

**KINDERGARTEN  
ENROLLMENT FORM**



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			
ASSIGNED TEACHER			

**OAKDALE ELEMENTARY  
SCHOOL**

171 OAKDALE ROAD  
BRANDON, MS 39047  
601.992.5442



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

**STUDENT DEMOGRAPHIC INFORMATION**

Student's Name      
LAST FIRST MIDDLE NICKNAME

Physical 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

Please provide a valid telephone number and email address for important updates and correspondence—as well as alerts.

Telephone  Email Address

Briefly list student's medications or special health problems

**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.**

**PREVIOUS EDUCATIONAL INFORMATION**

Type of program your child participated in when they were 4 years old:

Licensed Child Care Center   Head Start   Pre-K Public   Pre-K Private   Family/Friend Care   Home

Program / Care Giver Name

Program / Care Giver Address

City  State  Zip

**PLEASE CONTINUE TO PAGE 2**

**SPECIAL SERVICES**

Was student receiving special services at previous school?

SPED: YES NO

ELL: YES NO

Speech: YES NO

504: YES NO

**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 CHECK ONE)**

Full Name

LAST

FIRST

MAIDEN

Home Phone #  Cell Phone #  Email Address

Place of Employment  Work Phone #

**FATHER STEP-FATHER GUARDIAN (PLEASE CHECK 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.*

\* 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

**PLEASE CONTINUE TO PAGE 3**

## 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.

## ADDITIONAL INFORMATION

The following information would be helpful to the program evaluation conducted by the Mississippi Department of Education. Your response is optional. Thank you.

How often do you read to your child?    Daily    Weekly    Monthly    Seldom    Never



# RANKIN COUNTY SCHOOL DISTRICT PARENT VOLUNTEER FORM

## INFORMATION

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 / chaperon.*

Volunteer's / Chaperone's Signature

Date

Principal's Signature

Date

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



# RANKIN COUNTY SCHOOL DISTRICT STUDENT HEALTH RECORD

## STUDENT INFORMATION

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

### LIFE THREATENING ALLERGIES TO INSECT BITES

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

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.

[Empty text box for listing daily medications]

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?

[Empty text box for other medical conditions]

**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

**For Middle / High School Students Only:** I give consent for my child to participate in suicide prevention screening conducted by Region 8.

*View Screener Here*

Yes No

[Signature line for Parent's / Guardian's Signature]

Parent's / Guardian's Signature

[Date line]

Date



# 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, rout 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 it's 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   
Physician Phone #  Fax #

Prescriber Name & Title (Print)

Prescriber Signature (or signature stamp)

Date



# RANKIN COUNTY SCHOOL DISTRICT EMERGENCY CARD

## INFORMATION

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    Bus Number   am  pm

Walker  am  pm      Daycare      Daycare Name   am  pm

Frontiers  am  pm

*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.

Parent's / Guardian's Signature

Date

**PLEASE CONTINUE TO PAGE 2**



MEDICAL INFORMATION

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

DISCIPLINE PROCEDURES

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 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 School (print)  Student's Grade

Parent or Guardian's Name (print)

Parent's / Guardian's Signature

Date

**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 HOME LANGUAGE SURVEY

## 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  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
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

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

<input type="text"/>	<input type="text"/>
Parent/Guardian signature	Person completing this form (if other than parent/guardian)



## Mississippi Department of Education Employment Survey

Complete and Return to School

School Name:
Parent/Guardian Name(s):
Address:
Telephone Number(s):
Email:
1. Have you moved to a new town to find work within the last 3 years? <input type="checkbox"/> Yes <input type="checkbox"/> No (If you answered "No," <b>STOP HERE</b> . If you answered "Yes," continue.)
2. Did you or anyone in your household find work in <b>agriculture</b> or <b>fishing</b> (examples: planting or preparing fields for crops; harvesting crops; picking fruit or vegetables; processing fruit or vegetables; planting or cutting trees; greenhouse, cotton gin, poultry farm or dairy work; or farming/ harvesting/ processing chicken, catfish, beef, pork, shrimp, crab, crawfish, oysters, or other shellfish or fish)? <input type="checkbox"/> Yes <input type="checkbox"/> No (If you answered "No," <b>STOP HERE</b> . If you answered "Yes," continue.)
<b><i>If you answered "Yes" to both questions above, a state education representative may contact you to find out whether your child is eligible for additional educational services.</i></b>
What is the best time to get in touch with you? <input type="checkbox"/> During the day <input type="checkbox"/> Evening/night

<b><i>For School Use Only</i></b>	Date received from family: _____
<b>Do not email forms. Call 662-325-1815 and your MMESC Recruiter will pick up returned forms.</b>	
Or convey by regular mail, or fax to:	
MMESC - P.O. Box 1575 Mississippi State, MS 39762 (fax: 662-325-0864)	

### ***For MMESC Use Only***

School District: \_\_\_\_\_ Date received from school: \_\_\_\_\_



**Departamento de Educación de Mississippi  
Encuesta de Trabajo**

Complete y retorne a la escuela

Escuela:
Nombre del padre o guardián:
Domicilio:
Número de teléfono(s):
Correo electrónico (email):
<p>1. ¿Usted o alguien en su hogar que se ha mudado a un pueblo nuevo para encontrar trabajo en los últimos 3 años?</p> <p><input type="checkbox"/> Sí   <input type="checkbox"/> NO   (Si contestó "NO," <b><u>PARE DE CONTESTAR AQUÍ.</u></b> Si contestó "Si", continúe.)</p>
<p>2. ¿Usted o alguien en su hogar encontró trabajo en <b>agricultura</b> o la <b>pesca</b>? (Por ejemplo: preparando la tierra para plantar y cultivar fruta o verdura como el camote, cortando o pizcando otra fruta o verdura; procesando la fruta o verdura; plantando pino; trabajando en un vivero; moliendo algodón; en una granja criando pollo/huevo o ganado, ordeñando vacas; o en la pollera procesando pollo, pescado, carne de res, puerco, camarón, langosta, ostión, o cualquier otro tipo de marisco).</p> <p><input type="checkbox"/> Sí   <input type="checkbox"/> NO   (Si contestó "NO," <b><u>PARE DE CONTESTAR AQUÍ.</u></b> Si contestó "Si", continúe.)</p>
<b><i>Si usted contestó "Sí" a las dos preguntas de arriba, un representante de educación lo contactará para saber si su hijo/a es elegible para servicios educacionales adicionales.</i></b>
<p>¿Cuál es la mejor hora para comunicarse con usted?</p> <p><input type="checkbox"/> Durante el día   <input type="checkbox"/> En la tarde/Noche</p>

<b><i>For School Use Only</i></b>	Date received from family: _____
<b>Do not email forms. Call 662-325-1815 and your MMESC Recruiter will pick up returned forms.</b>	
Or convey by regular mail, or fax to:	
MMESC - P.O. Box 1575 Mississippi State, MS 39762	(fax: 662-325-0864)

***For MMESC Use Only:***

School District: \_\_\_\_\_ Date received from school: \_\_\_\_\_



# RANKIN COUNTY SCHOOL DISTRICT RACE / ETHNICITY SURVEY

## 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)**

*Updated 1/26/2024*

**Mississippi Department of Education  
Office of Child Nutrition  
Medical Statement for a Disabled Child**

**PART I** (to be completed by school district/organization/sponsor)

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

Name of School District/School/Organization/Sponsor \_\_\_\_\_

Name of Student/Individual \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_\_

School/Provider/Center Name \_\_\_\_\_

School/Provider/Center Address \_\_\_\_\_

**PART II** (to be completed by a physician)

Patients Name \_\_\_\_\_ Age \_\_\_\_\_

Diagnosis \_\_\_\_\_

Describe the individual's disability and the major life activity affected by the disability

Does the disability restrict the individual's diet?      Yes      No

If yes, list the food(s) to be omitted from the child's diet and food(s) that may be substituted

Special equipment needed

Date \_\_\_\_\_ Signature of Physician \_\_\_\_\_

**Mississippi Department of Education  
Office of Child Nutrition  
Medical Statement for a Non-Disabled Child**

**PART I** (to be completed by school district/organization/sponsor)

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

Name of School District/School/Organization/Sponsor \_\_\_\_\_

Name of Student/Individual \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_\_

School/Provider/Center Name \_\_\_\_\_

School/Provider/Center Address \_\_\_\_\_

**PART II** (to be completed by a medical authority)

Patients Name \_\_\_\_\_ Age \_\_\_\_\_

Diagnosis \_\_\_\_\_

Describe the medical or other special dietary needs that restricts the child's diet

List the food(s) that should be omitted from the child's diet and food(s) that may be substituted based on the answer given above

Special equipment needed

Date \_\_\_\_\_

Signature of Medical Authority \_\_\_\_\_



**Mississippi Department of Education  
Office of Child Nutrition  
Religious Statement for a Child/Children**

**PART I** (to be completed by school district/organization/sponsor)

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

Name of School District/School/Organization/Sponsor \_\_\_\_\_

Name of Student/Individual \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_\_

School/Provider/Center Name \_\_\_\_\_

School/Provider/Center Address \_\_\_\_\_

**PART II** (to be completed by a minister or head authority in religious denomination)

Name of Student/Individual \_\_\_\_\_ Age \_\_\_\_\_

Quote or list the religious belief or church law or canon that restricts the student's/individual's diet

List the food(s) that should be omitted from the child's diet and food(s) that may be substituted based on the answer given above

Date \_\_\_\_\_

Signature of religious authority \_\_\_\_\_