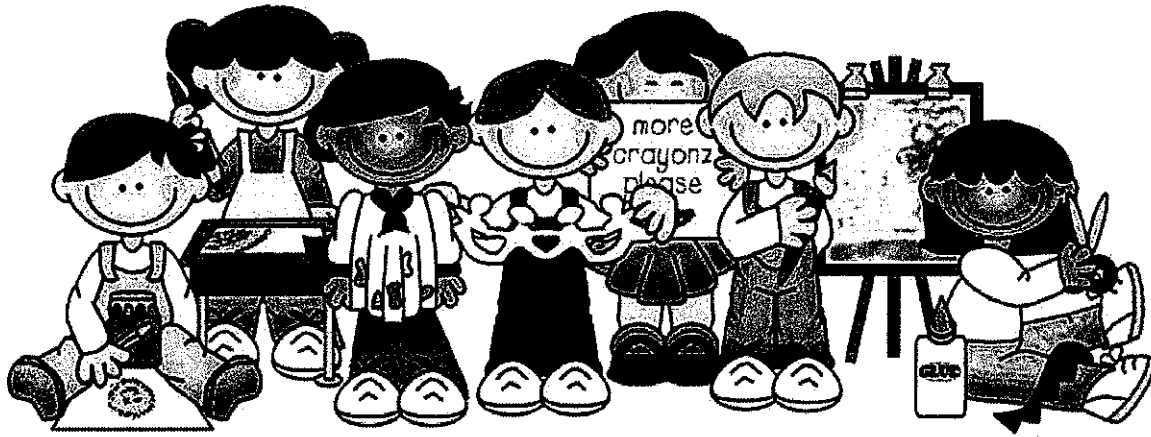


# PRESCHOOL



**Randolph Central School Corporation**

## Preschool Enrollment Packet

# Randolph Central Preschool Registration

## Student Information:

Grade: \_\_\_\_\_

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Address: Street \_\_\_\_\_

City, IN: \_\_\_\_\_ Zip \_\_\_\_\_

Home/Cell Phone: \_\_\_\_\_ Text Capable? Yes No

Age: \_\_\_\_\_ Sex: M F Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ City and State of Birth: \_\_\_\_\_

## For School Use Only:

STN # \_\_\_\_\_

Teacher: \_\_\_\_\_

Book Rent: \_\_\_\_\_

Owe: \_\_\_\_\_

Entry Date: \_\_\_\_\_

Withdrawal Date: \_\_\_\_\_

DOE Transfer: \_\_\_\_\_

Race Category: (Circle)

Ethnic Category:

1~American Indian or Alaskan

2~Black, Non-Hispanic

1~Hispanic/Latino

~AND~

(Circle)

3~Asian or Pacific

4~ Spanish or Hispanic

2~Not Hispanic/Latino

5~ White, Non-Hispanic

6~Multiracial

## Name of Parents or Guardians Who Live with Child:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Occupation: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Email Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell/Alt Phone: \_\_\_\_\_ Text Capable? Yes No

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Occupation: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Email Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell/Alt Phone: \_\_\_\_\_ Text Capable? Yes No

## Name of Divorced or Separated Parent Who is NOT Living with Child:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Occupation: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Email Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell/Alt Phone: \_\_\_\_\_ Text Capable? Yes No

## Brother and Sisters Living at Home & Their Ages:

Name:

Age:

Name:

Age:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

# Additional Information

## Prior School Experience/New Students

Last School Attended: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Has your child ever attended **Randolph Central School Corporation**? Yes No

Randolph Central School formerly attended: \_\_\_\_\_

## Special School Services ~ Check if your child has been in the following:

Title 1 \_\_\_\_\_ Speech \_\_\_\_\_ Special Education \_\_\_\_\_

Does your child have an IEP? YES NO

## District of Residence

County of Residence:

<input type="checkbox"/>	Randolph
<input type="checkbox"/>	Jay
<input type="checkbox"/>	Delaware
<input type="checkbox"/>	Other _____

If Randolph, which zone do you live in:

<input type="checkbox"/>	Randolph Central - Deerfield
<input type="checkbox"/>	Randolph Central - Baker/Willard
<input type="checkbox"/>	Randolph Eastern (Union City)
<input type="checkbox"/>	Randolph Southern (Lynn)
<input type="checkbox"/>	Monroe Central (Parker/Farmland)
<input type="checkbox"/>	Union (Modoc)

\*If you checked any box other than Randolph County and Deerfield, please fill out the appropriate transfer form to be approved by the superintendent. Thank you!

## Early Dismissal

In the event of an early dismissal, I wish my child to:

<input type="checkbox"/>	Go home as usual.
<input type="checkbox"/>	Be picked up by one of the individuals listed on the following contact sheet.

## Babysitter Information:

If your child will get off the bus at a babysitter's regularly, please provide details:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Bus Number: \_\_\_\_\_

Parent or Legal Guardian's Signature \_\_\_\_\_ Date: \_\_\_\_\_



## **Randolph Central School Corporation Preschool Additional Required Documentaiton for Enrollment**

**The following items need to be brought to Deerfield Elementary prior to the start of school to complete your child's enrollment packet.**

- ☐ **Copy of Birth Certificate**
- ☐ **Shot Record**
- ☐ **Proof of Indiana Residency**
  - ☐ **Utility, phone, or internet bill**
  - ☐ **Bank Statement**
  - ☐ **Mortgage Statement**
  - ☐ **Rental/Lease Agreement**
  - ☐ **Medical Bill**
  - ☐ **Other: Must show parent/guardian name and physical address.**

**Proof of Residency documents can be delivered to the school in the following ways:**

- 1. A document can be brought to the school and a copy will be made.**
- 2. Parents/Guardians can bring a copy to the school or send it with their child.**
- 3. Take a picture of the document and send it to the following email: [residency@randolphcentral.us](mailto:residency@randolphcentral.us)**
  - a. If sending by email, please include the name of the student(s) and school building(s) in the body of the email.**
  - b. If you email a document or send a copy in, please note if you have children in multiple schools. Only one proof or residency per family is required.**



## Randolph Central Preschool Emergency Contacts for Children

Child's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

Primary Contact: \_\_\_\_\_

Employer: \_\_\_\_\_ Wk #: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_

Alternate Contact: \_\_\_\_\_

Employer: \_\_\_\_\_ Wk #: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_

Alternate Contact: \_\_\_\_\_

Employer: \_\_\_\_\_ Wk #: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_

Special Medical Health Need(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

This form or one similar to it should be posted and will be verified by your LLEP Consultant during the  
Provider Eligibility Standards Certification visit.

**DEERFIELD/BAKER/WILLARD ELEMENTARY SCHOOLS**  
**TRANSPORTATION REQUEST TO/FROM BABYSITTER**  
**SCHOOL YEAR 2023-24**

STUDENT NAME \_\_\_\_\_

PARENT(S) OR LEGAL GUARDIAN(S) NAME \_\_\_\_\_

PHONE # OR EMERGENCY # \_\_\_\_\_

911 ADDRESS \_\_\_\_\_

SCHOOL BUILDING \_\_\_\_\_ GRADE \_\_\_\_\_

BUS DRIVER \_\_\_\_\_ BUS NUMBER \_\_\_\_\_

BABYSITTER'S NAME \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

BABYSITTER'S 911 ADDRESS \_\_\_\_\_

FROM BABYSITTER TO SCHOOL AM \_\_\_\_\_ FROM SCHOOL TO BABYSITTER PM \_\_\_\_\_

PARENT COMMENTS

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I understand this service must be performed within my child's school attendance area, with little time or mileage added to the route. The babysitter must be on a road the bus already travels. Transportation within the city limits of Winchester, Deerfield, Saratoga, and Ridgeville will be to/from closest scheduled bus stop to babysitter. If the babysitter or child-care service is not present to accept the child, the service will be discontinued. If this service is not a daily routine, a note must be sent to the child's teacher each day for this to take place. Babysitting requests will not be addressed until the second full week of school.

SIGNED BY PARENT OR LEGAL GUARDIAN \_\_\_\_\_

APPROVED \_\_\_\_\_ DENIED \_\_\_\_\_ DATE \_\_\_\_\_

SUPERINTENDENT \_\_\_\_\_

TRANSPORTATION DIRECTOR \_\_\_\_\_



## Randolph Central School Corporation Preschool Transportation Permission Slip

**This form is to be completely filled out and signed by the parent or legal guardian before a child may ride any Randolph Central School Corporation-provided transportation.**

**Please print:**

Parent or guardian name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Other/Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Please list the child's information who has permission to ride any Randolph Central School Corporation-provided transportation.**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Relationship to parent or guardian: \_\_\_\_\_

**Statement of permission and release:**

I/We, the undersigned, hereby grant the above-named child permission to travel to Randolph Central School Corporation Preschool-sponsored outings. I/We release and hold harmless Randolph Central School Corporation, from all liability for mishap or injury to the student named herein from the time of departure to the time of return.

I understand that my child will be under adult supervision at all times. By signing this permission slip, I release and hold harmless its employees, interns, and any volunteers from any liability, past or future, fully and completely. I authorize the staff and/or volunteers to administer emergency medical assistance if I cannot be reached.

Parent or Legal Guardian Printed Name: \_\_\_\_\_

Parent or Legal Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## *Randolph Central School Corporation Preschool Fees*

Please read the following fee options and choose the option that you will be utilizing for your child when they attend the Randolph Central School Corporation.

1. \_\_\_\_ I will be paying the daily fee of \$25 per day for my child while they attend the Randolph Central School Corporation preschool. I understand that a fee of \$25 per day is charged, regardless of attendance and that fees are due each week on Friday.
2. \_\_\_\_ I will be using the CCDF voucher program to pay for my child while they attend the Randolph Central School Corporation preschool. I understand that I must follow all guidelines of the Child Care and Development Fund (CCDF), through the Family and Social Services Administration.
  - a. Please go to <https://earlyedconnect.fssa.in.gov/onlineApp/home> for more information on how to apply for Child Care Assistance.
3. \_\_\_\_ I will be using the On My Way Pre-K grant program to pay for my child while they attend the Randolph Central School Corporation preschool. I understand that I must follow all guidelines of the On My Way Pre-K grant program. If the grant amount for the On My Way Pre-K program is less than the \$25/day RCSC Preschool tuition, I agree to pay the difference each week.
  - a. For the 2023-24 school year, a child is eligible for an On My Way Pre-K voucher if they will be 4 years old by Aug. 1, 2023, and plan to start kindergarten in the 2024-25 school year. An eligible child must live in a household with an income below 127% of the federal poverty level and have parents or guardians who are working, going to school, attending job training or searching for employment. Please go to this website to complete the On My Way Pre-K application.  
<https://www.in.gov/fssa/carefinder/on-my-way-pre-k/>





## Randolph Central Preschool Payment Agreement

**Provider: Randolph Central Preschool**

Payment for preschool tuition is required weekly. Your child's enrollment in the preschool program will be terminated after two weeks of non-payment. Payment arrangements can be made but must be initiated by the parent before the two-week nonpayment period. Payment plans must be followed, to eliminate your child's enrollment termination. Your signature below states that you have read and agree with the Randolph Central Preschool Payment Agreement.

\_\_\_\_\_  
Child's Name

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

\_\_\_\_\_  
Date

***Policy for 2 Hour Delay, Early Dismissal, eLearning Days, and School Closings (page 9 of the RCSC Preschool Handbook)***

In the event of bad weather that leads to school closings and school delays, the following is the 2 hour delay policy for preschool students:

- ❖ NO Preschool for students with an IEP that leave at 12:00 p.m. for a 2-hour delay. There will be NO AM special education transportation.
- ❖ Students who attend ALL DAY and are transported by their parents may attend beginning at 10:20 a.m.
- ❖ Fees will remain the same for a 2 hour delay, early dismissal, unplanned eLearning days, and school closings.
- ❖ For planned eLearning days the Preschool Teacher will not be in session and no fee is required.
- ❖ In the case of an early dismissal parents will be contacted through the school messaging system.

By signing this agreement, I am stating that I have read and agree with my chosen payment option and the policy information for 2 hour delays, Early Dismissal, eLearning Day, and School Closings for the Randolph Central School Corporation Preschool Program.

\_\_\_\_\_  
Parent/Guardian Printed Name

\_\_\_\_\_  
Child's Name

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

\_\_\_\_\_  
Date

# Randolph Central Personal Health History 2023-24

**Student's Name:** \_\_\_\_\_ **Sex:** ☐ M ☐ F **Grade** \_\_\_\_\_ **Teacher** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Primary Address:** \_\_\_\_\_  
**Student lives with** ☐ Both Parents ☐ Mother ☐ Father ☐ Other: Explain \_\_\_\_\_

**Mother/Guardian:** \_\_\_\_\_ **Daytime Phone:** \_\_\_\_\_ **Cell:** \_\_\_\_\_

**Father/Guardian:** \_\_\_\_\_ **Daytime Phone:** \_\_\_\_\_ **Cell:** \_\_\_\_\_

## DOCTOR & INSURANCE INFORMATION

**Does your child have a doctor?** ☐ Y ☐ N **Insurance Company:** \_\_\_\_\_ **ID#** \_\_\_\_\_

☐ Private ☐ Medicaid ☐ None

**Physician's Name:** \_\_\_\_\_ **Group/Office** \_\_\_\_\_ **Ph#** \_\_\_\_\_

## MEDICAL HISTORY

**I have been told by a Physician or Healthcare Professional that my child has the following condition/s:**  
**(CHECK ALL THAT APPLY AND LIST ADDITIONAL INFORMATION ON OTHER SIDE)**

<input type="checkbox"/> Asthma <input type="checkbox"/> Exercised Induced Asthma <input type="checkbox"/> Inhaler required at school <input type="checkbox"/> Self-carry inhaler (requires Dr.'s order)	<input type="checkbox"/> Heart Disease <input type="checkbox"/> Murmur <input type="checkbox"/> as infant <input type="checkbox"/> currently <input type="checkbox"/> Heart Problem with restrictions (explain on other side)
<input type="checkbox"/> ADD <input type="checkbox"/> ADHD <input type="checkbox"/> On ADD/ADHD Medications <input type="checkbox"/> Autism <input type="checkbox"/> Asperger's Syndrome <input type="checkbox"/> Other _____	<input type="checkbox"/> Seizures <input type="checkbox"/> From Fever <input type="checkbox"/> Epilepsy <input type="checkbox"/> Shunt <input type="checkbox"/> Unspecified <input type="checkbox"/> Date of last seizure: _____
<input type="checkbox"/> Bladder/Kidney concerns (explain on other side) <input type="checkbox"/> Encopresis <input type="checkbox"/> Crohn's disease	<input type="checkbox"/> Frequent Headaches(nonspecific) <input type="checkbox"/> Migraine (requiring medication)
<input type="checkbox"/> Blood/Clotting <input type="checkbox"/> Hemophilia <input type="checkbox"/> Sickle Cell	<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> OCD <input type="checkbox"/> Other: _____
<input type="checkbox"/> Deafness <input type="checkbox"/> Hearing aids <input type="checkbox"/> Blindness <input type="checkbox"/> Glasses	<b>ALLERGIES (CHECK ALL THAT APPLY)</b>
<input type="checkbox"/> Diabetes type I <input type="checkbox"/> Diabetes type II <input type="checkbox"/> Metabolic Syndrome	<input type="checkbox"/> Bee sting <input type="checkbox"/> Wasp sting <input type="checkbox"/> Other insect sting <input type="checkbox"/> Local (swelling at sting site only) <input type="checkbox"/> EpiPen/Hospital
<input type="checkbox"/> Diet Restrictions (explain on other side) <input type="checkbox"/> Obesity <input type="checkbox"/> Underweight <input type="checkbox"/> Anorexia <input type="checkbox"/> Bulimia <input type="checkbox"/> Food Intolerance <input type="checkbox"/> Gluten/Celiac <input type="checkbox"/> Lactose Intol.	<input type="checkbox"/> Seasonal (requiring medication) <input type="checkbox"/> Hay Fever <input type="checkbox"/> Animals (List animals on other side) <input type="checkbox"/> Latex (not life-threatening) <input type="checkbox"/> Latex (requires Epi Pen)
<input type="checkbox"/> Head Injury <input type="checkbox"/> Concussion <input type="checkbox"/> Date: _____	<input type="checkbox"/> Food (life threatening requires EpiPen, list on other side)
<input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> other musculoskeletal	<input type="checkbox"/> Medication (List medication allergies on other side)
<input type="checkbox"/> Chromosomal/Hereditary disorder (explain on other side)	<input type="checkbox"/> Other Health Condition: _____

To ensure the care of my child, I read and agree that pertinent health information may be provided to appropriate school staff. This will be done only on a "need to know" basis, in a confidential manner. I agree that the school nurse may consult with my child's family physician(s) about the above medical condition (s). I agree to alert the school nurse and my child's teacher, in writing, of any change in medications and/or health status of my child. In case of emergency involving your child, it is the policy of this school corporation to render first aid treatment while contacting parents for further instructions. If I am unavailable to be reached in order to obtain authorization directly, I do hereby grant the school principal, school nurse, or other appointed designee the authority to act for me and to provide consents and authorization for the delivery of emergency medical care, diagnosis, and treatment, including surgical intervention, if necessary, on behalf of my minor child listed above. The above permission will be valid for one year from the date below, unless I revoke the permission in writing.

☐ I believe the above checked conditions substantially limit one or more of his/her major life activities  
**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## Randolph Central Personal Health History 2023-24

Please give details for all that are marked YES on side one that may impact your child's routine at school.

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An additional, specific "Individual Health Care Plans" should be in place for students with Asthma, Diabetes, Seizures, Food Allergies, Insect Sting Allergies, and other specific health conditions. Many of these plans require doctor's signatures. Please contact your school nurse as soon as possible to complete the plans.

### ADDITIONAL HEALTH INFORMATION

#### Emergency Information:

My child may require the following emergency medications during school hours:

☐ Diastat for seizures      ☐ Epipen for allergic reaction      ☐ Emergency asthma inhaler/nebulizer treatment  
(The above listed emergency medications are to be provided by the parent/guardian for the student. The medication must be a current prescription)

☐ My child was hospitalized overnight IN THE LAST YEAR: Date: \_\_\_\_\_ Reason: \_\_\_\_\_

#### Medications:

Most medications may be taken at home. Will your child be *required* by a physician to take medication during school hours? ☐ Yes ☐ No

All medication taken at school will require an additional signed medication permit on file PRIOR to giving the medication at school. Any changes to the dosage of medications must be made in writing, by the prescribing physician.

List ALL Medications your child takes on a daily basis.

Medication	Amount	Time Taken	Prescribing Physician
1.			
2.			
3.			
4.			
5.			

#### Secondary Emergency Contacts:

I hereby give Randolph Central Schools permission to contact the following adults in order to pick up/transport my child in the case of emergency. If someone is not on our list and we are unable to contact you for confirmation, your child will NOT be released. Photo I.D.'s will be required before the child is released.

Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

# Randolph Central School Corporation

## Permission to Administer Over-the-Counter Medications

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Medication Allergy: \_\_\_\_\_

### STEP 1: CHECK ALL THAT APPLY

Over-The-Counter (OTC) medications which may be necessary during the school day can be administered during school hours. I hereby authorize the school nurse, principal or other principal designated employee to act on my behalf in administering the following medication(s) on an "as needed" basis during school hours. School hours include school-sponsored extracurricular activities.

☐

Acetaminophen (Tylenol)

☐

Ibuprofen (Advil)

☐

Antacid (Tums)

☐

Cough Drops

The school nurse's office stocks a limited supply of the above medications. If your child has a history of frequently needing OTC medications or requires a medication not listed above, please supply your own medication in the **original sealed container**. An additional medication release form will need to be filled out, signed, and returned to your child's school before the medication can be administered. All medications supplied to the nurse's office will be kept in a locked cabinet and used only for your child. The OTC medication, **Aspirin**, will not be given during the school day without a prescription order from your child's doctor due to the risk of Reye's Syndrome. Please understand that it still may be necessary for the school nurse, or other office staff, to call a parent to verify that no medicine has been administered in the morning prior to school hours and/or that there was not a recent health issue and of which the school is unaware. The use of antacids, ibuprofen, or acetaminophen is limited to **three doses in one month**. If these medications are needed more frequently, a doctor's evaluation and medication order will be required.

**\*\* Acetaminophen and Ibuprofen will not be given for fever or head injuries. Antacids will not be given for vomiting\*\***

**All over the counter medications will be administered as directed on the package.**

### Step 2: TO BE COMPLETED BY PARENT/GUARDIAN

I give permission for my child, \_\_\_\_\_, to receive the above medication(s) as directed on the package. I understand and agree that my signature on this form constitutes a waiver of liability. I further acknowledge and agree that when the above medication(s) is administered, I waive any claims I might have against the school district and its employees, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration of said medication(s). I have read and understand all of Step 1 and Step 2.

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

\_\_\_\_\_  
Daytime Phone

\_\_\_\_\_  
Date



## Randolph Central Preschool Discipline/Guidance Policy

### Provider: Randolph Central Preschool

It is essential a child's development is nurtured through caring, patience, and understanding. However, while caring for your children, I may have to respond to your child's misbehavior. Hitting, kicking, spitting, hostile verbal behavior, and other behaviors which will hurt another child are not permitted.

In response to these behaviors, I will not use:

- Threats or bribes
- Physical punishment, even if requested by the parent
- Deprive your child of food or other basic needs
- Humiliation or isolation

In response to misbehavior, I will:

- Respect your child
- Establish clear rules
- Be consistent in enforcing rules
- Use positive language to explain desired behavior
- Speak calmly while bending down to your child's eye level
- Give clear choices
- Redirect your child to a new activity.
- Move your child to a time-out chair for no longer than one minute per year of your child's age.

If your child's behavior is very disruptive or harmful to himself or other children, I will discuss the issue with you privately. If the situation can be resolved, the child may remain enrolled. If we cannot resolve the issue, you may be asked to make other preschool arrangements.

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
Date of Birth

Additional techniques to be used with my child:

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\_\_\_\_\_  
Parent/Guardian Signature  
LLEP FACILITY PACKET R2019

\_\_\_\_\_  
Date

Discipline Policy



***Randolph Central School Corporation Preschool Handbook  
Acknowledgment Form, Including the Suspension and  
Expulsion Policy***

By signing this document, I acknowledge that I have received and read the RCSC Preschool Handbook. I also acknowledge that I have read and understand the **Discipline Practices, including the Suspension and Expulsion Policy** and the rights and responsibilities pertaining to students and agree to support and abide by the rules, guidelines, procedures, and policies of the School Corporation. I also understand that this handbook supersedes all prior handbooks and other written materials on the same subjects.

Printed Name of Parent or Legal Guardian: \_\_\_\_\_

Signature of Parent of Legal Guardian: \_\_\_\_\_

Name of child: \_\_\_\_\_

Date: \_\_\_\_\_



## Randolph Central School Corporation Preschool Photo/Video Permission Slip



Dear Parents/Guardians:

This year we will be doing many fun activities that often result in Kodak moments. We would like to capture these moments through pictures and/or videos. This parental consent form is to both inform you and to request permission for your child's photo/image to be used for school purposes.

Please fill out the form below, marking your permission. If you have any questions, or at any time change your mind about this agreement, please contact us immediately.

Thank you!

☐ Yes, I give Randolph Central School Corporation Preschool permission to take photos/videos of \_\_\_\_\_ for classroom/school use. (Child's Name)

☐ No, I do not give Randolph Central School Corporation Preschool permission to take photos/videos of \_\_\_\_\_ for classroom/school use. ((Child's Name))

Parent Signature: \_\_\_\_\_

Date: \_\_\_\_\_





# Indiana Department of Education

Dr. Katie Jenner, Secretary of Education

## Home Language Survey (HLS)

The Civil Rights Act of 1964, Title VI, Language Minority Compliance Procedures, requires school districts and charter schools to determine the language(s) spoken in each student's home in order to identify their specific language needs. This information is essential in order for schools to provide meaningful instruction for all students as outlined Plyler v. Doe, 457 U.S. 202 (1982).

The purpose of this survey is to determine the primary or home language of the student. The HLS must be given to all students enrolled in the school district / charter school. The HLS is administered one time, upon initial enrollment in Indiana, and remains in the student's cumulative file.

Please note that the answers to the survey below are student-specific. If a language other than English is recorded for ANY of the survey questions below, the WIDA Screener will be administered to determine whether or not the student will qualify for additional English language development support.

**Please answer the following questions regarding the language spoken by the student:**

1. What is the native language of the **student**? \_\_\_\_\_
2. What language(s) is spoken most often by the **student**? \_\_\_\_\_
3. What language(s) is spoken by the **student** in the home? \_\_\_\_\_

**Student Name:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**Parent/Guardian Name:** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

By signing here, you certify that responses to the three questions above are specific to your student. You understand that if a language other than English has been identified, your student will be tested to determine if they qualify for English language development services, to help them become fluent in English. If entered into the English language development program, your student will be entitled to services as an English learner and will be tested annually to determine their English language proficiency.

### **For School Use Only:**

School personnel who administered and explained the HLS and the placement of a student into an English language development program if a language other than English was indicated:

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_



# Departamento de Educación de Indiana

Dra. Katie Jenner, Secretaria de Educación

## Home Language Survey (HLS) Spanish Version

### Encuesta del Idioma en el Hogar

El Decreto de los Derechos Civiles de 1964, Título VI, Cumplimiento de Normas para Minorías en Lenguaje, requiere a los distritos escolares y escuelas semi-autónomas que determinen el idioma o idiomas que se hablan en el hogar de cada estudiante. Esta información es esencial para que las escuelas puedan ofrecer instrucción útil a todos los estudiantes de acuerdo con Plyler v. Doe, 457 U.S. 202 (1982).

El propósito de esta encuesta es determinar el idioma principal de su hijo/a en el hogar. Esta encuesta (HLS) tiene que darse a todos los estudiantes en el distrito escolar/escuela semi-autónoma. Esta encuesta (HLS) es administrada una vez, durante la matrícula inicial en Indiana, y permanece en el archivo acumulativo del estudiante.

Por favor tenga en cuenta que las respuestas a la encuesta corresponden solamente a su hijo/a. Si en alguna de las tres preguntas escritas abajo, usted identifica un idioma diferente al inglés, la escuela administrará el examen WIDA Screener para determinar si su hijo/a calificará para el programa de desarrollo del idioma inglés.

**Por favor responda las siguientes preguntas acerca del idioma(s) hablado por su estudiante:**

1. ¿Cuál es el idioma o el dialecto nativo de su **hijo/hija**? \_\_\_\_\_
2. ¿Cuál es el idioma(s) más hablado por su **hijo/hija**? \_\_\_\_\_
3. ¿Cuál idioma(s) habla su **hijo/hija** en casa? \_\_\_\_\_

**Nombre del Estudiante:** \_\_\_\_\_ **Grado:** \_\_\_\_\_

**Nombre del Padre, Madre o Guardián:** \_\_\_\_\_

**Firma del Padre, Madre o Guardián:** \_\_\_\_\_ **Fecha:** \_\_\_\_\_

Al firmar aquí, usted certifica que las respuestas a las tres preguntas mencionadas arriba corresponden a su hijo/a. Usted entiende que si se ha identificado un idioma diferente al inglés, su hijo/a tendrá un examen para determinar si él o ella califica para el programa de desarrollo del idioma inglés, para ayudarlo/a a que sea fluente en inglés. Si entra en el programa de desarrollo del idioma inglés, su hijo/a, tendrá derecho a servicios que lo ayudarán a aprender el idioma inglés y tendrá un examen cada año para determinar su nivel de inglés.

#### **For School Use Only / Para Uso de la Escuela Únicamente:**

School personnel who administered and explained the HLS and the placement of a student into an English language development program if a language other than English was indicated:

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_