



# COTTER

PUBLIC SCHOOLS

AMANDA GIST ELEMENTARY

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## Kindergarten Information

Please complete the packet enclosed and provide a copy of the following:

\_\_\_\_\_ Copy of social security card

\_\_\_\_\_ Copy of current shot record

\_\_\_\_\_ Copy of birth certificate

\_\_\_\_\_ Copy of current physical

\_\_\_\_\_ Copy of a recent utility bill

**Cotter Kindergarten Enrollment Form**

**Email: abarrow@cotterschools.net**

**Fax number: 870-435-1300**

**COTTER ELEMENTARY SCHOOL Student Registration Information**

**Date of Entry** \_\_\_\_\_

**Grade** \_\_\_\_\_

Name \_\_\_\_\_  
(First) (Middle) (Last)

Social Security: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender \_\_\_\_ Race \_\_\_\_

Mailing Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Physical Address (if different from above): \_\_\_\_\_ City \_\_\_\_\_

Home Phone Number \_\_\_\_\_ How student gets to and from school \_\_\_\_\_

Parent/Guardian E-Mail Address: \_\_\_\_\_

Student's Cell Phone Number: \_\_\_\_\_

Student lives with (circle one): Both Parents Mother Only Father Only Legal Guardian  
Mother/Stepfather Father/Stepmother Foster Parent Other: \_\_\_\_\_

Legal Custody (circle one): Both Parents Mother Only Father Only Other: \_\_\_\_\_

Are there any legal restrictions which would prevent your child from being checked out by a particular adult? Yes or No If YES, please provide the office with the legal documents.

PLEASE NOTE THAT ONLY THE PERSONS LISTED BELOW WILL BE ALLOWED TO CHECK THE STUDENT OUT OF SCHOOL. NO OTHER PERSON IS AUTHORIZED WITHOUT PARENT/GUARDIAN APPROVAL.

**\*\*\*\*STUDENT LIVES WITH\*\*\*\***

Name: \_\_\_\_\_ Relationship \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_

**EMERGENCY INFORMATION**

Please list other people we can contact in the event the above are unavailable. These people will also be allowed to check your child out of school.

Name:	Relationship	Phone number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**\*\*IS STUDENT A MILITARY DEPENDENT? (circle one) Yes No**

**\*\*IF SO (circle branch):**

- Active Duty: Coast Guard, Air Force, Army, Marines, Navy OR
- National Guard: Air Force, Army OR
- Reserves: Air Force, Army, Marines, Navy OR
- Parents serve in multiple branches (example: Mom-Army; Dad-Marines) \_\_\_\_\_

**\*\*DOES STUDENT RESIDE IN THE HOUSEHOLD OF THE SERVICE MEMBER: (circle one) Yes No**

**\*\*IS STUDENT PART OF A MULTIPLE BIRTH (twin, triplets, etc.)? (circle one) Yes No**

**\*\*ETHNICITY (circle one): Hispanic/Latino OR NON Hispanic/Latino**

Home Language Survey:

1. What language is spoken in your home most of the time? \_\_\_\_\_
2. What language does the student speak most of the time? \_\_\_\_\_
3. What language do parents speak most of the time? \_\_\_\_\_

Does the student require special services? If yes, circle all that apply:

Speech      Resource      Inclusion      504 Plan      Gifted and Talented

Name, address, and phone number of last school attended: \_\_\_\_\_  
\_\_\_\_\_

Was student promoted to the next grade? (circle one) Yes No

Has student ever been retained? (circle one) Yes No

Has student been suspended or expelled from another school district? (circle one) Yes No

If yes, which school district: \_\_\_\_\_

IS STUDENT **CURRENTLY** SUSPENDED FROM ANOTHER SCHOOL: \_\_\_\_\_

IS STUDENT **CURRENTLY** UNDER ANY EXPULSION PROCEEDINGS: \_\_\_\_\_

If yes, which school district: \_\_\_\_\_

Has student ever been enrolled in Cotter School District: (circle one) Yes No

If yes, when did he/she last attend? \_\_\_\_\_

**Any special circumstances the school should be aware of (recent divorce, death of a loved one, etc.)?** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Travel Information:** Bus \_\_\_\_\_ Car Rider \_\_\_\_\_ Afterschool program: \_\_\_\_\_

**Address where student will be riding bus:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of parent or legal guardian \_\_\_\_\_ Date \_\_\_\_\_

Has your child attended

YES

NO

AR Better Chance (ABC)

\_\_\_\_\_

\_\_\_\_\_

21st Century Comm Lrn Ctr

\_\_\_\_\_

\_\_\_\_\_

Even Start

\_\_\_\_\_

\_\_\_\_\_

Early Childhood Sped

\_\_\_\_\_

\_\_\_\_\_

Headstart

\_\_\_\_\_

\_\_\_\_\_

Private Preschool

\_\_\_\_\_

\_\_\_\_\_

Public School Preschool

\_\_\_\_\_

\_\_\_\_\_

Other

\_\_\_\_\_

\_\_\_\_\_

**PLEASE FILL OUT:**

**Name of student:** \_\_\_\_\_

**Grade & Teacher:** \_\_\_\_\_

**Do you have internet access?** Yes or No

**Do you have a device at your residence?** Yes or No

**Email address:** \_\_\_\_\_

**CHROMEBOOK AGREEMENT**

I have received the handbook which explains the "Chromebook User Policy". I agree to abide by this policy for the 2024-2025 school year. I understand that if I do not sign this I will not be allowed to take a Chromebook home from Cotter Elementary School.

\_\_\_\_\_ My child may bring home his/her Chromebook daily.  
initial

\_\_\_\_\_  
Student signature

\_\_\_\_\_  
Parent signature

\_\_\_\_\_  
Teacher

\_\_\_\_\_  
Grade

\*Kindergarten students will be taking home ipads instead of chromebooks in the event of a school closure. They will not be taking them home everyday.

## PERMISSION TO DISPLAY PHOTO OF STUDENT ON WEBSITE(5.20F1)

I hereby grant permission to the Cotter School District to display the photograph or video clip of me/my student (if student is under the age of eighteen {18}) on the District's website, including any page on the site, or in other District publications without further notice. I also grant the Cotter School District the right to edit the photograph or video clip at its discretion.

The student's name may be used in conjunction with the photograph or video clip. It is understood, however, that once the photograph or video clip is displayed on a web site, the District has no control over how the photograph or video clip is used or misused by persons with computers accessing the District's website.

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Name of student (Printed)

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Signature of student (only necessary if student is over 18)

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Signature of parent (required if student is under 18)

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Date

## ARKANSAS DEPARTMENT OF EDUCATION HEALTH HISTORY

NOTE: To be completed by the parent/guardian of the Kindergarten student prior to the physical examination/nursing assessment (please print).

Student Name (Last, First, Middle) \_\_\_\_\_  
Date of Birth \_\_\_\_\_ School \_\_\_\_\_  
Medicaid Number \_\_\_\_\_ Medicaid Physician \_\_\_\_\_  
Parent/Guardian Name \_\_\_\_\_ Phone \_\_\_\_\_  
Parent/Guardian Name \_\_\_\_\_ Phone \_\_\_\_\_  
Physician Name, Address, Phone \_\_\_\_\_  
Dentist Name, Address, Phone \_\_\_\_\_  
Name and address of private health insurance \_\_\_\_\_

To be completed by parent/guardian (Please circle one):

- |  |     |    |
|--|-----|----|
| 1. Does your child pay attention when being read to?   | Yes | No |
| 2. Can your child play quietly along for over ½ hour?  | Yes | No |
| 3. Does your child mind adults and follow instructions?  | Yes | No |
| 4. Does your child speak clearly enough for others to understand?  | Yes | No |
| 5. Does your child have any speech problems (Stammering, delayed Speech development, etc.)?  | Yes | No |
| 6. Does your child object to being left with a sitter?   | Yes | No |
| 7. Can your child dress without help?  | Yes | No |
| 8. Does your child ever wet or soil him/herself during the day?  | Yes | No |
| 9. Do you have any concerns regarding your child (eating and sleeping habits, bowel or bladder, posture, teeth, skin, weight, etc.)?           | Yes | No |
| 10. Does your child have any eye problems (difficulty seeing, crossed eyes, frequently reddened or watery eyes, wear glasses or contact lens)? | Yes | No |
| 11. Does your child have any ear or hearing problems(frequent earaches, difficulty hearing, draining ear, use of hearing aid, etc.)?           | Yes | No |
| 12. Does your child have allergies (food, insects, drugs, pollens, etc.)?  | Yes | No |
| 13. Does your child have any specific sickness which might, in your opinion, affect his/her school performance or program?                     | Yes | No |
| 14. Do you have any concerns about your child's development behavior or emotional well-being of which the school should be aware?              | Yes | No |

Information on this form may be shared with appropriate personnel for health and educational purposes.

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

### Cotter Public School Emergency Card

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_

Is Student on Medicaid or AR Kids? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please list Medicaid number \_\_\_\_\_ AR kids number \_\_\_\_\_

#### Parent/Guardian Contact information in case of accident/illness

Parent/Guardian name \_\_\_\_\_ Phone \_\_\_\_\_

Place of work/work number \_\_\_\_\_

Parent/Guardian name \_\_\_\_\_ Phone \_\_\_\_\_

Place of work/work number \_\_\_\_\_

#### Emergency contacts if parent/guardian can't be reached

1. \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

2. \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Health Information: List any health conditions that your child has:

_____ ADHD	_____ Food Allergy	_____ High Blood Pressure
_____ Asthma	_____ Heart Disease	_____ Migraine Headache
_____ Bee Sting Allergy	_____ Heart Murmur	_____ Seizures
_____ Diabetes	_____ Hemophilia	_____ Vision Deficit
_____ Seasonal Allergy	_____ Hearing Deficit	_____ Other _____

I, the undersigned do hereby authorize officials of Cotter Public Schools to contact directly the persons named on this card and authorize the named physician to render such treatment as may be deemed necessary in an emergency for the health of said child. In the event the parent/guardian cannot be contacted, the officials are hereby authorized to take whatever action is deemed necessary, in their judgement, for the health of aforesaid child. I will not hold the school district financially responsible for the emergency care and/or transportation for said child. Information on this form may be shared with appropriate personnel for health and educational purposes only.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_



## Consent for "Over-the-Counter Medications"

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Medication Allergies \_\_\_\_\_  
Medications your child takes on a regular basis: \_\_\_\_\_

**It is the parent's responsibility to send any medications that are frequently taken by your child to the school nurse.**

I give permission for my child, listed above, to receive these OTC medications as deemed necessary by the school nurse/designee. I understand that the generic equivalent may be used in place of brand named items. (Draw a line through any medication your child can not have.)

**For headache, fever, muscle aches, menstrual cramps:** Acetaminophen (Tylenol), Ibuprofen (Motrin), Muscle Rub (Icy Hot)

**For mild cold symptoms, sore throat, cough** Cough Drop, Daytime Cough Syrup

**For mild allergic reactions (such as hives, seasonal allergies):**  
Diphenhydramine (Benadryl)

**For mild skin irritations (such as rash, poison ivy, scrapes, cuts):**  
Antiseptic/Analgesic spray/gel/wash, Hydrocortisone Cream, Medcaine Swabs, Antibiotic Ointment, Antifungal Cream, Alcohol, Peroxide, Band-Aid

**For Stomachache:** Antacid (like Maalox or Tums), Pepto Bismal

**For Toothaches:** Oragel

**For Eye Irritations:** Visine, Sterile Eye Wash

**For Chapped Lips:** Carmex, Vaseline

**I acknowledge that the District, its Board of Directors, and employees shall be immune from civil liability for damages resulting from the administration of medications in accordance with this form. The nurse/designee shall administer medications.**

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

In compliance with the Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. 1232g; 34 CFR Part 99)

I, \_\_\_\_\_, give permission for my child, \_\_\_\_\_  
(parent/guardian name) (First & last name)

Personally identifiable information/student education records to be disclosed to Cotter Public Schools for the purpose of billing Medicaid and/or private insurance.

I, also give permission for immunization information on my child to be released to Cotter Public School system for enrollment requirements.

Parent/Guardian Printed Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

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