



## KINDERGARTEN REGISTRATION

For New Students ONLY-Clinch County Pre-K students do not need to register.

**Tuesday-Friday, April 10- April 14**

**From 12:00 pm to 2:00 pm**

Children currently attending Clinch County Pre-K will be screened during the regular school day. Parents of these students do not have to attend registration.

### Documents Required for Registration

- 1) Official birth certificate
- 2) Immunization Record - Georgia Certificate of Immunization (GA Form 3231). This form is available from your child's physician.
- 3) Certificate of Vision, Hearing, Dental and Nutrition Screening (Georgia Form 3300). This form is available from your child's physician.
- 4) Social Security Card
- 5) Proof of residence (utility bill, rental agreement, cable bill, mortgage agreement, or land line phone bill only--statements must be current--within the last 30 days.
- 6) Guardian papers (if applicable)
- 7) Kindergarten Assessment-Completed at time of registration by teacher.

\*Please visit our school website at [www.clinchcounty.com](http://www.clinchcounty.com) to access the 2023-2024 kindergarten registration packet on the CCES page. If you do not have the capability to download and print the registration packet, one can be picked up at CCEMS.

**\*Registration is not complete until all documents have been received\***

If you have any questions, please contact Kayla Crumbley at [kcrumbley@clinchcounty.com](mailto:kcrumbley@clinchcounty.com) or call 912-487-5385.

**Note: Kindergarten students must be 5 years old on or before September 1, 2024.**

# Clinch County Elementary School Kindergarten Registration Form 2023-2024

**Name:** \_\_\_\_\_  
Last                      First                      Middle                      Preferred Name

**Social Security #:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Birthplace (city/state):** \_\_\_\_\_ **Country of Birth:** \_\_\_\_\_

**Gender:** M F **Home Phone #** (     ) \_\_\_\_\_ **County of Residence:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_  
Street    City    Zip

**Street Address (required):** \_\_\_\_\_  
Street    City    Zip

Is this address  home/mobile home  apartment  motel/hotel  family/friends home  other

**Parent/Guardian #1:** \_\_\_\_\_ **Parent/Guardian #2:** \_\_\_\_\_

Relationship to student \_\_\_\_\_ Relationship to student \_\_\_\_\_

Work Phone: (     ) \_\_\_\_\_ Work Phone: (     ) \_\_\_\_\_

Cell Phone: (     ) \_\_\_\_\_ Cell Phone: (     ) \_\_\_\_\_

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

\*\*\*\* Please note that the e-mail address and cell phone information obtained here will be used for our Alert Now call system.\*\*\*\*

**Emergency Contact #1** \_\_\_\_\_ Phone # (     ) \_\_\_\_\_

(Other than guardian)

Relationship to student \_\_\_\_\_

**Emergency Contact #2** \_\_\_\_\_ Phone # (     ) \_\_\_\_\_

(Other than guardian)

Relationship to student \_\_\_\_\_

**Emergency Contact #2** \_\_\_\_\_ Phone # (     ) \_\_\_\_\_

(Other than guardian)

Relationship to student \_\_\_\_\_

**Ethnicity:** Is student Hispanic?  Yes  No

**Race** (check ALL that apply):  American Indian/Alaska Native  Asian  Black/African American  
 Native Hawaiian/Other Pacific Islander  White

**Health:** Does this child have any health problems?  Yes  No

If yes, please explain: \_\_\_\_\_

**Language Survey:** What language(s) did the student first learn to speak? \_\_\_\_\_

What language(s) does the student speak at home? \_\_\_\_\_

What language(s) does the student speak most often? \_\_\_\_\_

**List siblings in the Clinch County School System:** \_\_\_\_\_

**Does this student's parent/legal guardian serve in the active duty armed forces?** \_\_\_\_\_

**Preschool Experience:**

Did student attend:  Georgia Pre-K  Head Start

Out-of-state Public Pre-K  Private (i.e. church school)

Is this child a repeater?  Yes  No

<i>Office Use Only</i>	
Birth Certificate	_____
Social Security Card	_____
Immunization Cert.	_____
Ear, Eye & Dental	_____
Proof of Residency	_____

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**



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

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

Parent Occupational Survey

Please complete this form to determine if your child(ren) qualify to receive supplemental services under Title I, Part C

Table with 3 columns: Name of Student(s), Name of School, Grade. Includes four rows of blank lines for data entry.

- 1. Has anyone in your household moved in order to work in another city, county, or state, in the last three (3) years?
2. Has anyone in your household been involved in one of the following occupations, either full or part-time or temporarily during the last three (3) years?

If you answer "yes", check all that applies:

- 1) Planting/Picking vegetables (tomatoes, squash, onions, etc.) or fruits (grapes, strawberries, blueberries, etc.)
2) Planting, growing, cutting, processing trees (pulpwood), or raking pine straw
3) Processing/Packing agricultural products
4) Dairy/Poultry/Livestock
5) Packing/Processing meats (beef, poultry, or seafood)
6) Commercial fishing or fish farms
7) Other (Please specify occupation):

Names of Parent(s) or Legal Guardian(s) \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Thank You! Please return this form to the school

Please maintain original copy in your files.

MEP funded school/district: Please give this form to the migrant liaison or migrant contact for your school/district.

Non-MEP funded (consortium) school/districts: When at least one "yes" and one or more of the boxes from 1 to 7 is/are checked, districts should fax occupational surveys to the Regional Migrant Education Program Office serving your district.

GaDOE Region 1 MEP, 201 West Lee Street, Brooklet, GA 30415
Toll Free (800) 621-5217 Fax (912) 842-5440

GaDOE Region 2 MEP, 221 N. Robinson Street, Lenox, GA 31637
Toll Free (866) 505-3182 Fax (229) 546-3251

Family Contacted/Attempt Date: \_\_\_\_\_

Sent to Regional Office on: \_\_\_\_\_

1854 Twin Towers East • 205 Jesse Hill Jr. Drive • Atlanta, GA 30334 • www.gadoe.org

Richard Woods, Georgia's School Superintendent

An Equal Opportunity Employer





Georgia Department of Education

Educating Georgia's Future

Distrito Escolar: \_\_\_\_\_

Fecha: \_\_\_\_\_

### Encuesta Ocupacional para Padres

Favor de completar este formulario para ayudarnos a determinar si su(s) hijo(s) califica(n) para recibir servicios suplementarios de parte del Programa de Título I, Parte C

Nombre del/los Estudiante(s)	Nombre de la Escuela	Grado
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

1. ¿Alguien en su casa se ha mudado para trabajar en otra ciudad, condado, o estado, en los últimos tres (3) años?  Sí  No
2. ¿Alguien en su casa trabaja o ha trabajado en una de las siguientes ocupaciones de forma permanente o temporaria en los últimos tres años?  Sí  No

Si la respuesta es "sí", marque todo trabajo que aplique:

- 1. Sembrando/Cosechando vegetales (tomates, calabazas, cebollas, etc.) o frutas (uvas, fresas, arándanos, etc.)
- 2. Sembrando, cortando, procesando árboles, o juntando paja de pino (*pine straw*)
- 3. Procesando/Empacando productos agrícolas
- 4. Trabajo en lechería, polleras o ganadería
- 5. Empacando/Procesando carnes (res, pollo, o mariscos)
- 6. Trabajos relacionados con la pesca (pesca comercial, o criadero de pescados)
- 7. Otra actividad. Por favor especifique en cuál: \_\_\_\_\_

Nombre de los padres o guardianes legales: \_\_\_\_\_

Dirección donde vive: \_\_\_\_\_

Ciudad: \_\_\_\_\_ Estado: \_\_\_\_\_ Código Postal: \_\_\_\_\_ Teléfono: \_\_\_\_\_

¡Muchas Gracias! Por favor regrese éste formulario a la escuela

Please maintain original copy in your files.

MEP funded school/district: Please give this form to the migrant liaison or migrant contact for your school/district.

Non-MEP funded (consortium) school/districts: When at least one "yes" and one or more of the boxes from 1 to 7 is/are checked, districts should fax occupational surveys to the Regional Migrant Education Program Office serving your district. For additional questions regarding this form, please call the MEP office serving your district:

GaDOE Region 1 MEP, 201 West Lee Street, Brooklet, GA 30415  
Toll Free (800) 621-5217 Fax (912) 842-5440

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Clinch County School System  
**Student Residency Questionnaire**

This form is intended to address the McKinney-Vento Act 42 U. S. C. 11435, and must be completed for each student. The information you provide is **confidential**. Your child will not be discriminated against based upon the information provided.

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

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Current Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Please identify the student's current living arrangements. Please check one box:**

- With another family or other person because of loss of housing or as a result of an economic hardship (i.e. foreclosure, eviction)
- Emergency or transitional shelter
- Hotel or motel
- With an adult who is not a parent guardian, or alone without an adult
- Campground, car, park, public places, abandoned building, street, or any other inadequate living space
- None of the above

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Parent/Legal Guardian Name (please print)

\_\_\_\_\_  
Date

**Note:** The answer you give above will help determine what services you or your child may be eligible to receive under the McKinney-Vento Act. Students who are protected under the Act are entitled to immediate enrollment in school, even if they don't have the documents normally needed, such as proof residency, school records, immunization records, or birth certificate.

The Homeless Liaison is required to assist the student in obtaining any necessary documents, including immunization or school records after the student has been enrolled. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation.

See the reverse side of this form for a one-page attachment titled, **"Information for Parents: McKinney-Vento Homeless Assistance Act"**.

**Information for Parents:  
McKinney-Vento Homeless Assistance Act**

**If your family lacks a fixed, regular and adequate nighttime residence and is forced to live in any of the following situations:**

- Sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason (example: evicted from home, etc.).
- In a motel, hotel, campground, or similar setting due to lack of alternative adequate accommodations.
- In an emergency or transitional shelter.
- Have a primary nighttime residence that is not designed for or ordinarily used as a regular sleeping accommodation for humans.
- In a car, park, public space, abandoned building, substandard housing, bus or train station, or a similar setting.

**Then your children have the right to:**

- Enroll in school without proof of residency, immunization, school records, or other documents.
- Choose between the local school where you are living or the school last attended before becoming homeless, when feasible.
- Receive transportation to school.
- Attend school and participate in school programs with children who are not homeless children cannot be separated from the regular school program because they are homeless.
- Receive all the school services available to other students.

Clinch County Public School System Homeless Liaison:

Renee Harris 912-487-5402

State Coordinator for Homeless Education:

Eric McGhee 404-651-7555

Georgia Department of Education  
ESOL & Title III Unit



Georgia Department of Education

## Required Home Language Survey

Dear Parent or Guardian:

In order to provide your child with the best possible education, we need to determine how well he or she speaks and understands English. This survey assists school personnel in deciding whether your child may be a candidate for additional English language support. Final qualification for language support is based on the results of an English language assessment.

Thank You

**Student Name (required information):**

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**Language Background (required information):**

1. Which language does your child best understand and speak?  

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2. Which language does your child most frequently speak at home?  

---
3. Which language do adults in your home most frequently use when speaking with your child?  

---

**Language for School Communication (not required):**

4. In which language would you prefer to receive all school information?  

---

**Signature of Parent/Guardian/Other**

**Date**

Georgia Department of Education  
ESOL Unit



**Encuesta obligatoria en el idioma nativo**

Estimado padre o tutor:

Para proporcionarle a su hijo la mejor educación posible, debemos determinar qué tan bien habla y entiende el inglés. Esta encuesta ayuda al personal de la escuela a determinar si su hijo puede ser un candidato para recibir apoyo adicional en inglés. La calificación final para el apoyo idiomático está basada en los resultados de una prueba en inglés.

Gracias.

**Nombre del estudiante (información obligatoria):**

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**Antecedentes Idiomáticos (preguntas obligatorias):**

1. ¿Qué idioma su hijo entiende y habla mejor?

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2. ¿Qué idioma su hijo habla con mayor frecuencia en el hogar?

---

3. ¿Qué idioma usan con mayor frecuencia los adultos del hogar cuando hablan con el niño?

---

**Idioma para la comunicación con la escuela (pregunta recomendada):**

4. ¿En qué idioma prefiere recibir toda la información escolar?

Firma del padre/tutor/otro

Fecha



**CLINCH COUNTY SCHOOLS CLINIC CONSENT FORM**

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

**Grade:** \_\_\_\_\_ **Home Room:** \_\_\_\_\_

**Family Doctor/Phone Number:** \_\_\_\_\_

**Contact Names, relation to child, phone numbers in the order you wish to be contacted in event of illness or injury:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**Medications student currently taking:** \_\_\_\_\_

**Allergies (include medications, foods, and insect bites):**

\_\_\_\_\_

**Medical History: (Please circle any that student has had in the past or currently has):**

- |                                   |                     |                 |
|-----------------------------------|---------------------|-----------------|
| Asthma (childhood and/or current) | Hearing Problems    | Vision Problems |
| Cerebral Palsy                    | Heart Problems      | Wears glasses   |
| Cystic Fibrosis                   | Hyperactivity       | Hearing Aids    |
| Diabetes                          | Seizures            | Other: _____    |
| Frequent Ear Infections           | Sickle Cell Disease | _____           |

\*In case of a serious illness/injury, the school nurse will render first aid. The parents/guardians will be contacted. If parent/guardian can not be reached and the situation is emergent, 911 will be called and the child will be transported to the emergency room. Any fees for that transportation and medical services will be the responsibility of the parent/guardian.

\*I give permission for my child to receive medical care by the school nurse in the school clinic for minor illnesses as in accordance with the Georgia School Health Resource Manual. This includes over-the-counter medications for minor pain and discomfort, menstrual cramps, stomach aches and/or indigestion, sore throat, headaches, and first aid care for minor abrasions, skin irritations, and injuries. I do hereby grant the school nurse permission to perform these and other School Health Services (as described on back of page) without further notification by signing. I do hereby release the school system and the school nurse from any adverse reaction that might occur as a result of taking these medications.

**(See reverse for list of clinic services, medications, and parent signature area.)**

**\*\*\* Check Yes or No to indicate if you allow your child to receive the following medications at school by the school nurse.**

- Administration of Acetaminophen (Tylenol ®) or Ibuprofen (Motrin ®, Advil ®) at an age appropriate dose for discomfort, pain, or fever  
Yes No **\*\*\* students with fever > 100°F will be dismissed home**
- Antacid liquid or Antacid tablets for indigestion/minor stomach discomforts and age appropriate dose  
Yes No
- Benedryl ® (Diphenhydramine) for symptoms of allergic reactions, insect stings, or rashes at an age appropriate dose  
Yes No
- Sore throat relief spray for sore throat  
Yes No
- Cough drops for coughing (age appropriate due to choking hazard)  
Yes No
- Itch and rash relief cream/ointment for minor skin irritations  
Yes No
- Lubricating eye drops for eye irritations  
Yes No
- Oral pain relief gel for tooth/mouth discomfort  
Yes No
- Saline cleansing solution for cleaning of minor abrasions/wounds/cuts  
Yes No
- Triple antibiotic ointment for minor skin abrasions/wounds  
Yes No
- Cough Suppressant (Dextromethorphan HBr) syrup for mild cough with normal breath sounds and age appropriate dosing  
Yes No

**Clinic Services:**

- Nursing assessment of illness, injury, and other health related problems
- Administration of over-the-counter medications at age-appropriate doses per protocol
- Administration of prescription medication with parental consent
- Blood pressure screenings
- Blood sugar screenings (by finger stick if symptoms indicate the need)
- Head Lice screenings per policy
- Health promotion and wellness education including nutrition education
- Height and weight measurements as needed
- Implementing “Asthma Protocol” and “Severe Allergic Reaction Protocol” for students with asthma and severe allergic reactions.
- Screening of vision and hearing as needed and during class screenings

**Parent/Guardian**

**Signature**

**Date**

**( ) I DO NOT WANT MY CHILD TO RECEIVE SCHOOL HEALTH SERVICE**