



**PAW CLASS OF 2037, PAW**

**ARE YOU READY TO BE A BULLDOG??**

PLEASE JOIN US ON  
APRIL 5TH FOR

**KINDERGARTEN SIGNING DAY!!**



**Kindergarten Registration Packet**



# White Hall School District

1020 West Holland Ave., White Hall, Arkansas 71602

phone: 870.247.2002 / fax: 870.247.3707

[www.whitehallsd.org](http://www.whitehallsd.org)

Gary Williams, Superintendent

## Kindergarten Registration Checklist 2024-2025

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

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

**The following information is needed to complete registration for your child.**

\_\_\_\_\_ The child entering kindergarten must be 5 years old on or before Aug. 1, 2024.

Documentation of student's date of birth (DOB) including one of the following:

- Copy of birth certificate
- A statement by the local registrar or a county recorder certifying the child's DOB
- An attested baptismal certificate
- A passport showing student's DOB
- An affidavit of the date and place of birth by the child's parent or guardian
- United States military identification showing student's DOB

\_\_\_\_\_ Identification number (SSN or you may request a school assigned number.)

\_\_\_\_\_ Proof of residency:

- Utility bill (gas, water, or electric in the parent/guardian's name)
- Rent receipt with current date and landlord's name
- Lease agreement with current date and landlord's name
- Dated contract for the purchase of home
- Dated contract for closing on construction of new home

\_\_\_\_\_ Enrollment Form \ Student Information

\_\_\_\_\_ Health Services Form

\_\_\_\_\_ Completed Immunization Form and record that includes: 4 doses of Diphtheria, Tetanus, Pertussis with 1 dose on or after the 4th birthday, 3 doses of Polio with 1 dose on or after the 4<sup>th</sup> birthday, 2 doses MMR (measles, mumps, rubella) with dose 2 on or after the 1st birthday, 3 doses of Hepatitis B, 1 dose of Hepatitis A on or after the 1st birthday, and 2 doses of Varicella (chickenpox) with dose 1 on or after the 1st birthday and dose 2 at least 28 days after dose 1.

\_\_\_\_\_ Physical Assessment Form - Current proof of a physical examination within the past 12 months.

\_\_\_\_\_ ADE Home Language Survey

\_\_\_\_\_ Custody paperwork (if applicable)

# White Hall School District

## Student Enrollment Data

### GENERAL STUDENT INFORMATION

|             |              |            |
|-------------|--------------|------------|
| FIRST NAME: | MIDDLE NAME: | LAST NAME: |
|-------------|--------------|------------|

Birthdate: \_\_\_\_\_

Gender: Female Male

Nickname: \_\_\_\_\_

Grade: \_\_\_\_\_

SSN (Optional): \_\_\_\_\_

Hispanic/Latino Ethnicity: Yes No

**RACE** Please answer the following in accordance with standards issued by the US Department of Education.

**PRIMARY RACE** (Please select only **ONE**).

- ☐ **American Indian or Alaska Native** (A person having origins in any of the original peoples of North and South America, including Central America, and who maintains tribal affiliation or community attachment)
- ☐ **Asian** (A person having origins in any of the original peoples of 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, Middle East or North Africa)

**ADDITIONAL RACES (check all that apply):**

\_\_\_\_ American Indian/Alaska Native      \_\_\_\_ Asian      \_\_\_\_ Black  
\_\_\_\_ Native Hawaiian/Other Pacific Islander      \_\_\_\_ White

Language Spoken At Home: \_\_\_\_\_ Parent Email Address: \_\_\_\_\_

**Student Physical/911 Address**

**Student Mailing Address**

|                              |  |
|------------------------------|--|
| Address: _____               | <input type="checkbox"/> Mailing Address is same as Physical/911 Address |
| City: _____                  | Address: _____   |
| State: _____ Zip Code: _____ | City: _____  |
|                              | State: _____ Zip Code: _____   |

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

### PARENT/GUARDIAN CONTACT INFORMATION

**Parent/Guardian 1**

**Parent/Guardian 2**

|  |  |
|--|--|
| Name: _____  | Name: _____  |
| Relationship to Student: _____   | Relationship to Student: _____   |
| Language of Correspondence: _____                                      | Language of Correspondence: _____                                      |
| Mailing Address: _____   | Mailing Address: _____   |
| City: _____  | City: _____  |
| State: _____ Zip Code: _____   | State: _____ Zip Code: _____   |
| Email: _____   | Email: _____   |
| Home Phone: _____ Cell Phone: _____                                    | Home Phone: _____ Cell Phone: _____                                    |
| Work Phone: _____ *Alert Phone: _____                                  | Work Phone: _____ *Alert Phone: _____                                  |
| *Alert Phone is used by the district's automated phone message system. | *Alert Phone is used by the district's automated phone message system. |
| Employer: _____  | Employer: _____  |
| <input type="checkbox"/> Student Primarily Resides with this Guardian. | <input type="checkbox"/> Student Primarily Resides with this Guardian. |

**OFFICE USE ONLY**

|                   |                |            |                 |                   |
|-------------------|----------------|------------|-----------------|-------------------|
| Entry Date: _____ | Meal ST: _____ | ESL: _____ | IMMG: _____     | Residency: _____  |
| Entry Code: _____ | M/V Act: _____ | SP: _____  | GT: _____       | Choice LEA: _____ |
| Curriculum: _____ | 504: _____     | MIG: _____ | Homeroom: _____ | P/T ADM %: _____  |

**ADDITIONAL STUDENT INFORMATION**

City of Birth: \_\_\_\_\_ State of Birth: \_\_\_\_\_ Birth Country: \_\_\_\_\_

**TRAVEL INFORMATION**

| Travel To School (Please check one)  | Travel From School (Please check one)  |
|--|--|
| <input type="checkbox"/> Bus (Bus Number _____)                                    | <input type="checkbox"/> Bus (Bus Number _____)                                    |
| <input type="checkbox"/> Drives Self   | <input type="checkbox"/> Drives Self   |
| <input type="checkbox"/> Parent/Guardian (includes walkers, child care vans, etc.) | <input type="checkbox"/> Parent/Guardian (includes walkers, child care vans, etc.) |
| <input type="checkbox"/> District Paid Transportation                              | <input type="checkbox"/> District Paid Transportation                              |
| Distance From Home to School (Miles) One Way: _____                                |  |

**Pre-School Participation:**

A - ARKANSAS BETTER CHANCE

H - HEADSTART

O - OTHER

E - EVEN START

NA - NOT APPLICABLE

P - PRIVATE PRE-SCHOOL

EC - EARLY CHILDHOOD

C - 21st CENTURY COMMUNITY LEARNING CENTER

PS - PUBLIC SCHOOL PRE-SCHOOL

Birth Certificate #: \_\_\_\_\_

Resident County: \_\_\_\_\_

Is this child a dependent of an active or reserve member of a branch of the United States Armed Services? Yes No

If this child resides in a household with an active or reserve member of a branch of the United States Armed Services, please select the branch below.

|   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Active Duty – US Army        | <input type="checkbox"/> Active Duty – US Air Force | <input type="checkbox"/> Active Duty – US Navy         | <input type="checkbox"/> Active Duty – US Marines           |
| <input type="checkbox"/> Active Duty – US Coast Guard | <input type="checkbox"/> Reserves – US Army         | <input type="checkbox"/> Reserves – US Air Force       | <input type="checkbox"/> Reserves – US Navy                 |
| <input type="checkbox"/> Reserves – US Marines        | <input type="checkbox"/> National Guard – US Army   | <input type="checkbox"/> National Guard – US Air Force | <input type="checkbox"/> Parents serve in multiple branches |

Is this student a twin (or a triplet, quadruplet, etc.)? Yes No

**ADDITIONAL CONTACT INFORMATION****Additional Guardian Contact**

|                                   |                 |  |                     |
|-----------------------------------|-----------------|--|---------------------|
| Name: _____                       |                 | Email: _____   |                     |
| Relationship to Student: _____    |                 | Home Phone: _____  | Cell Phone: _____   |
| Language of Correspondence: _____ |                 | Work Phone: _____  | *Alert Phone: _____ |
| Mailing Address: _____            |                 | *Alert Phone is used by the district's automated phone message system. |                     |
| City: _____                       |                 | Employer: _____  |                     |
| State: _____                      | Zip Code: _____ | <input type="checkbox"/> Student Primarily Resides with this Guardian. |                     |

**Emergency Information**

| Emergency Contact Information (Contacts Other Than Guardians to be Called in Case of an Emergency) |      |                       |         |                                   |
|--|------|-----------------------|---------|-----------------------------------|
| Contact Order  | Name | Relationship to Child | Phone # | Phone Type (ex: Home, Cell, Work) |
| 1  |      |                       |         |                                   |
| 2  |      |                       |         |                                   |
| 3  |      |                       |         |                                   |
| 4  |      |                       |         |                                   |
| 5  |      |                       |         |                                   |

Physician: \_\_\_\_\_ Physician: \_\_\_\_\_

Physician Phone: \_\_\_\_\_ Physician Phone: \_\_\_\_\_

Please list any medical concerns and/or medications for this child: \_\_\_\_\_

\_\_\_\_\_

Last School Attended: \_\_\_\_\_ Phone #: \_\_\_\_\_

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

Has this child been expelled from school in any other school district or is the child a party to an expulsion proceeding? Yes No

Has this child been retained? Yes No

Has this child met the requirements of the Arkansas State Health laws necessary to enter school? Yes No

Please list the names of anyone who IS NOT ALLOWED to check out/pick up this child from school: \_\_\_\_\_

\_\_\_\_\_

Parent/Guardian Signature

Date



# Arkansas Division of Elementary and Secondary Education (DESE) Home Language Usage Survey

The Home Language Usage Survey is completed by *all* students initially enrolling in Arkansas schools.

|  |                            |   |                       |
|--|----------------------------|---|-----------------------|
| <b>Student Name:</b>   |                            | <b>Grade:</b>   | <b>Date:</b>          |
| <b>School:</b>   | <b>Student State ID #:</b> | <b>Gender:</b>  | <b>Date of Birth:</b> |
| Parent/Guardian Name:  |                            | Parent/Guardian Signature:  |                       |
| <b>Right to Translation and Interpretation Services</b><br>Indicate your language preference so we can provide an interpreter or translated documents, free of charge, when you need them.   |                            | All parents have the right to information about their child's education in a language they understand.<br><br>1. a) In what language do you prefer to receive written communication from the school?<br>_____<br>b) In what language would you prefer to communicate with school staff when speaking?<br>_____                                    |                       |
| <b>Eligibility for Language Development Support</b><br>Information about the student's language usage helps us identify students who may qualify for extended support to develop the language skills necessary for success in school. Testing may be necessary to determine if language supports are needed. |                            | 2. What language(s) is (are) spoken in your home?<br>_____<br>3. What language did your child learn first?<br>_____<br>4. What language does your child use most often at home?<br>_____<br>5. What language does your family speak most often at home?<br>_____<br>6. What language do adults speak most often with each other at home?<br>_____ |                       |
| <b>Prior Education</b><br>Your responses about your child's birth country and previous education give us information about the knowledge and skills your child is bringing to school.<br><b><i>This form is not used to identify students' legal immigration status.</i></b>                                 |                            | 7. Where was your child born? _____<br><br>8. When did your child first attend a school in the United States (the 50 states, DC)? (Kindergarten – 12 <sup>th</sup> grade)<br>_____<br>Month                  Day                  Year<br><br>9. Has your child attended a school in Puerto Rico? _____   |                       |

Thank you for providing the information needed on the Home Language Usage Survey. Contact your child's school if you have further questions about this form or about services available at your child's school.



**Note to district:** This form is available in multiple languages on <http://www.arkansased.gov/divisions/learning-services/english-learners>. A response that includes a language other than English to questions #1-6 indicates English language proficiency screening is needed.

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*Gary Williams, Superintendent*

## Welcome to White Hall School District

For us to provide your child with the best educational program, we need as much information as possible. Please check the programs with which your child was involved at the previous school.

Speech

Special Reading Assistance

Resource

Special Education

Gifted and Talented

Things you should know about my child ...

Child's Name:

Parent's Signature:

Date:



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FERPA Consent Form

Parents:

As a student of White Hall School District you child may receive services through our Health Services Department. White Hall School District currently has six (6) nurses employed full time for our district. It is the goal of Health Services to provide quality care to all our students, help parents by being a resource to keep students healthy, in the classroom and learning!!

Part of our services includes routine screenings of vision and hearing as required by Arkansas law. The grades screened are Kindergarten, 1st, 2nd, 4th, 6th, 8th and any student transferring into the district. These screenings are very important to the overall health and wellness of our students. Through the screening programs we can help identify and refer students who may need further evaluation to help them see or hear better, which will also help them learn better.

Arkansas Medicaid Program allows school districts to bill a student's Medicaid or AR Kids A and B for the services of vision and hearing screenings. Parents must sign a consent allowing our district to have permission to bill. Revenue remains in Health Services and is used to provide continued care to your student and improve health and wellness throughout the district.

- Parents must consent annually for billing.
- Parents have the right to withdraw consent at any time during the year.
- If consent is denied or withdrawn, services will still be provided for the student.

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In compliance with the Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. 123g; 34 CFR Part 99)

I, \_\_\_\_\_, give permission for my child, \_\_\_\_\_'s  
(Parent/Guardian Name) (First and Last Name)

personally, identifiable information/student education records to be disclosed to a Third-Party Billing Agent for the purpose of billing Medicaid and/or private insurance.

---

Printed Name of Parent/Guardian

---

Parent/Guardian Signature

---

Date:



**White Hall School District**  
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**Health Services Form**

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

**General Information**

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Homeroom Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_  
Guardian 1 Name & Phone Number(s): \_\_\_\_\_  
Guardian 2 Name & Phone Number(s): \_\_\_\_\_  
List names & grades of siblings in school: \_\_\_\_\_

**Health Information**

Does the student have any health problems that might interfere with normal school activities including participation in physical education class?

No \_\_\_\_\_ Yes \_\_\_\_\_

Describe: \_\_\_\_\_

Does the student have any other health problems that the school nurse and teacher should know about such as diabetes, asthma, allergies, hearing, vision, epilepsy, heart condition, etc.?

No \_\_\_\_\_ Yes \_\_\_\_\_

Describe: \_\_\_\_\_

If a medical condition exists, does the **condition require** the development of an Individual Health Care Plan for your child?

No \_\_\_\_\_ Yes \_\_\_\_\_

Topical medications used in the nurse's office include: Antibiotic Ointment (Neosporin or generic equivalent); Hydrocortisone Cream, First Aid Burn Cream, Calamine, and Caladryl; Vaseline; and Bactine and Peroxide for cleaning injuries.

\_\_\_\_\_ No, I do NOT want any topical medications used on my child.

\_\_\_\_\_ Yes, I give the nurse permission to use any of the listed topical medications on my child as needed.

List allergies: \_\_\_\_\_

List prescription medications to be given on a daily basis at school: \_\_\_\_\_

**Emergency Information**

IN CASE OF EXTREME EMERGENCY, I AUTHORIZE THE SCHOOL TO ARRANGE FOR AMBULANCE OR EMERGENCY SERVICE AT MY EXPENSE, TO THE NEAREST HOSPITAL OR DOCTOR OF MY CHOICE, OR THE NEAREST HOSPITAL TO THE SCHOOL. I UNDERSTAND THIS INFORMATION WILL BE SHARED IN CONFIDENCE WITH INDIVIDUALS RESPONSIBLE FOR STUDENT CARE WHILE THE STUDENT IS AT SCHOOL OR AT SCHOOL FUNCTIONS.

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

FAMILY PHYSICIAN: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

HOSPITAL CHOICE: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

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## Immunization Verification

I understand that \_\_\_\_\_ is being enrolled in the White Hall School District on a conditional basis pending the receipt of records from the school that he/she last attended. The law of the State of Arkansas allows a provisional admittance of 30 days from the date of enrollment in order for the student to produce documentation of the required immunization. If records from that school do not include satisfactory evidence of immunizations required by the State of Arkansas, the student may be suspended from school until an immunization program is started.

Below is a listing of the immunizations required by the State of Arkansas in order to enroll in a public school. My signature below indicates that I agree to begin an immunization program if immunizations are incomplete.

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

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

### Pre-Kindergarten Requirements:

- 5 DTaP with 5<sup>th</sup> dose after 4<sup>th</sup> birthday OR 4 doses with last dose after 4<sup>th</sup> birthday
- 4 Polio with last dose after 4<sup>th</sup> birthday and a minimum interval of 6 months between 3<sup>rd</sup> and 4<sup>th</sup> dose
- 1 MMR
- 3 Hepatitis B given at correct intervals
- 1 Varicella – chicken pox (dose must be after 1<sup>st</sup> birthday) (2<sup>nd</sup> dose required before student enters Kindergarten)
- HIB 3-4 doses with last dose on/after 1<sup>st</sup> birthday OR 1 dose on/after 15 months of age if no prior (not required on/after 5<sup>th</sup> birthday)
- 3-4 Pneumococcal with last dose on/after 1<sup>st</sup> birthday OR 1 dose on/after 24 months of age if no prior doses OR 2 doses on/after 1<sup>st</sup> birthday (not required on/after 5<sup>th</sup> birthday)
- 2 Hepatitis A with one dose on or after 1<sup>st</sup> birthday and at least 6 months from first dose

### Kindergarten Requirements:

- 4 DTaP (with at least one dose on/after 4<sup>th</sup> birthday)
- 3 Polio (with at least one dose after 4<sup>th</sup> birthday and a minimum interval of 6 months between 3<sup>rd</sup> and 4<sup>th</sup> dose )
- 2 MMR (First dose on/after 1<sup>st</sup> birthday and 2<sup>nd</sup> dose at least 28 days after 1<sup>st</sup> dose)
- 3 Hepatitis B given at correct intervals
- 2 Varicella – chicken pox (with dose 1 on or after 1<sup>st</sup> birthday and dose 2 at least 28 days after dose 1<sup>st</sup> dose **or** A medical professional history of disease may be accepted in lieu of receiving vaccine )
- 1 Hepatitis A (1 dose on or after 1<sup>st</sup> birthday)

### 1<sup>st</sup> Through 12<sup>th</sup> Grade Requirements:

- 4 DTaP (with at least one dose after 4<sup>th</sup> birthday)
- 1 Tdap at age 11 years or older by September 1<sup>st</sup> of each year
- 3 Polio (with at least one dose after 4<sup>th</sup> birthday with a minimum interval of 6 months between the 3<sup>rd</sup> and 4<sup>th</sup> dose)
- 2 MMR (First dose on/after 1<sup>st</sup> birthday and 2<sup>nd</sup> dose at least 28 days after 1<sup>st</sup> dose)
- 3 Hepatitis B given at correct intervals
- **All 7<sup>th</sup> grade:** required to have one MCV4 (Meningococcal) vaccine - 2<sup>nd</sup> dose at age 16 years **or** if first dose is administered at age 16 years or older, no second dose required **or** 1 dose if not vaccinated prior to age 16 years
- 2 Varicella – chicken pox – (dose must be on/after 1<sup>st</sup> birthday and 2<sup>nd</sup> dose at least 28 days after 1<sup>st</sup> dose) **or** A medical professional history of disease may be accepted in lieu of receiving vaccine.
- **All 1<sup>st</sup> grade:** required to have one Hep A given on or after the 1<sup>st</sup> birthday

## KINDERGARTEN PHYSICAL ASSESSMENT

To be Completed by Physician, Nurse or School Health Professional

| REQUIRED  |    |      |          |
|---|----|------|----------|
|   | NL | ABNL | Comments |
| B/P: _____  |    |      |          |
| WT: _____ HT: _____   |    |      |          |
| SKIN: Color, Rash, Swelling, Hair, Nails  |    |      |          |
| EYES: Conjunctiva, Cornea, Pupils, Extraocular Movement                                       |    |      |          |
| EARS: Pinnae, Canals, Tympanic Membrane, Appearance, Mobility                                 |    |      |          |
| NOSE: Nares, Turbinates   |    |      |          |
| MOUTH: Tongue, Teeth, Oral Mucosa, Tonsils, Pharynx   |    |      |          |
| NECK: Thyroid, Range of Motion  |    |      |          |
| NODES: Cervical, Axillary, Inguinal, Other  |    |      |          |
| HEART: Rate, Rhythm, S1, S2, Murmur, Femoral Pulses   |    |      |          |
| LUNGS: Rate, Auscultation, Percussion   |    |      |          |
| ABDOMEN: Contour, Palpation of liver, Spleen, Kidneys, Mass: Tenderness                       |    |      |          |
| GENITO-URINARY: Female external, Male Penis, Meatus, Testes, Hernia                           |    |      |          |
| MUSCULOSKELETAL: Range of Motion, Tenderness, Edema, Clubbing Spine (Curvature).              |    |      |          |
| NEUROLOGICAL: Gait, Cerebular Function, Motor System (Strength, Tone): Cranial Nerves (Gross) |    |      |          |
| DEVELOPMENTAL   |    |      |          |
| Gross Motor   |    |      |          |
| Fine Motor  |    |      |          |
| Social  |    |      |          |
| Speech/Language   |    |      |          |
|   |    |      |          |

| SUPPLEMENTAL (optional)                |    |          |  |
|--|----|----------|--|
| Date                                   | NL | Comments |  |
| Hemoglobin                             |    |          |  |
| Hematocrit                             |    |          |  |
| Urinalysis                             |    |          |  |
| Other                                  |    |          |  |
|  |    |          |  |
| Medications _____                      |    |          |  |
| _____                                  |    |          |  |
| _____                                  |    |          |  |
| Diet Restrictions _____                |    |          |  |
| _____                                  |    |          |  |
| _____                                  |    |          |  |
| Special Equipment _____                |    |          |  |
| _____                                  |    |          |  |
| _____                                  |    |          |  |
| Allergies _____                        |    |          |  |
| _____                                  |    |          |  |
| _____                                  |    |          |  |
| General comments/Recommendations _____ |    |          |  |
| _____                                  |    |          |  |
| _____                                  |    |          |  |
| _____                                  |    |          |  |
| _____                                  |    |          |  |
| _____                                  |    |          |  |

I have performed a physical assessment on this child on the date indicated, and have arranged for any follow-up that was or is needed.

Signature \_\_\_\_\_ Phone \_\_\_\_\_ Date Signed \_\_\_\_\_ Date of Exam \_\_\_\_\_  
Physician, Nurse or School Health Professional