

# ELEMENTARY ENROLLMENT FORM



- ☐ Rouse Elementary
- ☐ Stonebridge Elementary
- ☐ Brandon Elementary
- ☐ Steen's Creek Elementary
- ☐ Florence Elementary
- ☐ McLaurin Elementary
- ☐ Flowood Elementary
- ☐ Northwest Rankin Elementary
- ☐ Northshore Elementary
- ☐ Oakdale Elementary
- ☐ Highland Bluff Elementary
- ☐ Pelahatchie Elementary
- ☐ Pisgah Elementary
- ☐ Puckett Elementary
- ☐ Richland Lower Elementary
- ☐ Richland Upper Elementary

FOR OFFICE USE ONLY			
School Documentation	✓	Required Documentation for Enrollment Received	✓
Homeroom Teacher		Withdrawal / Current Grades	
Student Scheduled		Birth Certificate	
Record Requested		Social Security Card	
Record Received		(2) Proofs of Residency	
Township / Range		MS Immunization Form	
MSIS #		Legal Paperwork (if app.)	
Bus Number or Mode of Transportation AM PM			
Third Grade Reading Gate: <input type="checkbox"/> Pass <input type="checkbox"/> Fail			

**ALL ENROLLMENT FORMS MUST BE COMPLETED BY A LEGAL PARENT/GUARDIAN.**

DATE: \_\_\_\_\_ GRADE: \_\_\_\_\_ TEACHER: \_\_\_\_\_

## STUDENT DEMOGRAPHIC INFORMATION

Student's Name: \_\_\_\_\_  
LAST FIRST MIDDLE

Residence Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Gender: \_\_\_\_\_  
A, B, H, NA, PI, W

\*Birth Certificate #: \_\_\_\_\_ \*Immunization Date: \_\_\_\_\_

Place of Birth: \_\_\_\_\_  
CITY COUNTY STATE

Parent / Guardian Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Briefly list student's medications or special health problems: \_\_\_\_\_

Please provide a valid email address for important updates and correspondence.

Email Address: \_\_\_\_\_

In case of emergency or serious illness, I request school officials to contact me. If the officials can not reach me, school officials may seek appropriate medical attention. \_\_\_\_\_ (Initial)

## PREVIOUS EDUCATIONAL INFORMATION

Last school attended: \_\_\_\_\_

Grade: \_\_\_\_\_ School Phone #: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Has student ever been enrolled in this district? ☐ Yes ☐ No If yes, \_\_\_\_\_ When? \_\_\_\_\_  
NAME OF SCHOOL YEAR

## SPECIAL SERVICES

Was student receiving special services at previous school?

Gifted ☐ Yes ☐ No SPED ☐ Yes ☐ No Speech ☐ Yes ☐ No ELL ☐ Yes ☐ No 504 ☐ Yes ☐ No

**Please continue to page 2**

### DISCIPLINARY INFORMATION

Has the student been suspended / expelled from any school? YES ☐ NO ☐ Dates: \_\_\_\_\_

Is the student a party to an expulsion proceeding from any school? YES ☐ NO ☐

If Yes to either question, give name/address/phone number of school \_\_\_\_\_

### PARENT / GUARDIAN / STEP-PARENT / SIBLING INFORMATION

Student Living with: \_\_\_\_\_ Relationship: \_\_\_\_\_  
FIRST & LAST NAME

If you are not the parent, do you currently have guardianship? YES ☐ NO ☐ (Documentation Attached)

#### MOTHER / STEP-MOTHER / GUARDIAN (Please Circle One)

Full Name: \_\_\_\_\_  
LAST FIRST MAIDEN

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Email Address: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

#### FATHER / STEP-FATHER / GUARDIAN (Please Circle One)

Full Name: \_\_\_\_\_  
LAST FIRST

Home Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_ Email Address: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

**NAME(S) AND AGE(S) OF BROTHERS AND SISTERS:** \_\_\_\_\_

**PLEASE NOTE:** Students are allowed access to BOTH parents unless there are copies of COURT documents in the student's cumulative records that state otherwise. If any legal actions that affect the child are still in process, current copies of legal documents must be in the child's cumulative folder until the process is completed. Please attach any court documents and explain restrictions concerning your child.

Second through fifth grade students coming from a non-accredited school or home school will be temporarily placed upon completion of the registration requirements. Placement test(s) will be administered as soon as possible to determine permanent grade/class placement.

\* A birth certificate may be obtained from the State Board of Health from the capital of the state where the child was born. An immunization record may be obtained from the county health department or private physician.

**I have read the above requirements. I understand that my child WILL NOT BE ENROLLED UNTIL I HAVE PROVIDED THE SCHOOL WITH ALL REQUIRED DOCUMENTATION.**

Parent / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Rankin County School District grants equal educational opportunities to all students regardless of race, creed, color, sex, national origin, marital status, religion, or disability.*

### Permission for Publication of Student Photographs, Work, and Information

I understand that from time-to-time the school or the Rankin County School District (RCSD) may wish to publish student names, photographs, vocal and video recordings, projects, and/or other student work in electronic (radio and TV), print (newspapers, magazines), digital or electronic publishing via the Internet/websites, including school and RCSD websites, and other media outlets for the purpose of gaining positive publicity for the RCSD.

The primary purpose of directory information is to allow the School or School District to include information from your child's education records in certain school publications. Examples include:

- A playbill, showing your student's role in a drama production;
- The annual yearbook;
- Honor roll or other recognition lists;
- Graduation programs; and
- Sports activity sheets, such as for football, showing weight and height of team members.

Directory information, which is information that is generally not considered harmful or an invasion of privacy if released, can also be disclosed to outside organizations without a parent's prior written consent. We are committed to the security of all student and or staff data and take every measure to safeguard that information. Please let us know what you would like for us to do in regards to your child.

☐ YES, I give permission to have my child's work/project, name, personal information, vocal and video recordings, and photograph submitted to the media and posted on the Internet or on the District website for the purpose of gaining positive publicity for the school or school district.

☐ NO, I would prefer that my child's work/project, name, personal information, vocal and video recordings, and photograph not be submitted to any media nor posted on the Internet or on the District website for the purpose of gaining positive publicity for the school or school district.



## RANKIN COUNTY SCHOOL DISTRICT VOLUNTEER / CHAPERONE REGISTRATION FORM

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Employer: \_\_\_\_\_

References:

1: \_\_\_\_\_  
NAME ADDRESS PHONE

2: \_\_\_\_\_  
NAME ADDRESS PHONE

School / Student: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you ever been charged with or arrested or convicted of a civil or criminal sexual offence?

Yes ☐

No ☐

*I understand there is a possibility that a background check  
may be required if assigned as a volunteer / chaperone.*

Volunteer's / Chaperone's: \_\_\_\_\_  
SIGNATURE DATE

Principal's Signature: \_\_\_\_\_  
SIGNATURE DATE

**Return this completed application to the school where you wish to volunteer/chaperone.**



## CONSENT FOR MEDICATIONS AT SCHOOL

PARENT AUTHORIZATION-INDEMNITY AGREEMENT AND PHYSICIAN  
ORDER FOR ADMINISTRATION OF PRESCRIPTION OR OVER  
THE COUNTER MEDICATION(S) AT SCHOOL

### STUDENT INFORMATION (To be completed by the parent):

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_ Homeroom Teacher: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Parent(s)/Guardian(s) Emergency Contact Numbers:

Name: \_\_\_\_\_ Home #: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Other: \_\_\_\_\_ Relation: \_\_\_\_\_

The undersigned parent(s) or guardian(s) of the student named above, a minor child, have requested personnel of the Rankin County School District or Region 8 Mental Health Services and their nurses, employees, directors, agents and volunteers to administer prescription and/or Over the Counter (OTC) medication to this student. This request has been made for my/our convenience as a substitute for parental administration of this medicine. If there is not a licensed and registered school based nurse available to administer medications at the school, it is understood that the school principal or his/her designee will assign unlicensed school personnel or employee/volunteer that does not have medical or nursing training but has completed the Mississippi Board of Nursing "Assisted Self Administration Curriculum" the task of assisting the child in taking the medication. I/We understand that additional parent/prescriber signed statements will be necessary if the medication or dosage of medication is changed. I/We also authorize the School based Nurse or employee to talk with the prescriber or pharmacist should a question come up about the medication. I/We understand that the medication must be in the original container and be properly labeled with the student's name, prescriber's name, pharmacy, pharmacy number, date of prescription, name of medication, dosage, strength, time interval, route of administration, and the date of drug's expiration when appropriate. If the medication is over the counter (non-prescription), then it must be registered with the school in the original container and the child's name must be written legibly on the bottle. All medication(s) must be registered by the principal or his/her assigned designee and approved by the school based nurse prior to administration of medication at school. I/We forever release, discharge and covenant to hold harmless the Rankin County School District, its personnel, its employees, agents, volunteers or nurses and Board of Trustees or Region 8 Mental Health Services and its nurses, employees, directors, agents and volunteers from any and all claims, demands, damages, expenses, loss of services and causes of action belonging to the minor child or to the undersigned arising out of or on account of any injury, sickness, disability, loss or damages of any kind resulting from the administration of the prescription medicine. The undersigned agree to repay the school district or Region 8, its personnel or Trustees any sum of money, expenses, or attorney's fees that any of them may be compelled to pay in defense of any action or on account of any such injury to the minor child as a result of the administration of medicine. I have read the foregoing release and indemnity agreement and fully understand it. Executed this the \_\_\_\_\_ day of 20\_\_\_\_\_.

Parent or Guardian Signature

Name Printed

Witness

### PRESCRIBER AUTHORIZATION (To be completed by a Physician or Licensed Practitioner)

Name of Medication (one per form): \_\_\_\_\_ Check Prescription ☐ or OTC ☐

Condition for which medication is needed (diagnosis): \_\_\_\_\_

Dosage: \_\_\_\_\_ Route: \_\_\_\_\_ Time(s)/Frequency to be given: \_\_\_\_\_

If PRN, list Frequency: \_\_\_\_\_

AND specific symptoms when to administer: \_\_\_\_\_  
(I.E. HEAD OR STOMACH ACHE, WHEEZING OR OTHER SYMPTOMS EXHIBITED WITH THE MEDICAL CONDITION)

If the medication is an asthma inhaler or epinephrine / epi-pen, this student is authorized for self carry and has been instructed on and demonstrated the proper technique in administering the medication? Yes ☐ No ☐

Prescriber Name & Title (Print)

Prescriber Signature (or signature stamp)

Date

Physician Phone #: Fax #: \_\_\_\_\_



## RANKIN COUNTY SCHOOL DISTRICT EMERGENCY CARD

Student's Name: \_\_\_\_\_  
LAST FIRST MIDDLE PREFERRED

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Birthday: \_\_\_\_\_ Age: \_\_\_\_\_ Race: \_\_\_\_\_ Gender: \_\_\_\_\_

PARENT/GUARDIAN NAME	EMAIL ADDRESS	PLACE OF EMPLOYMENT & PHONE NUMBER	CELL PHONE / PAGER
MOTHER			
FATHER			

1. Do both parents have custody of the student? Yes ☐ No ☐
2. If no, are the most current court papers on file in the school office? Yes ☐ No ☐
3. Are both parents allowed to check the student out of school? Yes ☐ No ☐
4. I wish to receive text messages and/or emails from the school and district Yes ☐ No ☐

Please check your child's primary mode of transportation.

☐ Car Rider: \_\_\_\_\_ AM \_\_\_\_\_ PM ☐ Bus Rider): \_\_\_\_\_ AM \_\_\_\_\_ PM  
☐ Walker: \_\_\_\_\_ AM \_\_\_\_\_ PM INCLUDE BUS NUMBER  
☐ Frontier: : \_\_\_\_\_ AM \_\_\_\_\_ PM ☐ Daycare: \_\_\_\_\_ AM \_\_\_\_\_ PM  
INCLUDE NAME

***I understand that transportation changes must be made in writing by a note sent  
with my child, brought to school by a parent, or faxed to the school office.***

My child may be checked out of school or (in emergency medical situations or other situations involving my child's care) be left in the care of individuals listed below and only those individuals. I understand that only the individuals listed may check my child out of school.

NAME OF INDIVIDUAL	RELATIONSHIP	HOME PHONE	WORK PHONE	CELL PHONE / PAGER

**\*\*You must have a minimum of three working telephone numbers on this emergency card at all times.**

Please contact the school if any of your telephone numbers change.

If I cannot be reached, the school has my permission to secure the most readily available medical services and, if necessary, have my child transported to the nearest emergency care facility. I understand that I will be responsible for any cost related to this action.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Describe any health condition or medical problem that may restrict or limit your child's school activities: \_\_\_\_\_

Allergies: \_\_\_\_\_

Please list the name and telephone number of local physician: \_\_\_\_\_



# RANKIN COUNTY SCHOOL DISTRICT EMERGENCY CARD

School Name: \_\_\_\_\_

Teacher Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Please initial **ONE** of the following regarding the **discipline procedures** involving my child.

\_\_\_\_\_ I DO NOT OBJECT to my child being paddled/spanked.

OR

\_\_\_\_\_ I prefer that paddling/spanking NOT be used as a consequence. I will PICK UP my child IMMEDIATELY if a severe problem is encountered.

STUDENT NAME				
	DATE	TIME	REASON	SIGNATURE
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				



## RANKIN COUNTY SCHOOL DISTRICT HOME LANGUAGE SURVEY

The Office of Civil Rights (OCR) requires that LEAs identify limited English proficient (LEP) students in order to provide appropriate language instructional programs for them. Mississippi has selected the Home Language Survey (HLS) as the method for the identification. The HLS must be administered to all students at enrollment.

LEA: Rankin County School District Date: \_\_\_\_\_

School: \_\_\_\_\_

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

1. What is/was the first language your child learned to speak? \_\_\_\_\_

2. Does the student speak a language(s) other than English? (Check Yes or No, Do not include languages learned in school.)

YES ☐ NO ☐ If yes, specify the language(s): \_\_\_\_\_

3. What language does your child speak most often? \_\_\_\_\_

4. What language(s) is/are spoken in your home? \_\_\_\_\_

(If one or more of questions 1–4 indicate a language other than English, the student must be administered the W-APT).

5. When did your child first enter school in the U.S.? Year \_\_\_\_\_

Name of School

State

\_\_\_\_\_

\_\_\_\_\_

6. Is the student attending the school as a foreign exchange student? YES ☐ NO ☐

7. Has the student ever been in a bilingual educational or an English as a Second Language (ESL) program in a school in the U.S.? YES ☐ NO ☐

8. Did the student exit the program? YES ☐ NO ☐ Exit Date: \_\_\_\_\_

Parent/Guardian signature: \_\_\_\_\_

Person completing this form (if other than parent/guardian: \_\_\_\_\_

## Mississippi Migrant Education Service Center

### Identification and Recruitment Parent Survey/Encuesta para Padres de Familia

**Nombre de los padres:** \_\_\_\_\_  
(Name of the Parents)

**Domicilio** \_\_\_\_\_  
(Address)

**Números para llamar:** \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
(Numbers to call)

**Mejor hora para llamar:** \_\_\_\_\_  
(Best time to call)

**¿Cuánto tiempo tienen de vivir en este domicilio?** \_\_\_\_\_ años (years) \_\_\_\_\_ meses (months)  
(How long has your family lived at your present address?)

**¿En cuál condado vivió antes de que se cambiara a la dirección de ahora?** \_\_\_\_\_  
(What city/county did you live in before you moved to the address above?)

**Por favor ponga en la lista a todos sus hijos menores de 22 años**  
(Please list all your children younger than 22 years of age)

Nombre Name	Primer Apellido Last name	Escuela School	Grado Grade	Fecha de Nacimiento Date of Birth

**¿Alguien de su familia ha trabajado en algunos de los trabajos que están en esta lista durante los últimos tres años?** ☐ Si (yes) ☐ No (No)  
(Has anyone in your family worked at any of the jobs listed below within the last three years?)

**Encierre en un círculo los trabajos que haya hecho usted o alguien de su familia, (Please circle the jobs a family member or you have done):**



Con el ganado,  
Procesando,  
Empacando  
Feed Cattle,  
Processing



En la Pollera,  
Procesando, Empacando  
Poultry Processing, Packing



Cultivando,  
Preparando la tierra  
Cultivation, Preparation of Soil



La Pesca,  
Procesando Pescado  
Fishing, Processing Fish



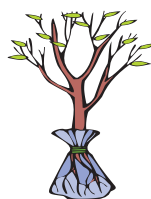
Verduras o camote  
Harvest of fruit and vegetables  
or sweet potatoes



Moliendo Algodón  
Milling, Cotton Gin work



Lechería  
Dairy



Plantando árboles o cortándolos  
Tree planting or cutting



Viveros, plantando plantas, trabajando con la tierra  
Tree Planting, or cutting. Greenhouse, Nursery, Sod





## RANKIN COUNTY SCHOOL DISTRICT PERMISSION FORM FOR THE PUBLICATION OF STUDENT PHOTOGRAPHS AND WORK

Date: \_\_\_\_\_

I understand that from time-to-time the school or the Rankin County School District (RCSD) may wish to publish student names, photographs, vocal and video recordings, projects, and/or other student work in electronic (radio and TV), print (newspapers, magazines), digital or electronic publishing via the Internet/websites, including school and RCSD websites, and other media outlets for the purpose of gaining positive publicity for the RCSD. Please let us know what you would like for us to do in regards to your child.

☐ YES, I give permission to have my child's work/project, name, vocal and video recordings, and photograph submitted to the media and posted on the Internet or on the District website for the purpose of gaining positive publicity for the school or school district.

☐ NO, I would prefer that my child's work/project, name, vocal and video recordings, and photograph not be submitted to any media nor posted on the Internet or on the District website for the purpose of gaining positive publicity for the school or school district.

If you checked "NO," please sign your initials in this blank to indicate that your child's photograph may be used in your school's yearbook: \_\_\_\_\_

Student's Name (print): \_\_\_\_\_

Student's Grade: \_\_\_\_\_

Student's School (print): \_\_\_\_\_

Parent or Guardian's Name (print): \_\_\_\_\_

Parent or Guardian's Signature: \_\_\_\_\_

**Principals: Please keep all original copies for your files and submit only copies of "No" responses to the RCSD Public Relations Department**



Rankin County  
School District

TRADITION OF EXCELLENCE

## RANKIN COUNTY SCHOOL DISTRICT RACE / ETHNICITY SURVEY

School Name: \_\_\_\_\_ Date: \_\_\_\_\_

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Is the student of Latino / Hispanic heritage? YES ☐ NO ☐

Please select the appropriate race from list. More than one may be selected.

☐ Asian

☐ Native American

☐ Black

☐ Pacific Islander

☐ Hispanic

☐ White

*Information is necessary to implement the Office of Management & Budget's (OMB) Standards for  
Maintaining, Collecting and Presenting Federal Data on Race and Ethnicity. (1997 Standards)*



## RANKIN COUNTY SCHOOL DISTRICT STUDENT HEALTH RECORD

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_ Male ☐ Female ☐  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height (Feet / Inches): \_\_\_\_\_' / \_\_\_\_\_" Weight (lbs): \_\_\_\_\_  
Parent / Guardian: \_\_\_\_\_ Address: \_\_\_\_\_  
Cell #: \_\_\_\_\_ Home #: \_\_\_\_\_ Work#: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
Medicaid #: \_\_\_\_\_ Health Ins.: \_\_\_\_\_  
Student's Healthcare Provider: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax: \_\_\_\_\_

### Student's Medical History

#### ASTHMA

Does your child have asthma? Yes ☐ No ☐ If yes, mark one: Mild ☐ Moderate ☐ Severe ☐

An *Asthma Plan* is REQUIRED to be on file at the school for all students with asthma.

#### FOOD ALLERGIES

Does your child have food allergies? Yes ☐ No ☐ If yes, please list foods allergic to and reactions below.

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#### LIFE THREATENING ALLERGIES TO INSECT BITES

Does your child have life threatening allergies to insect bites? Yes ☐ No ☐ If yes, list insects:

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All students with food and or insect allergies need an *Allergy Plan* on file at the school.

#### EPILEPSY / SEIZURES

Does your child have Epilepsy or seizures? Yes ☐ No ☐ If yes, your child needs an *Epilepsy / Seizure Plan* on file at the school.

CONTINUED ON NEXT PAGE

## DIABETES

Does your child have Diabetes? Yes ☐ No ☐ If yes, your child needs a Diabetes plan on file at the school.

Does your child have an insulin pump? Yes ☐ No ☐

## EMERGENCY MEDICATIONS

Epipen: ☐ Rescue Inhaler: ☐ Diastat: ☐ Glucagon: ☐ None of These: ☐

## DAILY MEDICATIONS

Is the student taking any daily prescription or OTC medication at home? Yes ☐ No ☐ If yes, please list below.

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Will the student need to take medication daily at school? Yes ☐ No ☐

If your child has daily and / or emergency medications at school, each will need a Medication Consent Form (signed by a physician) to be on file in the school office. You are responsible for supplying the medication.

## OTHER

Is there anything else related to a diagnosed medical condition that you feel the school should know about your child?

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## CONSENT

The undersigned parent or guardian understands, acknowledges and agrees that state or county employed Region 8 health care support service professionals / counselors will or may be providing counseling and / or health care services to all ages of RCSD students in addition to the health care / counseling services for students traditionally provided by employees, nurses and counselors of the Rankin County School District, and hereby consents to such proposed or provided services as may in the sole discretion of the school district or health care providers be necessary or desirable while my child (children) is in the care of the school district.

Yes ☐ No ☐

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_