Pioneer Springs Community School

9300 Bob Beatty Road, Charlotte, NC 28269
P.O. Box 480537
(p)704.494.0777 (f) 704.494.0288
www.PioneerSprings.org
Email: StudentRecords@PioneerSprings.org

Enrollment Packet
2019 – 2020 School Year

We are pleased to welcome you and your child to Pioneer Springs Community School! Please be advised that several hundred students entered our lottery this year, and more are applying daily. We have a waiting list of students who would like to learn with us, so we ask that you seriously consider your decision of accepting or declining your child's seat with a clear understanding of the philosophies and practices of Pioneer Springs.

To secure your child's seat, please complete the enclosed Enrollment Packet and submit with it the required additional documents within ten (10) calendar days of the lottery/acceptance email that was sent to you. Although we prefer to receive a completed Enrollment Packet in its entirety, we will enroll your student and secure his or her seat if you **submit in-person the following *minimum list of required documents* within ten (10) calendar days of the lottery / acceptance email that was sent to you:**

- **Enrollment Packet, pp. 1-4**
- **CERTIFIED Copy of Birth Certificate**
- **Proof of Residence** *(NC Driver's License or ID card -or- utility bill w/in past 30 days)*

The following checklist should help you organize your efforts to submit the remaining items by their required due dates:

- Enrollment Packet, pp. 5-10 *(due as soon as possible)*
- Health Assessment Report for Kindergartener *(due 08-14-2019)*
- Immunization Records *(due 10-25-2019)*

We are very passionate and committed to educating Pioneer Springs students in a holistic manner. Our nature-based approach is unique, and we want all parents to understand our school philosophy. We encourage you to check our school website and our official Pioneer Springs Community School Facebook page regularly for new information and upcoming community events. We are thrilled you are joining our Pioneer Springs family, and we look forward to our journey together!

With much peace and gratitude,

Erin C McDonald

Erin McDonald
Founding Director of Advancement and Community

ErinM@PioneerSprings.org

STUDENT ENROLLMENT FORM (2019 - 2020)

Birth Certificate Attached? YES NO
(Must submit certified birth certificate to enroll)

STUDENT DEMOGRAPHIC INFORMATION

Legal Last Name: _____

Legal First Name: _____

Preferred Name: _____

Legal Middle Name: _____

Gender: _____

Birthdate: _____

Born in US ___ yes or no (circle one)

Ethnicity: **(Check One:)**
- ◯ Hispanic / Latino
- ◯ Non-Hispanic / Non-Latino

Race: _____

**Race: _____
***Additional Race Field for Multi Racial Use Only*

APPROVED CARPOOL LIST

In addition to Parent/Guardian #1 and #2 above, the following are authorized to pick up my child:

Parent/Guardian Name/Date/Signature:

Name / Phone#: _____

Relationship to Child: _____

Name / Phone#: _____

Relationship to Child: _____

Name / Phone#: _____

Relationship to Child: _____

Special Services? IEP 504 NO

Immunization Records Attached? YES NO

PARENT / GUARDIAN INFORMATION

Living With (Relation): _____

#1 Living With (Name): _____

#2 Living With (Name): _____

HOME ADDRESS INFORMATION

Street Number: _____

Apartment Number: _____

Street Name: _____

City: _____

Zip Code: _____

County / City School System Zoned to Presently *(e.g., CMS, Cabarrus County Schools)* _____

PARENT / GUARDIAN CONTACT INFO

Main Household Phone#: _____

#1 Parent/Guardian Phone _____

#1 Parent/Guardian Email _____

#2 Parent/Guardian Phone _____

#2 Parent/Guardian Email _____

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Parent/Guardian, please complete the following contact information for the school your child last attended, as well as the box at the bottom authorizing Pioneer Springs to request a copy.

Records Request Authorization

Contact Information for School Last Attended:

School Name:	
Street Address:	
City, State, Zip:	
Phone:	
Fax:	

Please send the records indicated below to:

Pioneer Springs Community School
Student Records
9300 Bob Beatty Rd.
Charlotte, NC 28269

EMAIL to: ***StudentRecords@PioneerSprings.org***
- or -
FAX to: 704-494-0288

Please provide the following information:

- Grades to date by marking period or final grade *(Please include the grading codes.)*
- Attendance records
- All available test scores
- Health and Immunization records
- Copy of Birth Certificate

- Psychological evaluations *(if applicable)*
- IEP/504/PEP/ELL records *(if applicable)*

Parent/Guardian, please provide student name, DOB, your signature, and date:

_____ _____
Student's Full Name DOB

_____ _____
Parent / Guardian Signature Date

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Parent/Guardian, please replace this page in your student's Enrollment Packet with an original, certified copy of his or her Birth Certificate!

CERTIFIED COPY OF STUDENT BIRTH CERTIFICATE

(Insert here.)

Important Note:

You must provide this document within the timeframe allotted you to claim your child's seat.

We cannot enroll your child without this document.

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Parent/Guardian, please replace this page in your student's Enrollment Packet with a copy of your Proof of North Carolina Residence!

PROOF OF NORTH CAROLINA RESIDENCE

(Insert here.)

Acceptable Documents
(Place a checkmark beside the one you are providing.)

- ○ Utility Bill
- ○ Work Order
- ○ Valid N.C. Driver's License
- ○ Valid N.C. Identification Card

Important Note:
You must provide this document within the timeframe allotted you to claim your child's seat.

We cannot enroll your child without this document.

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Parent/Guardian of Kindergartener,
please replace this page in your student's Enrollment Packet with a copy of NC Form #PPS-2K *(a blank of which follows this page).*

There is a section of this form that must be completed by a physician.

NORTH CAROLINA KINDERGARTEN
HEALTH ASSESSMENT REPORT
(NC Form #PPS-2K)

(Insert here.)

Important Note:
You must provide this document by the due date noted at the top of the blank form, or your child will forfeit his / her seat.

Your child will forfeit his or her seat in Kindergarten if we do not receive this completed form by the due date.

PPS-2K Rev. 1/11

NORTH CAROLINA
KINDERGARTEN HEALTH ASSESSMENT REPORT

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

DUE ON OR BEFORE: 8/14/2019

Personal Data *Please bring your child's shot records with you to this visit*

PARENT COMPLETE

Please Print Clearly - See other side for more required information. Please present completed form to your child's school.

Child's Name _____ _____ _____
(Last) (First) (Middle)

Birth Date: ____/____/ 20 ____ (mm/dd/yyyy)

Address: _____ City: _____ State: _____ Zip: _____

Parent/Guardian Name: _____ Phone: _____

Yes	No	
☐	☐	Are you concerned about your child's health, weight, development or behavior?
☐	☐	Does anyone in your family have a condition that has affected their health, weight, development or behavior? **(Please explain in the comments section)**
☐	☐	Has your child been seen by a provider for any health, weight, development or behavior concern?
☐	☐	Has your child had a dental exam by a dentist in the last 12 months?
☐	☐	Has your child had a well-child visit or check-up in the last 12 months?

Comments: _____

Parental Consent: I agree to allow my child's health care provider and school personnel to discuss information on this form and allow the Department of Health and Human Services to collect and analyze information from this form to better understand health needs of children in NC. Signature: _____ Date: _____

HEALTH CARE PROVIDER COMPLETE

Recommendations to School Personnel Based on Health Assessment

☐ **No Recommendations, Concerns or Needs** ☐ **Requesting School Follow Up**

☐ **Medication**

☐ Child takes medicine for specific health conditions:

List medication(s): 1. _____ 3. _____
2. _____ 4. _____

☐ Medication must be given and/or available at school

☐ **Allergy**

☐ Food: _____ ☐ Insect: _____ ☐ Medicine: _____ ☐ Other: _____

Type of allergic reaction: ☐ Anaphylaxis ☐ Local reaction

Response required: ☐ Epinephrine Auto-injector ☐ Other: _____ ☐ None

☐ **Developmental Concerns Identified** (See comments below)
Child needs referral to school support team for further evaluation.

☐ **Special Diet**
Guidance: _____

☐ **Health-Related Recommendations to Enhance School Performance**
For example: sitting near the front of classroom, special equipment needs.
Please specify: _____

☐ **School Health Forms Attached**

☐ School Medication Authorization Form ☐ Diabetes Care Plan ☐ Asthma Action Plan

☐ Health Care Plan(s) List Condition _____

Comments: _____

Was this assessment completed in the child's regular health care provider's office? ☐ ***yes*** ☐ ***no***
If no, please provide a copy to the child's parent to give to the child's regular health care provider.

Health Care Professional's Certification - Attach a copy of the immunization record.

I certify that the information on this form is accurate and complete to the best of my knowledge.

Provider's Name: _____

Provider's Signature: _____ Date: _____

Practice/Clinic Name: _____

Practice/Clinic Address: _____

Practice/Clinic City, State & Zip: _____

Practice Phone: _____ Fax: _____

Provider Stamp Here

Personal Data

PPS-2K Rev. 1/11

PARENT COMPLETE

Child's Birthdate:_____ /_____ 20 _____ (mm/dd/yyyy)

Sex: ☐ 1 Male ☐ 2 Female

County of Residence: _____

Zip Code: _____

School your child will be attending:

_____

Place where your child gets regular health care:

☐ 1 Health Department
☐ 2 Hospital Clinic
☐ 3 Community Health Center
☐ 4 Private Doctor/HMO
☐ 5 Other _____
☐ 6 No regular place

Race: ☐ 1 Other Non-White ☐ 2 White ☐ 3 Black ☐ 4 American Indian ☐ 5 Chinese ☐ 6 Japanese ☐ 7 Hawaiian ☐ 8 Filipino ☐ 9 Other Asian ☐ 10 Unknown

Hispanic or Latino Origin: ☐ 1 Yes ☐ 2 No

Child has:
☐ 1 Medicaid
☐ 2 Private Insurance/HMO
☐ 3 No Insurance
☐ 4 Other: _____

Doctor/Practice Name: _____

Dentist Name: _____

HEALTH CARE PROVIDER COMPLETE

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
☐ Anemia ☐ At-Risk for Anemia
☐ Asthma
☐ Attention/Learning
☐ Bleeding Disorder
☐ Cancer/Leukemia
☐ Cerebral Palsy
☐ Cystic Fibrosis
☐ Dental Conditions
☐ Diabetes
☐ Emotional/Behavioral
☐ Encopresis
☐ Enuresis (Daytime)
☐ Genetic Disorders
☐ Heart Conditions
☐ Hearing Disorders
☐ Kidney Disorders
☐ Lead (Hx of ≥10 mcg/dL) ☐ At-Risk ☐ Test done
☐ Obesity
☐ Orthopedic Conditions
☐ Prematurity (<32 wks. EGA)
☐ Seizures/Convulsions
☐ Sickle Cell Anemia ☐ Trait
☐ Speech/Language
☐ Tuberculosis ☐ At-Risk for TB
☐ Vision Disorders
☐ Other: _____
☐ None

Screening Results

Developmental

Screening Tool(s) Used:

☐ 1 PEDS ☐ 4 PSC
☐ 2 ASQ ☐ 5 ASQ-SE

Developmental Domains:	Within Normal 1	Concern Identified 2	Referred to Specialist 3
Emotional/Social	☐	☐	☐
Problem Solving	☐	☐	☐
Language/Communication	☐	☐	☐
Fine Motor Skills	☐	☐	☐
Gross Motor Skills	☐	☐	☐

Comments: _____

Hearing

Hearing	1000 Hz	2000 Hz	4000 Hz
Right			
Left			

Indicate Pass (P) or Refer (R) in each box. Refer means any failure at any frequency in either ear at >20dB.

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 ☐ Pass ☐ Fail
Far:	20/	20/	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 Underweight (< 5%ile)
☐ 2 Healthy Weight (5%ile to < 85%ile)
☐ 3 Overweight (85%ile to < 95%ile)
☐ 4 Obese (≥ 95%ile)

Blood Pressure: _____ / _____

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

	Normal 1	Abnormal 2
HEENT	☐	☐
Dental/Oral	☐	☐
Lungs	☐	☐
Cardiac	☐	☐
Abdomen	☐	☐
Neurological	☐	☐
Back/Extremities	☐	☐
Genital	☐	☐
Skin	☐	☐

Comments: _____

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To Parents/Guardians of:

***Kindergartener**, or*

***Seventh (7th) Grader**, or*

Any Child Attending N.C. Public School for First Time

Please replace this page in your student's Enrollment Packet with a copy of current Immunization Records.

IMMUNIZATION RECORDS

(Insert here.)

To find out which vaccines students need by
Kindergarten –or– Seventh (7th) grade,
(or as a first-time enrollee in a N.C. public school at any age)

please visit: https://immunize.nc.gov/schools/schools.htm

Important Note:
You must provide these records by the due date noted.
Per N.C. state law,
your child will not be permitted to attend school
if we do not receive these records by the state-mandated due date.

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Student Permission Form

Photo / Video Release

Pioneer Springs Community School occasionally uses photos and videos of the students on the following types of media: newspapers, magazines, brochures, YouTube, and our school website and Facebook page.

Please indicate consent: ☐ YES, I grant permission. ☐ NO, I withhold permission.

EMail and Internet Use Policy

I have read and agree to the terms and conditions of the EMail and Internet Use Policy *(located on the school website)*, and:

☐ **I DO consent** to my child's supervised use of the computer and the Internet at school.

☐ **DO NOT allow** my child any access to Internet resources.

Parent/Guardian, please provide student name, your signature, and date:

_____ _____
Student's Full Name Parent/Guardian PRINTED Name

_____ _____
Parent / Guardian Signature Date

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Student Name: _____ Rising Grade: _____

Parent/Guardian Signature: _____ Date: _____

Home Language Survey

1. What is the *first language* your child learned to speak? _____

2. What language does your child *speak most often*? _____

3. What language is most often *spoken in your home*? _____

4. Besides languages studied in school, does your child speak any language(s) fluently other than English?

   ☐ No ☐ Yes (list the languages) _____

Note: *If the answer to any of these questions is a language other than English, your child will be assessed further for appropriate placement and English Language assistance.*

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Student Name: _____ Rising Grade: _____

Exceptional Needs Identification

At Pioneer Springs Community School, we see the student, not the label. We feel strongly that ALL students have the right and ability to learn! This form is vital in preparing us for ALL of our students' needs. We will also use your feedback to help us with class placement, as a balanced classroom is important.

Please read this entire form, and give us as much information as possible. ***If your child has an IEP, 504 Plan, or ELL plan, please include it in your Enrollment Packet, along with any other Specialist reports.*** *We want all students to have a smooth and happy transition into our school! The information you provide will help ensure this. Thank you.*

My child ***currently*** has / is *(Mark if applicable.)*: ☐ **IEP** ☐ **504 Plan** ☐ **ELL**

Under the plan(s), my child ***currently*** receives these services: _____

Our Concerns:

☐ Activity Level ☐ Attention ☐ Gross Motor ☐ Emotional Development

☐ Developmental Delays ☐ Behavior ☐ Fine Motor ☐ Social Development

☐ Language Development ☐ Sensory Sensitivity ☐ Mathematics ☐ Reading or Writing *(Which?)*

☐ Other Comments _____

_____

My Child's Current Academic Performance **B**elow, **O**n, or **A**bove Grade-Level?

Mathematics: **B O A** Reading: **B O A** Writing: **B O A**

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Student Name: _____ Rising Grade: _____

Class Placement

We do not accept teacher requests at Pioneer Springs, but we do spend time creating a balanced classrooms and healthy environments for our students. Since your child is new to us, please share any pertinent information about your child that may impact his/her classroom placement.

For example, does your child have any health concerns? Is (s)he shy or very active? Does your child have separation anxiety? Does (s)he struggle with transitions? Has your child qualified for Exceptional Needs services? *(If so, please provide the IEP.)* Are there any learning needs? Does your child receive Occupational Therapy or Physical Therapy? Language support? Has (s)he had vision therapy?

We cannot stress enough how important your input is in placing your child! Knowing this information BEFORE placement is critical for a smooth transition into a new school. We appreciate your input and your respect for our "no teacher request policy". Thank you!

_____

_____

_____

_____

_____

_____

_____

_____