SOUTH KINGSTOWN SCHOOL DEPARTMENT
307 Curtis Corner
Wakefield, RI 02879
(401) 360-1300

REGISTRATION INSTRUCTIONS

ELEMENTARY PARENTS - DUE TO THE REDISTRICTING OF OUR ELEMENTARY SCHOOLS, BUILDING PLACEMENT AND DUAL LANGUAGE PROGRAM PLACEMENT IS TO BE DETERMINED FOR THE 2022-2023 SCHOOL YEAR.

ALL FAMILIES WILL BE NOTIFIED OF THIS INFORMATION UPON FINAL DECISION.

STEP 1: Complete the online pre-registration process:

Prior to your registration appointment, please complete the online pre-registration process. Please visit our website www.skschools.net and click on the 'Enrolling Students' tab under 'Quick Links'. On the Registration Page, the pre-registration link will be found under Step 1: SKSD Pre-Registration. This process will create your Family Access account in Skyward.

STEP 2: Download, print and complete the registration packet. Included in the registration packet are the following forms:

- Home Language Survey Form (Required by the Rhode Island Department of Education)
- Request for Transportation Form
- Release of Information
- Residency Affidavit
- McKinney Vento Student Residency Form
- Student Health History Form

STEP 3: Gather Required Documentation:

In addition to the registration packet, the following documentation must be provided at the time of your registration appointment:

- Birth Certificate (Official Copy Only) or Passport or Military ID (Child must be 5 yrs old on or before September 1 to enter Kindergarten)
- Photo Identification of Parent/Guardian
- Court Documentation (Legal documentation proving custody or guardianship, if applicable)
- Residency Evidence - A true copy of one (1) piece of current residency evidence from Column A and one (1) piece from Column B

Column A	Column B
Copy of Mortgage Statement	Copy of Cable Bill
Copy of Property Tax Bill	Copy of Electric Bill
Copy of fully executed Lease; Rental Agreement, Letter from Landlord	Other

- Pediatrician/State Physical Form with Immunizations - All forms must be signed by your child's doctor and must contain the most recent immunizations and up to date physical information (dated within one year). Kindergarten age children must have a lead screening and a vision screening before they can be entered into school.)
- Any Additional Documentation - Please bring any information regarding services your child may receive, ie. Individual Education Plan, 504 Plans, Response to Intervention Services or English Language Learner Services)

STEP 4: Schedule your registration appointment:

Grade Level	Contact	Location	Office Hours
Grades PreK through 12	Kristen Gleason (401) 360-1325 kgleason@sksd-ri.net	SKSD Central Office 307 Curtis Corner Rd Wakefield, RI 02879	9:00 am - 3:00 pm

Please contact the Registrar's Office if you would like a copy of the printed packet or if you have any questions.

State of Rhode Island and Providence Plantations
DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
Shepard Building
255 Westminster Street
Providence, Rhode Island 02903-3400

Angélica Infante-Green
Commissioner

Home Language Survey (HLS)

Dear Parent or Guardian,

The information requested on this form is necessary for the most appropriate school placement of your child, and will not be used for any other purposes[1].

Thank you for your collaboration.

To be completed by Parent or Guardian

Student Name:	
First *Middle* *Last*	
Date of Birth:	**Place of Birth[2]:**
Month *Day* *Year*	
Parent or Guardian Relationship to student: ☐ *Mother* ☐ *Father* ☐ *Other* _____	

Home Language Code:

Language Background

(Please check all that apply)

1. **What is the primary language used in the home, regardless of the language spoken by the student?**	☐ English	☐ Other	_____ *Specify*	
2. **What is the language most often spoken by the student?**	☐ English	☐ Other	_____ *Specify*	
3. **What is the language that the student first acquired?**	☐ English	☐ Other	_____ *Specify*	
4. **What language(s) does your child understand?**	☐ English	☐ Other	_____ *Specify*	
5. **What language(s) does your child speak?**	☐ English	☐ Other	_____ *Specify*	☐ Does not speak
6. **What language(s) does your child read?**	☐ English	☐ Other	_____ *Specify*	☐ Does not read
7. **What language(s) does your child write?**	☐ English	☐ Other	_____ *Specify*	☐ Does not write

[1] *Required by Rhode Island Law (R.I.G.L. § 16-54-2) and the Equal Educational Opportunity Act (20 U.S.C. §1703(f))*

[2] *Families are not required to provide the place of birth, but providing the information can help LEAs to better prepare to be culturally responsive.*

Last Updated: 4/30/2020

The R.I. Board of Education does not discriminate on the basis of age, sex, sexual orientation, gender identity/expression, race, color, religion, national origin, or disability.

Family Interview – Educational History

1. **Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.**

   Yes* ☐ No ☐ Not sure ☐ *If yes, please explain:_____

How severe do you think these difficulties are? ☐ Minor ☐ Somewhat severe ☐ Very severe

2a. Has your child ever been referred for a special education evaluation in the past? ☐ No ☐ Yes*

If referred for an evaluation, has your child been identified? ☐ No ☐ Yes

*If referred for an evaluation, and identified has your child ever received any special education services in the past?

☐ No ☐ Yes – Type of services received: _____

2b. Age at which services received (Please check all that apply):

☐ Birth to 3 years (Early Intervention) ☐ 3 to 5 years (Special Education) ☐ 6 years or older (Special Education)

2c. Does your child have an Individualized Education Program (IEP), or 504 plan? ☐ No ☐ Yes

3. In which language do you prefer to receive oral communications from the school or district? ☐ English ☐ Other _____ *Specify*

4. In which language do you prefer to receive written communications from the school or district? ☐ English ☐ Other _____ *Specify*

5. Indicate date first enrolled in ANY U.S. school _____ **(mm/dd/yyyy)**

Is there anything else you think is important for the school to know about your child? (e.g., special talents, health concerns, etc.)

_____

_____

_____ Month: _____ Day: _____ Year: _____

Signature of Parent or Guardian ***Date***

_____

Print Parent/Guardian Name

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLS	
Name: _____	Position: _____
IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS: _____	
NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLS AND CONDUCTING INDIVIDUAL INTERVIEW	
Name: _____	Position: _____
IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS: _____	
Oral Interview Necessary: ☐ YES ☐ NO	**Date of Individual Interview:** _____ *Month Day Year*
NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING THE LANGUAGE SCREENING ASSESSMENT	
Name: _____	Position: _____
IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS: _____	
NAME/POSITION OF QUALIFIED PERSONNEL REPORTING THE LANGUAGE SCREENING SCORES	
Name: _____	Position: _____
Date of Screener: _____ *Month Day Year*	Name of the Language Screening Assessment: _____ Score achieved: _____
Proficiency Level Achieved: Entering 1 ☐ / Beginning 2 ☐ / Developing 3 ☐ / Expanding 4 ☐ / Bridging 5 ☐ / Reaching 6 ☐	
FOR STUDENTS WITH AN IEP OR 504 PLAN, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED:	

OCEAN STATE TRANSIT
45 FAIRGROUNDS ROAD
WEST KINGSTON, RI 02892
(401)284-3920 FAX (401)284-3929

Entity Code
103 Wakefield
107 Peace Dale
108 SKHS
110 CCMS
112 West Kingston
113 Matunuck
114 BRMS

Student Name: _____ School: _____ Grade: ____ ID: _____

Home Address: _____ Home Phone: _____

Additional students in the family:

Student Name: _____ School: _____ Grade: ____ ID: _____

Student Name: _____ School: _____ Grade: ____ ID: _____

Student Name: _____ School: _____ Grade: ____ ID: _____

Complete if Applicable:

ALTERNATE PICK UP ADDRESS
CONTACT NAME AND PHONE NUMBER

_____

_____

ALTERNATE DROP OFF ADDRESS
CONTACT NAME AND PHONE NUMBER

_____

_____

Please check below:

____ New Student

____ AM Transportation Needed Only

____ PM Transportation Needed Only

____ Both AM & PM Transportation Needed

____ Pick-up at Daycare Provider

____ Drop-off at Daycare Provider

____ Student Exited

____ Change of address (Previous Address: _____)

The South Kingstown School Department will transport your child to or from any bus stop location within the boundaries of the school your child attends. ***The only requirement is that your child be picked up at the same location and be transported to the same location every day.***

Transportation Information page can be found at: https://www.skschools.net/parents/bus_information

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(For Ocean State Transit use only)

Allow three days for transportation to start.

Bus Number: _____ Stop Location: _____

Pick-Up Time: _____ Drop-Off Time: _____

SOUTH KINGSTOWN SCHOOL DEPARTMENT
307 Curtis Corner Road
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(401) 360-1300

RELEASE OF INFORMATION

Student:_____ Grade: _____ DOB: _____

☐ **Matunuck Elementary School**
380 Matunuck Beach Rd
Wakefield, RI 02879
P (401) 360-1234
F (401) 360-1235

☐ **Peace Dale Elementary School**
109 Kersey Rd
Peace Dale, RI 02879
P (401) 360-1600
F (401) 360-1601

☐ **Wakefield Elementary**
101 High St
Wakefield, RI 02879
P (401) 360-1400
F (401) 360-1401

☐ **West Kingston Elementary School**
3119 Ministerial Rd
West Kingston, RI 02892
P (401) 360-1130
F (401) 360-1139

☐ **Broad Rock Middle School**
351 Broad Rock Rd
Wakefield, RI 02879
P (401) 360-1800
F (401) 360-1801

☐ **Curtis Corner Middle School**
301 Curtis Corner Rd
Peace Dale, RI 02879
P (401) 360-1333
F (401) 360-1334

☐ **South Kingstown High School**
215 Columbia St
Wakefield, RI 02879
P (401) 360-1000
F (401) 360-1464

☐ **South Kingstown School Dept**
307 Curtis Corner Rd
Wakefield, RI 02879
P (401) 360-1300
F (401) 360-1330

This Release of Information is valid from ____ /____ /____ to ____ /____ /____

I hereby authorize the South Kingstown School Department to:

Choose only one on the left:

❑ Release to
❑ Obtain from

AND/OR

❑ Exchange Verbal Information

PERSON/AGENCY: _____

ADDRESS: _____

PHONE: _____ **FAX:** _____

Records to be released or disclosed*:

❑ Cumulative School Records
❑ School Profile (High School Only)
❑ Health and Immunization Records
❑ RIDE Accountability Assessments
❑ 504 Plan, including testing/outside recommendations
❑ Personal Literacy Plan (PLP), including testing results
❑ Personal Math Plan (PMP), including testing results
❑ Personal Behavior Plan, including testing results
❑ Psychological Evaluation
❑ Educational Evaluation
❑ Psychiatric Evaluation
❑ Speech/ Language Evaluation
❑ Rating Scales
❑ RI Documentation for Free/Reduced Lunch Program
❑ Other: _____

The purpose of release/disclosure is:

_____

_____

_____

Medical/ Health information is protected under R.I. Law 78H-7522. Information released with this authorization will not be given, sold, transferred, or in any way released to any other person not specified on the release form. The consent for release or transfer of information may be withdrawn at any future time.

Signature of Parent/Guardian: _____ Date: ____/____/____

*Parent authorization is not required to transfer educational records to another school district.

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RESIDENCY AFFIDAVIT

CAUTION: Read this statement carefully before signing it. This document requires you to provide information which, if not true, could make you responsible for the payment of tuition for your child to attend the South Kingstown Schools.

All lines must be completed or checked off as directed.

I, _____, upon oath do hereby swear and say:
(parent/guardian name)

1. _____, whose birthdate is _____, herein
(child's legal name) *(month/day/year)*
referred to as the child, will reside permanently with me at my residence during the **2022-2023** school year at
_____, in the South
(street address)
Kingstown, Rhode Island Public School District.

2. ***(Check one only if you are not natural or adoptive parents of child):***
The child's parents:
_____are unknown; _____are not living; _____have abandoned the child; or, ____are unable to care for the child.

3. ***(Check one only if you are not natural or adoptive parents of child):***
I have assumed *(check one)* _____legal guardianship or ____parental responsibility as provided in Rhode Island General Law, Section 16-64-1, for the welfare and conduct of the child.

4. The child is not living in the South Kingstown School District for the sole purpose of attending the South Kingstown Schools.
_____True _____False

5. Submitted with this statement, if applicable, is a certified copy of a court order granting me legal guardianship or a statement from the child's parent(s) of inability to care for the child. **____Applicable ____Not Applicable**

6. I understand that only residents of the Town of South Kingstown who are otherwise eligible are entitled to be educated by the Town of South Kingstown without charge. _____***Please Initial***

If any of the statements in Section 1 through 6 above ceases to be true, I shall notify the South Kingstown School Department in writing immediately. If the child is permitted to remain in the South Kingstown School System, I will be responsible for payment of tuition for the child at the prevailing district rate on a pro-rated basis from the date any statement in Section 1 through 6 above ceases to be true. Such tuition shall become immediately due and payable.

_____ _____
(Parent/Guardian printed name) (Parent/Guardian signature)

_____ _____
(Street address) (City, State, Zip)

_____
(Relationship or designation to child)

Subscribed and sworn to in my presence this _____day of _____, 20_____

_____ _____
Notary Public Signature Notary Commission Expires

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MCKINNEY VENTO STUDENT RESIDENCY FORM

By completing this questionnaire, you help the school district comply with the McKinney-Vento Homeless Assistance Act, as amended by Title IX, Part A of the Every Student Succeeds Act, Pub. L. No. 114-95. Your truthful and accurate answers help the district identify services the student may be eligible to receive.

School _____

Student's name _____

❑ Male ❑ Female Birth date (Month/Day/Year) _____ Age _____

Parent(s)/Legal guardian(s) name _____

Address _____

City/State/Zip _____

Phone number _____

1. Where is the student living now? (*Check one box*)

- o ❑ In an emergency or transitional shelter.
- o ❑ In a motel or hotel or abandoned at a hospital.
- o ❑ In a car, park, abandoned building, or public space.
- o ❑ In a trailer park, bus or train station, or camping ground.
- o ❑ With more than one family in a house or apartment.
- o ❑ With friends or family members (other than parent/guardian).
- o ❑ In a permanent residence that is fixed, regular, and adequate.

If you checked the last box marked "in a permanent residence that is fixed, regular, and adequate," you do not have to complete the remainder of this form. Please sign below and return a copy of this form either by mail to *South Kingstown School Department, 307 Curtis Corner Road, Wakefield, RI 02879;* by fax at *(401) 360-1330* or by email to *Ginamarie Masiello, Director of Curriculum, Learning and Innovation at gmasiello@sksd-ri.net.*

2. Does the living arrangement checked in Question No. 1 result from a loss of housing or economic hardship?

❑ yes ❑ no ❑ unsure

The South Kingstown School Department does not discriminate on the basis of
age, sex, race, religion, national origin, color or disability in accordance with applicable laws and regulations.

3. **The student lives with:**
   - ❑ One (1) parent.
   - ❑ Both (2) parents.
   - ❑ A parent and another adult.
   - ❑ A relative, friend, or other adult.
   - ❑ Alone with no adults.
   - ❑ An adult who is not the parent nor the legal guardian.

4. **Name student's siblings, if any.**

_____

_____

_____

Parent/legal
guardian's signature _____ Date _____

Please return a copy of this form either by mail to *South Kingstown School Department, 307 Curtis Corner Road, Wakefield, RI 02879;* by fax at *(401) 360-1330* or by email to *Ginamarie Masiello, Assistant Superintendent at gmasiello@sksd-ri.net.*

FOR SCHOOL USE ONLY

❑ Student not covered under the McKinney-Vento Homeless Assistance Act.

❑ Student covered under the McKinney-Vento Homeless Assistance Act.

❑ Follow-up required.

[*Insert instructions for processing the form that are appropriate for your district, including, if applicable, state law or local policy notations.*]

Name and number of a contact person at the student's school who may know of the family's situation

_____ Date received _____

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STUDENT HEALTH HISTORY

Date:_____

Student's Name:_____ Date of Birth:_____

Home Address:_____ **Email Address:**_____

Home Phone_____ Grade/Teacher_____

Name of physician or pediatrician_____ Phone #_____

1.Check Any Current Health Conditions and describe

Asthma_____ Eczema_____ Bone or Joint Problems_____ Bladder/ GI/Bowel conditions_____

Diabetes_____ Scoliosis_____Anxiety_____Emotional Problems_____Bleeding Disorder_____

Seizures_____ Heart Conditions_____ Physical Disability_____ Other_____

2.Check Any Past Illnesses, Injuries, Conditions, Operations and describe

Strep Throat_____Hives_____ Chicken Pox____Pneumonia____Lyme Disease___Headaches___ Earaches or infections_____

Lead exposure and treatment_____Developmental Milestones delayed (Walking, talking, etc.)-_____

Past influential event or trauma (Describe)_____Anxiety_____Injuries_____Nightmares_____Sleep Difficulties_____Social/emotional difficulties (Describe)_____Surgery/Hospitalizations yes,describe,date)_____Other_____

3. Medications

Does your child presently take medication including inhalers **at home**? Yes_____ No_____

Please list here:_____

Is there any medication that needs to be taken **at school**? Yes_____ No_____

Please list here name of medication and time_____

MEDICATIONS IN SCHOOL must be administered by the nurse with specific written permission from the physician and parent (See South Kingstown Medication Policy).

4. Check any Allergies

Bee stings_____ Medications(Name of Med))_____ Food (Please list)_____

Requires Epipen_____ Requires Benadryl_____

Allergy to Environment_____ List allergens and treatments_____

_____

Any other allergies, reactions or treatments the school needs to know about_____

_____

5. Vision and Hearing

Does your child have any trouble hearing?_____ Tubes or hearing aides?_____

Does your child have difficulty seeing?_____ Wears glasses or contacts?_____

6. Dental Information

R.I. State Law mandates that all students in Grades K-5 be examined by a dentist at least once a year and once during grades 6-10. Please indicate here the dentist that follows your child or the school dentist will see your child.

Dentist's name:_____ Address_____ Phone#_____

Last seen or date to be seen_____

7. Other

Any Dietary Restrictions?_____

Is your child able to fully participate in school activities?_____

Is your child being treated for anything right now?_____ If yes, explain_____

Please note any additional information in regards to your child_____

_____

** School Nurse will notify Chartwells Food Service of any Life Threatening Food allergies.

**Parents are responsible to notify bus driver and any after school programs about any health issues. Updated-2-2021

***Teachers and support staff will be able to view health concerns via Skyward program or may be informed as needed.

Parent Signature_____ **Date**_____