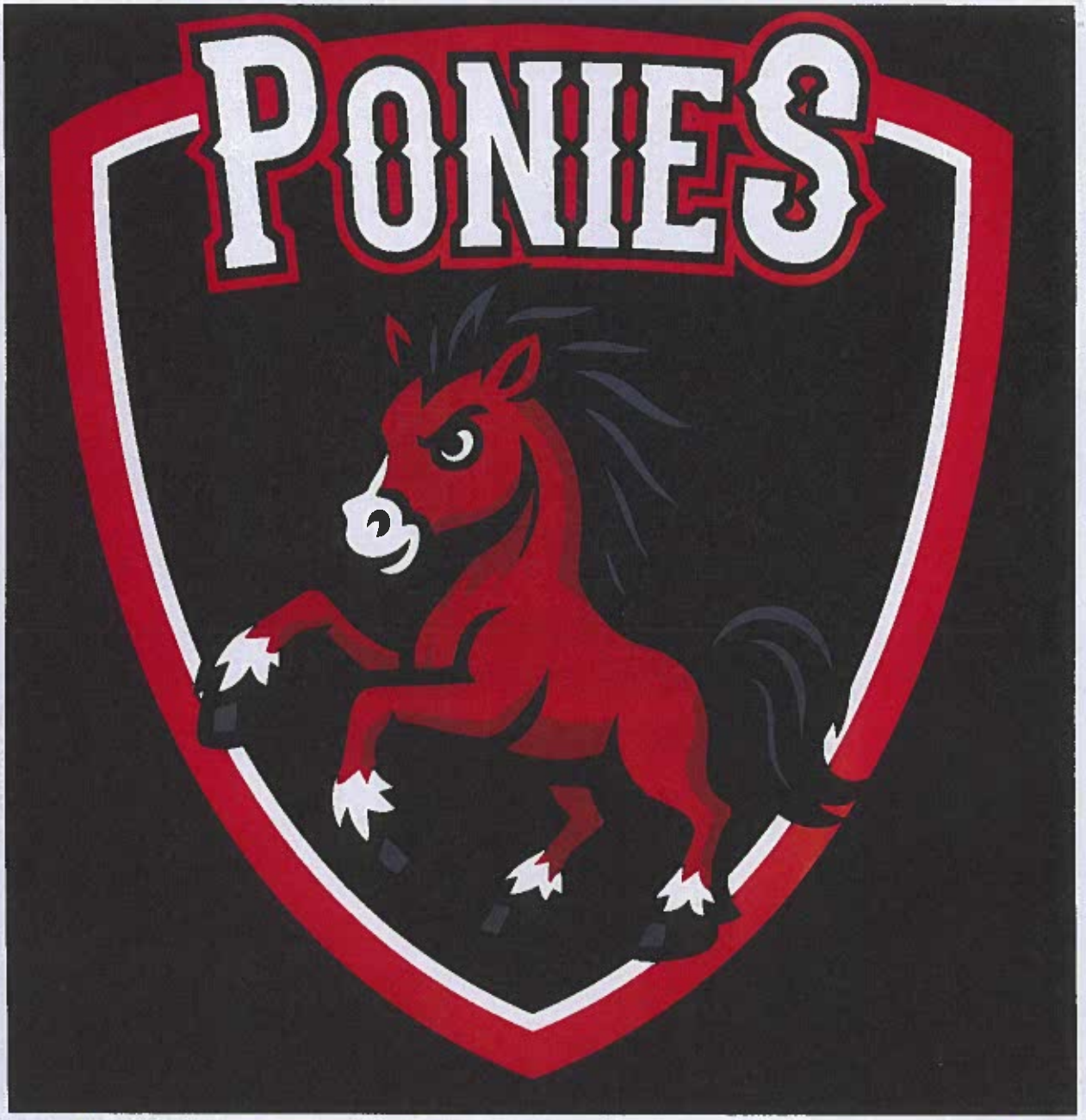
CONECUH COUNTY SCHOOLS'
EARLY LEARNING PROGRAM



Please complete and return

APPLICATION FOR STUDENT ENROLLMENT

Must be completed by Parent/Legal Guardian

PLEASE PRINT

DATE _____ SCHOOL _____ GRADE _____

LAST NAME _____ FIRST NAME _____ MIDDLE NAME _____

DATE OF BIRTH _____ SEX (Circle One): MALE FEMALE HOME PHONE _____

STREET ADDRESS _____ CITY _____ ZIP CODE _____

RACE – Circle One: ASIAN BLACK ISPANIC AMERICAN INDIAN MULTI WHITE PACIFIC ISLANDER

CHILD LIVES WITH (Circle One): PARENTS MOTHER FATHER GUARDIAN: RELATION _____

*SOCIAL SECURITY NUMBER (Voluntary) _____

PARENT(S) / GUARDIAN NAME: **If guardian, provide school with a copy of guardianship papers. **

Mother/Guardian _____	Address _____
Email Address _____	Cell Phone _____
Employer _____	Work Phone _____

Father/Guardian _____	Address _____
Email Address _____	Cell Phone _____
Employer _____	Work Phone _____

SPECIAL INFORMATION ABOUT CUSTODY _____

EMERGENCY CONTACTS:

EMERGENCY #1 DOB EMERGENCY #2 DOB

CONTACT _____ CONTACT _____

Relation _____ Phone _____ Relation _____ Phone

THESE PEOPLE HAVE PERMISSION TO CHECK MY CHILD OUT OF SCHOOL: (In accordance with the school's checkout policy)

1. _____ Relation _____ Phone _____
2. _____ Relation _____ Phone _____
3. _____ Relation _____ Phone _____

NAME AND ADDRESS OF FORMER SCHOOL (if applicable): _____

_____

PARENT SIGNATURE _____

*Disclosure of your child's social security number (SSN) is voluntary. If you elect not to provide a SSN, a temporary identification number will be

ALABAMA STATE DEPARTMENT OF EDUCATION
EMPLOYMENT SURVEY

SCHOOL SYSTEM: Conecuh County SCHOOL YEAR: 2025-2026

SCHOOL:_____GRADE:_____

Dear Parents or Guardians;

Please, complete the following survey. The results of this survey will be used to determine if you are possibly eligible for the Migrant Education Program.

Student Name:_____

Name of Parent or Guardian:_____

Address:_____

Telephone Number:_____

1. Have you moved during the last 3 years to work or to seek work even if it was for a short period of time? YES_____ NO_____

2. Are you or your spouse working or have you worked in an activity directly related to some of the following? Please, check (√) all applicable:

   - ☐ The production or process of harvests, milk products, poultry farms, poultry plants, cattle farms
   - ☐ Fruit farms
   - ☐ The cultivation or cutting of trees
   - ☐ Work in nurseries or sod farms
   - ☐ Fish or shrimp farms
   - ☐ Worm farms
   - ☐ Catching or processing seafood (shrimp, oysters, crabs, fish, etc.....)

3. From what city, state or country did you come from? _____

   _____

4. What type of work did you or your spouse do before coming here? _____

   _____

No person shall be denied employment, be excluded from participation in, be denied the benefits of, be subjected to discrimination in any program or activity on the basis of sex, age, race, religious belief, national origin, ethic group, or disability

Conecuh County School District
HOME LANGUAGE SURVEY

Student Name: _____ Birth Date: _____ Gender: □ Male □ Female

Parent/Guardian Name: _____

Address: _____

Home Telephone: _____ Work Telephone: _____

School: _____ Grade: _____ Date: _____

Federal and state laws require the following information be collected about the primary and home language of every student upon enrollment in the school district. Please complete a survey for each child you are enrolling in the school district.

1. What language did your child learn when he/she first began to talk? _____
2. What language does your child most frequently speak at home? _____
3. What language is spoken by you and your family most of the time at home? _____

If a language other than English is indicated for any of the above questions, the school district will test your child's English language proficiency to determine eligibility for initial and continuing placement in an English language development program. You will be notified about the results of this testing.

4. If available, in what language would you prefer to receive Information from the school? _____
5. Was your child born in the United States? □ Yes □ No

   If yes, in which state? _____

   If no, in what other country? _____
6. Has your child attended any school in the United States for any three years during their lifetime? □ Yes □ No

_____ _____

Parent or Guardian's Signature Date

No person shall be denied employment in, be excluded from participation in, be denied the benefits of, or be subjected to discrimination in any program or activity on the basis of sex, age, race, religious belief, national origin, ethnic group or disability.

ALABAMA STATE DEPARTMENT OF EDUCATION

Parent Survey

for Newly Enrolled Students

SCHOOL SYSTEM
SCHOOL NAME

DIRECTIONS

Please complete the following survey. Your child may be eligible for FREE additional educational services. If you answer yes to any of the questions below, an education representative may contact you to find out whether you, your child, or any member of your family is eligible for the migrant education program. All information will be kept confidential.

Please return the completed questionnaire to your child's school.

RELOCATION HISTORY

Have you ever traveled in or out of Alabama to work or find work in any of the pictures below in the past three (3) years?	☐ Yes	☐ No
Are you or your spouse currently working in agriculture, farming, fishing or any of the pictures below?	☐ Yes	☐ No
Mark all pictures of agriculture, farming, or fishing where you have worked in the past 3 years. See pictures below.	☐ Yes	☐ No

Other work you have done that is not shown in a picture below: _____

Fruit or Tomato Farms ☐ Yes 	Fish or Shrimp Farms ☐ Yes 	Nursery, greenhouse, sod farm ☐ Yes 	Planting / Harvesting Crops ☐ Yes 
Cattle Farms; Milk Products ☐ Yes 	Hatchery; feeding, processing chickens, gathering eggs ☐ Yes 	Working on a worm farm ☐ Yes 	Growing, tending, felling trees ☐ Yes 

PARENT INFORMATION

PARENT / GUARDIAN

ADDRESS	CITY	STATE	ZIP
PHONE NUMBER	PLACE OF EMPLOYMENT		
NUMBER OF CHILDREN IN HOME		DATE OF MOVE	

Revised 5/25/18

CONECUH COUNTY BOARD OF EDUCATION

McKinney-Vento Enrollment Form

This questionnaire is intended to address the issues identified in the ESSA McKinney-Vento Act. Your answers will help the administrator determine residency documents necessary for enrollment of this student.

1. Presently, where is the student living? Check one box:

Section A	Section B
☐ Shelter, transitional housing, awaiting foster care ☐ Doubled-up (e.g., living with another family) ☐ Unsheltered (e.g., car, park, abandoned building, temporary trailer, or campsite) ☐ Motel/Hotel CONTINUE: If you checked a box in Section A, complete #2 and the remainder of this form.	☐ Choices in Section A do not apply STOP: If you checked this section, you do not need to complete the remainder of this form. Submit to school personnel.

2. The student lives with: (check all that apply)

- o 1 parent
- o 2 parents
- o 1 parent & another adult
- o a relative, friend(s) or other adult(s) that is a Conecuh Co. School District resident
- o alone with no adults
- o an adult that is not the parent or the legal guardian

3. Is this a temporary living arrangement? ○ Yes ○ No

4. Is this temporary living arrangement due to loss of housing or economic hardship? ○ Yes ○ No

School:_____ Grade:_____

Name of Student_____ Male Female

Birth Date____/____/____ Age:_____ Social Security# _____
Month / Day / Year (If unavailable, assign)

Name of Parent(s)/Legal Guardian(s) _____

Address_____ ZIP:_____ Home Phone:_____
Cell Phone:_____

Signature of Parent/Legal Guardian:_____ Date: _____

**List ALL Other Children and Age(s):_____

If the parent has checked Section B above, completion of form is not required and you do not need to forward the form to the Central Office

Campus Administrator's determination of Section A circumstances: (Complete prior to emailing)

(ITEM #3: If no is answered, it is not a qualifying Homeless situation. If yes is answered, it could be a Homeless situation.

HOMELESS:_____ NOT HOMELESS: _____

Comments:

DATE: _____ School Homeless Liaison: _____
Signature

For any choices in Section A, this form must be completed and faxed or emailed to Dr. LeAnn Smith, Homeless Liaison, immediately after completion. All campuses must keep original forms separately from the Student Permanent Record for audit purposes during the year.

I certify, based on information submitted by the school and verified by the Principal, the above named student qualifies under the McKinney-Vento Act.

DATE_____ Central Office Homeless Liaison_____

ALABAMA STATE DEPARTMENT OF EDUCATION

HEALTH ASSESSMENT RECORD

School Year: 2025 - 2026

To Parent or Guardian:
The purpose of this form is to provide the school nurse with additional information regarding your child's health needs. The school nurse may contact you for further information. The information requested is essential for the school nurse to meet the health needs of your child.

This information will be kept confidential.

PLEASE complete both sides of this form (Return to the School Nurse)

Name of Student (Last, First, Middle)	Birth Date	Sex	School

Address (Street)

Home Telephone Number:	Cell Phone Number:	Additional Phone Number:	Grade	Teacher/Homeroom

Name of Parent/Guardian (Last, First Middle) | Work Phone Number:

Transportation

☐ Bus Rider Bus Number: ☐ Car Rider ☐ Special Needs Bus ☐ After School

Part I – Health Information

Place your child receives health care:

Physician's Name: _____

Address: _____

Phone: _____

☐ Community Health Center
☐ Health Department
☐ Hospital Clinic
☐ No Regular Place
☐ Private Doctor /HMO

Your child's Insurance Information:

☐ ALL KIDS
☐ Medicaid
☐ No Insurance
☐ Other _____
☐ Private Insurance

Place your child receives dental care:

Dentist's Name: _____

Address: _____

Phone: _____

☐ Community Health Center
☐ Health Department
☐ Hospital Clinic
☐ No Regular Place
☐ Private Dentist /HMO

Preferred Hospital: _____

Part II – Medical History Medical Equipment /Procedures Required at School

☐ Catheter ☐ Gastric Tube ☐ Nebulizer Treatments ☐ Oxygen Supplement ☐ Tracheostomy

☐ Vagal Nerve Stimulator (VNS) ☐ Ventilator ☐ Wheelchair ☐ Walker

☐ Other *Please explain:*

Medications and Procedures at School require a Prescriber/Parent Authorization Form (one for each medication or procedure) Please see your school nurse.

Please Complete Back of Form (Signature Required)

ALABAMA STATE DEPARTMENT OF EDUCATION

HEALTH ASSESSMENT RECORD

School Year: 2025 - 2026

Name of Student **Part III – Medical History**

YES NO	KNOWN HEALTH PROBLEMS If **NO**, go directly to the bottom of the page and provide parent/guardian signature If **YES**, and diagnosed by a physician, answer each question below.
YES NO YES NO	**Attention Deficit Disorder (ADD)** **Attention Deficit Hyperactivity Disorder (ADHD)** Requires medication ☐ At school ☐ At Home
YES NO	**Allergies:** ☐ **Food** _____ ☐ **Insects** _____ ☐ **Environmental** _____ ☐ **Medications** _____ ☐ Hives/rash ☐ Medications ☐ Breathing difficulty ☐ Epi-pen ☐ Other:
YES NO	**Asthma** ☐ Uses an inhaler at school ☐ Uses an inhaler at home
YES NO	**Blood/Bleeding Problems:** ☐ **Hemophilia,** ☐ **Von Willebrand's,** ☐ **Other** ☐ **Requires medication** ***Please explain:***
YES NO	**Frequent Nose Bleeds:** *Please explain*
YES NO	**Cancer/Leukemia:** *Please explain*
YES NO	**Cerebral Palsy:** *Please explain*
YES NO	**Cystic Fibrosis:** *Please explain*
YES NO	**Dental Problems:** *Please explain*
YES NO	**Diabetes** ☐ **Type 1 Diabetes** ☐ Monitors Blood Sugars at school ☐ Requires insulin at school ☐ Insulin pump ☐ Glucagon order ☐ **Type 2 Diabetes** ☐ Managed with diet ☐ Oral medication
YES NO	**Emotional/Behavioral/Psychological:** *Please explain*
YES NO	**Gastrointestinal/Stomach Problems:** *Please explain*
YES NO	**Genetic / Rare Disorders:** *Please explain*
YES NO	**Headaches:** *Please explain*
YES NO	**Hearing Problems:** ☐ Right Ear ☐ Left Ear ☐ Both ears ☐ Hearing loss ☐ Hearing aid ☐ Tubes ☐ Cochlear Implant
YES NO	**Heart Condition:** ☐ **Activity restrictions** ☐ **Medications taken at home** *Please explain*
YES NO	**Hypertension (High Blood Pressure):** *Please explain*
YES NO	**Juvenile Arthritis/Bone-Joint Problems:** *Please explain*
YES NO	**Kidney/ Bladder/ Urinary Problems:** *Please explain*
YES NO	**Scoliosis:** ☐ No Treatment ☐ Wears Brace ☐ Surgery ☐ Family History
YES NO	**Seizures/Convulsions:** Type of seizure _____ *Medications:* ☐ Diastat ☐ Klonopin ☐ Versed ☐ Medication taken at home ☐ Other _____ *Please explain*
YES NO	**Sickle Cell:** ☐ Anemia ☐ Trait
YES NO	**Shunt:** ☐ VP shunt *Please explain*
YES NO	**Spina Bifida:**
YES NO	**Special Diet:** *Please explain*
YES NO	**Vision Problems:** ☐ Wears glasses ☐ Wears contacts ☐ Other
YES NO	**Other Medical Conditions:** *Please include <u>any</u> medications taken at home only.*

Required Signatures

(Electronic or Written) Parent(s) or Guardian Signature: _____ **Date:** _____

(Electronic or Written) School Nurse Signature: _____ **Date:** _____

Conecuh County Schools' Early Learning Program

Mrs. Monica Mitchell, PreK Director

PHOTOGRAPHIC RELEASE FORM

During the 2025-2026 school year, your child may be involved in activities at Conecuh County Schools' Early Learning Program which may involve photographing, filming, and/or videotaping. These activities include, but may not be limited to the following:

- Photographs for the local newspaper
- School Facebook updates
- Public relation activities to include pictures of your child in slide presentations, videos, or television stations

Please sign and return the release below.

_____ I give permission for my child to be photographed, filmed, or videotaped, as described above.

_____ I do not give permission for my child to be photographed, filmed, or videotaped, as described above.

_____ _____

Parent's Signature Date

UNIVERSAL FIELD TRIP PERMISSION FORM

I _____ give permission for my child _____
(Print Parent/Legal Guardian's Name) *(Print Child's Name)*
to accompany his/her class on all CCS-sponsored field trips. Information regarding individual trips will be provided to me by the school in advance of all field trips.

- I understand that I will be notified in advance of any cost, the date, and time of departure, and the anticipated return time.
- In granting permission, I assume responsibility for any damage to person(s) or property that might be caused by my child while they are participating in a field trip.
- I agree that if it is necessary for my child to receive medical treatment during the course of the trip, I will be contacted and will be responsible for any and all relevant medical costs.
- I agree that if the behavior or health of my child should result in him/her being sent home prior to the expected return time, I will be responsible for making the necessary arrangements.
- I agree that I will not hold the Conecuh County Board of Education responsible for any loss of personal property while on a field trip.
- I understand that I have the right to refuse that my child attends any field trip.

I, _____ , certify that I am the parent/legal guardian of
_____ (Please Print) and I understand that all school policies and procedures, including those outlined in the Code of Student Conduct will apply to my child while on school-sponsored field trips.

I further agree to indemnify and hold harmless, the faculty sponsor, volunteer chaperone, the Board of Education its agents, employees, and representatives from and against any and all claims, suits, or causes of action which I or my child may have or claim to have for any injuries arising from, out of, during or in connection with my child's participation in the field trip or the rendering of emergency medical care or treatment.

Parent Signature: _____ Date: _____

This form will cover all field trips that your child will participate in this school year. The form must be signed and returned for your child to take part in any field trips. You will always receive advance notice and information about upcoming trips. Your child will not go on any field trip without you being notified prior to the trip.

Conecuh County Schools' Early Learning Program

Dear Parent/ Guardian,

If your child has a medical condition which may limit his/her activity during P.E. or any other program we may have, please complete the following information and return it to your child's teacher.

Thank you,
Monica Mitchell
PreK Director

Child's Name: _____

Child's Teacher: _____

Type of medical condition:

_____

_____

_____

Limitations of child:

_____

_____

_____

Do you have a doctor's statement about this problem on file?

_____

_____

_____

Conecuh County Schools' Early Learning Program

Mrs. Monica Mitchell, PreK Director

Conecuh County Schools' Student Handbook

A digital copy of the Student Handbook can be viewed on our Conecuh County Board of Education website at https://www.conecuh.k12.al.us/. It can be found by clicking Departments, Human Resources, Document Uploads, Student Handbook. If you have any questions, please contact the office.

NOTE: Please have the student return to his/her homeroom teacher.This ACKNOWLEDGMENT becomes a part of the student's cumulative file.

CONECUH COUNTY SCHOOLS HANDBOOK ACKNOWLEDGMENT

We acknowledge that we have viewed a copy of and have read, or had read to us, the foregoing Conecuh County Schools Student Code of Conduct & Grading Policy and the Parent/Student Compact, and we fully understand the terms thereof I am fully aware of my responsibility to see that my child attends school daily and properly conducts himself/herself, and of the penalty for my failure to do so. Each parent must notify their child's principal, teacher, bus driver, and other personnel regarding any health issue affecting their child. Parents are responsible for damage or loss to any and all school property that may be lost or damaged by their child. Students are strongly discouraged from bringing personal items of value (cell phones, iPods, cameras, electronic games, radios, CD players and computers, etc) to school since loss, theft, or damage is possible. Also, such items can be distracting to the educational process and may be confiscated by school personnel. The school system is not responsible for damaged, lost or stolen items including those in lockers or those that have been confiscated by school board personnel.

_____ _____

(Signed) Student Date

_____ _____

(Signed) Parent/ Guardian/ Custodian Date

CORPORAL PUNISHMENT

(Please check one)

I DO____ or DO NOT____ prefer that corporal punishment (paddling) be used as a disciplinary measure for my child. However, I acknowledge the right of the school system's authority to use any and all disciplinary measures provided for under board policy, statutory and case law, including paddling.

_____ _____

(Signed) Parent/ Guardian/Custodian Date

ANNUAL NOTIFICATION REGARDING SCHOOL PROVIDED OR SPONSORED MENTAL HEALTH SERVICES

Mental Health Services

The school system provides or sponsors the following mental health services[1] [**Note:** Systems are required to include the purpose and general description of each of the mental health services provided here. The following list contains examples, but should be updated to reflect the services your local school system provides]:

1. **Assessments or Surveys** - includes questionnaires provided to students related to social behaviors, feelings, etc.
2. **Crisis intervention** - short-term, immediate assistance by school counselor or professional for a specific situation.
3. **School-Based Mental Health** - On-going counseling services by school professionals or private practitioners in the school setting. [**Note:** Most school systems obtain written permission for outside counseling or one-on-one school counseling and will continue to do so. If that is the case, you may wish to add the following language to this paragraph: Parent or legal guardian's permission will be obtained during an intake meeting before services are provided.]

Review of Materials

You may request to review any materials used in the guidance and counseling programs available to students by contacting the student's principal [**Note:** You may choose another person for the parent to contact or another method for parents to obtain information.]

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[1] For purposes of this notification and policy, "mental health services" includes services, treatment, surveys, or assessments relating to mental health; however, it does not include instructional activities designed to educate students regarding topics related to mental health (1) contained in the school system's approved curriculum or (2) otherwise required to be taught by law (e.g., Erin's Law; Jamari Terrell Williams Student Bullying Prevention Act). "Ongoing school counseling services" for purposes of a required Opt-In shall not include those school counseling services which are split into domains not requiring a mental health therapist or other mental health therapeutic license.

OPT-IN FOR MENTAL HEALTH SERVICES BY PARENT OR LEGAL GUARDIAN

No student under the age of fourteen may participate in ongoing school counseling services including, but not limited to, mental health services, unless (1) the student's parent or legal guardian has submitted a written opt-in granting permission for the student to participate or (2) there is an imminent threat to the health of the student or others.

For purposes of this policy, "mental health services" includes services, treatment, surveys, or assessments relating to mental health; however, it does not include instructional activities designed to educate students regarding topics related to mental health (1) contained in the school system's approved curriculum or (2) otherwise required to be taught by law (*e.g.*, Erin's Law; Jamari Terrell Williams Student Bullying Prevention Act). Furthermore, "ongoing school counseling services" shall not include those school counseling services which are split into domains not requiring a mental health therapist or other mental health therapeutic license."

This policy is not applicable to any school counseling services or "mental health services" contained in a student's PST, IEP, or §504 plan. Consent for those services will be obtained in accordance the specific procedures required by federal and/or state law, and information regarding any mental health services will be provided in the pertinent plan.

A. **Written Notification** – At least annually, the school system shall provide parents and legal guardians a written notification regarding school provided or sponsored mental health services. The notification will include the purpose and general description of each of the mental health services available; information regarding ways parents may review materials to be used in guidance and counseling programs available to students; and information regarding ways parents may allow, limit, or prevent their student's participation in the programs.

The written notification may be provided electronically, including through the school system's online enrollment portal or by such other means and methods as are customarily used for such purposes.

B. **Opt-In To Participate in Mental Health Services** –

1. *General Requirement* – For a student under the age of fourteen to participate in mental health services, written permission by the student's parent or legal guardian is required annually. The written permission must be specific as to any treatment and not broad in nature. Parents and legal guardians may be provided the opportunity to opt-in electronically during online enrollment or by such other means and methods as are customarily used for such purposes.

2. *Rescinding Permission* – A parent or guardian may rescind permission for a student to participate in mental health services at any time by providing written notice to school administration [**Note:** School systems who want parents to submit this notice to a particular person should simply insert the person's title in place of "school administration" (*i.e.*, principal, school counselor, etc.)].

OPT-IN FOR MENTAL HEALTH SERVICES

As of the date of my signature below, my child, _____, is under the age of 14 years old:

€ Yes
€ No

If No, stop here.

If Yes, continue below.

I hereby give my permission for my child to participate in the following mental health services:

[Check the box for each mental health service you want to be available to your child]

€ **Assessments/Surveys** – includes questionnaires provided to students related to social behaviors, feelings, etc.

€ **Crisis intervention** - short-term, immediate assistance by school counselor or professional for a specific situation.

€ **School-Based Mental Health** - On-going counseling services by school professionals or private practitioners in the school setting. **[Note:** Most school systems obtain written permission for outside counseling or one-on-one school counseling and will continue to do so. If that is the case, you may wish to add the following language to this paragraph: Parent or legal guardian's permission will be obtained during an intake meeting before services are provided.]

You may rescind permission for a student to participate in mental health services at any time by providing written notice to school administration **[Note:** School systems who want parents to submit this notice to a particular person should simply insert the person's title in place of "school administration" (i.e., principal, school counselor, etc.)].

_____
Parent/Guardian Name (Printed)

_____
Parent/Guardian Name (Signature)

Date: _____

Appendix D: Health Screenings Permission and Review Form

The Alabama First Class Pre-K program is committed to making sure that pre-k children are healthy. To do this, our classrooms offer onsite health screenings at no cost. Please check the screenings you agree to allow medical personnel (such as nurses) and/or trained professionals to administer to your child. You may also choose to opt out of some or all of the screenings if you do not wish for your child to participate.

I agree that my child may participate in the following screenings:

_____ Vision

_____ Dental

_____ Hearing

_____ Physical

_____ All of the above

****

_____ My child has been screened within the last year for one or more of the above screenings and a copy of the screening(s) is attached.

****

_____ I do ***not*** want my child to participate in any health screenings offered through the Alabama First Class Pre-K program.

_____
Student Name

_____ _____
Parent/Guardian Signature Date

_____ _____
Teacher Signature Date

TO BE COMPLETED AFTER PARENT/GUARDIAN HAS REVIEWED SCREENING RESULTS

I have been given the opportunity to review the results of the health screenings my child received. PARENT/GUARDIAN SHOULD NOT SIGN BELOW UNTIL RESULTS HAVE BEEN REVIEWED!

_____ _____
Parent/Guardian Signature Date

Appendix H: Parent/Guardian Contract

Child's Full Name: _____

Name of Class: _____ County: _____

Lead Teacher: _____

The intent is for your child to gain the greatest possible benefits from this preschool experience. As space is limited, selection to the program is a privilege that requires parental responsibilities. Each parent is asked to carefully consider the following requirements for participating in the program. Your signature will acknowledge that you understand and agree to abide by these guidelines.

I agree to:

- Attend an orientation session at the beginning of the school year
- Attend two scheduled family conferences (one per semester)
- Attend additional conferences when requested to discuss my child's progress
- Complete a minimum of 12 hours of parent involvement
- Have my child at school by _____ a.m. (children are not admitted into the building before _____ a.m.)
- Pick up my child at _____ p.m. (children must be picked up no later than _____ p.m.)
- Send a written parent/doctor excuse to my child's teacher for every absence
- Submit all required forms and documentation to my child's teacher by given deadlines, such as the ASQ-3 Developmental Screener. (This screener is entered into the Enterprise Data Base System and may provide your family with connections to resources/support to benefit your child/family. Your child's teacher will provide instructions on the completion of the ASQ-3).
- Assume responsibility for my child's conduct and progress
- Work cooperatively with my child's teachers and other site personnel
- Give the ADECE permission to assess and follow the academic performance of my child
- Give permission to use my child's demographic information for ADECE reports and publications (no identifiable information will be directly associated with your child)
- Give permission for my child to receive any additional assessments administered for the First Class Pre-K program

I understand that this program is voluntary and that as the parent/guardian it is my responsibility to adhere to this Parent Contract and to work with the program to resolve any issues that may arise during the school year.

Parent/Guardian Signature: _____

Date: _____