

EL DORADO PUBLIC SCHOOL REGISTRATION

Enrollment Checklist

The following must be in place to complete registration and to receive a school assignment:

State Birth Certificate or Registrar Certificate, Baptismal Certificate, Passport, Affidavit, Military ID, Previous School Records or Hospital Birth Record

Proof of Address in the El Dorado District

Examples: Utility Bill, Deposit Slip, Rental Agreement, Rent Receipt, Doctor's Bill --- MUST BE DATED WITHIN THE LAST 30 DAYS!!!

Social Security Card or 9-digit # will be provided

Immunization Record

Physical Examination

No assignment can be made until all is in place. Delay in getting this material to the District might keep a student from being placed in the focus school of their choice.

Return all materials to: Ms. Rhonda Simmons, Assistant Superintendent
200 West Oak St.
El Dorado, AR 71730
870 864-5016

... **Where is the student currently living?** (Please check one box.)

- In permanent housing
- In a shelter
- With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")
- In a hotel/motel
- In a car, park, bus, train, or campsite
- Other temporary living situation (Please describe): _____

School Assignment _____ Grade Placed _____ Triand

EL DORADO PUBLIC SCHOOLS-STUDENT REGISTRATION 2020-2021 # _____

Today's Date: _____ Date child will start school: _____

First Name: _____ Middle Name _____ Last Name _____

Gender: _____ Date of Birth: _____ Grade: _____ Transportation: _____ bus _____ car _____ walks

Social Security # _____ (optional)

Parent or Guardian: _____ Relationship to student: _____

Home Address: _____
Number & Street City Zip

Home Phone: _____ Work Phone: _____ Message Phone: _____

Emergency Contact Person: _____ Emergency Phone: _____

Ethnicity (check one):	Primary Race (check only one):	Additional Race (check all that apply):
_____ Hispanic	_____ American Indian/Alaska Native	_____ American Indian/Alaska Native
_____ Non-Hispanic	_____ Asian	_____ Asian
	_____ Black	_____ Black
	_____ Native Hawaiian/	_____ Native Hawaiian/
	_____ Other Pacific Islander	_____ Other Pacific Islander
	_____ White	_____ White

Name and address of last school attended where records can be obtained:
School: _____
Address: _____

Is this child covered by Health Insurance? Yes No

Is this child receiving any of the following services (circle all that apply)?
Title I _____ Special Ed. _____ G/T _____ Other: _____

Pre-School Participation: (circle one)

A - Arkansas Better Chance	H - Headstart	E - Even Start
PS-Public School Pre-school	P - Private Pre-school	C - 21 st Century Community Learning Center
EC-Early Childhood	NA - Not Applicable	O-Other

Has this child attended El Dorado Schools in the past?
Yes , name of school: _____ No

Is this child currently expelled or under expulsion proceedings or suspended Yes No

What Language is spoken in your home most of the time? _____

What Language do parents speak to the student most of the time? _____

Is this child a military dependent? Yes No If yes, what branch of the military: _____

Other children in the El Dorado District:

Student	Grade	School	Student	Grade	School
1. _____			2. _____		

(complete reverse side)

El Dorado Public Schools
AFFIDAVIT of Legal Residence

Student's Name: _____

El Dorado address at which student is in residence from Sunday night through Thursday night:

Street Address: _____
El Dorado, AR 71730

I, the undersigned, acknowledge that giving a false address of residence for a public school student is punishable by a \$500 fine according to the ACT 663 of 1999.

Parent or guardian with whom the registrant is living:

Signature: _____

Date: _____

	Preference	
Hugh Goodwin Visual and Performing Arts <input type="checkbox"/>	Northwest Environmental Science	<input type="checkbox"/>
Retta Brown World Business/Tech. <input type="checkbox"/>	Yocum Math & Science	<input type="checkbox"/>

FOR DISTRICT USE ONLY

School Assignment: _____ Grade Placed: _____



Arkansas Department of Education (ADE)
Home Language Usage Survey

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

Form with sections: Student Name, School, Parent/Guardian Name, Right to Translation and Interpretation Services, Eligibility for Language Development Support, Prior Education. Includes questions about language preference and home language use.

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.

This work "Arkansas Department of Education (ADE), Home Language Survey" is a derivative of "OSPI Home Language Survey" by OSPI, used under CC BY. "Arkansas Department of Education (ADE), Home Language Survey" is licensed under CC BY by the English Learners Unit of the Arkansas Department of Education.



El Dorado Public Schools

Administrative Offices • 200 West Oak • El Dorado, Arkansas 71730

Keeping the Promise

Teaching and Learning for All

Dear Parent:

We welcome your kindergarten child to El Dorado Schools this fall and are anxious to help every student get off to a good start in his/her education year. Starting in 1994-95 all Arkansas school districts have had to participate in health screening to ensure that each student has no health problems that might impede his/her progress in school. This means every kindergarten student in the El Dorado School District must have a health screening.

We are asking that parents try to complete this screening prior to the beginning of school. Attached are two (2) forms. One is a **Health History** to be completed by the parent prior to the screening. The other is a **Physical Assessment** to be completed by a private physician.

If your kindergarten child has had a physical examination within the last year, a note from your physician to that effect will suffice. You may give these completed forms to your child's teacher on the first day of school.

We appreciate your cooperation and support in our efforts to give your child every opportunity for success in school. If you have any questions, please call my office at 870-864-5006.

Sincerely,

Jim Tucker
Superintendent of schools

Enclosures (2)

NOTE: To be completed by parent prior to physical examination/nursing assessment.

Health History

FOR KINDERGARTEN AND/OR FIRST GRADE STUDENTS

Student Name (Last, First, Middle)	Birth Date (Mo./Day/Year) / /	School	Medicaid Number
First Parent/Guardian Name		Phone 1	Phone 2
Second Parent/Guardian Name		Phone 1	Phone 2
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, and name of Health Insurance Company. (If none, write "None")			

To be completed by parent:

- | | | |
|---|-----|----|
| 1. Does your child pay attention when being read to? | Yes | No |
| 2. Can your child play quietly alone for over 1/2 hour? | Yes | No |
| 3. Does your child mind adults and follow instructions? | Yes | No |
| 4. Does your child speak clearly enough for others to understand? | Yes | No |
| 5. Does your child have any speech problems
stammering, delayed speech development, etc.? | 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 progress? | Yes | No |
| (A) Has your child received any medical or other evaluation, the findings of which could help school personnel in meeting his health or educational needs? | Yes | No |
| (B) Does this problem require any health care in the school? | Yes | No |
| (C) Does your child take medication? | 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.

Question Number

Description

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

Parents Signature: _____ Date: _____

PHYSICAL ASSESSMENT

To Be Completed by Physician, Nurse, School Health Professional, or Child Care Professional

Name _____ Race _____ Sex _____
 ID Number _____ Birthdate _____
 Parent or Guardian _____

REQUIRED			
	NL	ABNL	Comments
BP: 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, Axillary, Inguinal, Other			
HEART: Rate, Rhythm, S1, S2, Murmur, Femoral Pulses			
LUNGS: Rate, Auscultation, Percussion			
ABDOMEN: Contour, Palpation of Liver, Spleen, Kidney; Mass; Tenderness			
GENITO-URINARY: Female External, Male Penis, Meatus, Testes, Hernia			
MUSCULOSKELETAL: Range of Motion, Tenderness, Edema, Clubbing, Spine (Curvature)			
NEUROLOGICAL: Gait, Cerebellar Function, Motor System (Strength, Tone); Cranial Nerves (Gross)			
DEVELOPMENTAL:			
Gross Motor			
Fine Motor			
Social			
Speech/Language			

LABORATORY (as indicated)			
	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, School Health Professional, or Child Care Professional

AGRICULTURE SURVEY / ENCUESTA DE AGRICULTURA

Your child may qualify to receive: free school supplies, free school meals, free books, free high school credits through correspondence, college scholarships, a free year of college at selected sites, limited health services

Su hijo puede calificar para recibir: útiles escolares gratis, comida en la escuela gratis, libros gratis, créditos para la secundaria por correspondencia gratis, becas para la Universidad, un año de Universidad gratis en sitios seleccionados, servicios de salud limitados

Please answer	YES	NO
In the last 3 years (including summer), did you or a family member leave home/ move/ go stay elsewhere for more than a week to look for or get work in agriculture or fishing work? (See list of examples below)		

Por favor, responda	SI	NO
En los últimos 3 años (incluyendo el verano), ¿usted o algún miembro de su familia se fue de su casa/mudo/vivió en otro lugar por mas de una semana para buscar u obtener trabajo de agricultura o en granjas de peces?		

If you answered "NO", please sign and date the bottom of form and return. No further information is needed.

Si su respuesta es "NO", por favor firme y feche la parte de abajo de la forma y devuélvala. No se necesita mas información.

If "YES", please sign and date and provide the following information:

Moved from: _____

Check all that apply:	Date:
<input type="checkbox"/> Chicken or Meat Processing Plant	_____
<input type="checkbox"/> Chicken Houses (catching, caring for chickens, picking up eggs)	_____
<input type="checkbox"/> Caring for Livestock	_____
<input type="checkbox"/> Farming (planting, fertilizing, harvesting crops, cutting and bailing hay, etc.)	_____
<input type="checkbox"/> Nurseries (plants or trees)	_____
<input type="checkbox"/> Cotton Gin	_____
<input type="checkbox"/> Granary or Seed Companies	_____
<input type="checkbox"/> Fruit Harvesting (watermelons, picking berries)	_____
<input type="checkbox"/> Fish Farms	_____
<input type="checkbox"/> Timber Work (clearing land, skidding logs, planting, thinning, or harvesting trees)	_____
<input type="checkbox"/> Wood Processing (sorting, trimming, splitting logs, cutting lumber ie: pallet, chip, sawmills)	_____

Student Name:	Grade:
Parent Name:	
Contact Phone:	
Address (no P.O. Box):	City:

Add any remaining children on back of form

Si su respuesta es "Si", por favor de firmar y proveer la siguiente información:

De donde se movió: _____

Marque todo lo que aplique:	Fecha:
<input type="checkbox"/> Plantas procesadoras de pollo o carne	_____
<input type="checkbox"/> Granjas de pollo (agarrando, criando pollos, o levantando huevo)	_____
<input type="checkbox"/> Cuidando ganado	_____
<input type="checkbox"/> Agricultura (plantando, cosechando cultivos, cortando y empacando heno etc...)	_____
<input type="checkbox"/> Viveros (plantas o arboles)	_____
<input type="checkbox"/> Pisca de algodón	_____
<input type="checkbox"/> Graneros o compañías de semilla	_____
<input type="checkbox"/> Cosecha de fruta (sandía o recogiendo bayas)	_____
<input type="checkbox"/> Granjas de peces	_____
<input type="checkbox"/> Trabajo de Madera (limpiar la tierra, derrapar troncos, sembrar o cortar arboles)	_____
<input type="checkbox"/> Procesamiento de madera (clasificando, podando, corte de troncos, corte de madera es decir: paletas de madera, astillando madera, aserraderos)	_____

Nombre del estudiante:	Grado:
Nombre del Padre:	
Teléfono de contacto:	
Dirección Física (no P.O. Box):	Ciudad:

Agregue los nombres de sus otros niño atrás de esta forma.

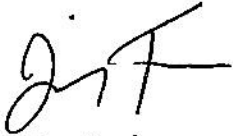
Parent Signature (Firma del Padre): _____

Date (Fecha): _____

El Dorado Public Schools Vision/Hearing Screenings Medicaid Billing

Effective July 2013, Medicaid is requiring that school districts seek parental consent prior to billing Medicaid for vision and hearing screenings. In order for the El Dorado School District to seek the federal Medicaid funds for reimbursement for vision and hearing screenings that are administered in each building, the school district must disclose information from your child's education records to Medicaid and Medicaid billing agencies. Under the Family Educational Rights and Privacy Act (FERPA), districts cannot release this information without parental consent. Medicaid funds help in supplying needed services that are provided by school nurses and related service providers.

Attached is the Parental Consent to Access Public Insurance and/or to Release Personally Identifiable Information that is required by Medicaid. Please complete this form and return it to your child's teacher. Thanks!



Jim Tucker,
Superintendent

EL DORADO PUBLIC SCHOOLS

In compliance with the Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 123g; 34 CFR Part 99)

I, _____, give permission for my child, _____'s
(Parent/Guardian Name) (First and Last Name)

personally identifiable information/student education records to be disclosed to a Third Party Billing Agent for the purpose of billing Medicaid and/or private insurance.

Printed Name of Parent/Guardian

Parent/Guardian Signature

Date Signed

PRIVATE INSURANCE

El Dorado School District

Parental Consent to Release Personally Identifiable Information Third Party Liability Section*

*This section should only be completed if the student is covered by private insurance.

Name: _____ ID: _____ Date of Birth: _____

Age: _____ Grade: _____ Local Education Agency: _____ El Dorado School District

Medicaid Number: _____

Information Related to Billing Third Party Insurance:

Title 42 Code of Federal Regulations (CFR), Part 433, Subpart D, Third Party Liability, requires that all third party sources must be utilized before reimbursement can be made by Medicaid. Part B of the Individuals with Disabilities Education Act (IDEA) prohibits a public agency from requiring parents, where they would incur a financial cost, to use insurance proceeds to pay for services that must be provided to a child with disabilities under the "free appropriate public education" requirements of these statutes. IDEA does not create exceptions to Title 42 CFR, Part 433, Subpart D. All Medicaid providers, including school districts, should attempt to exhaust third party liability prior to making claims to Medicaid.

Please check one of the following:

- I do NOT give permission to the school district to bill my private insurance for healthcare services delivered in the school.
- I give my permission to the school to bill my private insurance for healthcare services delivered in the school.

Private Insurance Information:

Insurance Company: _____

Address: _____

Phone: _____

Name of Policy Holder: _____

Policy Holder Date of Birth: _____ Social Security Number: _____

Policy Number: _____ Group Number: _____

Parent or Guardian Signature

Date

MEDICAID

El Dorado School District

ADE-SPED
REQUIRED
FORM
AUG 2017

Parental Consent to Access Public Insurance and to Release Personally Identifiable Information

Name: _____ ID: _____ Date of Birth: _____

Age: _____ Grade: _____ Local Education Agency: _____ El Dorado School District

Medicaid Number: _____

With parental consent, the school district can seek federal Medicaid reimbursement for the cost of the health services the school district provides to children who are eligible for Medicaid, and who receive those services that are identified in their individualized education program (IEP). In order to seek the federal Medicaid funds for reimbursement, the school district must disclose information from your child's education records to Medicaid and Medicaid billing agencies.

Under the Family Educational Rights and Privacy Act (FERPA), parental consent is required in order to release student personally identifiable information to agencies not identified in the Act. This consent grants the school district the ability to release student information for the purpose of billing Medicaid.

By signing below, you are indicating the following:

- I understand and agree that I am giving the school district permission to access my or my child's public benefits or insurance.
- I understand that my child's education records and information about the services my child receives through an IEP may be released to the Department of Human Services, Division of Medical Services, Arkansas Medicaid, and the school district's Medicaid billing agent for the purpose of billing Medicaid.
- I understand that this may include sharing information with DHS, contracted billing agents, and/or a physician to obtain necessary documentation to receive reimbursement for services provided through an IEP.
- I understand that information to be released may include: student's name, date of birth, social security number, Medicaid ID, disability, IEP and evaluations, type of service(s), times and dates services were delivered, and progress notes.
- I understand that this consent will remain in effect at all times the district is responsible for providing IEP services to my child, unless revoked by me.
- I understand that I may revoke consent at any time by notifying the school district in writing.
- I understand that revoking my consent does not change the school district's responsibility to provide all required IEP services to my child at no cost to me.
- Before giving my consent below, I was provided with a written notice further explaining my rights and protections under Part B of the Individuals with Disabilities Education Act (IDEA) regarding consent and the purpose of this form.

Parent or Guardian Signature

Date

Is your child covered by private insurance? No Yes (If yes, please complete Third Party Liability Section)