

North Side Elementary Student Information

Grade _____ Bus _____
Walker _____ Pick-up _____

1. Name (First, Middle, Last) _____
2. Preferred name to call child _____ Male _____ Female _____
3. Address _____
4. Phone Number _____ Social Security Number _____
5. Place of Birth _____ Date of Birth _____
6. Father's Name _____ Home Phone Number _____
Where Employed _____ Work Phone Number _____
Hours Worked _____ Cell Phone Number _____
7. Mother's Name _____ Home Phone Number _____
Where Employed _____ Work Phone Number _____
Hours Worked _____ Cell Phone Number _____
8. Step-Father's Name _____ Home Phone Number _____
Where Employed _____ Work Phone Number _____
Hours Worked _____ Cell Phone Number _____
9. Step-Mother's Name _____ Home Phone Number _____
Where Employed _____ Work Phone Number _____
Hours Worked _____ Cell Phone Number _____
10. Babysitter's Name _____ Phone Number _____
11. List all Adults living in Household _____
12. Child Lives With (circle one) Father Mother Both Other
If other, who? _____
13. Did your child attend preschool? If so, where? _____
14. Parent email address _____
15. Additional information, if needed: _____

Student's Name _____ Teacher _____

School Dismissal on a Normal School Day

In the morning, my child will:

- _____ Walk to School
- _____ Be Driven to School
- _____ Ride the Bus Bus # _____

Address _____

In the afternoon, my child will:

- _____ Walk Home
- _____ Picked Up
- _____ Ride the Bus Bus # _____

Address _____

School Dismissal on an Emergency School Day

These dismissals are when an emergency happens during the day, and school closes early. You will be notified by an automated telephone call if this happens. Please give us the following information:

Where will your child go? _____

How will he/she get there? _____

Holidays

North Side Elementary School celebrates the following holidays at school: Veteran's Day, Halloween, Thanksgiving, Christmas, Valentines, Easter, and Birthdays. **Please check below if you do NOT want your child to participate in holiday celebrations.** Please notify the school, per the attendance policy as stated in the North Side Handbook, if you plan to pick up your child from school during these celebrations because of an objection.

_____ No, my child may **not** participate in holiday celebrations

Field Trips

My signature indicates that I give permission for my child to participate in field trips as part of his/her education at North Side Elementary School. I understand that I will receive (at least one week ahead of time) notification of every field trip. I also understand that I can still revoke permission for a specific field trip, if needed. In order to revoke permission, I need to let the teacher know in writing that permission has been denied for a specific field trip.

Parent/Guardian Signature

Date

Randolph Eastern School Corporation Home Language Survey (HLS)

The Civil Rights Act of 1964, Title VI, Language Minority Compliance Procedures, requires school districts and charter schools to determine the language(s) spoken in each student's home in order to identify their specific language needs. This information is essential in order for schools to provide meaningful instruction for all students as outlined Plyler v. Doe, 457 U.S. 202 (1982).

The purpose of this survey is to determine the primary or home language of the student. The HLS must be given to all students enrolled in the school district / charter school. The HLS is administered one time, upon initial enrollment, and remains in the student's cumulative file.

Please note that the answers to the survey below are student-specific. If a language other than English is recorded for ANY of the survey questions below, the LAS Links placement test will be administered to determine whether or not the student will qualify for additional English language development support.

Please answer the following questions regarding the language spoken by the student:

1. What is the native language of the **student**? _____

2. What language(s) is spoken most often by the **student**? _____

3. What language(s) is spoken by the **student** in the home? _____

Student Name: _____

Place of Birth (State, Country): _____

Date child first attended school anywhere in the United States (Month, Year): _____

Parent/Guardian Name: _____

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

By signing here, you certify that responses to the three questions above are specific to your student. You understand that if a language other than English has been identified, your student will be tested to determine if they qualify for English language development services, to help them become fluent in English. If entered into the English language development program, your student will be entitled to services as an English learner and will be tested annually to determine their English language proficiency.

For School Use Only:

School personnel who administered and explained the HLS and the placement of a student into an English language development program if a language other than English was indicated:

Name: _____ Date: _____

Randolph Eastern School Corporation

Home Language Survey (HLS) Spanish Version

El Título VI, del Acta de los Derechos Civiles de 1964 Procedimientos y Cumplimiento del Lenguaje de Minorías, contiene requisitos legales que guían a las escuelas para determinar el idioma o idiomas que se hablan en el hogar de cada estudiante. Esta información es esencial para que las escuelas puedan ofrecer instrucción significativa a todos los estudiantes como se requiere por Plyler v. Doe, 457 U.S. 202 (1982).

Esta encuesta del idioma que se habla en casa (HLS) establece el idioma principal de su hijo/a. Tiene que darse esta encuesta (HLS) a todos los estudiantes en el distrito escolar / escuela semi-autónoma. Esta encuesta (HLS) es administrada una vez, durante la matrícula inicial, y se queda en el archivo escolar acumulativo del estudiante.

Las respuestas de la encuesta son relacionadas con su hijo/a. Si se ha identificado que el idioma no es inglés a cualquiera de las tres preguntas, la escuela administrará la Prueba del Desarrollo del Inglés (LAS Links) para determinar si su hijo/a calificará para el programa de Desarrollo del idioma Inglés.

Respuesta las preguntas acerca del idioma(s) de su estudiante por favor:

1. ¿Cual es el idioma o el dialecto nativo de su **hijo/hija**? _____

2. ¿Cual idioma(s) es hablado más por su **hijo/hija**? _____

3. ¿Cual idioma habla su **hijo/hija** en casa con más frecuencia? _____

Nombre Legal del Estudiante: _____

Lugar de nacimiento (Estado, País): _____

Fecha de la primera vez que su hijo/a asistió a una escuela en los Estados Unidos: _____

Nombre del Padre, Madre o Guardián: _____

Firma del Padre, Madre o Guardián: _____ **Fecha:** _____

Al firmar aquí, usted certifica que las respuestas a las tres preguntas mencionadas arriba son relacionadas con su hijo/a. Usted entiende que si se ha identificado que el idioma no es ingles, su hijo/a tendrá un examen para determinar si él o ella califica para el programa de Desarrollo del idioma Inglés, para ayudarlo/a a que sea fluente en Inglés. Todos los estudiantes en el programa de Desarrollo del idioma Inglés tienen el derecho a servicios que lo ayudaran a aprender el idioma Inglés y tendrá un examen cada año para determinar el nivel de inglés.

For School Use Only:

School personnel who administered and explained the HLS and the placement of a student into an English language development program if a language other than English was indicated:

Name: _____ Date: _____

DISTRICTS MUST COLLECT RACE AND ETHNICITY INFORMATION ON STUDENTS AND STAFF USING A TWO PART QUESTIONNAIRE. THE RESPONDENT MUST ANSWER BOTH QUESTIONS. DISTRICTS SHOULD IMPLEMENT THE RE-EVALUATION OF STUDENTS IN 2009-10 TO BE REPORTED IN JULY OF 2010. DISTRICT ENROLLMENT FORMS WILL NEED TO IMPLEMENT THE TWO PART QUESTIONNAIRE. FOR ALL FALL 2010 ENROLLEES. DISTRICTS SHOULD PLAN TO TRAIN STAFF TO ASSIST ENROLLEES IN REPONDING TO THE TWO PART QUESTIONNAIRE.

QUESTIONNAIRE

NAME _____

RACE AND ETHNICITY: (Note: Both Part 1 and 2 must be answered.)

PART 1: ETHNICITY

ARE YOU HISPANIC/LATINO? (Choose only one)

_____ No, Not Hispanic/Latino

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

PART 2: RACE

WHAT IS YOUR RACE? (Choose one or more)

_____ American Indian or Alaska Native: A person having origins in any of the original peoples of North America and maintaining cultural identification through tribal affiliation or community recognition.

_____ 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.

BECAUSE THE COLLECTION OF THE DATA IS ASSOCIATED WITH THE DISBURSEMENT OF FEDERAL FUNDS, THE REGULATORY REQUIREMENT FOR MAINTAINING ORIGINAL INDIVIDUAL RESPONSES IS A MINIMUM OF THREE YEARS UNLESS THERE IS AN AUDIT, INSPECTION, REVIEW, OR INVESTIGATION THAT HAS NOT BEEN RESOLVED (IN THAT CASE, THE RESPONSES MUST BE MAINTAINED UNTIL RESOLUTION IS COMPLETE). INSTITUTIONS MUST MAINTAIN THE INFORMATION IN THE RESPONSES AS IT WAS COLLECTED USING THE TWO-PART QUESTION, IN CASE THE DEPARTMENT NEEDS IT IN THE EXERCISE OF ITS OVERSIGHT AND ENFORCEMENT RESPONSIBILITIES. IN ADDITION, OTHER STATUES OR REGULATIONS, SUCH AS THE COMMON RULE FOR THE PROTECTION OF HUMAN SUBJECT IN RESEARCH (34 CFR 97), MAY REQUIRE THAT INDIVIDUAL RESPONSES BE RETAINED FOR A LONGER PERIOD FOR SOME DATA COLLECTIONS.

Randolph Eastern Emergency Medical Form

Student's Name: _____ Sex: M F Grade/Teacher: _____

Date of Birth: _____ Home Address: _____

Student lives with (please check): Both Parents Mother Father Other

If other, please explain _____

Mother's name/phone (day/cell): _____

Father's name/phone (day/cell): _____

Other contact person name/phone: _____

Hospital Preferred: _____

MEDICAL Does your child have a doctor? Y N Physician's name: _____

MEDICAL HISTORY I have been told by a Physician/Healthcare Professional that my child has the following condition(s). Check if apply and please provide the school with the necessary medical physician documentation.

<input type="checkbox"/> Asthma <input type="checkbox"/> Exercised Induced Asthma <input type="checkbox"/> Inhaler required at school <input type="checkbox"/> Self-carry inhaler (requires Dr.'s order)	<input type="checkbox"/> Heart Disease <input type="checkbox"/> Murmur <input type="checkbox"/> as infant <input type="checkbox"/> currently Heart Problem with restrictions: _____
<input type="checkbox"/> ADD <input type="checkbox"/> ADHD <input type="checkbox"/> On ADD/ADHD Medications <input type="checkbox"/> Autism <input type="checkbox"/> Asperger's Syndrome <input type="checkbox"/> Other: _____	<input type="checkbox"/> Seizures <input type="checkbox"/> From Fever <input type="checkbox"/> Epilepsy Date of last seizure: _____
<input type="checkbox"/> Bladder/Kidney concerns: _____ <input type="checkbox"/> Encopresis <input type="checkbox"/> Crohn's disease	<input type="checkbox"/> Frequent Headaches(nonspecific) <input type="checkbox"/> Migraine (requiring medication)
<input type="checkbox"/> Blood/Clotting <input type="checkbox"/> Hemophilia <input type="checkbox"/> Sickle Cell	<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> OCD <input type="checkbox"/> Other: _____
<input type="checkbox"/> Deafness <input type="checkbox"/> Hearing aids <input type="checkbox"/> Blindness <input type="checkbox"/> Glasses _____	<p style="text-align: center;">ALLERGIES (CHECK ALL THAT APPLY)</p> <input type="checkbox"/> Bee sting <input type="checkbox"/> Wasp sting <input type="checkbox"/> Other insect sting <input type="checkbox"/> Local (swelling at sting site only) <input type="checkbox"/> Epipen/Hospital <input type="checkbox"/> Seasonal (requiring medication) <input type="checkbox"/> Hay Fever <input type="checkbox"/> Animals (List animals: _____) <input type="checkbox"/> Latex (not life-threatening) <input type="checkbox"/> Latex (requires Epi Pen) <input type="checkbox"/> Food (requires epipen) list food: _____ <input type="checkbox"/> Medication allergy, please list: _____ <input type="checkbox"/> Other Health Condition: _____
<input type="checkbox"/> Diabetes type I <input type="checkbox"/> Diabetes type II	
<input type="checkbox"/> Diet Restrictions: _____ <input type="checkbox"/> Obesity <input type="checkbox"/> Underweight <input type="checkbox"/> Anorexia <input type="checkbox"/> Bulimia <input type="checkbox"/> Food Intolerance <input type="checkbox"/> Gluten/Celiac <input type="checkbox"/> Lactose Intolerant: Please list _____	
<input type="checkbox"/> Head Injury <input type="checkbox"/> Concussion Date: _____	
<input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> other musculoskeletal	
<input type="checkbox"/> Chromosomal/Hereditary disorder: _____	

To ensure the care of my child, I read and agree that pertinent health information may be provided to appropriate school staff on a need to know basis. I agree to alert the school nurse and my child's teacher, in writing, of any change in medications and/or health status of my child. I agree that the school nurse may consult with my child's physician about the above medical condition(s). If I am unavailable to be reached in order to obtain authorization directly, I do hereby grant the school principal, school nurse, or other appointed designee the authority to act for me and to provide consents and authorization for the delivery of emergency medical care and transport.

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

RANDOLPH EASTERN SCHOOL HEALTH PHYSICAL FORM

TO BE COMPLETED BY PARENT:

Child's name _____ Child's address _____ Date of Birth _____
Parent/Guardian name _____ Phone number _____

TO BE COMPLETED BY HEALTH CARE PROVIDER (If "yes" to any item, please explain)

1. Does the child have a past or present medical history of the following?

<input type="checkbox"/> asthma	<input type="checkbox"/> developmental/learning problem	<input type="checkbox"/> speech, hearing, or visual impairment
<input type="checkbox"/> anemia	<input type="checkbox"/> diabetes	<input type="checkbox"/> tuberculosis
<input type="checkbox"/> attention deficit hyperactivity disorder	<input type="checkbox"/> enuresis (daytime)	<input type="checkbox"/> other: _____
<input type="checkbox"/> bleeding disorder	<input type="checkbox"/> encopresis	<input type="checkbox"/> surgeries/date: _____
<input type="checkbox"/> cerebral palsy	<input type="checkbox"/> orthopedic injury/disability	_____
<input type="checkbox"/> chronic recurrent otitis media	<input type="checkbox"/> seizure disorder	_____

2. ALLERGIES none epipen

Drugs (list) _____
Foods (list) _____
Other (list) _____

3. MEDICATIONS none list below

4. DIETARY RESTRICTIONS if yes, list:

5. PHYSICAL EXAMINATION

Height _____ (ft.in.) _____ %tile
Weight _____ (lbs.) _____ %tile
Blood pressure _____ (normal/abnormal)

6. GENERAL APPEARANCE (check if normal):

<input type="checkbox"/> HEENT	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Language
<input type="checkbox"/> Dental	<input type="checkbox"/> Extremities	<input type="checkbox"/> Behavioral
<input type="checkbox"/> Neck	<input type="checkbox"/> Skin	<input type="checkbox"/> Weight
<input type="checkbox"/> Lymph nodes	<input type="checkbox"/> Neurological	<input type="checkbox"/> Developmental (cognitive, social/emotional, motor)
<input type="checkbox"/> Lungs	<input type="checkbox"/> Back/spine	
<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Psychological Development	

Describe abnormalities _____

7. SCREENING TESTS

Blood lead level: _____ (date done) _____ (normal or abnormal)

Lead Risk: _____ (date done) _____ (normal or abnormal)
Assessment (recommended annually, age 6 months to 6 years)

Hearing: _____ (date done) _____ (normal or abnormal)

Vision screen: glasses required right eye left eye strabismus

8. IMMUNIZATIONS: Are they up to date? Please attach a copy of child's record.

Date of verified Chicken pox disease if applicable: _____

9. RECOMMENDATIONS: full physical activity full diet Restrictions if any, specify: _____

10. Follow-up needed: no yes, for _____ Appt. date _____

Referral(s): none early intervention special education dental vision

HEALTH CARE PROVIDER SIGNATURE _____ DATE _____

Address: _____

Telephone: _____ Fax Number _____

Randolph Eastern School Corporation
Union City, IN 47390

I, _____, give the Randolph Eastern School Corporation, permission to release the following information concerning my child _____ to the Indiana State Department of Health's Children and Hoosiers Immunization Registry Program (CHIRP):

Name, Date of Birth, Immunization dates, Ethnicity, Parent or Legal Guardians Name and/ or Address

I understand that the information in the registry may be used to verify that my child has received proper immunizations and to inform me or my child of my child's immunization status or that an immunization is due according to recommended immunization schedules.

I understand that my child's information may be available to the immunization data registry of another state, a healthcare provider or a provider's designee, a local health department, an elementary or secondary school, a child care center, the office of Medicaid policy and planning or a contractor of the office of Medicaid policy and planning, a licensed child placing agency, and a college or university. I also understand that other entities may be added to this list through amendment to I.C. 16-38-5-3.

I hereby consent to the release of such information.

Signature

Date

Printed Name of Parent or Guardian

Address

(____)_____
Telephone Number

Child's Name

Grade Level

Child's Date of Birth

Name of School

Student Name _____

North Side Elementary Signature Page

Student Handbook / Athletic Handbook

I understand that the North Side Elementary School Student and UCJSHS Athletic Handbook is provided on the corporation website (www.resc.k12.in.us). My child and I agree to read the handbook, to become familiar with and to follow all school rules and policies. I understand that I may request a copy of the handbook from my school if I do not have internet access, but I understand that it is my responsibility, to become familiar with the content. Failure to sign this form does not exempt your child from school practices or policies found in the student handbook.

Parent Signature

Student Signature

Date

Media Release

North Side Elementary School would like to spread the news of what is happening in our corporation. This will be done via several different types of media. These include, but are not limited to, articles and photographs, in a school or district newsletter, video of a student program shown in school or on KISS TV, an article in a local newspaper, school sponsored social media, or posts on our RESC website. Pictures or videotape maybe of a large group of students or individual students singled out for achievement. I hereby grant permission and agree with the media release consent for the Randolph Eastern School Corporation. I understand that I need to complete a separate form for non – consent.

Parent Signature

Date

RESC Acceptable Use Policy For Technology (AUP)

Rules and regulations are necessary in order to offer technology opportunities to the students. In order to use technology resources, I agree to abide by the Acceptable Use Policy Guidelines as stated online at (www.resc.k12.in.us). I understand that I may request a copy of the policy from my school if I do not have internet access, but I understand that it is my responsibility, to become familiar with the content.

Parent Signature

Student Signature

Date

Transportation

I understand that the bus rules are found in the student handbook on the school website at (www.resc.k12.in.us) My child and I agree to read those rules. I understand that violations of the rules will result in disciplinary consequences that can include suspension from the bus transportation.

Parent Signature

Student Signature

Date

The Migrant Education Program (MEP) provides supplemental education and support services to eligible children through national funding. The purpose of the program is to ensure that all migrant students reach the academic standards and graduate with a high school diploma (or complete a GED).


WORK SURVEY

Thank you for answering the following questions. If your child is eligible for the Migrant Education Program, they may receive additional educational support. This information is **strictly confidential**.

Student's Name: _____ Parent's Name: _____

Address: _____ City: _____ Telephone: (____) _____

Date: _____ Parent Signature: _____

1. How long have you lived in this city/school district? _____
2. Within the last **3 years**, has your child(ren) moved from one school district to another within the United States, with a parent, relative or guardian so that person could look for seasonal or temporary work in agriculture? **YES** ___ **NO** ____ If you answered **NO**, please stop. 

If you answered **YES**, please continue.

3. When was the last time you or anyone in your household has moved to look for, or work in an agricultural activity within the United States? Month _____ Year _____
4. Please check any of the agricultural activities listed below that you have looked for or worked in:

- | | |
|--|---|
| <input type="checkbox"/> Plant or harvest vegetables or fruits
<input type="checkbox"/> Detassel corn
<input type="checkbox"/> Tobacco farm
<input type="checkbox"/> Poultry and/or egg farm
<input type="checkbox"/> Duck, turkey, chicken, pork or beef processing plant
<input type="checkbox"/> Aquaculture/fish hatcheries | <input type="checkbox"/> Canning vegetables or fruits
<input type="checkbox"/> Sod farm
<input type="checkbox"/> Planting, pruning or cutting trees
<input type="checkbox"/> Dairy farm
<input type="checkbox"/> Flora culture/gladiola farm
<input type="checkbox"/> Green house or plant nursery |
|--|---|

Please list the names of all of the children in the household under 22 years of age.


Child's Name	Date of Birth (D.O.B.)
1.	
2.	
3.	
4.	
5.	

El Programa de Educación Migrante (MEP) provee educación y servicios suplementarios a niños que califican a través de fondos nacionales. El propósito de MEP es asegurar que todos los estudiantes migrantes tengan éxito académico y que se gradúen con su diploma (o que completen el GED)

ENCUESTA DE TRABAJO

Gracias por contestar las siguientes preguntas. Si su hijo(a) resulta elegible para el Programa de Educación Migrante, podría recibir apoyo educativo adicional. La información es **totalmente confidencial**.

Nombre del Estudiante: _____ Nombres de los Padres: _____
 Dirección: _____ Ciudad: _____ Teléfono: (____) _____
 Fecha: _____ Firma de los Padres: _____

1. ¿Cuanto tiempo han vivido en esta ciudad/distrito escolar? _____
2. Durante los **últimos tres años**, ¿Se han mudado sus hijos o han cambiado de distrito escolar dentro de los Estados Unidos, solos, con un padre o pariente, para que esa persona pudiera buscar trabajo temporal o de temporada en algo relacionado con la agricultura?
SI _____ **NO** _____ Sí contestó **NO**, favor de parar aquí. 

Sí contestó **SI**, favor de continuar.

3. ¿Cuando fue la última vez que usted o un miembro de su familia se mudó para trabajar en la agricultura? Mes _____ Año _____
4. Por favor marque en la parte abajo la actividad agrícola en la cual usted buscó trabajo o trabajó.

<input type="checkbox"/> Matadero de patos, pavos, pollos, cerdos o vacas	<input type="checkbox"/> Enlatar o congelar verduras o frutas en la bodega
<input type="checkbox"/> La espiga (maíz)	<input type="checkbox"/> Trabajar en la siembra o cosecha de césped
<input type="checkbox"/> Cultivar tabaco	<input type="checkbox"/> Plantar, emparejar o cortar árboles
<input type="checkbox"/> Pollería o granja de huevos	<input type="checkbox"/> Granja de vacas lecheras
<input type="checkbox"/> Plantar o cosechar verduras o frutas	<input type="checkbox"/> Cultivar y cosechar flores
<input type="checkbox"/> Trabajar en un criadero de peces	<input type="checkbox"/> Trabajar en la cría de plantas

Por favor escribe los nombres de todos los niños, menos de 22 años de edad, que viven con usted.

Nombre del niño(a)	Fecha de nacimiento
1.	
2.	
3.	
4.	
5.	