Glenkirk Elementary School

8584 Sedge Wren Drive • Gainesville, VA 20155
703.753.1702 • FAX 703.753.4981 • glenkirkes.pwcs.edu
Marisa Miranda, Principal

2018-2019 Kindergarten Registration

Glenkirk Elementary's Kindergarten Registration for the 2018-2019 school year will be held at Glenkirk Elementary on Thursday, April 5th from 1:00pm – 7:00pm and Thursday, April 19th from 9:30am – 2:30pm, no appointments are necessary. We would like to perform an assessment of kindergarten readiness skills on your child, so ***please make sure to bring your child with you at that time****.*

Students who will be five years of age or older by September 30, 2018 are eligible for enrollment in kindergarten for the 2018-2019 school year. Registration will take place in our Library for the students who reside within Glenkirk Elementary school boundaries. If you are not sure of the school your child should attend during the 2018-2019 school year, you can call the School Planning Office at 703-791-7312 or go to www.pwcs.edu and click on Parents, then Find Your School.

The original or a certified copy of the child's ***birth certificate*** *is required at the time of registration. In addition,* ***three proofs of residence*** *(one must be a copy of the deed, rental or lease agreement, or a notarized Affidavit of Residency attesting to bona fide residency in Prince William County) the other two could be your driver's license, voter or car registration, tax or utility bill, ect. Also you will need to have a valid* ***immunization record*** *signed by a healthcare professional, and a comprehensive* ***physical exam*** *dated within twelve months of the child's entry into the public school system. All original documents will be returned to the parent. More information about registration requirements can be found at pwcs.edu under the Parent tab click on Kindergarten Enrollment.*

*The immunization record must document four doses of DTaP with one dose received after the fourth birthday; four doses of a polio vaccine with one dose received after the fourth birthday; two doses of the measles vaccine with first dose received at 12 months of age or older (usually given as MMR); two doses of mumps vaccine received at 12 months of age or older (usually given as MMR);one dose of a rubella vaccine received at 12 months of age or older (usually given as MMR) second dose of MMR given after 4th birthday; three doses of hepatitis B vaccine; *Effective March 3, 2010 all kindergarten students must have 2 doses of varicella (chicken pox) vaccine: first dose at 12 months or older AND a second dose administered no earlier than three months from the first dose (the second dose is usually administered after the fourth birthday).*

Prince William County Public Schools Registration Form

STUDENT INFORMATION (Please print) PLEASE COMPLETE ALL BLANKS EXCEPT SHADED AREAS

School Number

Legal Last Name	First Name	Middle Name	Grade	Gender

House Type	Street Number	Street Name (also designate Court, Drive, Lane, etc.)	(Apt#)	City	State	Zip

Mailing Address (if different from above)	10-digit Phone Number

Prince William County Public School last attended, if applicable	Virginia Public School last attended (if not in Prince William Co.)

Student's Birth Date	Birthplace (city, state/country)	Birth Certificate Number	Please circle yes or no Special Education Y / N

Ethnicity – Please circle yes or no Hispanic or Latino Y / N	Race: Please circle all that apply 1. American Indian or Alaska Native 2. Asian 3. Black or African American 4. Native Hawaiian or other Pacific Islander 5. White

Most Recent School Attended	City, State	From _____ MM / YY	To _____ MM / YY

Perm. ID#	G/T	ESOL	Sp. Ed.	New/Reentry	Base School	Transfer Code

PARENT/GUARDIAN INFORMATION PLEASE COMPLETE ALL APPLICABLE INFORMATION USING N/A WHEN NECESSARY

Father's Full Name ❑Parent ❑Stepparent ❑Legal Guardian ❑Foster Parent (check as applicable)	***Military Connected**: YES NO Anticipated PCS _____ *Member of the Armed Forces or a civilian employee of the DOD who is employed on Federal property

Street Number	Street Name (also designate Court, Drive, Lane, etc.)	(Apt#)	City	State	Zip

10-digit Home Phone #	Employed by	10-digit Work Phone #	Ext.	Cell phone

Work Address	City	State	Zip	E-Mail Address

Mother's Full Name ❑Parent ❑Stepparent ❑Legal Guardian ❑Foster Parent (check as applicable)	***Military Connected**: YES NO Anticipated PCS _____ *Member of the Armed Forces or a civilian employee of the DOD who is employed on Federal property

Street Number	Street Name (also designate Court, Drive, Lane, etc.)	(Apt#)	City	State	Zip

10-digit Home Phone #	Employed by	10-digit Work Phone #	Ext.	Cell phone

Work Address	City	State	Zip	E-Mail Address

Verification of Residency in School Attendance Area:

Deed or Contract_____ Lease_____ Affidavit_____ Other Documentation _____

Foster Child Yes No In-State Out-of-State Give County and State of Foster Child

If Tuition Student, is Tuition Paid by Parent Yes_____ No_____ In-State_____Out-of-State_____ Tuition Code_____

Medicaid Eligible Yes_____ No _____

PARENT OR GUARDIAN SIGNATURE_____ Date_____

Rev. 8/15

CONSENT FOR RELEASE OF INFORMATION

Please print

Full Name of Student _____

Date of Birth _____

I hereby authorize:

Previous School _____

Address _____

_____

_____

to release all educational records concerning my child including:

___ an up-to-date transcript and/or report card
___ grading scale
___ test scores
___ discipline records
___ health and attendance records
___I.E.P., if applicable
___ psychological and social history information, if applicable

To: Current School _____

Address _____

_____

_____

_____ _____
Signature of Parent or Guardian Date

_____ _____
Street Address Daytime Telephone

_____ _____
City State Zip Cell Phone

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM
Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization

Part I – HEALTH INFORMATION FORM

State law (Ref. Code of Virginia § 22.1-270) requires that your child is immunized and receives a comprehensive physical examination before entering public kindergarten or elementary school. **The parent or guardian completes this page (Part I) of the form.** The Medical Provider completes Part II and Part III of the form. This form must be completed no longer than one year before your child's entry into school.

Name of School: _____ Current Grade: _____

Student's Name: _____
Last First Middle

Student's Date of Birth: _____/_____/_____ Sex: _____ State or Country of Birth: _____ Main Language Spoken: _____

Student's Address: _____ City: _____ State: _____ Zip: _____

Name of Parent or Legal Guardian 1: _____ Phone: _____-_____-_____ Work or Cell: _____-_____-_____

Name of Parent or Legal Guardian 2: _____ Phone: _____-_____-_____ Work or Cell: _____-_____-_____

Emergency Contact: _____ Phone: _____-_____-_____ Work or Cell: _____-_____-_____

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes		
Allergies (seasonal)			Head injury, concussions		
Asthma or breathing problems			Hearing problems or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart problems		
Behavioral problems			Lead poisoning		
Developmental problems			Muscle problems		
Bladder problem			Seizures		
Bleeding problem			Sickle Cell Disease (not trait)		
Bowel problem			Speech problems		
Cerebral Palsy			Spinal injury		
Cystic fibrosis			Surgery		
Dental problems			Vision problems		

Describe any other important health-related information about your child (for example; feeding tube, hospitalizations, oxygen support, hearing aid, dental appliance, etc.):_____

_____

List all prescription, over-the-counter, and herbal medications your child takes regularly:

_____

Check here if you want to discuss confidential information with the school nurse or other school authority. ☐ Yes ☐ No

Please provide the following information:

	Name	Phone	Date of Last Appointment
Pediatrician/primary care provider			
Specialist			
Dentist			
Case Worker (if applicable)			

Child's Health Insurance: ____ None ____ FAMIS Plus (Medicaid) _____ FAMIS _____ Private/Commercial/Employer sponsored

I, _____ (do___) (do not___) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form. *This authorization will be in place until or unless you withdraw it.* ***You may withdraw your authorization at any time by contacting your child's school****. When information is released from your child's record, documentation of the disclosure is maintained in your child's health or scholastic record.*

Signature of Parent or Legal Guardian: _____Date: _____/_____/ _____

Signature of person completing this form: _____Date:_____/_____/_____

Signature of Interpreter: _____Date: _____/_____/_____

COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM

Part II - Certification of Immunization

Section I

To be completed by a physician or his designee, registered nurse, or health department official.
See Section II for conditional enrollment and exemptions.

A copy of the immunization record signed or stamped by a physician or designee, registered nurse, or health department official indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form.
Only vaccines marked with an asterisk are currently required for school entry. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box.

Student's Name:_____ Date of Birth: |____|____|____|
Last *First* *Middle* *Mo. Day Yr.*

IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
*Diphtheria, Tetanus, Pertussis (DTP, DTaP)	**1**	**2**	**3**	**4**	**5**
*Diphtheria, Tetanus (DT) or Td (given after 7 years of age)	**1**	**2**	**3**	**4**	**5**
*Tdap booster (6th grade entry)	**1**				
*Poliomyelitis (IPV, OPV)	**1**	**2**	**3**	**4**	
*Haemophilus influenzae Type b (Hib conjugate) *only for children <60 months of age	**1**	**2**	**3**	**4**	
*Pneumococcal (PCV conjugate) *only for children <60 months of age	**1**	**2**	**3**	**4**	
Measles, Mumps, Rubella (MMR vaccine)	**1**	**2**			
*Measles (Rubeola)	**1**	**2**	Serological Confirmation of Measles Immunity:		
*Rubella	**1**		Serological Confirmation of Rubella Immunity:		
*Mumps	**1**	**2**			
*Hepatitis B Vaccine (HBV) ❑ Merck adult formulation used	**1**	**2**	**3**		
*Varicella Vaccine	**1**	**2**	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Hepatitis A Vaccine	**1**	**2**			
Meningococcal Vaccine	**1**				
Human Papillomavirus Vaccine	**1**	**2**	**3**		
Other	**1**	**2**	**3**	**4**	**5**
Other	**1**	**2**	**3**	**4**	**5**

I certify that this child is **ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED** in accordance with the MINIMUM requirements for attending school, child care or preschool prescribed by the State Board of Health's *Regulations for the Immunization of School Children* (Reference Section III).

Signature of Medical Provider or Health Department Official:_____ **Date (*Mo., Day, Yr.*):**___/___/____

Student's Name:_____Date of Birth: |____ |_ ___|___ _|

Section II
Conditional Enrollment and Exemptions

Complete the medical exemption or conditional enrollment section as appropriate to include signature and date.

MEDICAL EXEMPTION: As specified in the *Code of Virginia* § 22.1-271.2, C (ii), I certify that administration of the vaccine(s) designated below would be detrimental to this student's health. The vaccine(s) is (are) specifically contraindicated because (please specify):

_____
_____
_____.

DTP/DTaP/Tdap:[___]; DT/Td:[___]; OPV/IPV:[___]; Hib:[___]; Pneum:[___]; Measles:[___]; Rubella:[___]; Mumps:[____]; HBV:[___]; Varicella:[___]

This contraindication is permanent: [___], or temporary [___] and expected to preclude immunizations until: Date (*Mo., Day, Yr.*): |___|___|___|.

Signature of Medical Provider or Health Department Official:_____ Date (*Mo., Day, Yr.*):|___|___|___|

RELIGIOUS EXEMPTION: The *Code of Virginia* allows a child an exemption from receiving immunizations required for school attendance if the student or the student's parent/guardian submits an affidavit to the school's admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. Any student entering school must submit this affidavit on a CERTIFICATE OF RELIGIOUS EXEMPTION (Form CRE-1), which may be obtained at any local health department, school division superintendent's office or local department of social services. Ref. *Code of Virginia* § 22.1-271.2, C (i).

CONDITIONAL ENROLLMENT: As specified in the *Code of Virginia* § 22.1-271.2, B, I certify that this child has received at least one dose of each of the vaccines required by the State Board of Health for attending school and that this child has a plan for the completion of his/her requirements within the next 90 calendar days. Next immunization due on _____.

Signature of Medical Provider or Health Department Official:_____ Date (*Mo., Day, Yr.*):|___|___|___|

Section III
Requirements

For Minimum Immunization Requirements for Entry into School and Day Care, consult the Division of Immunization web site at http://www.vdh.virginia.gov/epidemiology/immunization

Children shall be immunized in accordance with the Immunization Schedule developed and published by the Centers for Disease Control (CDC), Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP), otherwise known as ACIP recommendations (Ref. *Code of Virginia* § 32.1-46(a)).
(Requirements are subject to change.)

Part III -- COMPREHENSIVE PHYSICAL EXAMINATION REPORT

A qualified licensed physician, nurse practitioner, or physician assistant must complete Part III. The exam must be done no longer than one year before entry into kindergarten or elementary school (Ref. Code of Virginia § 22.1-270). Instructions for completing this form can be found at www.vahealth.org/schoolhealth.

Student's Name: _____ Date of Birth: _____/_____/_____ Sex: ☐ M ☐ F

Health Assessment

Date of Assessment: _____/_____/_____

Weight: _____lbs. Height: _____ ft. _____ in.

Body Mass Index (BMI): _____ BP_____

❑ Age / gender appropriate history completed

❑ Anticipatory guidance provided

Physical Examination

1 = Within normal 2 = Abnormal finding 3 = Referred for evaluation or treatment

	1	2	3		1	2	3		1	2	3
HEENT	□	□	□	Neurological	□	□	□	Skin	□	□	□
Lungs	□	□	□	Abdomen	□	□	□	Genital	□	□	□
Heart	□	□	□	Extremities	□	□	□	Urinary	□	□	□

TB Screening: □ No risk for TB infection identified □ No symptoms compatible with active TB disease
□ Risk for TB infection or symptoms identified
Test for TB Infection: TST IGRA Date:_____ TST Reading _____mm TST/IGRA Result: □ Positive □ Negative
CXR required if positive test for TB infection or TB symptoms. CXR Date: _____ □ Normal □ Abnormal

EPSDT Screens Required for Head Start – include specific results and date:
Blood Lead:_____ Hct/Hgb _____

Developmental Screen

Assessed for:	*Assessment Method:*	*Within normal*	*Concern identified:*	*Referred for Evaluation*
Emotional/Social				
Problem Solving				
Language/Communication				
Fine Motor Skills				
Gross Motor Skills				

Hearing Screen

❑ Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.

	1000	2000	4000
R			
L			

❑ Screened by OAE (Otoacoustic Emissions): □ Pass □ Refer

□ Referred to Audiologist/ENT □ **Unable to test – needs rescreen**

□ Permanent Hearing Loss Previously identified: ___Left ___Right

□ Hearing aid or other assistive device

Vision Screen

❑ With Corrective Lenses (check if yes)

Stereopsis	❑ Pass	❑ Fail		❑ Not tested
Distance	Both	R	L	Test used:
	20/	20/	20/	

❑ Pass ❑ Referred to eye doctor ❑ **Unable to test – needs rescreen**

Dental Screen

❑ Problem Identified: Referred for treatment

❑ No Problem: Referred for prevention

❑ No Referral: Already receiving dental care

Recommendations to (Pre) School , Child Care, or Early Intervention Personnel

Summary of Findings (check one):
□ **Well child; no conditions identified of concern to school program activities**
□ **Conditions identified that are important to schooling or physical activity** (complete sections below and/or explain here): _____
_____

___ **Allergy** □ food: _____ □ insect: _____ □ medicine: _____ □ other: _____
Type of allergic reaction: □ anaphylaxis □ local reaction Response required: □ none □ epinephrine auto-injector □ other: _____

___**Individualized Health Care Plan needed** (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)

___ **Restricted Activity** Specify: _____

___ **Developmental Evaluation** □ Has IEP □ Further evaluation needed for: _____

___ **Medication**. Child takes medicine for specific health condition(s). □ Medication must be given and/or available at school.

___ **Special Diet** Specify: _____

___ **Special Needs** Specify: _____

Other Comments: _____

Health Care Professional's Certification (Write legibly or stamp) **□ By checking this box, I certify with an electronic signature that all of the information entered above is accurate (enter name and date on signature and date lines below).**

Name: _____ **Signature:** _____ Date: ____/_____/_____

Practice/Clinic Name: _____ **Address**: _____

Phone: _____-_____-_____ **Fax**: _____-_____-_____ **Email:** _____

Attachment to:
Regulation 715-5
February 13, 2013

PRINCE WILLIAM COUNTY PUBLIC SCHOOLS
DISCLOSURE OF CHILD'S DISCIPLINARY AND CRIMINAL HISTORY PRIOR TO ENROLLMENT

Dear Parent or Guardian:

Under Virginia law and School Board regulation, you must provide the information requested below. You must disclose whether the child you are enrolling has ever been expelled, long-term suspended, or withdrawn from any school or placed in an alternative education program for disciplinary reasons, including an expulsion or long-term suspension which is pending at the time the student moves from another school or district. You must disclose this information regardless of whether it occurred in a public or private school location. The Virginia Code also requires disclosure of information concerning convictions or delinquency adjudications for criminal offenses including, but not limited to, those offenses listed on the reverse side of this document. Prince William County Public Schools also requires disclosure of charges for criminal offenses listed on the reverse side of this document.

You must complete this form before your child may be registered. The School Division will keep this document confidential as part of your child's scholastic record. IF YOU MAKE A FALSE STATEMENT ON THIS FORM, YOU MAY BE GUILTY OF A CLASS 3 MISDEMEANOR. A school employee will witness your signature.

Student's Name: _____

1. Has the child you are enrolling ever been suspended for more than five days for a single infraction? ☐ Yes ☐ No

2. Is there disciplinary action pending against the child you are enrolling in the previous school district? ☐ Yes ☐ No
   What was/were the offense(s) which resulted in the child you are enrolling being suspended for the above?
   _____
   _____

3. Has the child you are enrolling ever been placed on long-term suspension (10 or more consecutive days)? ☐ Yes ☐ No
   If yes, for how long? _____

4. Has the child you are enrolling ever been expelled? ☐ Yes ☐ No
   If yes, for what infraction? _____
   _____
   _____

5. Has the child you are enrolling ever been referred to or attended an alternative education program? ☐ Yes ☐ No
   If yes, name, address, and telephone number of program: _____
   _____
   _____

6. Has the child you are enrolling ever been withdrawn from any school for disciplinary reasons? ☐ Yes ☐ No
   If yes, for what reason?_____
   _____
   _____

7. Has this child been charged or adjudicated delinquent for any criminal or other offense? ☐ Yes ☐ No If yes, what was the offense and what resulting consequences were imposed by the judicial system?
   _____
   _____
   _____
   _____
   _____

Parent/Guardian Signature: _____ Date: _____

Witness: _____

(PLEASE REVIEW REVERSE SIDE OF THIS DOCUMENT)

Attachment I
Regulation 723-4

STUDENT'S NAME _____ **SCHOOL**_____

Dear Parent/Guardian:

Prince William County Public Schools regulations require that enrolling students, **who have spent at least three consecutive months outside of the United States and U.S. territories (Puerto Rico, Guam, U.S. Virgin Islands, American Samoa and the Northern Mariana Islands) during the previous five years,** submit proof of tuberculosis screening at the time of enrollment.

Such students are required to present documentary evidence as follows:

A. A written report of a negative PPD test (Mantoux method) administered within 30 calendar days prior to school registration or written report from a health care provider stating that the student is cleared to start school, as deemed appropriate for the results of screening. This written report must be certified by the Department of Health, a physician, or *a* nurse practitioner licensed to practice medicine in the United States.

or

B. A clearance letter from the Prince William Health District (PWHD) or licensed health care provider stating that the student is free of communicable tuberculosis (see Attachment II).

or

C. A medical exemption to the testing requirement issued by a licensed physician or nurse practitioner, or a local health department in Virginia. If the exemption is temporary, the exemption document must indicate the condition*s* of the exemption and the date the exemption expires. A TB symptom assessment shall be done (see Attachment III). If the TB symptom assessment is positive, the student shall have a chest x-ray and evaluation for active disease before school entry.

Please check the statement below which applies to the enrolling student:

_____ The enrolling student <u>has not</u> resided outside the United States for three consecutive months in the past five years.

_____ The enrolling student <u>has</u> resided outside the United States for at least three consecutive months within the past five years and I understand that I must present evidence of tuberculin screening as described in this document.

Students <u>will not</u> be permitted to enter school without written documentation as requested.

_____ _____

Parent/Guardian Signature Date

Attachment II
Regulation 723-4

Prince William County
Public Schools
P.O. Box 389
Manassas, VA 20108
(703)791-7200

Dear Licensed Health Care Provider:

Please provide the following information for:

Name of Student:_____

I certify that the above named student has had a chest x-ray and _____is/_____is not free from communicable tuberculosis.

Name of Licensed Physician or
Nurse Practitioner: _____

Address: _____

Phone: _____

_____ _____
Signature Date

Attachment III
Regulation 723-4

Student's Name _____ Date of Birth _____

School _____

Tuberculosis Symptom Assessment

_____ Cough for more than three weeks
_____ Unexplained fever
_____ Coughs up blood
_____ Unexplained weight loss
_____ Unexplained chest pain
_____ Night sweats
_____ Poor appetite

FOR CHILDREN UNDER SIX YEARS OLD

_____ Wheezing
_____ Failure to thrive
_____ Decreased activity and/or energy
_____ Lymph node swelling
_____ Personality changes

_____

_____
Comments

Parent Signature _____ School Nurse's Signature _____

Date _____ Date _____

If student presents with one or more of the above symptoms, refer to their health care provider for further evaluations prior to school entry.

Prince William County Public Schools
Home Language Survey (HLS)

Directions for Parent / Guardian: Please enter a complete and accurate response for each number 1 through 11, using Not Applicable (N/A) when needed. If you have a question, please contact a staff member, who will be happy to help. PWCS offers free language support. Say your language, or point to the Language Assistance Poster.

Student's Name (First, Last): _____ **Date of Birth:** _____

For questions 1-5, write all applicable languages:

1. **What was the first language your child spoke?** _____
2. **What language, other than English, does your child speak?** _____
3. **What language, other than English, does your child understand?** _____
4. **What language, other than English, is routinely used in the home?** _____
5. **In which languages do you prefer to receive communication from the school?**
   Please respond for both verbal and written: **Verbal: English or other** _____ (please specify) **Written: English or other** _____ (please specify)

6. **Country of Birth** _____
   (same as entered on Registration Form)

7. **Original Date of Entry into the U.S.A.** _____
   (if born outside the U.S.A.)

8. **Date of Most Recent Entry into U.S.A.** _____
   (if applicable)

For Questions 9 and 10, please use school records, if available:

9. **Did the student attend schools in the U.S. previously? Yes / No**
   If Yes, Date of original Entry into U.S. Schools _____
   If No, Registrar will enter expected first date of attendance in PWCS _____

10. **Did the student attend public schools in Virginia previously? Yes / No**
    If Yes, Original Date of Entry into Virginia public schools K-12 _____(date)
    If No, Registrar enters expected first date of attendance in PWCS _____(date)

11. **List ALL Schools Previously Attended**

School	Country / State	Grade Level	Dates (Start/End)	School Records Provided Yes/No

Name of parent/guardian who completed the form _____ **Relationship to Student** _____
(Please print first and last name)

Parent/guardian signature: _____ **Date** _____

Federal regulations require school systems to survey every student at the time of enrollment regarding the student's home language and other languages the student may speak and/or understand. This form meets requirements of the Equal Educational Opportunity Act 20 USC 1703 for identification of national origin minority children. Based on this survey, a student may be assessed, as required by federal regulations, for English language proficiency.

OFFICIAL USE ONLY: TO BE COMPLETED BY OFFICE STAFF (please print)

Form reviewed for completion and accuracy by:

PWCS staff member _____ **Title** _____ **Date** _____ **School/Office** _____

Home Language Survey forms are available at pwcs.edu, within the Translations Library. Circle the language provided to the family:

English, Spanish, Urdu, Arabic, Vietnamese, Farsi, Korean, Bengali, Amharic, French, Tagalog, Mandarin Chinese, Nepali

Print Name of Person or Company providing interpretation services: _____ **Specify Language** _____

Routing: School Registrar Instructions	Routing: Central Registration Services (CRS) Instructions
If a language other than English is indicated in questions 1, 2, or 3 provide a copy of the Home Language Survey and Base School Verification Form to Central Registration Services *Immediately*. Sent to CRS at Ann Ludwig or Stonewall Middle(*circle one)* Date Sent to Central Registration Services _____	Date Received by CRS _____ Initials _____ Date sent to Dept. Chair / Lead Teacher _____ **Home Language Identified in SMS** _____ Dates updated in SMS _____/_____/_____
Home Language Identified in SMS _____ Note: If school registrar completes the home language fields in SMS, please use guidance provided in PowerSchool SMS Training and Enrollment Manual.	☐ Updated HLS sent to Registrar for placement in File #1 and File #6 (used in cases when CRS does not have the original files)

Kindergarten Registration Only

PRESCHOOL SERVICES SURVEY
KINDERGARTEN REGISTRATION

This form is used to determine what preschool services your child was enrolled in during the year prior to kindergarten: Please tell us what type of preschool program your child attended and the number of hours per week they attended per week.

Child's Name _____

Circle the option that best describes what preschool services your child was enrolled in.

1 – Community based Head Start (**NOT in a public school**)

2 - Public Preschool (attended Head Start, VPI, VPI+, Speech Services, or Preschool Special Education in a public school)

3 - Private Preschool/ Day Care

4 - Department of Defense Child Development Program

5 - Family Home Daycare Provider

6 - Child did not attend preschool

Put an X next to the number of hours per week your child attended a preschool program:

_____ Child did not attend preschool

_____ Less than 15 hours per week

_____ Between 15 and 29 hours per week

_____ 30 or more hours per week