispanic, Black <input type="checkbox"/> Hispanic, White <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Other Spanish, Hispanic, Latino <input type="checkbox"/> Yes, Puerto Rican		<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Chinese <input type="checkbox"/> Immigrant <input type="checkbox"/> Migrant <input type="checkbox"/> Other <input type="checkbox"/> Samoan <input type="checkbox"/> White (non-Hispanic)					
		<input type="checkbox"/> Asian Indian <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other Asian <input type="checkbox"/> Unknown		<input type="checkbox"/> Black or African American <input type="checkbox"/> Guaanian or Chamorro <input type="checkbox"/> Korean <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other, Pacific Islander <input type="checkbox"/> Vietnamese			
Social Security Number:				Other ID		US Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	
Eligibility Information							
*Parental Status							
<input type="checkbox"/> Single Parent <input type="checkbox"/> Teen Parent <input type="checkbox"/> Homeless <input type="checkbox"/> Student Parent		<input type="checkbox"/> Two Parent <input type="checkbox"/> Dual Custody <input type="checkbox"/> Guardian <input type="checkbox"/> Migrant Parent		<input type="checkbox"/> Grand Parent <input type="checkbox"/> Group Home			
Child's Relation to Primary Caregiver:							
Child's Relation to Secondary Caregiver:							

Additional Eligibility Information		
<input type="checkbox"/> Special Need	Disability Status <input type="checkbox"/> No <input type="checkbox"/> Suspected <input type="checkbox"/> Certified IEP <input type="checkbox"/> Certified IFSP	
<input type="checkbox"/> Child Protective Services	<input type="checkbox"/> Non-English Speaking/LEP	
<input type="checkbox"/> Incarcerated Parent	<input type="checkbox"/> Active Duty	
<input type="checkbox"/> Non-parental custody/not living with Mother/Father	<input type="checkbox"/> Enrolled in HIPPY Year 1	
<input type="checkbox"/> Child Previously in Foster Care	<input type="checkbox"/> Enrolled in HIPPY Year 2	
<input type="checkbox"/> Parent Arrested/Convicted of Drug Offense	<input type="checkbox"/> Enrolled in HIPPY Year 3	
<input type="checkbox"/> Parent No HS Diploma	<input type="checkbox"/> Waiver - Income	
<input type="checkbox"/> Waiver	<input type="checkbox"/> Waiver - Kindergarten	
<input type="checkbox"/> Low Birth Weight	<input type="checkbox"/> Parents cannot read	
<input type="checkbox"/> Parent < 18 yrs. of age at birth	<input type="checkbox"/> Title I	
<input type="checkbox"/> Parent Substance Abuse/Addiction	<input type="checkbox"/> IDEA	
<input type="checkbox"/> History of Abuse/Neglect/Victim	<input type="checkbox"/> Developmental Delay	
Additional Points (Agency use only)		
Other Information		
<input type="checkbox"/> * Child is receiving a childcare subsidy (Voucher or Contracted slot) <input type="checkbox"/> *Father/father figure participates in regularly scheduled activities designed to involve fathers/father figures in Head Start or Early Head Start <input type="checkbox"/> Child has a medical card <input type="checkbox"/> Referred to Head Start or Early Head Start by a child welfare agency		
*Secondary Source of Child Care	<input type="checkbox"/> None <input type="checkbox"/> Family Child Care Home <input type="checkbox"/> Child Care Center or Classroom <input type="checkbox"/> Home or Another Home with a Relative or Unrelated Adult <input type="checkbox"/> Public School pre-Kindergarten Program <input type="checkbox"/> Other _____	
Current School District (where child resides):		
*Did child receive services before classes began in the current school Year?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
USDA Information		
USDA Enrollment Date (mm/dd/yyyy):	USDA Expiration Date (mm/dd/yyyy):	USDA/CACFP Income:

Additional Needs & Services	
Child Needs	
<input type="checkbox"/> Full Time Care <input type="checkbox"/> Part Time Care <input type="checkbox"/> Evening <input type="checkbox"/> Overnight <input type="checkbox"/> Weekend	
<input type="checkbox"/> Enrolled but Waiting (for transition):	
<input type="checkbox"/> Head Start <input type="checkbox"/> CDD Center or FCCHEN <input type="checkbox"/> State Preschool <input type="checkbox"/> AP Program <input type="checkbox"/> CDE After-school <input type="checkbox"/> Other	
<input type="checkbox"/> Previously served and seeking to return	
Comments	
Signature: _____ Date: _____	Signature: _____ Date: _____

Fields marked with (*) are required for PIR report

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Arkansas Better Chance Program
P.O. Box 1437, Slot S-160
Little Rock, Arkansas 72203

Family Eligibility Application

Enrolling Agency Sheridan School District

Desired Center (Circle One) East End Elementary Sheridan Elementary

Primary Caregiver's General Information

First Name	M. Initial	Last Name	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	*Application Date (Mm/dd/yyyy)	*Birth Date (Mm/dd/yyyy)	
Social Security Number: 	TANF 	*Receiving WIC <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Previously	DCFS <input type="text"/>
*Primary Language 	*Other Language 		*Food Stamp / SNAP <input type="checkbox"/> Yes <input type="checkbox"/> No

*Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Hispanic, Black <input type="checkbox"/> Hispanic, White <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Other Spanish, Hispanic, Latino <input type="checkbox"/> Yes, Puerto Rican	*Race <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"> <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Chinese <input type="checkbox"/> Immigrant <input type="checkbox"/> Migrant <input type="checkbox"/> Other <input type="checkbox"/> Samoan <input type="checkbox"/> White (Non-Hispanic) </div> <div style="width: 33%;"> <input type="checkbox"/> Asian Indian <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other Asian <input type="checkbox"/> Unknown </div> <div style="width: 33%;"> <input type="checkbox"/> Black or African American <input type="checkbox"/> Guaanian or Chamorro <input type="checkbox"/> Korean <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other, Pacific Islander <input type="checkbox"/> Vietnamese </div> </div>
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*Education Level: 	<input type="checkbox"/> Bachelor or Advanced Degree <input type="checkbox"/> College degree or training school certificate <input type="checkbox"/> ESL <input type="checkbox"/> GED <input type="checkbox"/> Grade 10 <input type="checkbox"/> Grade 11 <input type="checkbox"/> Grade 12	<input type="checkbox"/> Grade 9 or less <input type="checkbox"/> High School Graduate <input type="checkbox"/> No High School <input type="checkbox"/> Some College/ Vocational/Associates Degree <input type="checkbox"/> Some High School <input type="checkbox"/> Unknown
*Date Completed (mm/dd/yyyy): <hr/>		

Completed a job training program, professional certificate, or license:	YES	No	Date Completed (mm/dd/yyyy):
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> *Employment Status <input type="checkbox"/> Farmer <input type="checkbox"/> Full-time & training <input type="checkbox"/> Employed full-time <input type="checkbox"/> Homemaker <input type="checkbox"/> Job training/school(part-time) <input type="checkbox"/> Migrant Farm worker <input type="checkbox"/> Part-time & Training <input type="checkbox"/> Employed part-time </div> <div style="width: 45%;"> <input type="checkbox"/> Retired or disabled <input type="checkbox"/> Job Training or in School <input type="checkbox"/> Employed seasonal <input type="checkbox"/> Seasonal Farm worker <input type="checkbox"/> Self Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Unknown </div> </div>			

Are you: <input type="checkbox"/> A member of US military on active duty <input type="checkbox"/> Veteran of the United States military			
Employer/ School name:		What hours are you scheduled to work or attend school?	
Employer/ School Address:		Do you consent to receiving text messages? <div style="display: flex; justify-content: space-around;"> YES NO </div>	
Phone(home):	Phone (mobile):		
Phone(work)	Email:		
Home Address			
City			County
State	Zip Code		Work Zip
Other Address			Address Type Previous <input type="radio"/> Mailing <input type="radio"/> Other <input type="radio"/>
# in Family _____ NAME	List name and relationship to the child of all family members in the household.	* # in Household _____ RELATIONSHIP	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Other

Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Medical Insurance (for Child) <input type="checkbox"/> Yes <input type="checkbox"/> No	Specify: <div> <input type="checkbox"/> Aetna <input type="checkbox"/> blue <input type="checkbox"/> Medicare <input type="checkbox"/> Global <input type="checkbox"/> advantage <input type="checkbox"/> Private Health <input type="checkbox"/> Benefits <input type="checkbox"/> Blue Cross <input type="checkbox"/> Coverage <input type="checkbox"/> AHA Care <input type="checkbox"/> Blue Shield <input type="checkbox"/> QualChoice <input type="checkbox"/> Ambetter <input type="checkbox"/> CareFirst <input type="checkbox"/> TriCare <input type="checkbox"/> ARKids 1st <input type="checkbox"/> Cigna <input type="checkbox"/> UnitedHealthcare <input type="checkbox"/> ARKids A <input type="checkbox"/> Health <input type="checkbox"/> ARKids B <input type="checkbox"/> Network for Louisiana <input type="checkbox"/> Medicaid </div>	
*Current Housing <input type="checkbox"/> Homeless <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Other	*Current Housing Date (mm/dd/yyyy): _____	*Previous Housing <input type="checkbox"/> Homeless <input type="checkbox"/> Own <input type="checkbox"/> Rent <input type="checkbox"/> Other	
Has this family moved in the last 24 months?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Primary Caregiver Comment			
If there is NO Secondary Caregiver (skip application for secondary caregiver)			

Secondary Caregiver's General Information

First Name	Middle Initial	Last Name
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	*Application Date (Mm/dd/yyyy)	*Birth Date Date (Mm/dd/yyyy)
Social Security #	*Receiving WIC <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Previously	TANF – DCFS –
*Primary Language	*Other Language	*Food Stamp / SNAP <input type="checkbox"/> Yes <input type="checkbox"/> No

*Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Hispanic, Black <input type="checkbox"/> Hispanic, White <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Other Spanish, Hispanic, Latino <input type="checkbox"/> Yes, Puerto Rican	*Race <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Chinese <input type="checkbox"/> Immigrant <input type="checkbox"/> Migrant <input type="checkbox"/> Other <input type="checkbox"/> Samoan <input type="checkbox"/> White (Non-Hispanic) </div> <div> <input type="checkbox"/> Asian Indian <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Multi-Racial <input type="checkbox"/> Other Asian <input type="checkbox"/> Unknown </div> <div> <input type="checkbox"/> Black or African American <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Korean <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other, Pacific Islander <input type="checkbox"/> Vietnamese </div> </div>
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*Education Level: *Date Completed (mm/dd/yyyy): <hr/>	<input type="checkbox"/> Bachelor or Advanced Degree <input type="checkbox"/> College degree or training school certificate <input type="checkbox"/> ESL <input type="checkbox"/> GED <input type="checkbox"/> Grade 10 <input type="checkbox"/> Grade 11 <input type="checkbox"/> Grade 12	<input type="checkbox"/> Grade 9 or less <input type="checkbox"/> High School Graduate <input type="checkbox"/> No High School <input type="checkbox"/> Some College/ Vocational/Associates Degree <input type="checkbox"/> Some High School <input type="checkbox"/> Unknown
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Completed a job training program, professional certificate, or license:	YES	No	Date Completed (mm/dd/yyyy): <hr/>
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*Employment Status	<input type="checkbox"/> Farmer <input type="checkbox"/> Full-time & training <input type="checkbox"/> Employed full-time <input type="checkbox"/> Homemaker <input type="checkbox"/> Job training/school(part-time) <input type="checkbox"/> Migrant Farm worker <input type="checkbox"/> Part-time & Training <input type="checkbox"/> Employed part-time	<input type="checkbox"/> Retired or disabled <input type="checkbox"/> Job Training or in School <input type="checkbox"/> Employed seasonal <input type="checkbox"/> Seasonal Farm worker <input type="checkbox"/> Self Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Unknown
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Are you: <input type="checkbox"/> A member of US military on active duty		<input type="checkbox"/> Veteran of the United States military
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Employer/ School name: Employer/ School Address:	What hours are you scheduled to work or attend school?
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Phone(home):	Phone (mobile):	Do you consent to receiving text messages? <div style="display: flex; justify-content: space-around;"> YES NO </div>
---------------------	------------------------	--

Phone(work)		Email:			
Home Address					
City		Township		County	
State		Zip Code		Work Zip	
Other Address				Address Type Previous <input type="radio"/> Mailing <input type="radio"/> Other <input type="radio"/>	
# in Family _____ NAME 	<div> List name and relationship to the child of all family members in the household. </div>	* # in Household _____ RELATIONSHIP 	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Other		
Secondary Caregiver Comment 					

Signature: _____
 Signature: _____

Date: _____
 Date: _____

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**ARKANSAS BETTER CHANCE PROGRAM
WELL CHILD SCREENING (EPSDT) FORM**

To Parent or Guardian:

In order to provide the best learning experience for your child, teacher must understand your child's health needs. State regulations require any child enrolled in the Arkansas Better Chance Pre-K program to have a well child check-up. In addition, the child must be current on all required immunizations. Please complete this page of the form, sign it and give it to your child's physician or licensed nurse practitioner. Once form is completed and signed on both sides, return the form to your Pre-K program.

Child's Name (Last, First, Middle)	Child's Date of Birth	Sex	Parent/Guardian Name

Address, City and Zip Code

Name of Pre-K Program Where Enrolled	Pre-K Program Phone Number

Type of Health Insurance
D AR Kids A D Private Insurance D AR Kids B D Other:

Part I – To be completed by parent or guardian before well child screening.

Check answers to the following questions. Explain any "yes" answers in the space provided.

- | | Yes | No | |
|-----|-----|----|---|
| 1. | D | D | Do you have any concerns about your child's general health? |
| 2. | D | D | Has your child been diagnosed with any chronic disease (such as asthma or diabetes)? |
| 3. | D | D | Does your child have any allergies (like to food, medicine, dust)? |
| 4. | D | D | Does your child take any medications (daily or occasionally)? |
| 5. | D | D | Does your child have any problems with vision, hearing or speech? |
| 6. | D | D | Has your child had any hospitalization, operation, major illness or injury? |
| 7. | D | D | In the past 12 months, has your child experienced any difficulty with wheezing or night coughing? |
| 8. | D | D | In the past 12 months, has your child experienced excessive weight loss or weight gain? |
| 9. | D | D | Has your child had a dental examination in the last 12 months? |
| 10. | D | D | Would you like to discuss anything about your child's health with the health care provider? |

If you answered "yes" to any question, please explain below. For illnesses or injuries, include your child's age at the time.

Question #	Explanation

Parent/Guardian Permission and Release:

I give my permission for the information on this form to be used in meeting my child's health and educational needs while enrolled in the Arkansas Better Chance program.

Signature of Parent/Guardian

Date

Child's Name (Last, First, Middle)	Child's Date of Birth	Sex	Parent/Guardian Name

To Health Care Professional:

This child is enrolled in the Arkansas Better Chance Pre-K program. State regulations require a comprehensive well child screening for all enrolled children. The Division of Child Care and Early Childhood Education recommends an Early Periodic Screening and Diagnostic Treatment (EPSDT) which is age-appropriate. For children enrolled in AR Kids, the cost of the EPSDT may be billed to AR Kids A or B using the procedure codes below:

Patient Type	AR KIDS A		AR KIDS B	
	1-4 years	5-11 years	1-4 years	5-11 years
New	99382 EP U1	99383 EP U1	99382	99383
Established	99382 EP U2	99383 EP U2	99382	99383

Part II – To be completed by Health Care Provider. Complete all sections and sign at the bottom.

Weight		Height		BMI	Temp	Blood Pressure
lb.	%ile	in.	%ile	%		/

History Update

D Yes D No Any changes in patient health since last visit? Explain: _____
D Yes D No Any family history of heart disease for anyone under 55 years of age?
D Yes D No Any family history of abnormal cholesterol?

Health

D Good appetite D Picky or variable eater
D Drinks lowfat milk D Brushes teeth, sees dentist
D Encourage diet of fruit and vegetables
D Limits fast food

Social and Behavioral

D Parents discipline appropriately D Praised for good behavior
D Dresses self, helps at home D Has friends and playmates
D TV and video games are limited

Screening and Laboratory Results

Test	Result	Date	Comments if abnormal
Vision	L _____ R _____		
Hearing			
Test type:			
TB			
Risk: Yes / No			
Hemoglobin			
Risk: Yes / No			
Cholesterol			
Risk: Yes / No	mg/dL		

PHYSICAL EXAM

	Norm	Abnormal
General	D	D
Head	D	D
Neck	D	D
Eyes	D	D
Ears	D	D
Nose	D	D
Throat	D	D
Mouth	D	D
Teeth	D	D
Lungs	D	D
Heart	D	D
Femoral		
Pulses	D	D
Genitals	D	D
Extremities		
	D	D
Gait	D	D
Spine	D	D
Skin	D	D
Neuro	D	D

Immunizations

D Yes D No All immunizations are current.
D Yes D No Child has had all immunizations possible at this time.
Child needs: D DTaP D IPV D HepB D HiB D MMR D Varivax D PCV-7 at _____ years / _____ months

Referrals

D Follow up visit needed in _____ weeks / months
D Return check at _____ years _____ months
D Needs to see dentist. Referral to be made by physician or nurse practitioner.

Impressions

D Well child, normal growth and development
D _____

_____, MD / DO / NP

Date _____

CLINIC INFORMATION (or stamp)

Name _____
Address _____
City _____
Zip Code _____ Phone _____



Sheridan School District Health Services Form

Date: _____

General Information

Student Name: _____ Birth Date: _____

Homeroom Teacher: _____ Grade: _____

Guardian 1 Name & Phone Number(s): _____

Guardian 2 Name & Phone Number(s): _____

List names & grades of siblings in school: _____

Health Information

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 _____

Topical medications used in the nurse's office include: Antibiotic Ointment (Neosporin or generic equivalent); Hydrocortisone Cream, First Aid Burn Cream, Calamine, and Caladryl; Vaseline; and Bactine and Peroxide for cleaning injuries.

_____ No, I do NOT want any topical medications used on my child.

_____ Yes, I give the nurse permission to use any of the listed topical medications on my child as needed.

List allergies: _____

List prescription medications to be given on a daily basis at school: _____

Emergency Information

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. I UNDERSTAND THIS 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 _____

FAMILY PHYSICIAN: _____ PHONE NUMBER: _____

HOSPITAL CHOICE: _____ ADDRESS: _____

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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. <i>This form is not used to identify students' immigration status.</i>	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 – 12 th 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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Verification of Zero Earned Income

I, _____, do hereby declare that I am:
_____ Not employed, have zero earned income, and not receiving
_____ unemployment benefits at this time.

Verification of Employment

Business Name _____
Phone Number _____ Hire Date _____

I, _____ currently employ _____
Employee's First & Last Name

Gross Earned Income (\$) _____

☐ Weekly ☐ Bi-Weekly ☐ Twice Monthly ☐ Monthly ☐ Annually

Notarization

Printed Name _____

Signature _____ Date _____

- Signature – document must be signed in front of the Notary and notarized
- Photo identification is required to be present to notary

State of _____

County of _____

Signed and sworn before me, a Notary Public, this _____ day of _____, _____

Notary Public Signature

My commission expires _____

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EARLY CHILDHOOD SERVICES

Student Name: _____ Birth Date: _____

My child has received the following early childhood services (check all that apply and include dates of services):

- ☐ **HIPPY**
- ☐ **Head Start**
- ☐ **ABC/ ABCSS**
- ☐ **Private Day Care** Name of Center or Program: _____
- ☐ **Mother's Day Out** Name of Center or Program: _____
- ☐ **Speech & Language Therapy** Name of Center: _____
- ☐ **Physical and/or Occupational Therapy**
- ☐ **Psychological Counseling/Evaluations**
- ☐ **SLIDE**

Please provide any additional information about your child that might help us serve your child.
