

Instruction

Migrant Students

The Superintendent will develop and implement a program to address the needs of migrant children in the District.

This program will include a means to:

1. Identify migrant students and assess their educational and related health and social needs.
2. Provide a full range of services to migrant students including applicable Title I programs, special education, gifted education, vocational education, language programs, counseling programs and elective classes.
3. Provide migrant children with the opportunity to meet the same statewide assessment standards that all children are expected to meet.
4. Provide advocacy and outreach programs to migrant children and their families.
5. Provide parents/guardians an opportunity for participation in the program.

Migrant Education Program for Parent(s)/Guardian(s) Involvement

Parent(s)/guardian(s) of migrant students will be involved in and regularly consulted about the development, implementation, operation, and evaluation of the migrant program.

Parent(s)/guardian(s) of migrant students will receive instruction regarding their role in improving the academic achievement of their children.

Legal Reference: No Child Left Behind Act of 2001, §1301 et seq., 20 U.S.C. §6391 et seq., 34 C.F.R. §200.40 - 200.45.

Programs for Migrant Students - Family Interview Form

To be completed by Building Principal or designee: (please print)

Child 1 Name	Birth Date	Grade	School
Child 2 Name	Birth Date	Grade	School
Child 3 Name	Birth Date	Grade	School

Name of Parent/Guardian	Language(s)
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Telephone Number or other contact information	Today's Date
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Needs Assessment

Please check response

1. Do any of your children have health problems that interfere with their ability to learn? Explain: Yes No _____

2. In what areas might your child(ren) need additional help in school?

	Reading	Math	Language	Other (specify)
Child 1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Child 2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Child 3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____

3. Are your child(rens)' immunizations up to date? Yes No Don't know

4. Do you have immunization records? Yes No Don't know

5. Have you established a source of primary healthcare? Yes No Don't know

If not, would you be interested in information on primary healthcare? Yes No Don't know

Resources and Referrals

Please circle/check response

1. Would you be interested in information on:

- | | | | |
|---------------------|------------------------------|-----------------------------|-----------------------------------|
| Head Start | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Enrolled |
| District Preschool | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Enrolled |
| Parents as Teachers | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Enrolled |
| GED/ESL Classes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Enrolled |

2. Would you be interested in information on:

- | | | |
|-----------------------------|------------------------------|-----------------------------|
| Public/County Health Dept. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Division of Family Services | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

3. May we share your name and address with these agencies?

- | | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

4. When is the best time to reach you at home?

- | | |
|-----------------------------|-----------------------------|
| <input type="checkbox"/> AM | <input type="checkbox"/> PM |
|-----------------------------|-----------------------------|

Days of the week:

- | | | | | |
|---------------------------------|----------------------------------|------------------------------------|-----------------------------------|---------------------------------|
| <input type="checkbox"/> Monday | <input type="checkbox"/> Tuesday | <input type="checkbox"/> Wednesday | <input type="checkbox"/> Thursday | <input type="checkbox"/> Friday |
|---------------------------------|----------------------------------|------------------------------------|-----------------------------------|---------------------------------|

Name of Person Completing Form

Name of Person Being Interviewed and
His/Her Relationship to Family/Children