DOCUMENTS REQUIRED FOR SCHOOL REGISTRATION

Proof of Authorized Person to Enroll

The following persons are authorized to enroll students:

- **A Parent**
- **A Legal guardian**
- **An Eligible Student**
- **A grandparent with a properly executed Power of Attorney**
- **An adult who has assumed the duties and responsibilities of a parent with respect to the student seeking enrollment**

The person authorized to enroll should present one of the following:

- **Driver's License**
- **State identification card**
- **Passport**
- **Other official photo identification**

Documentation Needed:

1. Student's birth certificate or Federal, state, county, or school document with date of birth *(Examples include hospital-issued birth record; military I.D.; valid driver's license; passport; adoption record; religious record; school transcript; or affidavit of age sworn by parent/guardian or other authorized person accompanied by a certificate of age signed by a licensed, practicing physician which states the physician has examined the child and believes the age, as stated in the affidavit, is substantially correct.*
2. Proof of residence: Current utility bill plus one of the following: *current lease/rental agreement; recent income tax return; current pay check stub; current Medicaid card; current residential property tax statement or bill; current warranty or quit claim deed; third person affidavit of residency; current homeowner's insurance policy.*
3. Current Immunization Record (Georgia Immunization Form 3231) or medical or religious exemption.
4. If new to Georgia schools, GA Form 3300 – Certificate of Vision, Hearing, Dental, and Nutritional Screening.
5. Copy of student's social security card or signed waiver.
6. Previous school records: (Grades 1-8 latest report card) (Grades 9-12 latest transcript).
7. Legal documentation such as guardianship or custody paperwork, if applicable.

Residence/Primary Phone: ( )_____-_____ **Date:** _____

(Note: the *primary* phone number will be utilized for *ConnectEd* communication calls.)

Residence/Primary E-Mail: _____

(Note: the *primary* e-mail will be utilized for *non-emergency* communications.)

Previous Walton County School

___Yes ___No Has this student ever been enrolled in a Walton County School?

If yes: _____ | _____ | _____
School Name Grade Year

Student's Legal Name:

_____
Last First Middle Suffix Preferred Name

Date of Birth: _____/_____/_____ Do you live in Walton County? _____Yes _____No

Place of Birth:

City: _____ State: _____ Country: _____

Grade: _____ Gender: ____M ____F Social Security Number: _____-_____-_____

Current Address: Where student normally sleeps on a nightly basis

_____ _____
Street Number Street Name

City: _____ State: _____ Zip: _____

(Any changes to the student's current or mailing address must be reported to the school immediately.)
(If there are any custody restraints, school must be provided legal documents.)

Did your child attend any of the following?

____ Georgia PK Program - Public School
____ Publicly - Sponsored (Title I)
____ Head Start
____ Other Public School
____ Private - not for profit
____ Private - for profit
____ No Pre-K Program
____ Georgia PK Program - Private School

Ethnicity / Race Information - New Federally Mandated Question. Please answer parts A and B.

Part A - Ethnicity: Is the student Hispanic or Latino? (choose *only* one)

____ **No**, not Hispanic/Latino
____ **Yes**, Hispanic/Latino *(A person of Cuban, Mexican, Pureto Rican, South or Central American, or other Spanish culture or origin, regardless of race).*

The above part of the question is about ethnicity, not race. No matter what you selected above, please continue to ***Part B.***

Answer the following by marking one or more boxes to indicate what you consider this student's race to be.

Part B - Race: What is the student's race (choose *all* that apply)

____ **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.)

With whom does the child live?
____ Both Parents ____ Father Only ____ Mother Only ____ Father & Stepmother ____ Mother & Stepfather
____ *Legal Guardian (*Must provide school with copy of Legal Papers)

Primary Household Information - Where student *normally* sleeps on a nightly basis
Primary Household Parent/Guardian 1:

_____
Last First Middle Suffix (Jr, Sr, II, III, etc)

Relationship to student: (Mother, Father, Grandparent, Guardian, etc.) _____

Work Phone # ( )_____-_____ Cellular Phone # ( )_____-_____

If *different* from student, Home Phone # ( )_____-_____ ___ Same as Home/Primary Phone (page 2)

If *different* from student, Address: ___ Same as Current Address (page 2)

_____ _____
Street Number Street Name

City: _____ State: _____ Zip: _____

E-Mail Address for P/G: _____ ____ Same as Primary E-Mail (page 2)

Primary Household Parent/Guardian 2:

_____
___
Last First Middle Suffix (Jr, Sr, II, III, etc)

Relationship to student: (Mother, Father, Grandparent, Guardian, etc.) _____

Work Phone # ( )_____-_____ Cellular Phone # ( )_____-_____

If *different* from student, Home Phone # ( )_____-_____ ___ Same as Home/Primary Phone (page 2)

If *different* from student, Address: ___ Same as Current Address (page 2)

_____
_____
Street Number Street Name

City: _____ State: _____ Zip: _____

E-Mail Address for P/G: _____ ____ Same as Primary E-Mail (page 2)

Secondary Household Information - Where student sleeps on a part-time basis. Leave blank if this does not apply to your family situation.

Secondary Household Parent/Guardian 3:

_____
___
Last First Middle Suffix (Jr, Sr, II, III, etc)

Relationship to student: (Mother, Father, Grandparent, Guardian, etc.) _____

Work Phone # ( )_____-_____ Cellular Phone # ( )_____-_____

If *different* from student, Home Phone # ( )_____-_____ ___ Same as Home/Primary Phone (Page 2)

If *different* from student, Address: ___ Same as Current Address on Page 2

_____
_____
Street Number Street Name

City: _____ State: _____ Zip:
_____

E-Mail Address for P/G: _____

Emergency Contacts - If parents cannot be contacted in case of an emergency, please list other authorized emergency contacts.

Emergency Contact: _____ Relationship _____

Home # ( )_____-_____ Work # ( )_____-_____ Cell # ( )_____-_____

Emergency Contact: _____ Relationship _____

Home # ( )_____-_____ Work # ( )_____-_____ Cell # ( )_____-_____

Emergency Contact: _____ Relationship _____

Home # ( )_____-_____ Work # ( )_____-_____ Cell # ( )_____-_____

My child may be picked up by:
1. _____
2. _____
3. _____
4. _____

*My child may **NOT** be picked up by:
1. _____
2. _____

*Has legal documentation been provided for your child's folder? ____ Yes ____ No

Additional Household Members & Siblings - Please list the names of all additional household members and siblings (under 21 years of age.)

Last Name	First Name	Age	Relation to Student	School

Last Name | First Name | Age | Relation to Student | School

Student's School History

If applicable, school(s) previously attended:

1. Name of school:

Address:

Date of Last Day Attendance:

2. Name of school:

Address:

Date of Last Day Attendance:

3. Name of school:

Address:

Date of Last Day Attendance:

4. Name of school:

Address:

Date of Last Day Attendance:

Special Programs

Was your child receiving any of the following support services?

___ Early Intervention Program (EIP)
___ Gifted Program
___ Pyramid of Intervention (POI) or Response to Intervention (RTI)
___ Remedial Ed Program (REP)
___ Section 504 Plan
___ Title I Program (TA only - targeted assistance)
___ Readiness Class
___ English Language (EL)

Was your child receiving special education services (IEP)? ___ Yes ___ No (If Yes, check the area(s) of service below)

___ Autism
___ Deaf/Blind
___ Emotional & Behavioral Disorder
___ Hearing Impairment
___ Intellectual Disability
___ Orthopedic Impairment
___ Other Health Impairment
___ Severe Emotional & Behavior Disorder (Psychoed Programs)
___ Significant Developmental Delay
___ Specific Learning Disability
___ Speech/Language Impairment
___ Traumatic Brain Injury
___ Vision Impairment
___ Other (Explain):

_____

Please indicate if your child participates or is eligible for any of the following (check all that apply):

___ SSI ___ TANF ___ Medicaid ___ Peachstate
___ Amerigroup ___ Food Stamps ___ Wellcare ___ Peachcare
___ Free and Reduced Price Meals under Child Nutrition Program/School Nutrition Program

Student Residency Questionnaire (Optional)

This questionnaire is intended to address the McKinney-Vento Act 42 U.S.C 11435. The answers to this residency information helps to determine the services the student may be eligible to receive.

1. Is your current address a temporary living arrangement?
   ___ Yes ___ No

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

If you answered YES to the above questions, please complete the remainder of this form. ***If you answered NO, you may stop here.***

Where is the student presently living? (Check one box)

___ Sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason (example: evicted from home, cannot afford housing, etc.)
___ In a motel, hotel, campground or similar setting due to lack of alternative adequate accommodations.
___ In emergency or transitional shelters such as domestic violence or homeless shelter or transitional housing shelter or agency.
___ Have a primary nighttime residence that is a place not designed for or ordinarily used as a regular sleeping accommodation for humans.
___ In cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings.
__ None of the above.

How long do you anticipate living at this location? _____

(School Registrar - Present this form to the school-level counselor to complete the MV Worksheet.)

Student's Name: _____

Discipline

1. ___Yes ___ No Is this student under a current expulsion or suspension order from this or another school system?

2. ___ Yes ___ No Has this student ever been expelled?

If Yes to either of the above questions, please fill out the following information:

Reason for Expulsion: _____

School System: _____

Date Expelled or Suspended: _____

3. ___ Yes ____ No Has this student been adjudicated delinquent or convicted of murder, voluntary manslaughter, rape, aggravated sodomy, aggravated child molestation, aggravated battery, or armed robbery?

If Yes, where did this offense occur?

_____|_____|_____
Court County State

Person Completing This Form

Name (must be legal guardian): _____
name - please print

Signature: _____
signature

Date: _____|_____|_____
mm dd yyyy

ANY PERSON WHO KNOWINGLY PROVIDES FALSE INFORMATION OR DOCUMENTATION IN CONNECTION WITH THE REGISTRATION OF A STUDENT MAY BE CRIMINALLY LIABLE UNDER O.C.G.A. 16-10-20. SHOULD SCHOOL OFFICIALS DETERMINE THAT FALSE INFORMATION OR DOCUMENTATION HAS BEEN SUBMITTED, A REPORT WILL BE FILED WITH THE APPROPRIATE LAW ENFORCEMENT OFFICIALS.

EMERGENCY CLOSING INSTRUCTIONS

Should school be dismissed early, we need to know if your child is to ride the bus, go to day care, or be picked up by you. Weather, plumbing, electrical problems or other emergencies could cause us to dismiss early. It is important that arrangements are made in case of these unforeseen events. Sometimes our phone lines are busy so we cannot rely on a last minute phone call for directions. If the need to close early occurs, our elementary leveled schools would call all day care centers that pick up from their school.

Student's Name: _____

Address: _____

Phone: _____

CHECK ONE:

_____ Ride regular bus home

_____ Day Care

Day Care Name: _____ Phone Number: _____

_____ Parent Pickup

_____ Other (please explain below):

_____

_____

_____

_____

Parent Signature: _____ Date: _____

Thank you. We hope we do not need this information. Please discuss this plan with your child.

SCHOOLWIDE E-MAIL OPTION

Dear Parents,

In an atmosphere of true economic concern and faced with impending financial cutbacks, we wish to be as fiscally responsible as possible. One thing we can do is reduce the number of "hard copy" information sheets sent home. Throughout the county, schools are attempting to save toner and paper costs by using email when possible.

We realize that everyone does not have access to email but a large number of families do. One school reported 75% savings by updating their email directory and using email instead of "hard copy" handouts.

Please complete the appropriate portion of the form below and return to the school as soon as possible. If you have a current email address that school information could be sent to, please give that address. If you must continue to receive "hard copy" handouts, please indicate which of your children (for families with more than one child) you would like us to send information home with.

Thank you for your help and understanding in these challenging times.

Student Name: _____ HR Teacher _____

Please write clearly and case sensitive

Preferred E-Mail: _____

Parent/Guardian: _____

Secondary E-Mail: _____

Parent/Guardian: _____

I wish to continue to receive "hard copy" handouts. Please send them home with (**choose 1 child only**):

Student Name: _____

SCHOOL HEALTH INFORMATION CARD **(School Year 20____ to 20____)**

Student # _____ Grade _____ Teacher/HR _____

Student: _____ Gender: ___M ___F DOB: _____|_____|_____

Address:

_____

Health History

ALLERGIES	___ YES	___ NO	PHYSICAL HANDICAPS	___ YES	___ NO
DIABETES	___ YES	___ NO	SEIZURE DISORDER	___ YES	___ NO
SICKLE CELL DISEASE	___ YES	___ NO	ASTHMA	___ YES	___ NO
CANCER	___ YES	___ NO	ADHD/ADD	___ YES	___ NO

If you answered *yes* to any of the above, please detail specifics in the space provided below along with any other physical or mental health issues which may be a concern at school.

_____

___

_____

___

___ Does your child have any condition that would limit physical education activities? List:_____

___ Does your child take any prescribed medications routinely? List: _____

Do we have permission to complete Hearing and/or Vision Screenings on your child? ___ Yes ___ No

List name(s) of school-aged siblings:

1. _____ Grade/School _____|_____
1. _____ Grade/School _____|_____
1. _____ Grade/School _____|_____
1. _____ Grade/School _____|_____

Emergency Contact Information

Parent/Guardian #1

_____|_____|_____

___

Last Name First Name Relation

Home # _____|_____|_____ Work # _____|_____|_____ Cell # _____|_____|_____

Parent/Guardian #2

_____|_____|_____

___

Last Name First Name Relation

Home # _____|_____|_____ Work # _____|_____|_____ Cell # _____|_____|_____

If parents/guardians cannot be reached, list two persons show will assume care of your child.

Name _____ Relationship _____ Phone: _____|_____|_____

Name _____ Relationship _____ Phone: _____|_____|_____

Child's Healthcare Provider: _____ Phone: _____|_____|_____

I give permission to give my child (check all that apply) __Tylenol __Advil __Caladryl/Calamine Lotion __Benadryl Cream __Tums (or generic equivalent) according to label instructions; __cough drops according to label instructions.

Dear Parents/Guardians:

Please see the information below on the medication policy for administration of medication at school. Every student is given a new health information form at the beginning of the school year. Every student is required to turn this form in by the end of the FIRST week of school. Forms go to the school nurse to keep on file for emergencies.

School nurses must have written permission to administer any medication. Please check the medication box and the YES/NO box to give permission for medication at school. Parents will be contacted prior to administration. Please see the school nurse for any additional forms for asthma, seizures, diabetes, etc that you may need.

Please note that medications brought to school in "baggies" will not be given by the school nurse. Medication forms must be on file in the school clinic.

MEDICATION POLICY:

JGCD-R: Medication Guidelines for Administration of Medication at School

NO medication of any kind will be administered to any student without a signed authorization form from the student's parent/guardian and the prescribing physician, subject to the exception of emergency administration of auto-injectable epinephrine.

NO over the counter medication or herbal/dietary supplements will be administered on a **routine basis** to any student for more than a two week period without a written order from a health care provider authorized to prescribe medication in the State of Georgia.

STUDENTS ARE NOT ALLOWED TO TRANSPORT ANY MEDICATION TO OR FROM SCHOOL.

Parents and guardians are responsible for delivering student medications to the school nurse. Students are NOT permitted to transport medication to or from school or to possess such medication at school, unless the student is granted an exception to this rule as provided in the student's Individualized Education Plan, Section 504 Plan; Emergency Medication Plan; or Diabetes Management Plan.

Prescription medications must be in the original container bearing a prescription label from the pharmacy. Over the counter medications must be in the original container with a label from the manufacturer.

Medications which may be self- administered at school include asthma medications, auto injectable epinephrine, diabetes treatment medications, and, as authorized by school administrators, other potentially life-saving medications that may be administered in an emergency.

Please keep this page for parent reference

__Yes __No *(Box MUST be checked for medication administration – Parent will be contacted prior to administration.)*

I also understand that, if in the event of an emergency, I cannot be reached, the school will have my child transported to the hospital via the EMS/911 service to receive appropriate treatment. __Yes __No

Parent Signature: _____ Date: _____

Georgia Department of Education

Richard Woods, Georgia's School Superintendent
"Educating Georgia's Future"

School District: _____ **Date Completed:** _____

Parent Occupational Survey
Please complete this form to determine if your child(ren) qualify to receive additional services under Title I, Part C

Has your family moved in order to work in another city, county, or state, in the last three (3) years? ☐ Yes ☐ No

If so, what is the date your family arrived in the city/town you reside? _____

Has anyone in your immediate family been involved in one of the following occupations, either full or part-time or temporarily during the last three (3) years? (Check all that apply)

☐ 1) Agriculture: planting/picking vegetables or fruits such as tomatoes, squash, grapes, onions, strawberries, blueberries, etc.
☐ 2) Planting, growing, or cutting trees (pulpwood)/raking pine straw
☐ 3) Processing/packing agricultural products
☐ 4) Dairy/Poultry/Livestock
☐ 5) Meatpacking/Meat processing/Seafood
☐ 6) Fishing or fish farms
☐ 7) Other (Please specify occupation): _____

Name of Student(s)	Name of School	Grade
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Names of Parent(s) or Legal Guardian(s) _____

Current Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Thank You!
Please return this form to the school
The answers to this survey will help determine if your child(ren) are eligible to receive supplemental services from the Title I, Part C Program.

Note for the school/district: When both "yes" and one or more of the boxes from 1 to 7 is/are checked, please give this form to the migrant liaison or migrant contact for your school/district. Please file original in student's records. Non-funded (consortium) systems should fax occupational parent surveys to the regional MEP office serving their district. For additional questions regarding this form, please call the MEP office serving your district:

GaDOE Region 1 MEP, P.O. Box 780, 201 West Lee Street Brooklet, GA 30415
Toll Free (800) 621-5217 Fax (912) 842-5440
GaDOE Region 2 MEP, 221 N. Robinson Street, Lenox, GA 31637
Toll Free (866) 305-3182 Fax (229) 546-3251

Home Language Survey

School: _____

Student's Legal Name: _____
Last First Middle Suffix (Jr., Sr., II, etc)

Dear Parent or Guardian:
In order to provide your child with the best possible education, we need to determine how well he or she speaks and understands English. This survey assists school personnel in deciding whether your child may be a candidate for additional English language support. Final qualification for language support is based on the results of an English language assessment.
Thank You

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1. Which language does your child most frequently speak at home? _____

2. Which language do adults in your home most frequently use when speaking with your child? _____

3. Which language(s) does your child currently understand or speak? _____

4. If possible, would you prefer notice of school activities in a language **other** than English? ___ Yes ___ No

If yes, which language? _____

Where was your child born (what country)? _____

Date your child entered the USA (if applicable): _____/_____/_____

Date your child first started school in the USA: _____/_____/_____

Date your child first started school in Georgia: _____/_____/_____

Has your child received ESOL instruction before? ___ Yes ___ No

If Yes, School System: _____ School: _____ Dates of Service: _____

_____ _____
Signature of Parent/Guardian/Other *Date*

Registrars: Place in Permanent Record Folder and forward a copy to the Federal Program Director.

If the answer to any of the four questions above is a language other than English, send a copy of this form to the designated ESOL contact at your school for the required student screening.