School Enrollment Checklist

Student Name: _____ **Date:** _____

Registration Packet

_____ Student Enrollment Form

_____ Home Language Survey

_____ Birth Certificate (original to be copied at registration)

_____ Student Health History

_____ Immunizations (Copy of student's most recent immunizations. Must have dates of all immunizations and be signed by physician.)

_____ School Physical Form (for Kindergarten and Out-of-State Students)

_____ Third Party Release Form

_____ Request for Transportation Form

_____ Free and Reduced Lunch Application (if applicable)

_____ Email/Listserv Form

Residency Documentation

_____ Residency Affidavit **(must be notarized)**

Registration must include the following from each column to be accepted as proof of residency. Provide one piece of evidence from Column A and Column B.

Column A	Column B
❑ Copy of mortgage statement	❑ Copy of Cable Bill
❑ Copy of property tax bill	❑ Copy of Gas/Electric Bill
❑ Copy of fully executed lease agreement/letter from landlord	

_____ Release form faxed to previous school Date _____

_____ Records received from school Date _____

SOUTH KINGSTOWN SCHOOL DEPARTMENT - STUDENT ENROLLMENT FORM
EXACT INFORMATION IS REQUIRED ON THIS FORM ~~ PROVIDE LEGAL NAMES – NO NICK NAMES

Please note, the fields marked with an * MUST be completed.

*Last Name _____ *First Name _____ Middle Name _____

*Physical Address _____ Town _____ Zip Code _____

Mailing Address (if different) _____

*Birth Date _____ Grade _____ *Sex _____

Place of Birth _____ Languages other than English spoken at home _____

*Is the student Hispanic or Latino? (choose one) Yes ☐ No ☐

*What is the student's race? (choose one or more)
American Indian/Alaskan Native ☐
Asian ☐
Black or African American ☐
Native Hawaiian or Other Pacific Islander ☐
White ☐

Last School Attended _____ Grade in previous school _____

Address of last school attended _____

Please check if your child receives any of the following services: _____ IEP _____ 504 PLAN _____ OT
(Please provide any documentation regarding services) _____ SPEECH _____ READING SPECIALIST
_____ COUNSELING _____ OTHER: _____

INFORMATION ON BOTH PARENTS IS REQUESTED

1st Contact (Mother/Guardian): _____ **Home Phone#** _____

Address of Mother/Guardian _____

Cell Phone # _____ E-Mail Address _____

Place of employment of Mother/Guardian _____ Work Phone # _____

2nd Contact (Father/Guardian): _____ **Home Phone #** _____

Address of Father/Guardian _____

Cell Phone # _____ E-Mail Address _____

Place of employment of Father/Guardian _____ Work Phone # _____

3rd Contact: Name _____ Relationship to Student _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

4th Contact: Name _____ Relationship to Student _____

Home Phone # _____ Work Phone # _____ Cell Phone# _____

Siblings: Name: _____ Grade: _____
Name: _____ Grade: _____

If there is any court intervention related to this child, please indicate and provide documentation
____ None ____ Documentation Provided

SOUTH KINGSTOWN SCHOOL DEPARTMENT

HOME LANGUAGE SURVEY

Dear Parent(s)/Guardian(s):

The General Assembly of the State of Rhode Island mandates an assessment of the number of children who speak a language other than English. To fulfill this requirement, the South Kingstown School Department needs a survey of the home language of all students enrolled in the public schools. We are requesting your cooperation in completing this form. Please answer this questionnaire and return it to school. Families with more than one child will need to complete a questionnaire for each child enrolled in school. If you have any questions, please contact the school principal. Thank you for your cooperation.

Student's Name: _____ Date of Birth: _____

School: _____

PLEASE ANSWER EACH QUESTION BY CIRCLING THE APPROPRIATE LETTER.

IF YOU CIRCLE "O" FOR OTHER, PLEASE SPECIFY WHICH OTHER LANGUAGE.

1. What language do you **most often** use when speaking to your child?
   - ◯ E English
   - ◯ O Other (specify)_____
2. What language did your child **first** learn to speak?
   - ◯ E English
   - ◯ O Other (specify)_____
3. What language does your child **most often** use when speaking to siblings, and other children?
   - ◯ E English
   - ◯ O Other (specify)_____
4. What language does your child **most often** use when speaking with you or other adults in the home? (Grandparents, aunts, uncles, guests)
   - ◯ E English
   - ◯ O Other (specify)_____
5. What language does your child **most often** use when speaking with friends or neighbors, outside the home?
   - ◯ E English
   - ◯ O Other (specify)_____

_____ _____

Signature of Parents or Guardian Date

SOUTH KINGSTOWN SCHOOL DEPARTMENT STUDENT HEALTH HISTORY

Date: _____

Child's Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Grade/Teacher: _____

Name of Physician/Pediatrician: _____

Address: _____ Phone: _____

1. Check Any Current Health Conditions:

Asthma ☐ Eczema ☐ Bone or Joint Problems ☐ Diabetes ☐ Scoliosis ☐ Emotional Problems ☐

Seizures ☐ Heart Condition ☐ Physical Disability ☐ Other _____

2. Check Any Past Illnesses, Injuries, Conditions Operations

Strep Throat ☐ Hives ☐ Chicken Pox ___ Operations ___ Scarlet Fever ___ Diarrhea ___ Pneumonia ___

Sinus Infections ___ Headaches ___ Stomachaches ___ Earaches/Infections ___ Other _____

Teachers & support staff will be notified of health concerns on a confidential health list.

3. Medications:

Does your child presently take medication including inhalers at home? Yes ____ No ____

Please list here: _____

Is there any medication that needs to be taken at school? Yes ____ No ____

Please list name of medication and time to be taken. _____

MEDICATIONS IN SCHOOL: Must be administered by the nurse with specific written permission from the physician and parent. No child should bring medication to school.

4. Check Any Allergies:

Allergy to Bee Stings: ___ Requires Epipen ___ Requires Benadryl ___

Allergy to Foods: ___ Requires Epipen ___ List Foods _____

Allergy to Medications: ___ List Medication(s) here: _____

Allergy to Environment: ___ List Allergens & Treatment: _____

Any other allergies, reactions or treatments the school needs to know: _____

5. Vision and Hearing:

Does your child have any trouble hearing?_____ Tubes or hearing aides? _____

Does your child have difficulty seeing? _____ Wears glasses or contacts? _____

6. Dental Information: RI State Law mandates that all students in elementary schools be examined by a dentist at least once a year and once during grades 6-12. Please indicate the dentist that follows your child or the school dentist will exam your child.

Dentist's Name: _____ Address: _____ Phone#: _____

Date of last or next examination: _____

7. Other:

Is your child able to fully participate in school activities? _____

Is your child being treated for anything at this time? _____ If yes, please explain: _____

Please note any additional information in regards to your child: _____

Parent/Guardian Signature:_____ **Date:**_____

**** South Kingstown School District is a KIDSNET Authorized user.**
**** Parent(s)/Guardian(s) is/are responsible for notifying the bus driver and any after school programs regarding any health issues for their child(ren).**

SOUTH KINGSTOWN HIGH SCHOOL
215 COLUMBIA STREET
WAKEFIELD RI 02879

Health Care Provider Name and Address:

Phone:

STATE OF RHODE ISLAND SCHOOL PHYSICAL FORM

This form may substitute for any district-issued form. All districts must accept this form. General health examinations shall be documented in a standardized format with one copy available from the Rhode Island Department of Health or in any such format that captures the same fields of information (R16-21SCHO Section 8.4)

Student Name: Last	First	Middle	Date of Birth	Sex

Address: Street	Apt #	City	State	Zip Code	Home Phone

PLEASE COMPLETE ALL INFORMATION BELOW (May attach immunization transcript).

IMMUNIZATIONS	Please enter dates in MM/DD/YYYY format				
Hepatitis B					
Diphtheria-Tetanus-Pertussis DTP/DTaP	Check ☐ If DT	Check ☐ If DT	Check ☐ If DT	Check ☐ If DT	Check ☐ If DT
Pneumococcal Conjugate PCV					
Polio					
Haemophilus influenzae Type B Hib					
Measles-Mumps-Rubella MMR					
Varicella			☐ Student has history of varicella disease		
Tetanus-Diphtheria-Pertussis TdaP/Td	Check ☐ If Td	Check ☐ If Td	Check ☐ If Td		
Rotavirus					
Hepatitis A					
Meningococcal					
HPV					

Immunization Exemption: ☐ Medical ☐ Religious

☐ Hep B ☐ DTaP ☐ PCV ☐ Polio ☐ Hib ☐ MMR ☐ Varicella ☐ Td/Tdap ☐ Rotavirus ☐ Hep A ☐ Mening ☐ HPV

PHYSICAL EXAMINATION

Date of PE___/___/___ Height_____ Weight_____ BP_____

Please note any health problem, chronic health condition or disability that may affect behavior or health at school:

ASTHMA: No ☐ Yes ☐ DIABETES: No ☐ Yes ☐ OTHER: _____

Significant Systems Findings: _____

ALLERGIES: No ☐ Yes ☐ (Please explain) _____ EPINEPHRINE AUTO-INJECTOR REQUIRED: No ☐ Yes ☐

Treatment Plan: _____

MEDICATION (REQUIRED AT SCHOOL): No ☐ Yes ☐ (Please list) _____

Other medication(s) that may affect behavior or health at school: _____

RESTRICTIONS: Can participate in physical education: Fully☐ With limitation ☐ _____

Can participate in sports: Fully☐ With limitation ☐ _____

LEAD SCREENING (Required for children < 6 years of age only) Student is in compliance with lead screening requirements: Yes ☐ No ☐	SCOLIOSIS SCREENING Yes ☐ No ☐	VISION SCREENING (Children entering Kindergarten) ☐ Passed screening ☐ Screened and referred for comprehensive exam ☐ Referred for comprehensive exam, but not screened Screening Date: Comprehensive Exam Date:
TUBERCULOSIS (If required by school district) Date of TB test:		

HEALTH CARE PROVIDER SIGNATURE: _____ DATE: _____

PRINT NAME: _____

Revised 8-09

SOUTH KINGSTOWN SCHOOL DEPARTMENT THIRD PARTY RELEASE FORM

I give permission to: _____
Name

_____
Address

_____
City/Town State Zip

_____ _____
Phone Number Fax Number

To release the following records of my child _____
Name of Student Date of Birth

To: _____
Name

_____
Address

_____
City/Town State Zip

_____ _____
Phone Number Fax Number

For the purpose of _____

Records Requested

_____ Official Cumulative Record (e.g. name, address, birth certificate, grade level completed, grades, class standing, attendance record, standardized test scores, teacher and/or counselor recommendations)

_____ School Profile, to include grading system (High School level only)

_____ NCLB Accountability Assessments

_____Health and Immunization Records

_____ Special Education Records, including testing results

_____ 504 Plan, including testing results and outside party recommendations

_____ Personalized Literacy Plan (PLP), including testing results

_____ RI Documentation for Approved Free & Reduced Lunch Program

_____
Parent/Guardian Signature

This authorization is requested in compliance with Public Law 93-380 Family Educational Right and Privacy Act of 1974, which requires that Parents permit the release of records and know that such student information is being forwarded to another institution.

The above records were: _____ requested and sent on _____

_____ received and filed on _____ By: _____

Residency Policy Appendix A

SOUTH KINGSTOWN PUBLIC SCHOOLS
South Kingstown, RI

AFFIDAVIT

CAUTION: Read this statement carefully before signing. This document requires you to provide information which, if not true, could make you responsible for the payment of tuition under penalty of law for your child to attend South Kingstown Public Schools.

Section I

I, (name) _____, affirm that (child's name) _____ whose birth date is (month/day/year) _____ resides permanently with me at my residence at (street address) _____, in the South Kingstown Public School District. I am the (check one):

_____ custodial parent
_____ legal guardian
_____ state-appointed custodian
_____ person responsible for the child who resides with me for purpose other than attending South Kingstown Public Schools

of the above-named child. Submitted with this statement, if applicable, is a certified copy of a court order granting me custody, legal guardianship, or temporary state custody of the above-named child.

Section II

I understand that only legal residents of the Town of South Kingstown who are otherwise eligible are entitled to be educated by the Town of South Kingstown without charge. A school department designee may visit for the purpose of verifying residence in South Kingstown.

Section III

If any of the information above ceases to be true, I shall immediately notify the South Kingstown School Department in writing and, if the child is permitted to remain in the South Kingstown School System, I will be responsible for the payment of tuition for the child at the prevailing district rate on a pro-rated basis (unless otherwise permitted to remain in the district by applicable law or regulation). Such payment shall be charged from the date that any of the above information ceases to be true. Such tuition shall become immediately due and payable.

I affirm under the pain and penalties of perjury that the above statements are true and accurate to the best of my knowledge.

_____ _____
Signature Date

_____
Notary Public

OCEAN STATE TRANSIT
45 FAIRGROUNDS ROAD
WEST KINGSTON, RI 02892
(401)284-3920 FAX (401)284-3929

Please check below:

Entity Code
103 Wakefield
107 Peace Dale
108 SKHS
110 CCMS
112 West Kingston
113 Matunuck
114 BRMS
190 The Center

____ New Student

____ AM Transportation Needed Only

____ PM Transportation Needed Only

____ Both AM & PM Transportation Needed

____ Pick-up at Daycare Provider

____ Drop-off at Daycare Provider

____ Student Exited

____ Change of address (Previous Address: _____)

Home Address: _____

_____

Home Phone: _____

Student Name: _____ School: _____ Grade: ____ ID: _____

Additional students in the family:

Student Name: _____ School: _____ Grade: ____ ID: _____

Student Name: _____ School: _____ Grade: ____ ID: _____

Student Name: _____ School: _____ Grade: ____ ID: _____

Complete if Applicable:

ALTERNATE PICK UP ADDRESS
CONTACT NAME AND PHONE NUMBER

_____

_____

ALTERNATE DROP OFF ADDRESS
CONTACT NAME AND PHONE NUMBER

_____

_____

The South Kingstown School Department will transport your child to or from any bus stop location within the boundaries of the school your child attends. *The only requirement is that your child be picked up at the same location and be transported to the same location every day.*

(For Ocean State Transit use only)

Allow three days for transportation to start.

Bus Number: _____ Stop Location: _____

Pick-Up Time: _____ Drop-Off Time: _____