IBERVILLE PARISH SCHOOL BOARD STUDENT COORDINATED ENROLLMENT FORM

58030 Plaquemine Street • Plaquemine, LA 70764• Phone: 225.687.4341• Fax: 225-687-5408

School Year _____ - _____

Student's Name _____ **Date of Birth** _____

Early Childhood Childcare Based Sites: (Please check the box of choice)

☐**A Garden of Angels Learning Center**◆78045 Wheelock Lane◆ Maringouin, LA 70757◆225.625.2245◆**Owner: Xavier Anderson**
☐**Holmes House Child Care Center**◆56511 Breaux Street◆Bayou Goula, LA 70788◆225. 545.2527◆**Owner: Juanita Williams**
☐**From Cradles to Classrooms**◆57951 Barrow Street◆Plaquemine, La 70764◆225.687.9250◆**Owner: Raymond Smith, Jr.**
☐**Precious Tots**◆24819 Dennis Street◆Plaquemine, LA 70764◆225.687.0998◆**Owner: Joann Bosley**
☐**Toddlers College Learning Center**◆23725 Ephriam Street◆Plaquemine, LA 70764◆225.385.4716◆**Owner: Tyiesha Fuertes**
☐**Bright Star Child Care Center**◆24400 Sebastian Street◆Plaquemine, LA 70764◆225.238.2139◆**Owner: Rockeisha Walker**
☐**Honey Bee Child Care Center**◆32850 Bowie Street◆White Castle, LA 70788◆225.716.8066◆**Owner Barbara Batiste**
☐**True Care Learning Center**◆24915 B, LA-1◆Plaquemine, LA 70764◆225.238.5058◆**Owner: Kevin Snaril**
☐**Chiefcornerstone Daycare Center**◆58830 Annex Street◆Plaquemine, LA 70764◆225.386.3700◆**Owner: Sondra Washington**

Elementary School Sites: (Please check the box of choice).

☐Math, Science & Arts Academy West (PK3-12)
☐Math, Science & Arts Academy East (PK3-12)
☐East Iberville Elementary (PK3-6)
☐Crescent Elementary School (PK3-6)
☐North Iberville Elementary (PK3-6)
☐Dorseyville Elementary (PK3-6)
☐Iberville Elementary (PK3-6)

High School Sites: (Please check the box of choice).

☐Plaquemine High School (7-12)
☐White Castle High School (7-12)
☐ East Iberville High School (7-12)
☐Iberville STEM Academy (6-12)

Students are not officially enrolled until ALL required documents are received.

- ✓ **Early Childhood Child Care Based Sites require:** Birth Certificate, Social Security Card, Updated Immunization.
- ✓ **Early Childhood School Based Sites require**: Birth Certificate, Social Security Card, Updated Immunization, copy of insurance card, 3-proofs of residency, proof of income, completed dental & physical forms.
- ✓ **High School sites require**: Birth Certificate, Social Security Card, Updated Immunization, 3-proofs of residency.

Grade Level: (Circle one) Infant age 1 age 2 PK3 PK4 K 1 2 3 4 5 6 7 8 9 10 11 12

Previous School Site: _____ Previous Grade: _____

Student Information:

Student's Name: _____

Last First Middle

Age: _____ Sex: ☐Male ☐ Female

Student's Date of Birth: _____

Month Date Year

Place of Birth_____ Birth Certificate Number _____

Student's Social Security Number: _____-_____-_____

Student's Ethnicity: (Check One)

___American Indian
___Asian or Pacific Islander
___Black
___Hispanic
___White
___Latino

Student's Dominant Language (Check One)

__English
__Non-English

Does your child speak any other language?

___Yes ___ No If yes, what_____

In case of an Emergency Contact:

Name: _____ Phone Number: _____

Medical Information:

Primary Doctor's Name: _____ Phone Number: _____

Primary Dentist Name: _____ Phone Number: _____

Known Allergies: _____ Insurance Provider: _____

Additional Medical Information:

_____

_____

_____

Education Information:

Has your child repeated a grade?

☐No ☐Yes_____

Does Your Child have a current evaluation or IEP to receive special needs services?

☐ No

☐ Yes (check one) _____Speech _____OT ____PT _____APE ___Special Instruction

Do you have any concerns regarding your child's development or behavior?

☐No

☐Yes, please explain:

_____

_____

_____

Parent/Guardian Information:

Primary Parent/Guardian Name: _____

Relationship to Child: _____ Ethnicity: _____ Age: _____

Home Phone Number: _____ Alternate Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address: _____

Email Address: _____

Highest level of education: 0 1 2 3 4 5 6 7 8 9 10 11 12

High School Graduate GED Some College College Graduate

Currently Employed? ☐ Yes ☐ No Employment Status: _____Full-time ____Part-time

Employer and Phone Number: _____

Secondary Parent/Guardian Name: _____ _____

Relationship to Child_____ Ethnicity: _____ Age: _____

Home Phone Number: _____ Alternate Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address: _____

Email Address: _____

Highest level of education: 0 1 2 3 4 5 6 7 8 9 10 11 12

High School Graduate GED Some College College Graduate

Currently Employed? ☐ Yes ☐ No Employment Status: _____Full-time ____Part-time

Employer :_____

Phone Number: _____

Household Members:

	Name	DOB	Relationship to Student	Employed/In School
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Number of Adults_____ Number of Children_____ Family Size_____

AGREEMENT: I understand that I must report any changes that would affect my child within ten working days of the change. I understand that providing false information is subject to penalty under the law. I certify that all information given is true and correct to the best of my knowledge.

Parent Signature _____ Date _____

FOR OFFICE USE ONLY

Date received_____ **Time received** _____

45 Day Complete _____ **90 Day Complete**_____

Meal Status: **Free** **Reduced** **Paying**

Funding Code: **HS** **8G** **LA4** **CCAP** **B-3**

IPSB Employee Signature_____

DEPARTMENT of EDUCATION
Louisiana Believes

Louisiana Student Residency Questionnaire Form

(Form Must Be Included In School Enrollment Packet)

Date: _____ LEA: _____ School Name _____

Student Name: _____ ID#: _____ Gender: Male / Female

Address: _____ Telephone Number: _____

Last School Attended: _____ Current Grade: _____ Date of Birth: _____

Parent / Guardian / Adult Caring for Student: _____ Relationship: _____

Disclaimer: This questionnaire is intended to address the McKinney-Vento Act. Your child may be eligible for additional educational services through Title I Part A, Title I Part C Migrant, Individuals with Disabilities Education Act (IDEA) and/or Title IX, Part A, Federal McKinney-Vento Assistance Act, 42 U.S.C.11435. Eligibility can be determined by completing this questionnaire. It is illegal to knowingly make false statements on this form. If eligible, students are to be immediately enrolled in accordance with Bulletin 741, section 341.

1. ☐YES ☐ NO Is the student's address a temporary living arrangement? (Note: If this is a permanent living arrangement or the family owns or rents their home, sign under item 9 and submit form to school personnel.)
2. ☐YES ☐ NO Is the temporary living arrangement due to loss of housing or economic hardship?
3. ☐YES ☐ NO Does the student have a disability or receive any special education-related services? (Check one)
4. Where is the student currently living? (Check all that apply.)

   ☐ In an emergency/transitional shelter.
   ☐ Temporarily with another family because we cannot afford or find affordable housing.
   ☐ With an adult that is not a parent or legal guardian, or alone without an adult.
   ☐ In a vehicle of any kind, trailer park or campground without running water/electricity, abandoned building or substandard housing.
   ☐ Emergency Housing (i.e. FEMA Trailer or FEMA Rental Assistance)
   ☐ In a hotel/motel. ☐ Other specific information: _____

5. ☐ YES ☐ NO Does the student exhibit any behaviors that may interfere with his or her academic performance?
6. Would you like assistance with uniforms, student records, school supplies, transportation, other? (Describe): _____
7. ☐ YES ☐ NO Migrant – Have you moved at any time during the past three (3) years to seek temporary or seasonal work in agriculture (including Poultry processing, dairy, nursery, and timber) or fishing?
8. ☐ YES ☐ NO Does the student have siblings (brothers or sisters)? Note: Use back of page if more space is needed.
   Name _____ School _____ Grade _____ DOB _____
   Name _____ School _____ Grade _____ DOB _____
   Name _____ School _____ Grade _____ DOB _____
9. The undersigned certifies that the information provided above is accurate.

Print Parent/Guardian/Adult Caring for Student's Name | Signature | Date

(Area Code) Phone Number | Street Address | City | State | Zip Code

Print School Contact Name | Title | Signature | Date

Homeless Liaison Use Only – *Check All that Apply:*

☐ Sheltered ☐ Doubled-Up ☐ Unsheltered/FEMA/Substandard ☐ Hotel/Motel Unaccompanied Youth: ☐ YES ☐ NO

School Use Only: ☐ Free or Reduced Price Meals Form submitted/signed ☐ Copy Placed in Student's Cumulative Record

03/2019

DEPARTMENT of EDUCATION
Louisiana Believes

Formulario del cuestionario de residencia de estudiantes de Louisiana

(El formulario se debe incluir en el Paquete de inscripción escolar)

Fecha: _____ LEA: _____ Nombre de la escuela: _____

Nombre del estudiante: _____ No. de ID: _____ Género: Hombre/Mujer

Dirección: _____ Número de teléfono: _____

Última escuela a la que asistió: _____ Grado actual: _____ Fecha de nacimiento: _____

Padre/Tutor/Cuidador del estudiante: _____ Relación: _____

***Descargo de responsabilidad:** Este cuestionario tiene la finalidad de abordar la Ley McKinney-Vento. Su hijo puede ser elegido para servicios educativos adicionales a través del Título I Parte A, Título I Parte C Inmigrante, Ley para la Educación de Individuos con Discapacidades (IDEA, por sus siglas en inglés) y/o Título IX, Parte A, Ley Federal McKinney-Vento de Asistencia, 42 U.S.C.11435. La elegibilidad se puede determinar completando este cuestionario. Es ilegal hacer declaraciones falsas a sabiendas en este formulario. Si es elegible, los estudiantes se deben inscribir de inmediato de acuerdo con el Boletín 741, sección 341.*

1. ☐ SÍ ☐ NO ¿Es la dirección del estudiante un arreglo de vivienda temporal? (Nota: Si esta es un arreglo de vivienda permanente o si la familia es propietaria o renta su hogar, firme bajo el artículo 9 y envíe el formulario al personal de la escuela).
2. ☐ SÍ ☐ NO ¿Se debe el arreglo de vivienda temporal a la pérdida de su hogar o dificultades económicas?
3. ☐ SÍ ☐ NO ¿Tiene el estudiante una discapacidad o recibe algún servicio relacionado con la educación especial? (Marque uno).
4. ¿En dónde vive el estudiante ahora? (Marque todos los que apliquen).

   ☐ En un albergue de emergencia/temporal.
   ☐ Temporalmente con otra familia porque no podemos pagar o encontrar una vivienda asequible.
   ☐ Con un adulto que no es uno de los padres, tutor legal o solo sin un adulto.
   ☐ En un vehículo de cualquier tipo, paradero de casas rodantes o campamento sin agua corriente/electricidad, edificio abandonado o viviendas de calidad inferior.
   ☐ Alojamiento de emergencia (es decir, Remolque de FEMA o Asistencia de alquiler de FEMA).
   ☐ En un hotel/motel. ☐ Otro, informacióne specifique: _____

5. ☐ SÍ ☐ NO ¿Presenta el estudiante algún comportamiento que pueda interferir con su desempeño académico?
6. ¿Le gustaría recibir asistencia para los uniformes, registros del estudiante, artículos escolares, transporte, otro? (Describa): _____
7. ☐ SÍ ☐ NO Inmigrante: ¿Se ha cambiado en algún momento durante los últimos tres (3) años para buscar un trabajo temporal o estacional en agricultura (incluyendo, procesamiento de aves de corral, productos lácteos, viveros y madera) o la pesca?
8. ☐ SÍ ☐ NO ¿Tiene hermanos o hermanas el estudiante? Nota: Use el reverso de la página si necesita más espacio.
   Nombre _____ Escuela _____ Grado _____ Fecha de nacimiento _____
   Nombre _____ Escuela _____ Grado _____ Fecha de nacimiento _____
   Nombre _____ Escuela _____ Grado _____ Fecha de nacimiento _____
9. El abajofirmante certifica que la información proporcionada anteriormente es correcta.

_____
Escriba el nombre del Padre/Tutor/Cuidador del estudiante | Firma | Fecha

_____
(Código de área) Número de teléfono | Dirección Calle | Ciudad | Estado | Código Postal

_____
Escriba el nombre del contacto de la escuela | Título | Firma | Fecha

Uso exclusivo de enlace para personas sin hogar – *Marque todas las que correspondan*

☐ Protegido ☐ Compartida ☐ Sin protección/FEMA/De calidad inferior ☐ Hotel/Motel

Joven sin acompañante: ☐ SÍ ☐ NO

Uso de la escuela solamente: ☐ Formulario de alimentos gratuitos o precio reducido enviado/firmado ☐ Copia incluida en el Registro acumulativo del estudiante

03/2019

Primary/Home Language Survey for All New Incoming Students

Survey should be completed by parents or guardians of
ALL new incoming students K-12.

Student Information:

First Name: _____ **Date of Birth:** _____

Last Name: _____ **Date Entered US School:** _____

Questions for Parents or Guardians	Response
What is the most common language(s) spoken in your home?	
Which language did your child learn first?	
Which language does your child use most often at home?	
In what language do you most often speak to your child?	
What language does your child use with friends?	

Has your child received ESL/EL services previously? Yes No

In what language would you prefer to receive information from the school? _____

_____

Parent's or Guardian's Signature Date

Updated 01/2020

Encuesta de Idioma principal/en el hogar para todos los estudiantes entrantes nuevos

Los padres o tutores de deben completar la encuesta
TODOS los estudiantes entrantes de K-12.

Información del estudiante:

Nombre: _____ **Fecha de nacimiento:** _____

Apellido: _____ **Fecha de ingreso a la escuela de EE. UU.:** ___

Preguntas para los padres o los tutores	**Respuesta**
¿Cuál es el(los) idioma(s) más común(es) que se habla(n) en su hogar?	
Qué idioma aprendió su hijo primero?	
¿Qué idioma usa su hijo con más frecuencia en el hogar?	
¿En qué idioma le habla más a menudo a su hijo?	
¿Qué idioma usa su hijo con sus amigos?	

¿Ha recibido su hijo servicios de ESL/EL antes? Sí No

¿En qué idioma preferiría recibir la información de la escuela? _____

_____

Firma del padre o tutor Fecha

Actualizado 01/2020

CHILD HEALTH RECORD: FORM 3, SCREENINGS, PHYSICAL EXAMINATION/ASSESSMENT

CHILD'S NAME: _____ SEX: _____ BIRTHDATE: _____

HEAD START CENTER: _____ PHONE: _____

ADDRESS: _____

PART I. TO BE COMPLETED BY HEAD START STAFF OR HEALTH CARE PROVIDER BEFORE PHYSICAL EXAMINATION/ASSESSMENT

1. RELEVANT INFORMATION *(from Health History, Parent/Teacher Observations):*

2. SCREENING TESTS. *Starred items (*) are required by Head Start and recommended by the American Academy of Pediatrics for children 3-5 years. Enter dates if done previously. When recording results, enter at a minimum "N", "S", or "A" for NORMAL, SUSPECT, OR ATYPICAL/ABNORMAL, respectively.*

TEST	DATE	RESULTS	TEST	DATE	RESULTS
a. PRESENT AGE*		____Yrs., ____Mos.	g. VISION (Type of Test)* _____		
b. HEIGHT (no shoes, to nearest 1/8 in.)*			ACUITY, R/L _____		
c. WEIGHT (light clothing to nearest 1/4 lb.:)*			RESCREENING _____		
d. BLOOD PRESSURE			STRABISMUS _____		
e. HEMATOCRIT or HEMOGLOBIN*			COMMENTS		
f. HEARING (Type of Test)* _____			h. OTHER TESTS (if indicated)		
RESULTS, R/L _____			(1) TB _____		
RESCREENING _____			(2) Sickle Cell _____		
COMMENTS			(3) Lead _____		
			(4) Ova & Parasites _____		
			(5) Urinalysis _____		
			(6) Other _____		

PART II. TO BE COMPLETED BY HEALTH CARE PROVIDER DURING AND AFTER PHYSICAL EXAMINATION/ASSESSMENT

3. PHYSICAL EXAMINATION/ASSESSMENT. *Complete and return top three copies to Head Start.*

	NORMAL FOR AGE	ABNOR-MAL	NOT EVAL.	COMMENTS *(Use Additional sheet if necessary)*
a. GENERAL APPEARANCE				
b. POSTURE, GAIT				
c. SPEECH				
d. HEAD				
e. SKIN				
f. EYES: (1) External Aspects				
(2) Optic Fundiscopic				
(3) Cover Test				
g. EARS: (1) External & Canals				
(2) Tympanic Membranes				
h. NOSE, MOUTH, PHARYNX				
i. TEETH				
j. HEART				
k. LUNGS				
l. ABDOMEN (include hernia)				
m. GENITALIA				
n. BONES, JOINTS, MUSCLES				
o. NEUROLOGICAL/SOCIAL				
(1) Gross Motor _____				
(2) Fine Motor _____				
(3) Communication Skills _____				
(4) Cognitive _____				
(5) Self-Help Skills _____				
(6) Social Skills				
p. GLANDS (Lymphatic/Thyroid)				
q. MUSCULAR COORDINATION				
r. OTHER				

s. GENERAL STATEMENT ON CHILD'S PHYSICAL STATUS:

Signature: _____ Date: _____

4. FINDINGS, TREATMENTS, AND RECOMMENDATIONS

ABNORMAL FINDINGS/DIAGNOSIS	TREATMENT PLAN	RECOMMENDED FOLLOW-UP OR RESULTS *(initial when complete)*	DATE
a.			
b.			
c.			
d.			

CHILD HEALTH RECORD:

FORM 5, DENTAL HEALTH

(COMPLETE AT INTERVIEW)

CHILD'S NAME:_____ SEX:_____ BIRTHDATE:_____

HEAD START CENTER:_____ PHONE:_____

ADDRESS:_____

PART I. TO BE COMPLETED BY HEAD START STAFF

1. IS THE CHILD NOW RECEIVING: *If "yes," include length of time receiving fluoride*
   - Topical Fluoride Application? No_____ Unknown_____ Yes_____
   - Fluoridated water? No_____ Unknown_____ Yes_____
   - Fluoride Supplement diet? No_____ Unknown_____ Yes_____
     (tablets_____, liquid_____)

2. DOES THE CHILD HAVE ANY TROUBLE WITH TEETH, GUMS, OR MOUTH THAN THE PARENT KNOWS ABOUT?

3. CHILD (____HAS, ____HAS NOT) PREVIOUSLY SEEN A DENTIST.
   Dentist's name_____ Date last visit_____

4. CHILD (____IS, ____IS NOT) UNDER A PHYSICIAN'S CARE.
   Physician's name_____

5. CHILD (____IS, ____IS NOT) RECEIVING MEDICATION.
   Type_____

6. CHILD IS REPORTED TO HAVE *(Give details or attach Health History, Form 2A).*

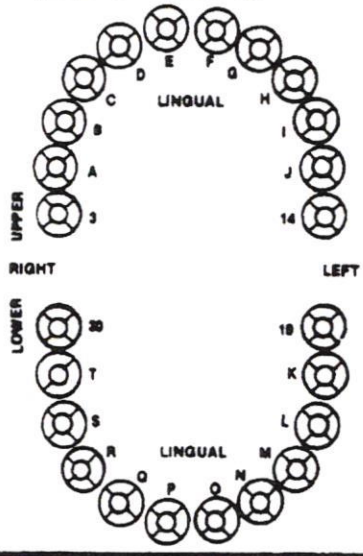
	YES	NO		YES	NO
Allergies	___	___	Liver Dis.	___	___
Asthma	___	___	Rheumatic Fever	___	___
Bleeding	___	___	Sickle Cell Dis.	___	___
Diabetes	___	___	Other (List Below)	___	___
Epilepsy	___	___	_____		
Heart/Vascular Dis.	___	___	_____		

7. SOURCE OF REIMBURSEMENT OR SERVICES
   - ☐ EPSDT/Medicaid
   - ☐ Federal, State, or local Agency _____
   - ☐ Head Start
   - ☐ In-kind Provider_____
   - ☐ Parents/Guardians
   - ☐ Other (3rd Party)_____

8. PRIORITY GROUP
   - ☐ A. Needs Attention Immediately
   - ☐ B. Needs Attention Soon
   - ☐ C. Needs Routine Care

PART II. TO BE COMPLETED BY DENTAL CARE PROVIDER

9. ORAL CONDITIONS BEFORE TREATMENT: *missing (⊗), decayed (●), or filled (■); indicate restorations you perform in Item 10.*



10. EXAMINATION AND TREATMENT RECORD *(List recommended services in order).*

Tooth # or Letter	Surfaces	Description of Work	Treatment Approved	Date Service Performed MO.	DAY	YR.	A.D.A. Procedure Number	Actual Charges (Fee)

11. DENTAL NEEDS *(Check one or more and return 3 copies to Head Start after first visit).*
   - ☐ A. TREATMENT (restoration, pulp therapy, extraction)
   - ☐ B. CLEANING
   - ☐ C. FLUORIDE
   - ☐ D. OTHER
   - ☐ E. NO PROBLEMS

   Approximate number of visits_____. Approximate cost_____.

12. CHILD ORAL HEALTH SUMMARY *(Complete and return 2 copies to Head Start after final visit).*
   All planned treatment (____is, ____is not) complete. If not, explain here, as well as items checked.
   _____
   _____
   - ☐ a. Routine recall visits
   - ☐ b. Special home emphasis, oral hygiene
   - ☐ c. Dietary problem(s)
   - ☐ d. Developmental problem(s)
   - ☐ e. Harmful oral habits
   - ☐ f. Needs fluoride supplement

   I certify that I have completed the service(s) listed in Part II, Item 10, and that itemized charges do not exceed my usual and customary fees.

   Signature_____ Date_____

INTERVIEWER: GO TO FORM 6