CROSSETT SCHOOL DISTRICT ENROLLMENT CHECKLIST K-12

1. CSD Registration Form

2. Home Language Form

3. Agriculture Survey

4. Health Form (for medications given at school, medical problems)

5. *Must have to enroll any student:
    - *Birth Certificate
    - *Social Security Card
    - *Shot record
    - *Physical Assessment Form -- **KINDERGARTEN**
    - *Health History Form- **KINDERGARTEN**
    - *Preschool Information Form- **KINDERGARTEN**

For Office Use:

If the student came from an Arkansas school, REQUEST RECORDS THRU TRIAND FIRST BEFORE YOU DO ANYTHING. Do not activate students until this is done. If you have questions about a student ask the principal before enrolling.

- Record Request Form (for other records)

Be sure and check the address. Make sure the student lives in the district. If a student does not live in the district, remember and tell them about school choice forms that have to be turned in before May 1.

CROSSETT SCHOOL DISTRICT REGISTRATION FORM

GRADE: _____

FIRST NAME	MIDDLE NAME	LAST NAME

SSN (Optional):_____ **Date of Birth:** _____ **Gender:** __Female __ Male **Twin:** __Yes __ No

(failure to provide copy of Soc Sec# will result in State provided ID#) Language Spoken at Home: _____

PLEASE CHECK IF YOUR CHILD HAS: IEP____ OR 504____

Hispanic/Latin 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
__Asian
__Black or African American
__Native Hawaiian or Other Pacific Islander
__White

ADDITIONAL RACES (check all that apply)

__American Indian/Alaska Native __Asian __Black __White
__Native Hawaiian/Other Pacific Islander

Student Physical/911 Address			**Student Mailing Address**		
Address			___Mailing Address is same as Physical/911 Address		
			Address:		
City	State	Zip Code	City:	State:	Zip Code:

Student Home Phone:_____ **Student Cell Phone**_____

PARENT/GUARDIAN CONTACT INFORMATION

PARENT GUARDIAN 1

Name:_____
Relationship to Student:_____
Mailing Address:_____
City:_____State:_____Zip:_____
Home Phone:_____Cell Phone:_____
Employer:_____Work Phone:_____
_____Student Primarily Resides with this Guardian.

PARENT GUARDIAN 2

Name:_____
Relationship to Student:_____
Mailing Address:_____
City:_____State:_____Zip:_____
Home Phone:_____Cell Phone:_____
Employer:_____Work Phone:_____
_____Student Primarily Resides with this Guardian.

TRAVEL INFORMATION

Travel To School (Please Check One)	**Travel from School (Please Check One)**
____Bus(Bus Number_____)	____Bus(Bus Number_____)
____Drivers Self	____Drives Self
____Parent/Guardian	____Parent Guardian
____Walker	____Walker

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 ___Nation Guard – US Air Force ___Parents serve in multiple branches

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

Contact	Name	Relationship to Child	Phone#
1			
2			

Physician: _____ **Physician Phone #:**_____

Last School Attended: _____ Phone #:_____

Address: _____

Is your child currently under expulsion proceedings at the school he/she is transferring from? **__Yes __No.** Is your child currently expelled from the school he/she is transferring from? **__Yes __No.** Is your child currently involved in any disciplinary proceeding or punishment? **__Yes __No**

Please list the names of anyone who has permission to check out/pick up this child from school: _____

_____

_____ _____

Parent/Guardian Signature Date

Arkansas Department of Education (ADE)
Home Language Usage Survey

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

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 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*

AGRICULTURE SURVEY / ENCUESTA DE AGRICULTURA

Title I, Part C **Título I, Parte C**

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 altos 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 **move to look for or get work in farming,** livestock, grain elevators, cotton gins, chicken houses or meat/poultry plants, fish farms, seed companies or cutting wood?		

If you answered yes, please provide information below:

Please mark any jobs you looked for or worked at:

___Chicken or Meat Processing (Land of Frost, ConAgra,Boar's Head, Pilgrim's Pride, Townsend's etc)
___Farming (planting, harvesting crops, cutting and bailing hay, etc.)
___Cotton Gin
___Timber Work(clearing land, skidding logs, harvesting trees)
___Fruit Harvesting(watermelon work, picking berries)
___Fish Farms
___Chicken Houses
___Granary(Riceland, Rice Mill, etc)
___Seed companies
___Working on farm with fertilizer and chemicals
___Plant or Tree nurseries
___Caring for livestock
___Growing or picking vegetables
___Other _____

Por favor, responda.	**Si**	**No**
En los últimos 3 años(incluyendo el verano), usted o algún miembro de su familia **se cambió para buscar u obtener trabajo** en agricultura, ganado, silo de granos con elevador mecánico, pizca de algodón, gallineros o plantas de carne/pollo, granjas de peces, compañías de semillas o cortadoras de madera?		

Si usted contestó si, por favor provea la siguiente información:

Por favor marque cualquier trabajo(s) que usted buscó o que trabajó:

___Procesamiento de pollo o carne (Land of Frost, ConAgra, Boar's Head, Pilgrim's Pride, Townsend's etc)
___Agricultura (plantando, cosechando cultivos, cortando y acomodando paja, etc.)
___Pizca de algodón
___Trabajo de Madera (limpiar la tierra, arrastrar troncos, cosechar árboles)
___Cosechar fruta(trabajo de sandías, escoger bayas)
___Granjas de peces
___Gallineros
___Granero(Riceland, Rice Mill, etc)
___Compañías de Semillas
___Trabajo en granja con fertilizante y químicos
___Viveros de plantas o árboles
___Cuidado de Ganado
___Cultivar o escoger vegetales
___Otros _____

Student Name:	Grade:
Parent Name:	
Day Phone:	Message Phone:
Address:	City:

If you have more than one child, please list their names and grades on the back.

Thank you.

Nombre del Estudiante:	Grado:
Nombre de los Padres:	
Teléfono de Día:	Teléfono para mensaje:
Dirección:	Ciudad:

Si usted tiene más de un niño, por favor anote los nombres y el grado en la parte de atrás.

Gracias.

CROSSETT SCHOOL DISTRICT
STUDENT HEALTH/EMERGENCY INFORMATION SHEET
PLEASE PRINT AND FILL OUT COMPLETELY:
(TO BE GIVEN TO THE SCHOOL NURSE)

TEACHER: _____ GRADE: _____

STUDENT'S NAME: _____

PARENT TO CONTACT: _____ CELL#: _____ HOME#: _____

SECOND NAME TO CONTACT: _____ CELL#: _____ HOME#: _____
(RELATION TO STUDENT ABOVE): _____

LIST ANY MEDICAL PROBLEMS YOUR CHILD HAS: _____

LIST ANY PHYSICAL CHALLENGES YOUR CHILD HAS: _____

LIST ANY KNOWN ALLEGERIES: _____

DOES YOUR CHILD USE INHALERS/EPIPEN/BENADRYL? YES OR NO (CIRCLE ONE)

WILL THEY HAVE ANY OF THE ABOVE AT SCHOOL? YES OR NO (CIRCLE ONE)

I GIVE THE SCHOOL DISTRICT PERMISSION TO CALL 911 IN THE EVENT I CANNOT BE REACHED AT THE ABOVE NUMBERS. Signature of Parent or Guardian _____

RELEASE OF MEDICAL INFORMATION: I HEREBY UNDERSTAND AND AUTHORIZE THAT MY CHILD'S MEDICAL RECORDS OR OTHER MEDICAL INFORMATION, FURNISHED TO THE SCHOOL, WILL BE SHARED WITH SCHOOL OFFICIALS AND EMERGENCY PERSONNEL WHO HAVE A LEGITIMATE MEDICAL/EDUCATIONAL PURPOSE FOR ACCESSING SUCH MEDICAL RECORDS AND INFORMATION.
PARENT SIGNATURE: _____ DATE: _____

RE-DISCLOSURE:
I understand that the Requestor (School District) will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's education record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate and least restrictive educational settings and school health services and programs.

I have a right to receive a copy of this authorization. Signing this authorization may be required in order for the student to obtain appropriate services in the educations setting.

APPROVAL: _____ _____ _____
Printed Name Signature Date

_____ _____
Relationship to Patient/Student Area Code and Telephone Number

Kindergarten Physical Assessment

To Be Completed by Physician, Nurse, or School Professional

Required			Supplemental (Optional)			
	NL ABNL	Comments		Date	NL	Comments
BP:_____			**Hemoglobin**			
WT:_____HT:_____			**Hematocrit**			
SKIN Color, Rash, Swelling, Hair Nails **EYES**: Conjunctiva, Cornea, Pupils, Extrocular Movement **EARS**: Pinnae, Canals: Tympanic Membrane Appearance, Mobility			**Urinalysis** **Other**			
			Medications			
NOSE: Nares, Turbinate			**Diet Restrictions**			
MOUTH: Tongue, Teeth, Oral Mucosa, Tonsils, Pharynx						
NECK: Thyroid Range of Motion			**Special Equipment**			
NODES: Cervical, Axillary, Inguinal, Other						
HEART: Rate, Rhythm, S1, S2, Murmur, Femoral Pulse			**Allergies**			
LUNGS: Rate, Auscultation, Percussion			**General Comments/Recommendations**			
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 one) Cranial Nerves Gross)						
DEVELOPMENTAL: Gross Motor						
Fine Motor						
Social						
Speech/Language						

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_____

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):

1 Does your child pay attention when being read to ?	Yes	No
2 Can your child play quietly alone for over a 1/2 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 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 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 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 below.

Question Number	Description

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

Parent's Signature_____ Date_____

Pre-school Program

Student was in before Kindergarten

Student Name: _____ Date:_____

Has your kindergarten student attended a full-time (at least twenty (20) hours a week for nine (9) months) four-year-old preschool program. ____Yes ___No

If yes please indicate which program your child was in:

____Arkansas Better Chance (ABC)

____Early Childhood Special Education

____Even Start

____Head Start

____Public School Preschool

____Private Preschool

____Other

Please explain_____

_____

Please indicate where program attended was:

Name: _____

Address: _____

Phone number: _____

_____

Parent's Signature: