MOUNTAIN HOME SCHOOL DISTRICT

Phone: (870)425-1256 **Mountain Home Kindergarten Enrollment Form** **Fax: (870)425-1090**

GENERAL STUDENT INFORMATION

FIRST NAME:	MIDDLE NAME:	LAST NAME:

Birthdate:_____ Gender: Female Male Siblings:_____Grade:_____

Nickname:_____ Grade:_____ _____Grade:_____

SSN (Optional):_____ Hispanic/Latino Ethnicity: Yes No _____Grade:_____

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:_____ Student Cell Phone:_____

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.

PLEASE CIRCLE Yes/Y or No/N		Does your child have any of the following:	
Does your child receive sp. Ed. Services? Y or N	Is your child currently on Medicine? Y or N	IEP plan Y or N	504 Plan Y or N
Please list services:_____	Is there a custody issue? Y or No	Behavior Plan Y or N	Health Plan Y or N
	Legal documents on file? Y or N	RTI Plan Y or N	IRI/AIP Plan Y or N

Office Use Only: Entry Date: _____ **Entry Code:** _____ **Teacher:** _____

Mountain Home Kindergarten Enrollment Form

ADDITIONAL STUDENT INFORMATION

City of Birth:_____ State of Birth:_____ Birth Country:_____

TRAVEL INFORMATION

Travel To School (Please check one)

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

Travel From School (Please check one)

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

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

Pre-School Participation:

A - ARKANSAS BETTER CHANCE
E - EVEN START
EC - EARLY CHILDHOOD
H - HEADSTART
NA - NOT APPLICABLE
C - 21st CENTURY COMMUNITY LEARNING CENTER
O - OTHER
P - PRIVATE PRE-SCHOOL
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 Coast Guard
____ Reserves – US Marines
____ Active Duty – US Air Force
____ Reserves – US Army
____ National Guard – US Army
____ Active Duty – US Navy
____ Reserves – US Air Force
____ National Guard – US Air Force
____ Active Duty – US Marines
____ Reserves – US Navy
____ 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 met the requirements of the Arkansas State Health laws necessary to enter school? Yes No

Is student's physical address above in Mountain Home School District? Yes No (All addresses will be confirmed by district).

Please list the names of anyone who IS ALLOWED to check out/pick up this child from school: _____

_____ _____ _____

_____ _____

Parent/Guardian Signature Date

MHK Student Health Form

(Please answer all questions) **(2020-2021)**

Student Name: _____ M F DOB: _____

Student resides with: _____

Mom/Guardian name:_____ 1st Phone #_____

2nd Phone #_____ Place of work/work #_____

Dad/Guardian name:_____1st Phone #_____

2nd Phone #_____Place of work/work #_____

Physicians' name:_____ Phone #_____

Address: _____

EMERGENCY CONTACTS IF PARENT CAN'T BE REACHED

NAME_____RELATIONSHIP_____ PHONE_____

NAME_____RELATIONSHIP_____ PHONE_____

1. DOES YOUR CHILD HAVE A **CURRENT MEDICAL CONDITION** THAT WILL REQUIRE SUPERVISION AND/OR RESTRICT HIS/HER ACTIVITY? IF YES, PLEASE EXPLAIN:

   _____

2. Does your child have a severe or life threatening allergy? If so, what are they allergic to and do they have a prescription for an epi-pen?

   _____

3. Is your child allergic to Latex? (Circle one) YES NO
4. Is your child currently taking any medication, if so what medication are they taking and will they need this medication at school?

   _____

If medication needs to be given at school, the medication must be brought to the office and checked in by a parent/guardian. Medication cannot be sent to school on the school bus.

You are authorizing the use of: Calamine Lotion, Cough Drops, First Aid Spray, Generic Tylenol, Hydrocortisone Cream, Orajel, Sore Throat Spray, and Triple Antibiotic Ointment.

(Please Mark Through Any of the Above Medication(s) You May Not Want Given To Your Child)

PLEASE TURN PAGE OVER AND SIGN THE BACK.

I acknowledge that the Mountain Home School District, the Board of Directors, and School Employees shall be immune from civil liability for damages resulting from the administration of medications with this consent.

I will notify the school of any changes in phone number, emergency contact or said child's health status. I understand that the above information may be released to appropriate School District employees, named physician, and emergency personnel. In the event that parents or other person(s) named on this form cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child. The hospital and its medical staff have my authorization to provide treatment that a physician feels necessary for the well-being of said child. I authorize the school nurse and my child's health care provider to exchange verbal and/or written information regarding the health needs of said student at school.

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

In compliance with the Family Education Rights and Privacy Act (FERPA) (20U.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:_____ Signature of Parent/Guardian:_____

LOG OF OFFICE VISIT (for office use only)

_____

_____

_____

_____

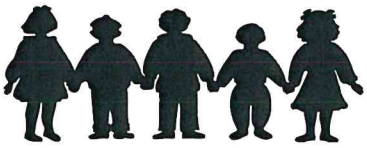
_____

_____

_____

Kindergarten Social/Emotional/Behavioral Survey

Name: _____



(2020-2021)

Preschool: _____

Directions: Please rate each item according to how often you have observed the child demonstrating that behavior. Add comments as needed. In order for this information to assist with the child's specific needs, please answer as accurately as possible in the setting in which you have the child.

Rating Scale:
0 – Seldom or Never
1 - Some or a couple of times
2 - More than some or more than a couple of times
3 - Often or consistently

PERSONAL BEHAVIORS COMMENTS:

Difficulty attending to bathroom and needs help..... 0 1 2 3 Does your child wear pull-ups/diapers?
Difficulty sitting still..... 0 1 2 3
Easily frustrated..... 0 1 2 3
Temper outbursts; explosive, ... 0 1 2 3
Unpredictable behavior..... 0 1 2 3
Exhibits other concerning behaviors..... 0 1 2 3

AUTHORITY FIGURES

Argues with adults/authority figures..... 0 1 2 3
Defiant attitude/refuses to comply with requests..... 0 1 2 3
Intentionally harms adults/authority figures..... 0 1 2 3

OTHER CHILDREN

Argues with other children..... 0 1 2 3
Uncooperative with other children..... 0 1 2 3
Intentionally harms other children..... 0 1 2 3

SERVICES, TREATMENT, DIAGNOSIS

Please provide any other information that you are willing to share that will be helpful to us as we begin addressing your child's specific needs.

CIRCLE ALL THAT APPLY.

- **Possible services received?**
  Special Education Services, Speech Therapy, Pediatric Therapy, Residential Treatment Center, Counseling Services, Self-Contained Classroom, Alternative Classroom. IEP, ELL, OT, PT

- **Possible diagnosis received?**
  ADD, ADHD, Autism, Learning Disability, PTSD, Other _____

If needed, please feel free to include additional information on the back of this document. Thank you.

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Parent/Guardian Signature_____Date:_____