

CHARLOTTE-MECKLENBURG SCHOOLS

STUDENT PLACEMENT ENROLLMENT INFORMATION

The following documents are required for enrollment:

- ☐ **Student Enrollment Form**
- ☐ **Original Certified copy of student's birth certificate**
 - No hospital, souvenir or photo copies accepted
- ☐ **Current Proof of Mecklenburg County residency**
- ☐ **Safe Schools Enrollment Declaration**

The following documents are required by the 30th day of school:

- ☐ **Current Immunization record**
- ☐ **Health Assessments for all new Pre-K and Kindergarten students**

Special Notes:

In compliance with North Carolina law, effective for 2009-2010 school year students must be 5 years of age on or before August 31st to be considered for Kindergarten. Students applying for the Montessori schools Pre-K program must be 4 years of age on or before August 31st in order to be considered.

Students must enroll by December 23, 2008 in order to participate in the 2009-2010 first Magnet Lottery. Students who enroll from January 5, 2009 – May 15, 2009 will be eligible to participate in the 2009-2010 second Magnet Lottery.

Questions about Guardianship should be directed to Student Placement at student.placement@cms.k12.nc.us or 980-343-5335.

Questions about students with special needs should be directed to Exceptional Children Department at 980-343-6960.

Students whose primary language is not English or who are not United States citizens should contact the International Center at ic@cms.k12.nc.us or 980-343-3784. The International Center is located in the Family Application Center, 700 Marsh Road, Charlotte, NC 28209.

Enrollment forms should be submitted to:
Student Placement - Family Application Center 700 Marsh Road, to any CMS school, or any CMS Learning Community office.

Student Placement Email: student.placement@cms.k12.nc.us phone: 980-343-5335
Office hours: Monday–Friday, 7:00am – 5:00pm

2009-2010 SCHOOL YEAR



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STUDENT ENROLLMENT FORM

Student's Name _____
 Last Name First Name Middle Name

Please indicate the student's academic placement.

- ☐ New Kindergartener for the _____ school year
☐ New Pre-Kindergarten - Montessori for the _____ school year
☐ New student entering grade _____ for the _____ school year

Please indicate the student's previous academic placement. (if applicable)

- ☐ Private school in Mecklenburg County ☐ Charter school outside of Mecklenburg County
☐ Charter school in Mecklenburg County ☐ Public school (other than Charter) outside of Mecklenburg County
☐ Group home or other institution ☐ Home School setting
☐ Private school outside of Mecklenburg County

Is the student identified as a student with special needs and being served with an Individualized Education Program (IEP)?

☐ Yes ☐ No

In what country was your child born? _____

Please answer the following questions. Circle English or write the name of the language used most often.

- | | | |
|--|---------|-------------|
| 1. What language did your child speak when he or she first began to talk? | English | Other _____ |
| 2. What language does your child speak most often at home with parents? | English | Other _____ |
| 3. What language does your child speak most often with his or her friends? | English | Other _____ |
| 4. What language do YOU use most often when speaking to your child? | English | Other _____ |

If a language other than English is indicated, or if the student was born outside of the United States, please contact the **International Center** (980-343-3784) before enrolling in a school. It will be necessary to assess the language ability of your child.

If this is an exchange student, please contact Student Placement (980-343-5335) for enrollment information.

For office use only:

Referred to International Center: Date _____ By _____
 Recommendation of International Center: Grade _____ School _____

Registration completed _____	Enrollment Date _____ Grade _____
Student ID _____	School _____
Need: Immunization Record _____	_____
Need: Birth Certificate _____	_____
Need: Proof of Residency _____	_____

.....
 School receiving packet: _____
 Name of person receiving packet: _____

School Date Stamp

Student Placement Date Stamp

Student Information

Birth certificate or other satisfactory evidence of age and official record of immunizations must be presented at time of enrollment. Copies of these documents are to be placed in folder and originals returned to parent/guardian.

Legal Name _____ / _____
Last First Middle Nickname
Address _____
Street City State Zip Code
Home Phone _____
☐ Male ☐ Female Date of Birth _____ Place of Birth _____
Month / Day / Year City / State / Country
Race: ☐ American Indian ☐ Black ☐ Asian ☐ Hispanic ☐ White ☐ Multiracial
Child resides with _____ Relationship _____

Family Information

Father's Full Name _____ Deceased ☐ Yes ☐ No
Address _____ Zip _____ Home Phone _____
Employer _____ Cell Phone _____
Highest education level completed _____ Business Phone _____
Mother's Full Name (include maiden name) _____ Deceased ☐ Yes ☐ No
Address _____ Zip _____ Home Phone _____
Employer _____ Cell Phone _____
Highest education level completed _____ Business Phone _____
Stepparent's, Legal Guardian's, or Sponsor's information (if applicable)
Name _____ Relationship _____
Address _____ Zip _____ Home/Cell Phone _____
Employer _____ Business Phone _____

Other Family Information

Other children in the family attending CMS:

Name _____	School _____	Grade _____
Name _____	School _____	Grade _____
Name _____	School _____	Grade _____
Name _____	School _____	Grade _____

School Information

Last School Attended _____ Grade _____
Address _____
Street City State Zip Code
Date last attended _____ / _____ Homeroom Teacher _____
Month Year

Parent/Legal Guardian _____ Signature _____ Date _____

CHARLOTTE-MECKLENBURG SCHOOLS

NEW PROCEDURES FOR PROOF OF RESIDENCY

Before any student is assigned to attend Charlotte-Mecklenburg Schools (CMS), the student's parent or legal guardian* must provide proof of legal residence in Mecklenburg County.

Effective October 6, 2008, all students must submit three proofs of residency.

Documents must be pre-printed with the name and address of the student's parent or legal guardian* and must be presented at the time of enrollment. Families can enroll at any CMS school or at the Family Application Center.

Change of address request will require one document from each of the following columns.

All applicants must submit at least one document from <u>each</u> of the following columns:		
COLUMN A	COLUMN B	COLUMN C
<ul style="list-style-type: none">• Copy of Deed OR record of most recent mortgage payment• Copy of Lease (including Charlotte Housing Authority and HUD leases) AND record of most recent rent payment• Affidavit from landlord affirming tenancy AND record of most recent rent payment• Section 8 agreement• Letter from approved agency (group & foster home purposes only)	<p>A utility bill or work order dated within the past 30 days, including:</p> <ul style="list-style-type: none">• Gas bill• Water bill• Electric bill• Telephone bill• Cable bill	<ul style="list-style-type: none">• Valid North Carolina driver's license• Current vehicle registration• Valid North Carolina photo identification card <p><i>Dated within the past year:</i></p> <ul style="list-style-type: none">• W-2 form• Vehicle tax bill• Property tax bill <p><i>Dated within the past 60 days:</i></p> <ul style="list-style-type: none">• Medicaid Card• Payroll stub• Bank or credit card statement

**Legal guardianship requires additional documentation from a court or agency.*

This residency policy does not apply to homeless students, as defined by the McKinney-Vento Act.
Group homes are required to provide proofs from Columns A & B only.

For more information about the CMS residency policy visit www.cms.k12.nc.us, or email student.placement@cms.k12.nc.us or call 980-343-5335.

CHARLOTTE-MECKLENBURG SCHOOLS

Safe Schools Enrollment Declaration

North Carolina General Statute 115C-366 (a4) requires that parents, guardians, or legal custodians of all students who transfer into Charlotte-Mecklenburg Schools provide a statement as to whether the student is, under suspension or expulsion from attendance at a private or public school in this or any other state or has been convicted of a felony in this or any other state. This does not apply to a student who has never been enrolled in or attended a private or public school in this or any other state.

Enrolling Student Information

Name _____
Last First Middle
Address _____
Street City State Zip Code
Date of Birth _____ Age _____ Grade _____

Suspensions and Expulsions

Please check the appropriate box as it relates to the student named above.

- ☐ **IS NOT** currently suspended or expelled from any school and does not have a pending suspension or expulsion
- ☐ Has been recommended for long term (more than 10 days) suspension or expulsion from _____ (school). Explain offense and pending discipline. _____
- ☐ Has been long-term suspended or expelled from _____ (school). Explain offense and pending discipline. _____
- Address of Previous School: _____
- Previous School Telephone: _____

Felony Convictions

Please check the appropriate box as it relates to the student named above.

- ☐ **HAS NOT** been convicted of a felony in this or any other state.
- ☐ Has been convicted of a felony.
- Convicted of: _____
- in (City, Town, & State): _____
- Date of Conviction: _____
- Description of offense: _____
- Probation Officer: _____ Phone: _____
- Court Counselor: _____ Phone: _____

I, _____ (Parent/Guardian/Legal Custodian) hereby swear or affirm that the above information is true and accurate.

Parent/Guardian/Legal Custodian Name: _____

Home/Cell/Work Phone: _____

KINDERGARTEN HEALTH ASSESSMENT INSTRUCTION SHEET
FOR PARENTS

There are two sections on the form that you will need to fill out. Please print clearly.

Front: "Parent Complete."

Please write in:

1. Your child's name with last name first, then first name, then middle name or initial.
2. Your child's date of birth, starting with month, day, and year.
3. Your child's entire address, including city, state, and zipcode.
4. Your name and the phone number at which you can be reached. This may be a home number, work number, or cell phone number.
5. There are some statements that are about your child. Please answer each one by filling in the box, either "Yes" or "No":
 - Does your child have a problem that bothers you about his or her general health, how much he or she weighs, how he or she is growing, or about the way your child acts?
 - Have you taken your child to the doctor for any of these problems?
 - Does anyone in your family have any of these problems? If so, please write about it on the lines below.
 - Has your child been to the dentist in the last year?
 - Has your child been to the doctor for a checkup, not because he or she was sick, in the last year?

There is a space on the form for you to sign that will allow the school nurse to talk to your doctor about your child's health. If this is ok with you, please write your name and the date in the space. If this is not ok with you, just leave it blank.

Back: "Parent Complete"

Please write in your child's date of birth, starting with month, day, and year.

Please check the right box for your child's race. If you are not sure, check "Unknown". If your child is Hispanic or Latino, please check the box.

Please write in the county you live in, and your zip code.

Please write in the school your child will be attending.

Please check the box for where your child usually sees the doctor.

Please check the box for what kind of health insurance your child has.

Please write in the name of your child's doctor or clinic.

Kindergarten Health Assessment

Glossary of Terms

1. **Anaphylaxis:** Severe allergic reaction of the whole body that may include trouble breathing and itchy rash. It must be treated immediately or death may occur.
2. **Anemia:** Low red blood cell levels that slows oxygen flow to the body. Children with this disorder may become very tired or have low energy levels.
3. **At-Risk:** The provider will ask you some questions to see if your child may be at risk of having these problems.
4. **BMI (Body Mass Index):** A formula that relates weight to height for measuring over and under weight in children.
5. **Cardiac:** Pertaining to the heart and circulatory system.
6. **Cerebral Palsy:** Children born with this permanent disorder have trouble moving, standing, talking, listening and understanding.
7. **Cystic Fibrosis:** Children born with this permanent disorder have trouble breathing and digesting food.
8. **Diabetes:** Children who have this have trouble controlling their blood sugar. These children eat foods that are low in sugar or need medicine or shots to help control their blood sugar.
9. **EGA (Prematurity):** Baby born earlier than 8 weeks before the due date.
10. **ENT:** Ear, Nose and Throat Specialist
11. **Epinephrine auto-injector:** Automatic shot of medicine for severe allergic reactions prescribed by the doctor
12. **Encopresis:** Children with this have trouble controlling bowel movements.
13. **Enuresis:** Children with this have trouble controlling passage of their water.
14. **HEENT (Head, Eyes, Ears, Nose & Throat):** An examination of the head, eyes, ears, nose and throat done by the doctor.
15. **HMO (Health Maintenance Organization):** Type of medical provider group.
16. **Hx:** Abbreviation for "history." For example: Has your child ever had problems with high levels of lead in his/her blood?
17. **School Follow Up:** When this box is checked, the form should go to the School Nurse so he/she can follow up on any health concerns documented on the form.
18. **Sickle Cell Anemia:** Children born with this permanent disorder have blood problems that cause severe pain and trouble breathing that comes and goes.
19. **TB (Tuberculosis):** Children with this illness have trouble breathing and coughing. Children who have this condition are on medication to cure this illness.
20. **Test Done:** The provider will ask you if your child has ever been tested for high levels of lead in their blood.

Developmental Screening Tools: Tools used by the doctor to see if a child is developing normally.

- **ASQ:** Ages and Stages Questionnaire
- **ASQ-SE:** Ages and Stages Questionnaire for Social and Emotional Behavior
- **Brigance:** A developmental testing tool for doctors to use.
- **CDI:** Child Development Inventory or Communication Developmental Inventory
- **IDI:** Infant Developmental Inventory
- **PEDS:** Parent Evaluation of Developmental Status
- **PSC:** Pediatric Symptom checklist
- **OAE:** Otoacoustic Emissions Test (Sounds that are produced by healthy ears in response to acoustic stimulation.

Child's Birthdate: ____ / ____ 20 ____ (mm/dd/yyyy) Race: ☐ 1 Other Non-White ☐ 5 Chinese ☐ 9 Other Asian

Sex: ☐ 1 Male ☐ 2 Female ☐ 2 White ☐ 6 Japanese ☐ 10 Unknown

County of Residence: _____ ☐ 3 Black ☐ 7 Hawaiian

Zip Code: _____ ☐ 4 American Indian ☐ 8 Filipino

School your child will be attending: _____ Hispanic or Latino Origin: ☐ 1 Yes ☐ 2 No

Place where your child gets regular health care: Child has:

☐ 1 Health Department ☐ 4 Private Doctor/HMO ☐ 1 Medicaid ☐ 2 Private Insurance/HMO

☐ 2 Hospital Clinic ☐ 5 Other _____ ☐ 3 No insurance ☐ 4 Other : _____

☐ 3 Community Health Center ☐ 6 No regular place **Doctor/Practice Name:** _____

Date of Health Assessment: ____ / ____ / ____

The health assessment must be conducted by a physician licensed to practice medicine, a physician's assistant as defined in General Statute 90-18, a certified nurse practitioner, or a public health nurse meeting the state standards for Health Check Services.

Immunizations - Attach a copy of the immunization record.

Pertinent Illnesses, Risks or Developmental Problems: *(Please check all that apply)*

☐ Allergy ☐ Diabetes ☐ Orthopedic Problems

☐ Anemia ☐ At-Risk for Anemia ☐ Emotional/Behavioral ☐ Prematurity (<32 wks. EGA)

☐ Asthma ☐ Encopresis ☐ Seizures/Convulsions

☐ Attention/Learning ☐ Enuresis (Daytime) ☐ Sickle Cell Anemia ☐ Trait

☐ Bleeding Problems ☐ Genetic Disorders ☐ Speech/Language

☐ Cancer/Leukemia ☐ Heart Problems ☐ Tuberculosis ☐ At-Risk for TB

☐ Cerebral Palsy ☐ Hearing Problems ☐ Vision Problems

☐ Cystic Fibrosis ☐ Kidney Problems ☐ Other: _____

☐ Dental Problems ☐ Lead (Hx of >10 mcg/dL) ☐ At-Risk ☐ Test done ☐ None

☐ Obesity

Screening Results

Developmental

Screening Tool(s) Used:
☐ 1 PEDS ☐ 4 PSC
☐ 2 ASQ ☐ 5 ASQ-SE
☐ 3 CDI/CDR ☐ 6 Brigance

Developmental Domains:
Emotional/Social
Problem Solving
Language/Communication
Fine Motor Skills
Gross Motor Skills

Within Normal 1
Concern Identified 2
Referred to Specialist 3

Comments:

Hearing

Hearing	1000 Hz	2000 Hz	4000 Hz
Right			
Left			

Screening Tool Used:
☐ 1 OAE
☐ 2 Audiometry

☐ 1 Pass
☐ 2 Scheduled for re-screen due to middle ear fluid. Re-screen appt. in _____ weeks.
☐ 3 Referral to audiologist/ENT (check if yes)
☐ 4 Child has previously diagnosed hearing loss. Screening is not necessary.

Vision

Please remember that vision screening is not a substitute for a comprehensive eye examination.

	Right	Left	Stereopsis	<input type="checkbox"/> Pass <input type="checkbox"/> Fail
Far:			Acuity Test Used:	

Was test performed with corrective lenses? ☐ yes ☐ no

☐ 1 Pass (Acuity, Stereopsis, & Symptoms)
☐ 2 Referral to eye doctor (check if YES) Refer if worse than 20/40 in either or both eyes, a two line difference between eyes, unable to test, failed stereopsis, or signs of disease.
☐ 3 Child has a diagnosed vision condition and has had an eye exam in the last 12 months. Screening is not necessary.

Physical Examination

Weight: _____ lbs. Height: ____ ft. ____ in.

Body Mass Index (BMI) - for age: _____

☐ 1 Normal (5%ile - <85%ile)
☐ 2 Underweight (<5%ile)
☐ 3 At-Risk (85%ile to <95%ile)
☐ 4 Overweight (95%ile)

Blood Pressure: _____ / _____

☐ 1 Within Normal Range
☐ 2 > 90th Percentile (_____ %ile)

	Normal 1	Abnormal 2
HEENT	<input type="checkbox"/>	<input type="checkbox"/>
Dental/Oral	<input type="checkbox"/>	<input type="checkbox"/>
Lungs	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Back/Extremities	<input type="checkbox"/>	<input type="checkbox"/>
Genital	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____