ENROLLMENT PACKET

Mr. Dodd Hawthorne, Superintendent

DOCUMENTS INCLUDED:

- ❑ VERIFICATION OF RESIDENCY CHECKLIST
- ❑ APPLICATION FOR STUDENT ENROLLMENT *(ENGLISH, KOREAN, SPANISH)*
- ❑ ADDITIONAL STUDENT INFORMATION
- ❑ STUDENT INFORMATION FORM
- ❑ HOME LANGUAGE SURVEY
- ❑ EMPLOYMENT SURVEY *(ENGLISH AND SPANISH)*
- ❑ STUDENT RESIDENCY QUESTIONNAIRE *(ENGLISH AND SPANISH)*
- ❑ PARENT NOTICE: MEDICAL
- ❑ HEALTH ASSESSMENT RECORD

www.crenshaw-schools.org

2019-2020

CRENSHAW COUNTY SCHOOL SYSTEM
Verification of Residency Checklist

Student Name: ______________________________________

Parent/Guardian: ____________________________________

E-911 Address: ______________________________________

Mailing Address: _____________________________________

Parents of new students seeking to enroll in Crenshaw County Public Schools must offer proof of residency by presenting at least two items documenting the physical address. Examples are listed below. Please check items of proof presented and keep this form in student's permanent record.

- ☐ 1. Property Tax Records indicating a homestead exemption
- ☐ 2. Mortgage Documents or Property Deeds
- ☐ 3. Apartment or Home Lease
- ☐ 4. Utility Bills
- ☐ 5. Driver's License
- ☐ 6. Voter Precinct Identification
- ☐ 7. Automobile Registration
- ☐ 8. Affidavit and/or Personal Visit by a designated school district official
- ☐ 9. Other ___________________________________

Anyone other than the parents of the student must show documentation of guardianship, along with the items specified above.

Proof of guardianship verified by ______________________________.
(School official signature)

Proof of residency verified by ______________________________.
(School official signature)

PLEASE PRINT **APPLICATION FOR STUDENT ENROLLMENT** **PLEASE PRINT**

Must be completed by Parent/Legal Guardian

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 HISPANIC AM. 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: **(PLEASE LIST NUMBERS OTHER THAN YOUR OWN...VERY IMPORTANT!!!)**

EMERGENCY #1
CONTACT ______________________
↓
Relation ______________ Phone ______________

EMERGENCY #2
CONTACT ______________________
↓
Relation ______________ Phone ______________

THESE PEOPLE HAVE PERMISSION TO CHECK MY CHILD OUT OF SCHOOL:

1. ______________________ Relation ______________ Phone ______________
2. ______________________ Relation ______________ Phone ______________
3. ______________________ Relation ______________ Phone ______________
4. ______________________ Relation ______________ Phone ______________

NAME AND ADDRESS OF FORMER SCHOOL: ______________________

____

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 generated and utilized instead. Your child's SSN is being requested for use in conjunction with enrollment in school as provided in Ala. Admin. Code §290-3-1-.02(2)(b)(2). It will be used as a means of identification in the statewide student management system.*

Crenshaw County Public Schools

학생 등록 신청서

정자체로 작성해 주십시오 | 학부모/법적 보호자가 작성해야 합니다 | 정자체로 작성해 주십시오

날짜: ____________ 학교: ______________________ 학년: ________

성: ______________ 이름: ______________ 중간 이름: ______________

생년월일: ______________ 성별 – 하나에만 동그라미 표시: 남성 여성 집 전화번호: ________

실거주지 주소: ______________ 시: ______________ 우편번호: ______________

우편주소: ______________ 시: ______________ 우편번호: ______________

학생과 함께 거주하는 사람 - 하나에만 동그라미 표시: 부모 어머니 아버지 보호자: 관계 ________

*사회보장번호(Social Security Number)(필수 아님): ______________

부모/보호자: (증명은 지역 학교 위원회 정책에 따릅니다.)

어머니/보호자: ______________	주소: ______________
이메일 주소: ______________	휴대폰 번호: ______________
고용주: ______________	직장 전화번호: ______________

아버지/보호자: ______________	주소: ______________
이메일 주소: ______________	휴대폰 번호: ______________
고용주: ______________	직장 전화번호: ______________

양육권에 대한 특별 정보:

<u>비상 시 연락처:</u> (중요 - 귀하의 연락처 이외의 연락처를 기재하십시오.)

비상 시 연락처 #1 ______________ 비상 시 연락처 #2 ______________

관계: ________ 전화번호: ________ 관계: ________ 전화번호: ________

이 학생을 학교 밖으로 데리고 나가도록 허가받은 사람

(학교 시스템 체크 아웃 절차에 따름)

	관계	전화번호
1. ______________	관계: ______________	전화번호: ________
2. ______________	관계: ______________	전화번호: ________
3. ______________	관계: ______________	전화번호: ________

마지막으로 다닌 학교의 이름 및 주소: ______________

____

부모/보호자 서명: ______________

자녀의 사회보장번호(Social Security Number (SSN)) 공개는 의무적인 것이 아닙니다. SSN 을 제공하지 않을 경우 임시 신원 확인 번호가 대신 사용됩니다. Ala. Admin. Code §290-3-1.02(2)(b)(2)항에 따라, 학교 등록과 관련하여 사용될 목적으로 귀하 자녀의SSN 이 요청될 수 있습니다. 해당 정보는 주 학생 관리 시스템에서 신원 확인의 수단으로 사용됩니다.

Korean

Crenshaw County Public Schools

SOLICITUD DE INSCRIPCIÓN DEL (DE LA) ALUMNO(A)

LLENAR CON LETRA DE IMPRENTA Debe ser llenada por el padre/madre/tutor legal LLENAR CON LETRA DE IMPRENTA

FECHA: ________________ ESCUELA: ______________________________________ GRADO: ___________

APELLIDO: _______________________ PRIMER NOMBRE: _______________ SEGUNDO NOMBRE: ________

FECHA DE NACIMIENTO: ____________ SEXO - marque con un círculo   MASCULINO   FEMENINO

TELÉFONO DE CASA: _______________

DIRECCIÓN FÍSICA: ____________________________ CIUDAD: ____________ CÓDIGO POSTAL: __________

DIRECCIÓN POSTAL: ____________________________ CIUDAD: ____________ CÓDIGO POSTAL: __________

EL (LA) ALUMNO(A) VIVE CON - marque con un círculo: PADRES   MADRE   PADRE
TUTOR: RELACIÓN/PARENTESCO _________________

*NÚMERO DE SEGURO SOCIAL (optativo): ______________________________

PADRE/MADRE/TUTOR: (la verificación debe hacerse de acuerdo con las normas del consejo escolar local)

MADRE/TUTOR: ________________________________ Dirección: _____________________________________

Dirección de correo electrónico: ____________________ Teléfono celular: _______________________________

EMPLEADOR: _______________________________ Teléfono del trabajo: ____________________________

PADRE/TUTOR: ________________________________ Dirección: _____________________________________

Dirección de correo electrónico: ____________________ Teléfono celular: _______________________________

EMPLEADOR: _______________________________ Teléfono del trabajo: ____________________________

INFORMACIÓN ESPECIAL SOBRE LA CUSTODIA:

CONTACTOS EN CASO DE EMERGENCIA: (INDIQUE NÚMEROS DE OTRAS PERSONAS)

CONTACTO DE EMERGENCIA #1 __________________ CONTACTO DE EMERGENCIA #2 __________________
Relación: ______________ Teléfono: ____________ Relación: ________________ Teléfono: ____________

ESTAS PERSONAS TIENEN PERMISO PARA RECOGER A MI HIJO(A) DE LA ESCUELA
(De acuerdo con los procedimientos de salida del sistema escolar)

1. ______________________________ Relación: ________________________ Teléfono: ___________
2. ______________________________ Relación: ________________________ Teléfono: ___________
3. ______________________________ Relación: ________________________ Teléfono: ___________

NOMBRE Y DIRECCIÓN DE LA ÚLTIMA ESCUELA A LA QUE ASISTIÓ: ________________________________
____

FIRMA DEL PADRE/MADRE/TUTOR: ____

**La divulgación del número de seguro social (Social Security Number (SSN)) de su hijo(a) es optativa. Si opta por no indicar un SSN, se otorgará y utilizará un número de identificación temporal. Se pide el SSN de su hijo(a) para utilizarlo junto con la inscripción en la escuela, según se estipula en el Ala. Admin. Code §290-3-1.02(2)(b)(2). Se utilizará como medio de identificación en el sistema estatal de administración de alumnos.*

Spanish

Ethnicity and Race

Student's Name: ____ Grade: ________

Parent/Guardian Signature: ______________________________________ Date: ____________

Please answer BOTH Question 1 AND Question 2

Question 1: Is this student Hispanic/Latino? CHOOSE ONLY ONE ETHNICITY:

□ **NO**, not Hispanic/Latino

□ **YES**, Hispanic/Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

The above question is about ethnicity, not race. No matter what you selected above, **please continue to answer the following Question 2 by marking one or more boxes to indicate what you consider your student's race to be.*

Question 2. What is the student's race? CHOOSE ONE OR MORE:

□ **AMERICAN INDIAN OR ALASKA NATIVE.** A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

□ **ASIAN.** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

□ **BLACK OR AFRICAN AMERICAN.** A person having origins in any of the black racial groups of Africa.

□ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER.** A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

□ **WHITE.** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Office use only:	
Ethnicity – Choose only one: _______ NOT Hispanic/Latino _______ Hispanic/Latino	Race – Choose one or more: ______American Indian or Alaska Native ______Asian ______Black or African American ______Native Hawaiian or Other Pacific Islander ______White
Date:	Staff Signature:

Additional Requested Information:

MILITARY

Student connected to an Active Duty Military parent	Circle One: YES NO

PRESCHOOL

Head Start Circle One: YES NO	First Class Funded Preschool – Circle One: Yes NO
Centered Based Child Care - Circle One: YES NO	Home Based Child Care – Circle One: YES NO
Home Visitation Program – Circle One: YES NO	Other Preschool – Circle One: YES NO
No Preschool – Check if no Preschool ☐	Special Education Funded – Circle one: YES NO

SPECIAL EDUCATION SERVICES

Student currently receiving special education services Circle One: YES NO

CRENSHAW COUNTY SCHOOL SYSTEM
Student Information Form

Date: ____________________ **Student Name:** __________________________________

The following information is being requested to enable the school to be more aware of additional student needs and services that are NOT addressed on the OFFICIAL Enrollment Application. (optional)

Transportation (Check One): ❑ Bus ❑ Car Rider

Name of Bus Driver: ____________________________________ Bus Number: ________

Family Health Care Provider: ____

Physician's Name: __________________________ Phone Number: ________________

Special Education Services
(Check One): ❑ Yes ❑ No

(Indicate if this student has been identified to receive services through special education.)
Briefly Explain: ____
____

Previous Attendance
(Check One): ❑ Yes ❑ No

(Indicate whether or not this student has attended school here before.)
If YES, indicate last year of attendance: ___________________________

List any household members attending school here:

Name ____ Grade: ______________

Name ____ Grade: ______________

Name ____ Grade: ______________

Special Information/Instruction:

____
____

Parent/Legal Guardian Signature _________________________________

CRENSHAW COUNTY PUBLIC SCHOOLS

Home Language Survey

Schools are required to determine the language(s) spoken by each student. This information is essential in order for schools to provide meaningful instruction for all students. Your cooperation in helping us to meet this important requirement is requested. Please answer the following questions and return this form to the school's office.

Student's Name ____ Date of Birth ___/___/___
(Last) (First) (Middle)

Country of Birth (if other than United States): ______________________________
Grade Level Entered U.S. Schools (if lived outside of U.S. at any time): _____

Date of Entry in U.S. Schools (if lived outside of United States at any time): _____/_____/_____

School ______________________________ Grade ____ Date Enrolled___/___/___

1. What language did your child first learn to speak ?______________________________

1. What language does your child most often speak ?______________________________

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

If English is not your child's primary language, has your child ever participated in an English as a Second Language Program ? YES______ NO______ If yes, when ?_____/_____/_____
In which school district and state ?______________________________

______________________________ (Parent's Signature)

______/______/______ (Date)

ALABAMA STATE DEPARTMENT OF EDUCATION
EMPLOYMENT SURVEY

SCHOOL SYSTEM: ______________________________ SCHOOL YEAR: _______

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 three 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?

   ____

Revised: 4/1/18

Crenshaw County Public Schools

McKinney-Vento Act
Student Residency Questionnaire

Name of Student: ______________________________ Date of Birth: ______________

Name of School: ______________________________ Age: __________ Grade: __________

Please answer the questions below concerning your residency. The information you provide is confidential. The purpose of this information is to ensure the rights of your child and youth under the McKinney-Vento Law (42 US code 11431 and Title X under ESEA/NCLB).

1. Is your address a temporary living arrangement? ☐ Yes ☐ No
2. Is your living arrangement due to loss of housing or economic hardship? ☐ Yes ☐ No

If you answered YES to either of the above questions, please complete the remainder of this from. If you answered No to both questions, you may stop here.

Where is the student currently living? (Please check one)

- ☐ In a motel/hotel
- ☐ In a shelter
- ☐ With another family in a house or apartment due to loss of housing or economic hardship
- ☐ In a car, park, campground, street, or abandoned building
- ☐ Moving from place to place
- ☐ Temporary or emergency foster care
- ☐ Other: ______________________________

Last school student attended:

School: ______________________________ District: ______________________________

City: ______________________________ State: ______________________________

Name of Parent/Guardian(s):

Name: ______________________________ Signature: ______________________________

Name: ______________________________ Signature: ______________________________

OR

Student (unaccompanied homeless youth):

Name: ______________________________ Signature: ______________________________

Address: ____

Home Number: ______________ Work Number: ______________ Cell Number: ______________

If the student is NOT living in permanent housing, proof of residency and other documents normally needed for enrollment are not required and the students is to be enrolled immediately.

© 2013 TransACT Communications, Inc.
7034

Spanish
McKinney-Vento Act Student Residency Questionnaire

Crenshaw County Public Schools

Ley McKinney-Vento
Cuestionario sobre la residencia de los alumnos

Nombre del alumno: ______________________ Fecha de nacimiento: ____________

Nombre de la escuela: ______________________ Edad: ________ Grado: ________

Responda las siguientes preguntas sobre su residencia. La información que proporcione es confidencial. El propósito de esta información es garantizar los derechos de su hijo en conformidad con la Ley McKinney-Vento (Artículo 42 del Código de Estados Unidos, 11431 y Artículo X en conformidad con ESEA/NCLB).

1. ¿Su dirección corresponde a una vivienda temporal? ☐ Sí ☐ No
2. ¿Su vivienda temporal se debe a la pérdida de vivienda o dificultades económicas? ☐ Sí ☐ No

Si respondió SÍ a alguna de las preguntas anteriores, complete el resto del formulario. Si respondió No a ambas preguntas, termine aquí.

¿Dónde vive actualmente el alumno? (Marque una opción)

- ☐ En un motel/hotel
- ☐ En un albergue
- ☐ Con otra familia en una casa o departamento debido a la pérdida de vivienda o dificultades económicas
- ☐ En un automóvil, parque, campamento, calle o edificio abandonado
- ☐ Se desplaza de un lugar a otro
- ☐ Con una familia adoptiva temporal o de emergencia
- ☐ Otra: ______________________

Última escuela a la que asistió el alumno:

Escuela: ______________________ Distrito: ______________________

Ciudad: ______________________ Estado: ______________________

Nombre de padre/madre/tutor(es):

Nombre: ______________________ Firma: ______________________

Nombre: ______________________ Firma: ______________________

O BIEN

Alumno (menor sin hogar y solo):

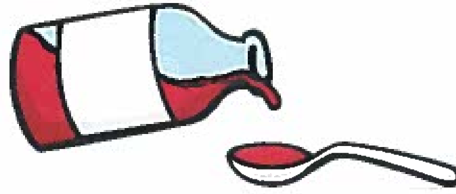
Nombre: ______________________ Firma: ______________________

Dirección: ______________________

Número de casa: ____________ Número de trabajo: ____________ Número de celular: ____________

Si el alumno NO vive en una vivienda permanente, no se requieren pruebas de residencia ni otros documentos que normalmente se solicitan para la inscripción, y debe inscribirse al alumno de inmediato.

© 2013 TransACT Communications, Inc.
7034



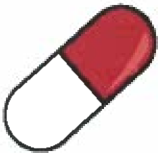
ADMINISTRATION OF MEDICINE

1. Parents or legal guardians must fill out an official registration form stating any medical problems which can effect the child in a class room situation or at physical education.

2. Medication shall be administered at school only when absolutely necessary. The school nurse should be notified of all medicines to be brought on campus by students or parents for students.

3. Students shall not bring medicine from home to be administered for minor illness. For example: A student with an illness such as a cold, severe enough to require medication, should remain at home. This protects all on campus.

4. There will be cases where a student will need to receive medication for either a short or possibly extended period of time. In many of these situations, the medication can be given at home before school hours and when the child arrives at home in the afternoon. When no alternative is possible and the student needs medication during school hours, the school may cooperate with parents for the administration of the medicine. Contact the school nurse.



REQUIREMENTS TO RECEIVE MEDICATION AT SCHOOL

- A written statement from the licensed physician, prescribing the medication, requesting that the student be medicated during school hours.

- A letter from the parent or legal guardian requesting that the medication be given at school and giving permission for the school nurse or other officials/person(s) to administer the medicine. Call the principal and the school nurse.

- The medication must be in a pharmacy container, properly labeled with the name of the medicine, the dosage, the pharmacist, the prescribing doctor and the child to whom the medicine belongs.

PARENTS ARE NOT TO SEND MEDICINE TO SCHOOL WITH A CHILD. PARENTS ARE TO BRING THE MEDICINE TO THE SCHOOL NURSE OR THE OFFICE.

ALABAMA STATE DEPARTMENT OF EDUCATION

HEALTH ASSESSMENT RECORD

School Year: ____________-____________

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: ____________-____________

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:** ☐ Hives/rash ☐ Medications ☐ **Food** ________ ☐ **Insects** ________ ☐ Breathing difficulty ☐ Epi-pen ☐ **Environmental** ________ ☐ **Medications** ________ ☐ 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 **any** medications taken at home only.*

Required Signatures

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

(Electronic or Written) School Nurse Signature: ____________________ **Date:** ____________