Cutter Morning Star School District

Phone: (501)262-2414

Cutter Morning Star Elementary Enrollment Form

Fax: (501)262-0670

GENERAL STUDENT INFORMATION

FIRST NAME:	MIDDLE NAME:	LAST NAME:

Birthdate:_____ Gender: Female Male Grade:_____

SSN (Optional):_____ Nickname:_____ 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:_____	☐ Mailing Address is same as Physical/911 Address
City:_____	Address:_____
State:_____ Zip Code:_____	City:_____
	State:_____ Zip Code:_____

Student Home Phone:_____ Does this child have Internet Access at home? _____ Yes _____ No

PARENT/GUARDIAN CONTACT INFORMATION

Parent/Guardian 1	Parent/Guardian 2
Name:_____	Name:_____
Relationship to Student:_____	Relationship to Student:_____
Language of Correspondence:_____	Language of Correspondence:_____
Mailing Address:_____	Mailing Address:_____
City:_____	City:_____
State:_____ Zip Code:_____	State:_____ Zip Code:_____
Email:_____	Email:_____
Home Phone:_____ Cell Phone:_____	Home Phone:_____ Cell Phone:_____
Work Phone:_____ *Alert Phone:_____	Work Phone:_____ *Alert Phone:_____
*Alert Phone is used by the district's automated phone message system.	*Alert Phone is used by the district's automated phone message system.
Employer:_____	Employer:_____
☐ Student Primarily Resides with this Guardian.	☐ Student Primarily Resides with this Guardian.

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 %:_____

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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)
____Bus (Bus Number_____)	____Bus (Bus Number_____)
____Drives Self	____Drives Self
____Parent/Guardian (includes walkers, child care vans, etc.)	____Parent/Guardian (includes walkers, child care vans, etc.)
____District Paid Transportation	____District Paid Transportation

Distance From Home to School (Miles) One Way:_____

Pre-School Participation:

A - ARKANSAS BETTER CHANCE	H - HEADSTART	O - OTHER
E - EVEN START	NA - NOT APPLICABLE	P - PRIVATE PRE-SCHOOL
EC - EARLY CHILDHOOD	C - 21st CENTURY COMMUNITY LEARNING CENTER	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.

____ 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

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:_____ ☐ 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 ALLOWED to check out/pick up this child from school: _____

_____ _____ _____

_____ _____

Parent/Guardian Signature Date

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First Name _____ Middle Name _____ Last Name _____

Grade_____ Birth Date_____ Teacher_____

Home Address

_____

_____

Mailing Address (same as home)_____

_____

_____

High Speed Internet: Yes_____ No_____

Parent/Guardian 1 Name_____

Address	
Phone	
Work Phone	
Email	

Parent/Guardian 2 Name_____

Address	
Phone	
Work Phone	
Email	

Emergency contacts: Contacts not listed above who may pick up student in case of emergency or illness:

Name	Phone Number	Relationship

In the event of an emergency and I cannot be reached, I authorize CMS to get emergency care for my child as determined necessary by school personnel. The school will not assume responsibility for the cost incurred for treatment.

_____ _____

Parent signature Date

HEALTH INFORMATION (please answer all questions) School Year _____

Name_____ M___ F___ Teacher_____Grade_____
(Last) (First) (MI) Date of Birth_____

Parent/Guardian _____ Phone Number_____Work_____

Parent/Guardian_____ Phone Number_____Work_____

Authorized Emergency Contact_____ Phone Number_____

Authorized EmergencyContact_____ Phone Number_____
Health Insurance ___Yes___No Medicaid or AR Kids#_____
Physician's Name_____ Phone Number_____
Does student have a ***current*** medical diagnosis of any of the following conditions? Check all that apply:
___ASTHMA ___ADD/ADHD ____WEARS CONTACTS/GLASSES ____DIABETES
___HEARING LOSS RIGHT___ LEFT___ _____HEARING AID ___HEART CONDITION ___SEIZURES
___CEREBRAL PALSY ___BLOOD DISORDER ___KIDNEY DISORDER
ALLERGIC TO MEDICATION(specify)_____ ___OTHER(specify)_____
SEVERE OR LIFE-THREATENING ALLERGY TO NUTS, LATEX, OR STINGS (specify)_____
What medication(s)is your child currently taking?_____

_____YES _____NO (Please mark through any medication you may not want your child to receive)
Do you authorize the use of over the counter medications (Tylenol, Ibuprofen, Advil, Aleve, Aspirin, Antibiotic Cream, Hydrocortisone Cream, Midol, eye drops or cough drops)?

I acknowledge that the Cutter Morning Star School District, the Board of Directors, and School Employees shall be immune from civil liability for damages resulting from the administration of medications in accordance with this consent.

I will notify the school of any change in address, phone number, emergency contact or my child's health status. I understand that the above information may be released to appropriate School District employees and emergency personnel in order to facilitate health care for my child. I also understand that in the event of an emergency, EMS will treat and transport my child to the nearest hospital. The hospital and its medical staff have my authorization to provide treatment that a physician deems necessary for the well-being of my child.

In compliance with the Family Education Rights and Privacy Act (FERPA) (20 U.S.C. and 1232g; 34 CFR Part 99). I give permission for my child's personally identifiable information/student education records to be disclosed to Third Party Billing Vendor for the purpose of billing Medicaid and/or private insurance.

In compliance with the Family Education Right to Privacy Act (FERPA) (20 U.S.C. $ 1232g; 34 CFR Part 99) I give permission for my child to participate in the School Immunization Clinic. I understand that the appropriate Arkansas Department of Health consent forms will be provided for my consideration prior to the clinic.

Date_____ Parent/Guardian Signature_____

PLEASE FILL OUT BOTH SIDES

Arkansas Division of Elementary and Secondary Education (DESE)
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. ***This form is not used to identify students' legal immigration status.***	7. Where was your child born? _____ 8. When did your child first attend a school in the United States (the 50 states, DC)? **(Kindergarten – 12th grade)** _____ Month Day Year 9. Has your child attended a school in Puerto Rico? _____

Thank you for providing the information needed on the Home Language Usage 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.*

2022-2023 Household Application for Free and Reduced Price School Meals

Complete one application per household. Please use a pen (not a pencil)

All highlighted areas need to be filled in for application to be considered **COMPLETED.**

STEP 1 List ALL Household Members who are infants, children, and students up to and including grade 12 (if more spaces are required for additional names, attach another sheet of paper)

Definition of **Household Member:** "Anyone who is living with you and shares income and expenses, even if not related."

Children in **Foster care** and children who meet the definition of **Homeless, Migrant** or **Runaway** are eligible for free meals. Read **How to Apply for Free and Reduced Price**

Child's First Name	MI	Child's Last Name	Name of School	Grade	Student? Yes	Student? No	Foster Child	Homeless, Migrant, Runaway
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐
					☐	☐	☐	☐

Check all that apply

STEP 2 Do any Household Members (including you) currently participate in the following assistance program: Supplemental Nutrition Assistance Program (SNAP)?

If NO> Go to STEP 3. If YES > Write a case number or identifier here, then go to STEP 4. (Do not complete STEP 3)

Write only one case number or identifier. **Case Number or Identifier:**

STEP 3 Report Income for ALL Household Members (Skip this step if you answered 'Yes' to STEP 2)

Are you unsure what income to include here?

Flip the page and review the charts titled "Sources of Income" for more information.

The "Sources of Income for Children" chart will help you with the Child Income section.

The "Sources of Income for Adults" chart will help you with the All Adult Household Members section.

A. Child Income

Sometimes children in the household earn or receive income. Please include the TOTAL income received by all Household Members listed in STEP 1 here.

Child income	How often? Weekly	Bi-Weekly	2x Month	Monthly
$	○	○	○	○

B. All Adult Household Members (including yourself)

List all Household Members not listed in STEP 1 (including yourself) even if they do not receive income. For each Household Member listed, if they do receive income, report total gross income (before taxes) for each source in whole dollars (no cents) only. If they do not receive income from any source, write '0'. If you enter '0' or leave any fields blank, you are certifying (promising) that there is no income to report.

Name of Adult Household Members (First and Last)	Earnings from Work	How often? Weekly	Bi-Weekly	2x Month	Monthly	Public Assistance / Child Support/Alimony	How often? Weekly	Bi-Weekly	2x Month	Monthly	Pensions/Retirement/ All Other Income	How often? Weekly	Bi-Weekly	2x Month	Monthly
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○
	$	○	○	○	○	$	○	○	○	○	$	○	○	○	○

Total Household Members (Children and Adults)

Last Four Digits of Social Security Number (SSN) of Primary Wage Earner or Other Adult Household Member X X X X X ☐ Check if no SSN.

Disclosure (Optional) ○ I do not want school officials to share information from my free and reduced price meal application with Medicaid or the State Children's Health Insurance Program (ArKids 1st).

STEP 4 Contact information and adult signature

"I certify (promise) that all information on this application is true, and that all income is reported. I understand that this information is given in connection with the receipt of Federal funds, and that school officials may verify (check) the information. I am aware that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted under applicable State and Federal laws."

Street Address (if available) Apt # City State Zip Daytime Phone and Email (Optional)

Printed name of the adult signing the form Signature of adult Today's date

Cutter Morning Star Elementary Student and Parent Handbook

_____ I have received a copy of the CMS Elementary Parent and Student Handbook.

_____I have accessed an electronic copy of the CMS Elementary Parent and Student Handbook found on the District's website.

Cutter Morning Star Elementary School Parent Involvement Summary

_____ I have read a copy of the Cutter Morning Star Elementary School Parent Involvement Summary located in the district section of the handbook.

Name/Photo/Website/Video Release

_____ Yes, permission **IS** granted to use photographs of my child in various media given guidelines stated in the handbook for the current school year.

_____ No, permission **IS NOT** granted to use photographs of my child in various media given guidelines stated in the handbook for the current school year.

Right to Request Teacher Qualifications

_____ I have read a copy of the Cutter Morning Star Elementary School Right to Request Teacher Qualifications Annual Parent Notice located in the Parent and Student Handbook.

Student Computer Internet Use Agreement

_____ I have read and understand the Terms and Conditions for the CMS Public School Computer Network.

Parent/Student Tutoring Compact

_____ Yes, my child may participate in the CMS tutoring program if needed.

_____ No, my child may not participate in the CMS tutoring program. I understand that by declining this service my child could be subject to retention.

Notification of Yearly Health Screenings – Permission to bill Medicaid

BMI: Grades- K, 2, 4, 6 SCOLIOSIS- 6th Grade Girls
Please submit a letter in writing if you do not want your child screened for BMI or Scoliosis

Student Name: _____ Student Signature: _____

Parent Name: _____ Parent Signature: _____

Date: _____

Elementary Internet and Computer Access Information

(ONE PER FAMILY. ELEMENTARY STUDENTS ONLY)

Parent Name: _____ Phone: _____

Student Name: _____

Student Name:_____

Student Name:_____

Student Name:_____

_____IF NO CHANGES FROM LAST YEAR, PLEASE CHECK AND DO NOT FILL OUT

1. What is your internet type? Please circle

A. Residential Broadband B. Cellular Network C. Hot Spot

D. Community provided Wi-Fi E. Satellite F. Dial-Up

G. Other _____ H. None

2. If you do not have internet access, what is keeping you from getting it? Please circle

A. Not Affordable B. Not Available Other_____

3. What is your level of internet performance? Please circle

A. Unable to access Internet B. Regularly experience internet interruptions

C. Few or no internet interruptions