

CHILD MAINTENANCE

CHILD'S LIVING ARRANGEMENTS: BOTH PARENTS MOTHER FATHER OTHER

CHILD'S LEGAL GUARDIAN: BOTH PARENTS MOTHER FATHER OTHER

THE CHILD MAY BE RELEASED TO THE PERSON(S) SIGNING THIS AGREEMENT OR TO THE FOLLOWING:

| <u>NAME</u> | <u>ADDRESS</u> | <u>RELATIONSHIP</u> |
|-------------|----------------|---------------------|
|-------------|----------------|---------------------|

CHILD'S PHYSICIAN OR CLINIC'S NAME (CHILD'S PRIMARY HEALTH SOURCE):

DATE OF LAST FULL HEALTH SCREENING: _____ PHONE: ()

MY CHILD HAS THE FOLLOWING SPECIAL NEED(S):

THE FOLLOWING SPECIAL ACCOMMODATION(S) MAY BE REQUIRED TO MOST EFFECTIVELY MEET MY CHILD'S NEEDS WHILE AT THIS CENTER:

MY CHILD IS CURRENTLY ON MEDICATION(S) PRESCRIBED FOR LONG-TERM CONTINUOUS USE AND/OR HAS THE FOLLOWING PRE-EXISTING ALLERGIES, ILLNESS, OR HEALTH CONCERNS:

GENERAL RELEASE

I verify the above information to be correct and true. I hereby grant permission for the information provided in the preceding Registration Form to be distributed to Pre-K providers, the Department of Early Care and Learning (DECAL), and certain agencies or those entities contracted by Pre-K providers or DECAL which shall include, but not be limited to, the Georgia Department of Education, and colleges/universities.

SIGNATURE (Parent/Guardian): _____

DATE: _____

PHOTOGRAPH/VIDEOTAPE RELEASE

I hereby grant permission for the Pre-K provider specified below, the Georgia Department of Early Care and Learning (DECAL) and certain agencies or entities contracted by the Pre-K provider or DECAL which shall include, but not be limited to, the Georgia Department of Education, and colleges/universities, to record the participation and appearance of my child,

The undersigned hereby jointly and severally releases, acquits, forgives, and discharges the Pre-K provider, DECAL, and other entities contracted by the Pre-K provider or DECAL, from any actions, agreements, claims, controversies, demands, judgments, liabilities, proceedings, and suits, whether arising in equity or in law regarding such participation and appearance by said child.

This release shall remain binding upon all successors in interest and personal representatives of the parties, to the extent permitted by law.

PRE-K PROVIDER NAME/ADDRESS: _____

SIGNATURE (Parent/Guardian): _____

DATE: _____



Newton County School System
PRE-K STUDENT REGISTRATION PACKET

Registration Checklist

 The following documents are required in order for Pre-k registration packet to be considered complete.

Two Proofs of Residency:

(Electric, gas, garbage or water bill in the name of the person enrolling the child; **AND** a mortgage statement or lease agreement.) *Please note: If the child does not live with one or both parents, guardianship or custody documents must be presented.

Utility Bill, AND

Lease Agreement OR Mortgage Statement

Certified Birth Certificate-- **The child must be 4 years old on or before September 1, 2019.**

Child's Immunization Record – GA Form 3231 (obtain from your child's Physician or Health Department)

Eye, Ear, Dental (EED) and Nutrition Screening– GA Form 3300 (obtain from your child's physician or Health Department). Only needed for students entering a Georgia public school for the first time or re-entering a Georgia school after being gone for one entire school year

Child's Social Security Card, or signed waiver request

Bright from the Start Pre-K Registration Form

Newton County Pre-K Registration Form

Proof of Custody/Guardianship (if applicable)



Newton County School System

PRE-K STUDENT REGISTRATION PACKET

Student's Legal Name: _____
Last Name First Name Middle Name Suffix (Jr, Sr, II, III, etc)

Gender: Male Female Date of Birth: _____
mm dd yyyy

Student's Social Security Number: _____

Last school attended: _____ Grade: _____

Services received (check if applicable): EL Gifted SPED EBIS RTI 504

Previous Newton County School

Yes No Has this student ever been enrolled in a Newton County School?

If Yes: _____
School Name Grade Year

Ethnicity / Race Information - New Federally Mandated Questions. Please answer both parts.

Part A - Ethnicity: Is the student Hispanic or Latino? (choose only one)

No, not Hispanic/Latino

Yes, Hispanic/Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race).

The above part of the question is about ethnicity, not race. No matter what you selected above, please continue to answer the following by marking one or more boxes to indicate what you consider this student's race to be.

Part B - Race: What is the student's race? (choose all that apply)

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 the 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, the Middle East, or North Africa.)



Newton County School System
PRE-K STUDENT REGISTRATION PACKET

Student's Name: _____

Student's **Residence** Address: _____
Number Street Name Apt #

_____ City State Zip code

Household **Mailing** Address: _____
(if different from above) Number Street Name Apt #

_____ City State Zip code

Preferred phone number the school should normally use to contact you: _____

PRIMARY HOUSEHOLD INFORMATION - Where student *normally* sleeps on a nightly basis.

Parent/Guardian: _____
Last Name First Name Middle Name

Parent/Guardian Date of Birth: _____
mm dd yyyy

Relationship to Student: (Mother, Father, Grandparent, Guardian, etc) _____

Email Address: _____

Residence Phone: _____ Work Phone: _____

Cell Phone: _____ Place of Work: _____

Parent/Guardian: _____
Last Name First Name Middle Name

Parent/Guardian Date of Birth: _____
mm dd yyyy

Relationship to Student: (Mother, Father, Grandparent, Guardian, etc) _____

Email Address: _____

Residence Phone: _____ Work Phone: _____

Cell Phone: _____ Place of Work: _____

Does the child have a parent or guardian who is currently on active duty in the U.S. Armed Forces, including the National Guard or Reserve Forces? Yes or No



Newton County School System

PRE-K STUDENT REGISTRATION PACKET

Student's Name: _____

SECONDARY HOUSEHOLD INFORMATION - Where student sleeps on a part time basis. Leave blank if this does not apply to your family situation.

Parent/Guardian: _____
Last Name
First Name
Middle Name

Parent/Guardian Date of Birth: _____
mm
dd
yyyy

Relationship to Student: (Mother, Father, Grandparent, Guardian, etc) _____

Email Address: _____

Residence Address: _____
Number
Street Name
Apt #

City
State
Zip code

Residence Phone: _____

Work Phone: _____

Cell Phone: _____

Place of Work: _____

Additional Household Members & Siblings - Please list the names of all additional household members and siblings (under 21 years of age).

| Last Name | First Name | Date of Birth | Relation to Student | School |
|-----------|------------|---------------|---------------------|--------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |



Newton County School System
PRE-K STUDENT REGISTRATION PACKET

Student's Name: _____

Emergency Contact Information - Please list at least two family members or friends who could assume temporary care of your child in the event that you cannot be reached.

Emergency Contact #1: _____
Name Phone Relation to Student

Emergency Contact #2: _____
Name Phone Relation to Student

Student Residency Statement - Do you live in any of the following situations? Please mark as appropriate.

- ___ Sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason (example: evicted from home, cannot afford housing, etc).
- ___ In a motel, hotel, campground or similar setting due to lack of alternative adequate accommodations.
- ___ In emergency or transitional shelters such as domestic violence or homeless shelters or transitional housing through MUST, Center for Family Resources, or other shelter or agency.
- ___ Have a primary nighttime residence that is a place not designed for or ordinarily used as a regular sleeping accommodation for humans.
- ___ In cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings.
- ___ None of the above.

How long do you anticipate living at this location? _____



Newton County School System

PRE-K STUDENT REGISTRATION PACKET

Student's Name: _____

Home Language Survey

Home Language Survey - In order to comply with state guidelines, we are required to have a Home Language Survey on file **for ALL students**.

Student's Legal Name: _____
Last Name First Name Middle Name Suffix (Jr, Sr, II, III, etc)

Student's Address: _____
Number Street Name Apt #

City State Zipcode

Telephone: _____

Parent/Guardian: _____
Last Name First Name Middle Name

Where was this student born (in what country)? _____

Date this student entered the USA (if applicable): _____
mm dd yyyy

Date this student first started school in the USA: _____
mm dd yyyy

1. Which language does your child most frequently speak at home? _____
2. Which language do adults in your home most frequently use when speaking with your child? _____
3. Which language(s) does your child currently understand or speak? _____
4. If possible, would you prefer notice of school activities in a language **other** than English?
Yes No

If yes, which Language? _____

Parent signature _____ Date _____

PLACE IN PERMANENT RECORD FOLDER

If the answer to any of the above questions is a language other than English, send a copy of this form to the designated ESOL contact at the school for student screening.



Newton County School System
PRE-K STUDENT REGISTRATION PACKET

Student's Name: _____

Kindergarten and Pre-Kindergarten
Parent Questionnaire

(Complete this section ONLY if registering a student for Pre-Kindergarten or Kindergarten for THE 2019-2020 SCHOOL year.) Form SHOULD ONLY BE COMPLETED ONCE—AT THE BEGINNING OF PRE-KINDERGARTEN OR AT THE BEGINNING OF KINDERGARTEN (if child did not attend Pre-K in the Newton County School System)

Which of the following services are you presently receiving, if any? Check all that apply.

___ Medicaid ___ TANF ___ Food Stamps ___ SSI ___ PeachCare ___ CAPS

Have you applied for pre-kindergarten anywhere else? ___ If so, where? _____

Do you have guardianship or custody of the child who you are registering for pre-kindergarten? _____

If so, how is this child related to you? _____

Do you get your child's immunizations at the Newton County Health Department? _____

If not, where do you get your child's immunizations? _____

Any problems during pregnancy or delivery? _____

At birth was the child ___ Full Term ___ Premature Birth weight ___ pounds ___ ounces

Do you have special concerns about this child? _____

BEHAVIOR AND FAMILY INTERACTION

How is the child disciplined? _____ For what is he/she disciplined? _____

Are there any family problems which might affect your child's school success? _____

Has your child ever attended pre-school? ___ Head Start? ___ Nursery? ___

Where? _____



Newton County School System
PRE-K STUDENT REGISTRATION PACKET

Student's Name: _____

Kindergarten and Pre-Kindergarten
Parent Questionnaire (continued)

DEVELOPMENTAL HISTORY
(If guess, label as such)

Give Age:

When did this child: Sit? _____ Crawl? _____ Walk? _____ Use Words? _____

Talk in sentences? _____ Feed self? _____ Dress self? _____ When was the child weaned? _____

Is the child toilet trained? _____ When was child toilet trained? _____

Does the child perform the following? Mark one by placing an "X" under the best answer:

| | Often | Sometimes | Rarely |
|---|--------------------------|--------------------------|--------------------------|
| Talk a lot? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 1. Seems to speak as well as other children the same age? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Speak so you can understand him or her? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Speak so other adults understand him or her? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Speak so other children understand him or her? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If the child does not talk, does he or she (mark one):

- | | | | |
|---------------------------------|--------------------------|--------------------------|--------------------------|
| 1. Make any sounds? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Use gestures to communicate? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

What language(s) is spoken most frequently in the home? _____



Newton County School System
PRE-K STUDENT REGISTRATION PACKET

Student's Name: _____

Kindergarten and Pre-Kindergarten
Parent Questionnaire (continued)

Medical Information

- | | | | |
|-------------------------|---------------------|--------------------------|-------------------------|
| _____ Asthma | _____ Sinus trouble | _____ Thumb sucking | _____ Heart trouble |
| _____ Indigestion | _____ Allergies | _____ Nail biting | _____ Frequent fevers |
| _____ Diarrhea | _____ Vomiting | _____ Headaches | _____ Nightmares |
| _____ Constipation | _____ Bed wetting | _____ Nose bleeding | _____ Difficulty seeing |
| _____ Epilepsy/seizures | | _____ Difficulty hearing | |

_____ Overtired or lacking pep

_____ Other physical problems (Explain): _____

Hearing problems: _____

Vision problems: _____

Childhood diseases: _____

Hospitalization: _____

Serious injuries: _____

Allergies: _____

Family Doctor: _____

(Name)

(Telephone Number)

(Address)

Is this child currently on medication? _____ No _____ Yes (If yes, describe) _____

I UNDERSTAND THAT WITHIN 30 DAYS OF ENROLLMENT, I MUST SUBMIT MY CHILD'S HEALTH SCREENING.

DATE: _____ **SIGNATURE:** _____

I UNDERSTAND THAT THIS APPLICATION DOES NOT GUARANTEE MY CHILD'S PLACEMENT IN THE PRE-KINDERGARTEN PROGRAM.

DATE: _____ **SIGNATURE:** _____



Newton County School System
PRE-K STUDENT REGISTRATION PACKET

Student's Name: _____

EMERGENCY CLOSING INSTRUCTIONS

Should school be dismissed early, we need to know if your child is to ride the bus, go to day care, or be picked up by you. Weather, plumbing, electrical problems or other emergencies could cause us to dismiss early. It is important that arrangements are made in case of these unforeseen events. Sometimes our phone lines are busy so we cannot rely on a last minute phone call for directions. If the need to close early occurs, we would call all day care centers that pick up at our school.

Child's Name: _____

Address: _____

Phone: _____

CHECK ONE:

____ Ride regular bus home

____ Ride bus to neighbor/friend/relative:

Name: _____ Bus Number: _____

____ Day Care:

Name: _____ Phone _____

____ Parent Pickup

____ Other (please explain): _____

Parent/Guardian signature _____ Date: _____

Thank you. We hope we do not need this information. Please discuss this plan with your child.



Newton County School System
PRE-K STUDENT REGISTRATION PACKET

Student's Name: _____

SCHOOLWIDE E-MAIL OPTION

Dear Parents,

In an atmosphere of true economic concern and faced with impending financial cutbacks, we wish to be as fiscally responsible as possible. One thing we can do is reduce the number of "hard copy" information sheets sent home. Throughout the county, schools are attempting to save toner and paper costs by using email when possible.

We realize that everyone does not have access to email but a large number of families do. One school reported a 75% savings by updating its email directory and using email instead of "hard copy" handouts.

Please complete the appropriate portion of the form below and return to the school as soon as possible. If you have a current email address that school information could be sent to, please give that address. If you must continue to receive "hard copy" handouts, please indicate which of your children (for families with more than one child) you would like us to send information home with.

Thank you for your help and understanding in these challenging times.

Student Name: _____

Homeroom Teacher: _____

Please write clearly and case sensitive.

Preferred E-mail: _____
(the above is for Parent/guardian name _____)

Secondary E-mail: _____
(the above is for Parent/guardian name _____)

____ I wish to continue to receive "hard copy" handouts. Please send them home with (**choose 1 child only**)

Student name _____

Homeroom Teacher _____

Home Telephone # _____



Newton County School System

PRE-K STUDENT REGISTRATION PACKET

CLINIC INFORMATION CARD

Gender: Male Female Student's Name: _____

Date of Birth: _____ Grade _____ HmRm Teacher _____

mm dd yyyy

Name of siblings enrolled in this school: _____

HEALTH HISTORY (If yes, please explain)

| | | | |
|--|--|--|--------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Allergies (LIST ALL) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problem |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headache |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No | Physical Handicaps |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Condition |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Menstrual | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Drug Allergies/Reaction | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Other | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | My child needs an inhaler/nebulizer available at school (if YES, provide medication to keep at school) | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | My child requires an Epi-Pen for severe allergic reaction (if YES, provide Epi-Pen to keep at school) | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | My child received immunizations this past year | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | If YES list type and date: | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | My child takes prescribed medications routinely/occasionally | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | If YES please list: | | |

EMERGENCY INFORMATION

Parent/Guardian #1: _____ Relationship to Student: _____
 Residence Ph: _____ Work Ph: _____ Cell Ph: _____

Parent/Guardian #2: _____ Relationship to Student: _____
 Residence Ph: _____ Work Ph: _____ Cell Ph: _____

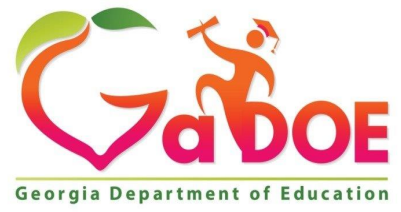
If parents cannot be reached, list two (2) Emergency Contacts who will assume care of your child:

Emerg.Contact #1: _____ Relationship _____ Ph: _____
 Emerg.Contact #2: _____ Relationship _____ Ph: _____

| | |
|--|--|
| Please Note | In the event that Emergency Medical care is deemed necessary, the school will immediately attempt to make contact using phone numbers provided on the clinic card and will contact Emergency Medical Services (911) to respond to the school for evaluation and possible transport. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Medical information, as indicated above, may be shared with appropriate staff as needed. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | In an emergency , I give the principal, or designee, permission to administer Tylenol or Benadryl in the event the parent or contact person cannot be reached. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | In non-emergency health concerns I authorize the school nurse/school personnel to utilize the following medications: anti-itch medication (caladryl, cortisone cream/lotion), antiseptic sprays, cough drops or the generic of these. I understand that it is the parents' responsibility to provide non-prescription medications to have available at school such as Motrin, Tylenol, Benadryl, etc. All medication must be labeled and must be in the original container. School Nurses are prohibited by their license restrictions to dispense prescription medication without the prescribing doctor's signature. |

Should there be a need for school personnel to dispense prescription/nonprescription medication to my child, I will contact the school for the appropriate medication form that must accompany medication. I understand that **all medication must be provided by the parent/guardian** and that no personnel can dispense without parent/guardian signature.

Parent/Legal Guardian Signature



Required Home Language Survey

Dear Parent or Guardian:

In order to provide your child with the best possible education, we need to determine how well he or she speaks and understands English. This survey assists school personnel in deciding whether your child may be a candidate for additional English language support. Final qualification for language support is based on the results of an English language assessment.

Thank You

Student Name (required information):

Language Background (required information):

1. Which language does your child best understand and speak?

2. Which language does your child most frequently speak at home?

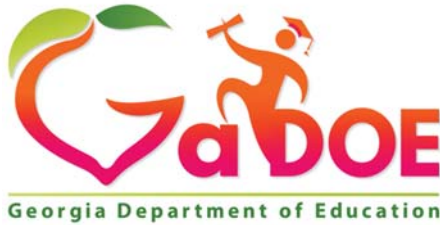
3. Which language do adults in your home most frequently use when speaking with your child?

Language for School Communication (not required):

4. In which language would you prefer to receive all school information?

Signature of Parent/Guardian/Other

Date



Richard Woods, Georgia's School Superintendent
"Educating Georgia's Future"

School District: _____

Date: _____

Parent Occupational Survey

Please complete this form to determine if your child(ren) qualify to receive supplemental services under Title I, Part C

| Name of Student(s) | Name of School | Grade |
|--------------------|----------------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

1. Has anyone in your household moved in order to work in another city, county, or state, in the last three (3) years? Yes No
2. Has anyone in your household been involved in one of the following occupations, either full or part-time or temporarily during the last three (3) years? Yes No

If you answer "yes", check all that applies:

- 1) Planting/picking vegetables (such as tomatoes, squash, onions) or fruits (such as grapes, strawberries, blueberries)
- 2) Planting, growing, cutting, processing trees (pulpwood), or raking pine straw
- 3) Processing/packing agricultural products
- 4) Dairy/Poultry/Livestock
- 5) Meatpacking/Meat processing/Seafood
- 6) Fishing or fish farms
- 7) Other (Please specify occupation): _____

Names of Parent(s) or Legal Guardian(s) _____

Current Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Thank You!

Please return this form to the school

Please maintain original copy in your files.

MEP funded school/district: Please give this form to the migrant liaison or migrant contact for your school/district.

Non-MEP funded (consortium) school/districts: When at least one "yes" and one or more of the boxes from 1 to 7 is/are checked, districts should fax occupational surveys to the Regional Migrant Education Program Office serving your district. For additional questions regarding this form, please call the MEP office serving your district:

GaDOE Region 1 MEP, P.O. Box 780, 201 West Lee Street, Brooklet, GA 30415
Toll Free (800) 621-5217 Fax (912) 842-5440

GaDOE Region 2 MEP, 221 N. Robinson Street, Lenox, GA 31637
Toll Free (866) 505-3182 Fax (229) 546-3251

Regional Office use only: