



Cultivation, Personalization, Innovation - Every Student Every Day!

Address Verification Form

Dear Parent / Guardian:

The Principal of each school has the responsibility to obtain and verify the legal residence of each student enrolled at the school. The verification of address must be accompanied by two or more of the items from the list shown below. Please be sure that the documents that you provide have a physical address. No documents with only post office box info will be accepted. **Please complete this form, provide the documents you selected below and return this form to the school.**

- Property / Tax records Medicaid card Voter registration card
- Mortgage documents or Deed to property Phone bill U.S. Passport
- Lease agreement Bank statement REAL ID
- Current utility bill Cable / Internet bill Motor vehicle registration
- Current driver's license Payroll / W-2 stub Military ID card
- Motor vehicle insurance card Correspondence from government authority regarding receipt of benefits
- Other documents (specify) _____ **(Requires Central Office review and approval)**

School: _____ Student Grade: _____

Student Legal Name (Please Print): _____
First Name Middle Name Last Name

Parent / Guardian Name: _____
Current Street Address _____ Apartment Number? _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Cell Phone Number: _____

Email Address: _____

Is your Mailing Address the same as the one listed above? _____

If your mailing address is not the same as your physical address, please enter your mailing address below:

Mailing Address _____ Apartment Number? _____

City: _____ State: _____ Zip Code: _____

This form will be reviewed within 30 days of enrollment. All documents must be submitted to the school .

Signature of Parent / Guardian: _____ Date: _____

Printed Name of Parent / Guardian: _____

VERIFICATION COMPLETED
<u>Office use only</u>
2 documents Address matches school district
Home visit on date: _____ by _____ (Position) _____
Final verification on date: _____ by _____ (Position) _____

KINDERGARTEN SURVEY DATA

What is your child's LEGAL NAME? Please Print.

First Name: _____ Middle Name: _____

Last Name: _____

Do you currently call your child by his/her first name or middle name?

I call him/her by their First Name Shown Above.

I call him/her by their Middle Name Shown Above.

Which WCPS Elementary School will your child be enrolling in for the 2020-2021 school year?

Please select the box for the appropriate school below:

Brogden Primary

Carver Elementary

Eastern Wayne Elementary

Fremont Stars

Grantham Elementary

Meadow Lane Elementary

North Drive Elementary

Northeast Elementary

Northwest Elementary

Rosewood Elementary

Spring Creek Elementary

Tommy's Road Elementary

Did your child attend any Wayne County Pre-K program during the 2019-2020 school year (Head Start/NC Pre K/Other)? Please check the applicable box below.

My child did not attend a Pre-K Program.

Happy Days Childcare

My child attended.....

Meadow Lane Elementary

Antioch Daycare

Northeast Elementary

Belfast Head Start Center

North Drive Elementary

Bright Beginnings

Rosewood Elementary

Bright Beginnings II

Royall Ave. Head Start

Brogden Primary NC Pre K

Royall Ave. NC Pre-K

Bryan Sutton CDC Head Start

SSELC NC Pre K

Carver Elementary

SSELC Creative Cubs

Carver Head Start

SSELC Collaborative

Chestnut Head Start

Small World Childcare

Dillard Academy

Spring Creek Elementary

Eastern Wayne Elementary

Tommy's Road Elementary

Fairview Community Ctr.

Wee Are the World

Fremont Stars

Other: _____

THIS SECTION FOR SCHOOL USE ONLY

Assigned Kindergarten Teacher: _____ Homeroom Number: _____

Staggered Entry Dates: _____

Special Identifiers? Medical IEP Court Order Other

NOTES:

WAYNE COUNTY PUBLIC SCHOOLS

School Health Form

Attention: Parents of Kindergarten Children

North Carolina Law requires Health Assessments (physical examinations) and updated immunizations for all children starting kindergarten each year. The Health Assessment has to be done within 12 months before the first day of kindergarten. School principals are required to send kindergarten children home from school if they have not had their immunizations and/or physical examinations within 30 calendar days after the first day of school.

If your kindergarten child has not had a physical examination since August 24, 2019, call your child's doctor or the Health Department for an appointment.

August 24, 2020, is the start date for elementary schools for the upcoming 2020 – 2021 school year.

If an appointment is needed, you need to call now to schedule an appointment at the facility of your choice. This will avoid the fall rush and the probability that your child will be sent home from school until the physical examination can be obtained.

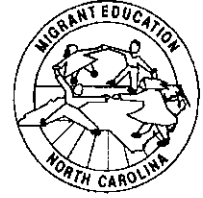
Thank you for your prompt attention to this matter.



PUBLIC SCHOOLS OF NORTH CAROLINA

DEPARTMENT OF PUBLIC INSTRUCTION | Mark Johnson, Superintendent of Public Instruction

WWW.NCPUBLICSCHOOLS.ORG



**MIGRANT EDUCATION PROGRAM
OCCUPATIONAL SURVEY**

The Migrant Education Program, through the North Carolina Department of Public Instruction, provides support and instructional services to children and families that have migrated to North Carolina within the last 3 years. To qualify for the program, families must have moved in search of work in agriculture, food processing, and/or fishing industries. The program enrolls youth from age 3 through 21, whether they attend school or not. Please help us determine if your children qualify to receive these free services.

Parent/Guardian Name: _____

Current Address: _____

_____ Zip Code: _____

Telephone Number: _____ Cell: _____

When did you move to Wayne County, NC? Month ____ Year ____

Where did you live before you came here? _____

Did your family come here to do agricultural work? YES NO

Did your family come here to work in food processing plants? YES NO

Has your family done this kind of work in the last 3 years? YES NO

Where have you found work since you came here?

Parent/Guardian Signature _____ Date: _____

FEDERAL PROGRAM MONITORING & SUPPORT DIVISION

6351 Mail Service Center, Raleigh, North Carolina 27699-6351 | (919) 807-3957 | Fax (919) 807-3968

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

GENERAL ENROLLMENT INFORMATION

STUDENT'S LEGAL NAME					
Last Name:		First Name:		Middle Name:	Suffix:
Parent/Guardian # 1 Name		Parent/Guardian # 2 Name		Student's Date of Birth	
Relationship to Student:		Relationship to Student:		MONTH <small>Please enter 2-Digit Month</small>	DAY <small>Please enter 2-Digit Day</small>
Parent/Guardian Contact Info:		Parent/Guardian Contact Info:		YEAR <small>Please enter 4-Digit Year</small>	Student Gender
Home:		Home:		<input type="checkbox"/> Male or <input type="checkbox"/> Female	Federal Ethnicity
Cell:		Cell:		Is the student Hispanic or Latino? <input type="checkbox"/> Yes or <input type="checkbox"/> No	
Email:		Email:		Select the student's race:	
Parent Guardian # 1 Workplace & Work Phone		Parent Guardian # 2 Workplace & Work Phone		<input type="checkbox"/> American Indian or Alaskan Native	
Workplace:		Workplace:		<input type="checkbox"/> Asian	
Work Phone:		Work Phone:		<input type="checkbox"/> Black or African American	
				<input type="checkbox"/> Native Hawaiian/other Pacific Islander	
				<input type="checkbox"/> White	
Does this student have any serious medical conditions? If so, please provide a copy of the doctor's note.					
Has this student participated in the exceptional children's program? If so, please provide a copy of the student's IEP.					
Are there any custody matters concerning this student? If so, please provide a copy of the court order.					
STUDENT PHYSICAL ADDRESS					
House Number or Building Number:		Street Name:			Apartment Number:
Name of Housing Development or Apartment Complex:		What City do you live in?			Zip Code
STUDENT MAILING ADDRESS					
<input type="checkbox"/> Check here mailing address is the same as above or enter info below if different					
P.O. Box, House Number or Building Number:		Street Name:			Apartment Number:
Name of Housing Development or Apartment Complex:		What City do you live in?			Zip Code



NORTH CAROLINA HEALTH ASSESSMENT TRANSMITTAL FORM

This form and the information on this form will be maintained on file in the school attended by the student named herein and is confidential and not a public record.

(Approved by North Carolina Department of Public Instruction and Department of Health and Human Services)

PARENT to COMPLETE THIS SECTION

Student Name:

(Last)

(First)

(Middle)

Birthdate (M/D/YYYY):

School Name:

Home Address:

City:

State:

County:

Parent Information: Name of Parent, Guardian, or person standing in loco parentis:

Telephone(s)

Home:

Work:

Cell Phone:

Health Concerns to be shared with authorized persons (school administrators, teachers, and other school personnel who require such information to perform their assigned duties):

HEALTH CARE PROVIDER TO COMPLETE THIS SECTION

Medications prescribed for student:

Student's allergies, type, and response required:

Special diet instructions:

Health-related recommendations to enhance the student's school performance:

Vision screening information:

Passed vision screening: Yes No

Concerns related to student's vision:





January 2016rev

Hearing screening information:

Passed hearing screening: Yes No

Concerns related to student's hearing:

Recommendations, concerns, or needs related to student's health and required school follow-up:

School follow-up needed: Yes No

Medical Provider Comments:

Please attach other applicable school health forms:

- Immunization record attached:
- School medication authorization form attached:
- Diabetes care plan attached:
- Asthma action plan attached:
- Health care plans for other conditions attached:

Health Care Professional's Certification

I certify that I performed, on the student named above, a health assessment in accordance with G.S. 130A-440(b) that included a medical history and physical examination with screening for vision and hearing, and if appropriate, testing for anemia and tuberculosis. I certify that the information on this form is accurate and complete to the best of my knowledge.

Name:

Title:

Signature: _____

Date (m/d/yyyy):

Date of Exam (if Different):

Practice/Clinic Name:

Practice/Clinic Address:

Practice/Clinic City:

State:

Zip:

Phone:

Fax:

Provider Stamp Here:



Picture Box

Please paste or staple child's picture here.

Pre K Teacher Perception Survey for students entering WCPS 2020-2021

Child's Name: _____ Date of Birth: _____

Pre-K Teacher or childcare provider's name: _____

School or childcare facility name: _____

Name of school child plans to attend: _____

SECTION I

Based on your personal observations and experience, please mark the column that best describes the child's abilities at this time:

	Most of the time	Some of the time	Not yet
Attitude Toward Learning			
Shows enthusiasm about learning			
Shows curiosity about learning			
Makes own choice in activity selection			
Completes most tasks			
Language and Literacy Development			
Communicates needs and wants verbally			
Communicates thoughts verbally			
Listens with interest to stories read aloud			
Familiar with nursery rhymes/rhyming			
Recognizes some beginning sounds in words			
Recognizes/identifies some letters of alphabet			
Follows two-step directions			
Can say first and last name			
Can print first name			
Mathematical Thinking Development			
Knows the names of some colors			
Knows the names of some shapes			
Sorts by like properties (color, shape, etc.)			

Attempts to count			
Can count up to _____			
Points to objects while counting			
	Most of the time	Some of the time	Not yet
Social and Emotional Development			
Shares toys or objects with other children			
Takes turns with other children			
Expresses feeling with appropriate words			
Keeps hands and feet to self			
Follows classroom routines			
Follows classroom rules			
Physical Development			
Has experience using scissors			
Has experience using glue			
Enjoys writing and coloring			
Zips own clothing			
Snaps and buttons own clothing			
Pedals and steers a tricycle or wagon avoiding obstacles			

Additional Comments About This Child's Abilities:

SECTION II

Please check the appropriate response:

1.) Average length of child's attention span:

- Less than 5 minutes
 5 -- 10 minutes
 More than 10 minutes

2.) Child's overall attendance (coming regularly and following set arrival and departure times):

- Most of the time
 Some of the time
 Rarely

SECTION III

Please circle answers and write responses in the spaces provided:

3.) To the best of your knowledge, has the child been referred to or evaluated by an outside source for special needs or services?

Yes No Do Not Know

4.) If the answer is yes, please explain and give dates (if available), describe any placements either made or in-process, and identify a contact person for further information.

Explanation	Dates of Evaluation or Referral	Describe Any Placements (Made or In-Process)	Contact Person(s) for Further Information

5.) If the answer is no, do you have any academic or social concerns about this child?

Yes No Do Not Know

6.) If the answer is yes, please explain why:

7.) Please use the following space to describe any needs or circumstances in this child's life and hints that would be helpful for a future teacher to know.

Examples: "Has unusual fear of dogs because he was bitten as a toddler."
"Settles down for a rest much faster if she has a stuffed animal to hold."

Needs or Circumstances in this Child's Life	Helpful Hints for Future Teachers

Thank you for completing this **All About Me!** Form.
Your responses will help support this child's smooth transition into Kindergarten.

_____ Signature of person completing this form

_____ Date

_____ Title

_____ Phone Number