

### **ALL REQUIREMENTS (1-6) MUST BE MET BEFORE REGISTERING**

1. Have a child 5 years old on or before August 1, 2020
2. Have a birth certificate on child (original copy)
3. Have a social security card for your child
4. Have an up-to-date immunization record (must have 4yr. old shots)
5. Have a physical exam by the doctor of your choice
6. If your child has any medical problem/s or food allergies, please have your doctor fill out the individual Health Care Plan form for your child.

**\*\*The parent listed on the birth certificate must fill out the registration forms.**

**\*\*If the child lives with someone other than the parents, you must have legal court papers or notarized statement from the parent.**

### **Kindergarten Registration**

**Please, DO NOT BRING CHILDREN**

**If your child attends the ABC Program at Crossett Learning Center he/she still must register for Kindergarten. Being in the ABC program does not automatically enroll him/her in Kindergarten.**

**It is very important that you get your child registered as soon as possible. Your child will not be placed in a classroom until the registration has been completed. You will receive a letter in August from your child's teacher.**



# CROSSETT SCHOOL DISTRICT REGISTRATION FORM

GRADE: \_\_\_\_\_

FIRST NAME	MIDDLE NAME	LAST NAME
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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

<b>PRIMARY RACE (Please select only ONE)</b> <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White	<b>ADDITIONAL RACES (check all that apply)</b> <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Other Pacific Islander
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<b>Student Physical/911 Address</b> Address: _____ City: _____ State: _____ Zip Code: _____	<b>Student Mailing Address</b> <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: _____ Mailing Address: _____ City: _____ State: _____ Zip: _____ Home Phone: _____ Cell Phone: _____ Employer: _____ Work Phone: _____ <input type="checkbox"/> Student Primarily Resides with this Guardian.	Name: _____ Relationship to Student: _____ Mailing Address: _____ City: _____ State: _____ Zip: _____ Home Phone: _____ Cell Phone: _____ Employer: _____ Work Phone: _____ <input type="checkbox"/> Student Primarily Resides with this Guardian.
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## TRAVEL INFORMATION

<b>Travel To School (Please Check One)</b> <input type="checkbox"/> Bus (Bus Number _____) <input type="checkbox"/> Drives Self <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Walker	<b>Travel from School (Please Check One)</b> <input type="checkbox"/> Bus (Bus Number _____) <input type="checkbox"/> Drives Self <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Walker
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Is this child a dependent of an active or reserve member of a branch of the United States Armed Services? Yes ☐ No ☐

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

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

## 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

English/October 2017

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:	
<b>Right to Translation and Interpretation Services</b> 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? _____		
<b>Eligibility for Language Development Support</b> 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? _____		
<b>Prior Education</b> 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. <b><i>This form is not used to identify students' immigration status.</i></b>	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 <sup>th</sup> 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.

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.



# 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): \_\_\_\_\_



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 ALLEGORIES: \_\_\_\_\_

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 educational setting.

APPROVAL: \_\_\_\_\_  
Printed Name Signature Date

Relationship to Patient/Student

Area Code and Telephone Number



# PHYSICAL ASSESSMENT

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

Required			Supplemental (Optional)			
	NL	ABNL	Comments	Date	NL	Comments
BP: _____						
WT: _____ HT: _____						
SKIN: Color, Rash, Swelling, Hair, Nails						
EYES: Conjunctiva, Cornea, Pupils, Extrocular 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 Pulse						
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, Tender- ness, Edema, Clubbing, Spine (Curvature)						
NEUROLOGICAL: Gait, Cerebellar Function, Motor System (Strength, Tone) 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 \_\_\_\_\_



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) _____	
Date of Birth _____	School _____
Medicaid Number _____	Medicaid Physician _____
Parent Guardian Name _____	Phone _____
Physicians Name (if no regular physician, write "None") _____	
Physicians Address _____	Phone _____
Dentist Name (if no regular dentist, write "None") _____	
Dentist Address _____	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 ½ hour?                                     | Yes | No |
| 3. Does your child mind adults and follow directions?                                       | 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 |

(More questions on back of page)

# 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:





## RESIDENCY FORM

Your answers will help determine if the student meets eligibility requirements for services under the McKinney-Vento Act.

List all children in your family birth through age 21.

Name of Child	School	Age	Grade	Date of Birth

Parent/Guardian \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

Zip Code \_\_\_\_\_ Phone Number: \_\_\_\_\_

Is this address Temporary or Permanent? (circle one)

Please choose which of the following situations the student currently resides in (you can choose more than one):

- \_\_\_\_\_ House or apartment with parent or guardian
- \_\_\_\_\_ Motel, car, or campsite
- \_\_\_\_\_ Shelter or other temporary housing
- \_\_\_\_\_ With friends or family members (other than or in addition to parent/guardian)

If you are living in shared housing, please check all of the following reasons that apply:

- \_\_\_\_\_ Loss of housing
- \_\_\_\_\_ Economic situation
- \_\_\_\_\_ Temporarily waiting for house or apartment
- \_\_\_\_\_ Provide care for a family member
- \_\_\_\_\_ Living with boyfriend/girlfriend
- \_\_\_\_\_ Loss of employment
- \_\_\_\_\_ Parent/Guardian is deployed
- \_\_\_\_\_ Other (Please explain)

Are you a student under the age of 18 and living apart from your parents or guardians?

Yes              No

## **Housing and Educational Rights**

Students without fixed, regular, and adequate nighttime residences have the following rights:

- 1) Immediate enrollment in the school they last attended or the local school where they are currently staying even if they do not have all of the documents normally required at the time of enrollment without fear of being separated or treated differently due to their housing situations;
- 2) Transportation to the school of origin for the regular school day;
- 3) Access to free meals, Title I and other educational programs, and transportation to extra-curricular activities to the same extent that it is offered to other students.

Any questions about these rights can be directed to the local McKinney-Vento liaison at [Insert phone number] or the State Coordinator at 501-683-5428.

By signing below, I acknowledge that I have received and understand the above rights.

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*Signature of Parent/Guardian/Unattached Youth*

*Date*

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*Signature of McKinney-Vento Liaison*

*Date*





## Services for McKinney-Vento Identified Students

Student: \_\_\_\_\_

School: \_\_\_\_\_

Grade \_\_\_\_\_

Please check the services needed or desired:

<input type="checkbox"/> Free Lunch
<input type="checkbox"/> Transportation to the school of origin
<input type="checkbox"/> Clothing/Uniform
<input type="checkbox"/> School supplies
<input type="checkbox"/> Counseling
<input type="checkbox"/> Medical/dental referral
<input type="checkbox"/> Vision referral
<input type="checkbox"/> Medicaid/DSHS services – food stamps
<input type="checkbox"/> Preschool Enrollment records
<input type="checkbox"/> Missing enrollment records
<input type="checkbox"/> Birth certificate

<input type="checkbox"/> Immunization/medical records
<input type="checkbox"/> Tutoring
<input type="checkbox"/> After-school programs
<input type="checkbox"/> Teen Center
<input type="checkbox"/> Mentoring
<input type="checkbox"/> Special Education
<input type="checkbox"/> Gifted/talented
<input type="checkbox"/> Vocational/technical
<input type="checkbox"/> Community resource
<input type="checkbox"/> Prior academic records
<input type="checkbox"/> LEP/Bilingual program
<input type="checkbox"/> Guardianship issues

\_\_\_\_\_  
*Signature of Parent/Guardian/Unattached Youth*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature of McKinney-Vento Liaison*

\_\_\_\_\_  
*Date*