*District Use Only
- ☐ DIAL-4
- ☐ Medicaid
- ☐ Lunch Application
- ☐ D.D.

ROCK HILL Schools
YORK COUNTY DISTRICT THREE

4K Enrollment Checklist

Name of Student_____

☐ Completed Application Packet (*Includes Early Childhood Registration Form, Medicaid Cover Letter, Medicaid Consent Forms, Home Language Survey, & Student Health Information Form)

☐ Legal Birth Certificate (*long form)

☐ SC Certificate of Immunization

☐ Proof of Residency (*Acceptable forms of proof of residence: current electric or gas bill; lease or rental agreement)

☐ Medicaid Identification Card (*If applicable)

☐ Lunch Application (*If applying)

***Central Child Development Center and ATC 4K** are needs based programs. Age-eligible children qualify through the Free & Reduced Lunch Application or Medicaid or documented developmental delays or through the screening process.

South Carolina Early Childhood Registration Form
2020–21 School Year

School and District Information

School: School District:

Child Information

Last Name: First Name: Middle Name:

Check if Applicable Generation: ☐ II ☐ III ☐ IV ☐ V ☐ Jr. ☐ Sr.
Nickname:

Date of Birth *(mm/dd/yy)*: __/__/__ Social Security number *(Preferred but optional)*: _____-___-_____
Sex: ☐ M ☐ F Federal Race/Ethnicity: Is the student Hispanic or Latino? ☐ Yes ☐ No
What is the student's race? Check all appropriate.
☐ Asian ☐ Black or African American ☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ No response

Child lives with: ☐ both parents ☐ mother ☐ father ☐ grandparent ☐ other (specify):

Does your child have any legal issues concerning custody/guardianship affecting school pick-up or family participation in school activities? ☐ Yes ☐ No *(*If yes, current legal documents must be provided)*

Student is in a Foster Home? ☐ Yes ☐ No

Home Address:

City:

County: South Carolina Zip Code: Home Phone:

Mailing Address (if different from Home Address):

City: County: South Carolina Zip Code:

Parents/Guardians ☐ both parents ☐ mother ☐ father ☐ other (specify):

Mother's/Guardian's Last name: First Name: Middle Initial:

If different from child's information:

Street Address:

City: County: South Carolina Zip Code:

Home Phone: Cell Phone:

Place of Employment: Daytime Phone:

Phone number for attendance and school messaging calls:

Mother's Education (*highest level*)☐ Less than high school diploma ☐ GED ☐ H.S. Diploma ☐ Associate Degree
☐ Bachelor's Degree ☐ Master's Degree ☐ Doctorate

Mother's/Guardian's email:

Father's/Guardian's Last Name: First Name: Middle Initial:

If different from child's information:

Street Address:

City: County: South Carolina Zip Code:

Home Phone: Cell Phone:

Place of Employment: Daytime Phone:

Phone number for attendance and school messaging calls:

Father's/Guardian's email:

Emergency Contact Information (other than parent/guardian information already provided)

Primary Contact Name: Cell Phone:

Relationship to Child: Email:

Daytime Street Address: Daytime Phone:

City: South Carolina Zip Code:

Second Contact Name: Cell Phone:

Relationship to Child: Email:

Daytime Street Address: Daytime Phone:

City: South Carolina Zip Code:

Child's Prior Care/Education Provider *Definitions of providers and full day/partial day are attached

Last year my child's care was provided by the following ***public provider*** **(Check one)**:

☐ Head Start

☐ Prekindergarten at a public school

☐ Unknown

My child attended the program **(check one)** ☐ full day ☐ partial day

Name of provider:

☐ Last year my child's care was provided by a ***private provider*** **(see attached examples of private providers)**

My child attended the program **(check one)** ☐ full day ☐ partial day

Name of provider:

Last year my child's care was provided in a home by an informal child care provider (Check one):

☐ Parent or relative

☐ Non-relative

Child's healthcare information

Did your child weigh less than 5.5 pounds at birth? ☐ Yes ☐ No
My child receives regular medical care from: ☐ Health Clinic (Health Department)
☐Emergency Room ☐Family Doctor ☐Other
Name: Phone:
Medicaid: ☐ Yes ☐ No Medicaid Number_____ *Copy of Medicaid Card attached ☐

List any long-term health concerns, illnesses, and/or allergies:

List any medication(s) prescribed for continuous long-term use:

List any special accommodation(s) that may be required to meet my child's needs most effectively while he or she is at the school:

Family Income Range

Number of persons on family or household:

Income Range of Family: ☐ $0-$10,000 ☐ $10,001-$20,000 ☐ $20,001-$30,000 ☐ $30,001-$40,000
☐ $40,001-$50,000 ☐ $50,001-$60,000 ☐ $60,000 and above

Language Background

What is the child's primary language?

What language is primarily spoken in the home?

Oral communication language:

Written communication language:

Family Literacy Services

Who in your family has participated in a school district Family Literacy Program, such as adult literacy, adult education (GED, High School Diploma, ESL), parent education, child development, or parent and adult/child interactive literacy?
☐ Both Parents ☐ Mother ☐ Father ☐ Guardian/Grandparent ☐ No One

Did your child ever participate in school district Family Literacy Services? ☐ Yes ☐ No
If, "yes," please check how long: ☐ 1 Year ☐ 2 Years ☐ 3 Years ☐ 4 or more years

Child's Special Needs

Does your child have a current Individual Education Program (IEP) or Section 504 plan? ☐ Yes ☐ No

Student's Disability Status: ☐ None ☐Emotional ☐Learning ☐Speech ☐Physical ☐Other

Child's Transportation

How do you anticipate your child will get to school? ☐ School Bus ☐ Car
☐ Child Care or Day Care Transportation ☐ Walk ☐ Bicycle ☐ Not applicable
Address:_____
How do you anticipate your child will travel from school? ☐ School Bus to home address
☐ School Bus to different location ☐ Car ☐ Child Care or Day Care ☐ Walk ☐ Bicycle
☐ Not applicable ☐ After School Program at School
Address:_____

Below is for District Use Only

ALL CHILDREN PARTICIPATING IN A CERDEP CLASSROOM MUST BE CODED WITH A CERDEP PROGRAM SERVICE CODE.

Early Childhood Placement: ☐ 3 year Class ☐ 4 year Class ☐ 5 year Class ☐ Multi-Age Classroom
☐ Parent Pay ☐ District funded 4K ☐ State funded EIA 4K ☐ State funded CERDEP/CDEP

Student Identification Number:

Program Entry Date: Program Exit Date: Reason for exit:

Income Verification Method (☐ Medicaid, ☐ Free or Reduced Lunch, ☐ W2 forms, ☐ Pay Stubs,
Other Income Verification Documented): _____
Meals: Free or Reduced Lunch ☐ Yes ☐ No ☐ N/A if District enrolled in Community Lunch Program

Classroom Type:
☐ FDS District / School Based Full-Day
☐ PDS District / School Based Partial-Day

Was child served by Head Start any time from birth to age 4? ☐ Yes ☐ No

DIAL 3 or 4: (Indicate which) ___ Screening Date: _____
Scores: Motor: ____ Concepts: ____ Language: ____ Self-Help: ____ Social: ____

Classroom Curriculum: ☐ Big Day in PreK ☐ Creative Curriculum ☐ High Scope ☐ InvestiGator
☐ Montessori ☐ World of Wonders

Readiness Assessment: ☐ myIGDIs ☐ PALS- Pre-K ☐ Teaching Strategies GOLD ☐ Other

Medicaid: ☐ Yes ☐ No Medicaid Number_____ Medicaid Active ☐ Yes ☐ No
* Copy of Medicaid Card attached ☐

Migrant/Immigrant: ☐ Yes ☐ No Birth Country: _____ State Id #: _____

Did the child participate in Countdown to Kindergarten? ☐ yes ☐ no

Definitions of Full Day and Partial Day Care

Full Day – A full day program is one in which students attend for 6.5 hours or more a day.

Partial Day – A partial day program is one in which students attend for less than 6.5 hours a day.

Definitions of Public Child Care Providers

Head Start – A program of the US Department of Health and Human Services that provides comprehensive early childhood education, health, nutrition, and parent involvement services to low income children and their families. Locate your local Head Start: https://www.benefits.gov/benefits/benefit-details/1938

Prekindergarten program in a public school – A state, district, or federally-funded, developmentally-appropriate program for 4-year-olds in a public school adhering to best practice, using research-based curriculum and assessment that must adhere to district and/or federal guidelines.

Unknown – Self-explanatory

Examples of Private Child Care Providers[1]

Military Child Care Centers – On-post child care centers that offer full-day, partial day, or hourly child care services to military families that must be registered with DSS. Locate your local military child care centers: http://www.militaryonesource.mil/-/military-child-care-programs

Registered Faith Based – Faith based care for 13 or more children that are sponsored by a religious organization that must be registered with DSS. Locate your local registered faith based providers: http://www.scchildcare.org/

Registered Family Home – A family home that provides care for up to 6 children at any given time within the home of the child care provider that maintains a registration or license if a person provides care to more than one unrelated family of children on a regular basis (more than four hours day or more than two days a week). Locate your local registered family home providers: http://www.scchildcare.org/

Registered Group Home Provider – Group Homes provide care for 7 to 12 children in the home of the child care provider. They may care for up to 8 children without an additional caregiver. For details on registered group homes: http://www.scchildcare.org/providers/become-licensed/licensing-requirements/licensed-group-child-care-home.aspx

[1] On the registration form, you do not have to provide the specific type of private childcare; these examples are listed as reference.

Exempt Provider – A child care provider that operate less than 4 hours a day or less than 2 days a week or care for children from only 1 unrelated family. It is not inspected by DSS Child Care Licensing and monitored only because they volunteer for ABC Quality. For details on exempt providers: http://scchildcare.org/providers/become-licensed/licensing-exemptions.aspx

First Steps (CERDEP/CDEP) – A private state-funded, income based, developmentally appropriate education program adhering to best practice, using research-based curriculum and assessment that must adhere to DSS regulations and SCDE Guidelines. It is housed in a private, registered child care facility. Contact your local First Steps: https://scfirststeps.org/who-we-are/local-partnerships/

Definitions of Informal Child Care

Relative: Informal Child Care – Unregulated or licensed care provided by family that is not subject to regulations or formal guidelines.

Non-Relative: Informal Child Care – Unregulated or licensed care provided by another caregiver (non-relative) that is not subject to regulations or formal guidelines.

Home Language Survey (HLS)

The Civil Rights Act of 1964, Title VI, Language Minority Compliance Procedures, requires school districts and charter schools to determine the language(s) spoken in each student's home in order to identify their specific language needs. This information is essential in order for schools to provide meaningful instruction for all students as outlined Plyler v. Doe, 457 U.S. 202 (1982).

The purpose of this survey is to determine the primary or home language of the student. The HLS must be given to all students enrolled in the school district / charter school. The HLS is administered one time, upon initial enrollment in South Carolina, and remains in the student's permanent record.

Please note that the answers to the survey below are student-specific. If a language other than English is recorded for ANY of the survey questions below, the W-APT/WIDA Screener will be administered to determine whether or not the student will qualify for additional English language development support.

Please answer the following questions regarding the language spoken by the student:

1. What is the native language of the **student**? _____
2. What language(s) is spoken most often by the **student**? _____
3. What language(s) is spoken by the **student** in the home? _____

4. In what language do you wish to have communication from the school? _____

Student Name:_____ **Grade:**_____

Parent/Guardian Name:_____

Parent/Guardian Signature:_____ **Date:**_____

By signing here, you certify that responses to the three questions above are specific to your student. You understand that if a language other than English has been identified, your student will be tested to determine if they qualify for English language development services, to help them become fluent in English. If entered into the English language development program, your student will be entitled to services as an English learner and will be tested annually to determine their English language proficiency.

For School Use Only:

School personnel who administered and explained the HLS and the placement of a student into an English language development program if a language other than English was indicated:

Name:_____ Date:_____

ROCK HILL Schools
YORK COUNTY DISTRICT THREE

Dear Parent/Guardian,

Rock Hill School District and the South Carolina Department of Education have entered into an agreement with SC Department of Health and Human services that will allow the school district to bill Medicaid for health related services that are provided by the school nurses during the school day. Medicaid reimbursement for school based health-related will not affect any other Medicaid services for which your child is eligible.

If your family participates in the SC Medicaid program and you give the district permission to bill Medicaid please sign the attached consent form. This consent will allow the school district to do the following:

- Release and exchange the following information from my child's record to the Department of Health and Human Services (Medicaid Agency) or Medicaid agency for the purpose of billing for the health-related services provided to my child;
- Bill the Medicaid Agency for the health-related services; and
- Receive payment from the Medicaid Agency for the health-related services that the District provides to my child;
- The District will continue to provide required health-related services for my child at no cost to me even if I refuse to allow billing for services;
- Granting consent is voluntary on my part and may be revoked at any time. If I later revoke consent, that revocation is not retroactive (i.e., it does not negate an action that has occurred after the consent was given and before the consent was revoked).

Please complete the attached consent form and return to your child's school. Feel free to contact me with any questions.

Thank you,

Sadie Kirell, RN

Sadie Kirell, RN
Clinical Lead Nurse

ROCK HILL Schools
YORK COUNTY DISTRICT THREE

Consent to Bill Private Insurance and Medicaid

The Rock Hill School District and the South Carolina Department of Education (SCDE) have my permission to provide services to my child and release and exchange medical, psychological, and other personally-identifiable confidential information, as necessary, to the South Carolina Department of Health and Human Services (SCDHHS) and any applicable third-party insurer regarding billable services provided to my child. I understand the purpose of this consent is to bill Medicaid and/or private third-party insurer for services under the Individuals with Disabilities Education Act (IDEA).

By signing this form, I give the District and the SCDE my permission to bill and receive payment from Medicaid and any third-party insurer for diagnostic and psychological evaluation services, behavioral health services, nursing services, and other health-related screenings and treatment services billable to Medicaid or a third-party insurer with or without the requirement of an individualized education program (IEP). The District provided me written notification consistent with the IDEA regulation at 34 C.F.R. §§ 300.154(d)(2)(v) and 300.503(c), prior to my signing this consent to release information to bill Medicaid or any third-party insurer and prior to accessing Medicaid or my child's third-party insurance benefits.

I further understand that the District must provide me annual written notification of my rights relative to Medicaid or any third-party insurer accessing my child's information and before the District and the SCDE access my benefits to pay for services under the IDEA. This consent for release of information to bill Medicaid and any third-party insurer is a one-time consent and is not required annually thereafter, unless there is a change in the type or amount of services to be provided to my child or a change in the cost of the services to be charged to Medicaid or a third-party insurer. I understand that Medicaid and third-party insurance reimbursement for billable services provided by the District and the SCDE will not affect any other Medicaid services or insurance benefits for which my child is eligible. I understand that my child will receive the services listed in the IEP regardless of whether my child is covered by public or private insurance programs and regardless of whether I provide consent to access those benefits. I understand that my refusal to consent to the SCDHHS or any third-party insurer accessing my child's personally-identifiable information does not relieve the District of its responsibility to ensure that all required services in my child's IEP are provided at no cost to me.

I understand that this consent is voluntary on my part and may be revoked at any time. If I later revoke consent, the revocation is not retroactive (i.e., it does not negate an action that occurred after the consent was given and before the consent was revoked).

I also understand that the District and the SCDE will operate under the guidelines of the IDEA and the Family Educational Rights and Privacy Act (FERPA) to ensure confidentiality regarding my child's treatment and provision of services.

Student's Name: _____ DOB: _____ Medicaid #: _____

_____ _____

Signature of Parent/Guardian Date

ROCK HILL Schools
YORK COUNTY DISTRICT THREE

Grade: _____

Teacher: _____

Student Health Information

Student: _____ DOB: _____

In order to better care for your child while at school, it is very important to complete the following information. Please check any and all conditions that apply and provide an explanation below. The school does NOT provide any medications. Medication will not be accepted at school without a completed prescription or non-prescription medication permission form. The prescription medication permission form must be signed by your child's doctor.

Allergies:

- ☐ Food Allergy
- ☐ Insect Allergy
- ☐ Seasonal Allergy
- ☐ Other Allergy

List Specific Allergy: _____

Medication needed to treat allergic reaction:

- ☐ EpiPen
- ☐ Benadryl
- ☐ No treatment needed

Medical Conditions:

- ☐ Asthma/Breathing treatments
- ☐ ADHD/ADD
- ☐ Autism
- ☐ Bleeding Disorder
- ☐ Cerebral Palsy
- ☐ Diabetes
- ☐ Eczema
- ☐ Ear Infections (frequent)
- ☐ Eye/Vision Problems
- ☐ Hearing Impairment
- ☐ Heart Problems
- ☐ Headaches/Migraines
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Psychological/Behavioral Problems
- ☐ Seizure Disorder
- ☐ Sickle Cell
- ☐ Other (please explain below)

If any of the above are checked, please explain details of medical condition:

_____

_____

_____

_____

Please list any meds your child takes routinely/daily: _____

_____

Child's Physician: _____ Phone: _____

Does your child have: (This information will allow the school nurse to assist in identifying program eligibility if needed)

☐ Private Insurance ☐ Medicaid/Medicaid number _____ ☐ No insurance coverage

School nurses use several different treatments for minor first aid in the health room. These treatments include topical antibiotic for any cuts or scrapes, anti-sting swabs for insect bites, benzocaine based oral anesthetic for mouth or dental pain, Caladryl and/or topical cortisone cream for itchy skin and petroleum jelly for minor skin irritations. If you do NOT want the school nurse to use these items for first aid, please see the school nurse to decline this treatment.

School district policy states that if a child experiences an unexpected allergic reaction at school, the school nurse may administer an EpiPen prescribed to the school and call EMS for emergency treatment.

Please notify the school nurse if there are any changes in the student's medical history throughout the school year. It is very important the school nurse be able to contact a parent/guardian or other responsible adult in a timely manner when your child is sick. Please contact the school when you have a change in your phone number(s).

Thank you for your time in completing your child's health form. This is considered a confidential document and will only be shared with appropriate staff when your child's health must be taken into consideration in the school setting. Please feel free to call the school nurse at any time with your concerns or questions.

PARENT/GUARDIAN SIGNATURE: _____ Phone: _____

Print Name: _____ Email: _____