SOUTH KINGSTOWN SCHOOL DEPARTMENT
307 Curtis Corner Road, WAKEFIELD, RI 02879

Kindergarten Enrollment Checklist

Home School_____

Student Name_____Date_____

_____Student Enrollment Form

_____Birth Certificate (original required to be copied at time of enrollment)

_____Home Language Survey

_____Request for transportation

_____Student Health History

_____RI Department of Health Form

_____Physical and Immunizations (Provide a copy of the most recent physical including immunizations. Must include dates of all immunizations and be signed by physician.)

_____Enrollment Survey

Residency Documentation Required

_____Student Eligibility Form

_____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 for residence	☐ Copy of utility bill (gas/electric)
☐ Copy of fully executed lease agreement or letter from landlord	

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

Administration Building
307 Curtis Corner Road
Wakefield, RI 02879
(401) 360-1300
(401) 360-1330 FAX

RI Department of Education Home Language Survey

The information requested on this form is necessary for the most appropriate placement for your child as required by Rhode Island Law (R.I.G.L. § 16-54-2) and the Equal Educational Opportunity Act (20 U.S.C. §1703(f)) and will not be used for any other purposes. Thank you for your cooperation.

To be completed by parent or guardian:

Student Name:_____

Registration Date: _____ Date of Birth:_____

1. What language do you use most often when speaking to your child?

_____

2. What language did your child first learn to speak?

_____

3. What language does your child use most often when speaking to you?

_____

4. What language does your child use most often when speaking to other adults in the home or to their primary caretaker?

_____

5. What language does your child use most often when speaking to siblings or other children in the home?

_____

6. What language does your child use most often when speaking to friends or neighbors outside the home?

_____

_____
Signature of Parent or Guardian Date

_____
Print Parent/Guardian Name

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

Please check below:

____ 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: _____)

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

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:

Daycare Provider Name: _____

Daycare Provider Address: _____

_____

Daycare Provider Phone: _____

(For Ocean State Transit use only)

Allow three days for transportation to start.

Bus Number: _____ Stop Location: _____

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

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).**

Rhode Island Department of Health
Immunization Program

Pre-screen form for pre-school/daycare and kindergarten records.

Please complete the following to be attached to the child's record:

1. **Child's Date of Birth**_____
2. **Gender** ___M ___F
3. **Ethnicity** ___Hispanic ___Non-Hispanic
4. **Race** ___White ___Black/African American
   ___Asian ___American Indian/Alaskan Native
   ___Other (specify) _____
5. **Place of Birth** **USA:** ___yes ___no **Rhode Island:** ___yes___no
6. **Lead Screening** ___yes ___no
7. **Date of last physical**_____
8. **Height**_____ **Date taken if different than #7**_____
10. **Weight**_____ **Date taken if different than #7**_____

All information is confidential and is reported only in aggregate with no identifying information about any individual child.

ENROLLMENT SURVEY

Please take a moment to complete the following survey so that the South Kingstown Public Schools can benefit from your feedback.

Please circle the most important response:

1. Why are you enrolling your child in the South Kingstown Public Schools?

   Moved to the district

   No longer home schooling

   No longer attending private school

   No longer attending charter school

2. Briefly explain why you made this choice:

3. Would you like someone to follow up with you?
   Yes No

4. Contact information (Name and email or telephone number)

Thank you for taking the time to complete this survey.

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