School Year _____ TROY CITY SCHOOLS ☐ Please check if this is a new address

Residency Affidavit Form

Grade _____ This registration form should not be considered a barrier to enrollment

I. STUDENT INFORMATION: DATE: _____

Full Legal Name of Child _____ Male_____ Female_____

Race: Black____ White____ Asian____ American Indian/ Alaskan Native____ Not Specified (Hispanic Students Only)____ Pacific Islander____ Multi Race____

Birth Date: _____ (Voluntary) Birthplace: _____

*Child's Social Security # _____ (Voluntary) Home Telephone #_____

Complete Mailing Address _____

_____

Parent/Guardian E-mail Address: _____Student's E-mail Address: _____

Parent/Guardian Cell Number: _____ Parent/Guardian Cell Number: _____

The following individuals have permission to check-out this student.

Emergency Name: _____ Emergency Number: _____

II. FAMILY INFORMATION:

Child Lives With: Father____ Step-Father____ Mother____ Step-Mother____ Legal Guardian____ Foster Care____
(Check all that apply)

Father, Step-Father, Mother, Step-Mother, Legal Guardian, Foster Care (Circle One)

Guardian's Name_____

Work Place_____

Phone #_____

Father, Step-Father, Mother, Step-Mother, Legal Guardian, Foster Care (Circle One)

Guardian's Name_____

Work Place_____

Phone # _____

III. TRANSFER INFORMATION:

Transferring From: Name of School _____ School Phone # _____

Was your child in any Exception Child programs (special education/gifted education)? If Yes, Please List _____

Has your Child Previously Attended Troy City Schools? Yes_____ No _____ When? _____

Has your Child Been Retained? Yes_____ No _____ What Grade? _____

IV. I certify that I have the responsibility of providing for the needs of this student and that I am in charge and control of his/her actions.

_____ _____

PARENT/LEGAL GUARDIAN/FOSTER CARE SIGNATURE **DATE**

***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.**

V. MEDICAL HISTORY:

1. List all current medical problems (allergies, diabetes, etc.)_____

_____

2. Does your child take any medication? Please list all prescriptive and non-prescriptive drugs he/she takes _____

_____

3. Is he/she allergic to any medication? _____

4. Please include any additional information you feel would be helpful to the school nurse and other personnel._____

_____

VI. STATE OF ALABAMA
COUNTY OF PIKE

RESIDENCY AFFIDAVIT UNDER OATH

I, _____, am the _____of
Parent/Legal Guardian/Foster Care **(Print Full Name)** Mother, Father, Legal Guardian, Foster Care

CHILD'S FULL NAME	**SCHOOL ATTENDING**	**GRADE LEVEL**
_____	_____	_____

Do hereby certify, under oath that our residence and domicile is presently within the city limits of the City of Troy, Pike County, Alabama; that we have our permanent address in the city limits of the City of Troy, Pike County, Alabama; and that said permanent address is

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I further certify, under penalty of perjury, that my child spends weekdays, weeknights, and weekends at the above permanent address, and that I have notified the District if my child spends nights during the week or weekends outside of the Troy City Limits with any regularity.
I understand that the purpose of this affidavit is to induce the Troy City Board of Education to allow my/our child to attend the public schools in the City of Troy, Alabama. I further consent and agree that the Troy City Board of Education shall have the right to verify this affidavit as to our residence and that this affidavit may be submitted to a Federal Court or other authority as proof of our residence, and I consent to the use of this affidavit by the Troy City Board of Education as proof of our residence. I understand fully and completely that the execution of a false affidavit will result in the removal of my/our child from school rolls.

I further hereby agree that if there is any change whatsoever in my residence or in the residence of the above named child, I will notify the Troy City Board of Education immediately and will sign a new affidavit stating the correct residence. Failure to report a change will result in the withdrawal of your child.

Sworn to and subscribed before me this _____day of _____, 20_____

_____ _____
Notary Public **Parent/Legal Guardian/Foster Care Signature**

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 strictly confidential.

To be completed by parent/guardian.

PLEASE PRINT. Return to the School Nurse.

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

Address (Street)	Race/Ethnicity	
	☐ American Indian	☐ White, not of Hispanic origin
(City and Zip code)	☐ Asian	☐ Hispanic/Latino
	☐ Black, not of Hispanic origin	☐ Other

Home Telephone Number	Cell Telephone Number	School	Grade

Name of Parent/Guardian (Last, First, Middle)

Transportation

☐ Bus Rider ☐ Car Rider ☐ Special Needs Bus ☐ After School Program

Part I – Health Information

Place where your child receives regular health care:
- ☐ Health Department
- ☐ Hospital Clinic
- ☐ Community Health Center
- ☐ Private Doctor/HMO
- ☐ Other _____
- ☐ No regular place

Physician's Name: _____

Address: _____

_____

Tel: _____

Place where your child receives regular dental care:
- ☐ Health Department
- ☐ Hospital Clinic
- ☐ Community Health Center
- ☐ Private Doctor/HMO
- ☐ Other _____
- ☐ No regular place

Dentist's Name: _____

Address: _____

_____

Tel: _____

Type of Insurance your child has:
- ☐ Medicaid
- ☐ No Insurance
- ☐ Private Insurance
- ☐ ALLKIDS
- ☐ Other: _____

Authorizations:

☐ **I authorize the school nurse, the registered nurse (RN) or licensed practical nurse (LPN), to talk with the physician(s) should a question come up about my child's medical conditions.**

☐ **I do NOT authorize the school nurse, the RN or LPN, to talk with the physician(s) should a question come up about my child's medical conditions.**

☐ **I authorize for my child to participate in all school health screenings, such as vision, hearing and scoliosis.**

☐ **I authorize the yearly review of my child's Certificate of Immunization (Blue Slip) by the local Public Health Department.**

FOR OFFICE USE ONLY Acuity Scale:			
Level A Nursing Dependent	Level B Medically Fragile	Level C Medically Complex	Level D Health Concerns

State of Alabama Department of Education
Health Assessment Record
School Year: _____ - _____

Part II – Medical History

☐ **NO KNOWN HEALTH PROBLEMS**

(If no, please go directly to the bottom of the page and provide parent/guardian signature.)

☐Attention Deficit Disorder (ADD) OR ☐ Attention Deficit Hyperactivity Disorder (ADHD)	☐Requires medication? *(Requires medication authorization from physician)* ☐To be given while at school?
☐Allergies: *Please Specify :* ☐ Food _____ ☐ Insects _____ ☐ Environmental _____ ☐ Medications _____	☐Hives/rash? ☐Breathing difficulty? ☐Epi-pen? *(Requires medication authorization from physician)*
☐Asthma:	☐He/She uses an inhaler at school?*(Requires authorization from physician)* ☐He/She uses an inhaler at home?
☐Bleeding Problems: (Hemophilia, Von Willebrand's, frequent nosebleeds)	☐Requires medication? Please explain: *(Requires medication authorization from physician)*
☐Cancer/Leukemia:	Please explain:
☐Cerebral Palsy:	Please explain:
☐Cystic Fibrosis:	Please explain:
☐Dental Problems:	☐Braces? OR Please explain:
☐Diabetes:*(Requires medication and procedure authorization from physician)* ☐ Type 1 Diabetic ☐ Type 2 Diabetic	☐Monitors Blood Sugars while at school? ☐Requires Insulin at school? ☐Glucagon order? ☐Insulin pump? ☐Managed with diet?

☐Emotional/Behavioral/Psychological: *Please explain:*	
☐Gastrointestinal/Stomach Problems: *Please explain:*	
☐Genetic Disorder: *Please explain:*	
☐Headaches: *Please explain:*	
☐Hearing Problems:	☐Right Ear ☐ Left Ear ☐ Both ears ☐ Tubes ☐Hearing loss? ☐Hearing aid? ☐ Cochlear Implant
☐Heart Condition: *Please explain: Are there any activity restrictions? Any medications taken at home only?*	
☐Hypertension (High Blood Pressure):	
☐Juvenile Arthritis/Bone-Joint Problems: *Please explain:*	
☐Kidney Problems: *Please explain:*	
☐Scoliosis:	☐No Treatment ☐ Wears Brace ☐ Surgery
☐Seizures/Convulsions: *Please explain:*	Type of seizure: _____ ☐Diastat order
☐Sickle Cell Anemia:	
☐Spina Bifida:	
☐Special Diet: *Please explain:*	
☐Vision Problems:	☐Wears glasses ☐ Wears contacts ☐ Other, _____
☐Other Medical Conditions: *Please include **any** medications taken at home only.*	

Part III – Medical Equipment /Procedures Required at School

☐ Catheter ☐ Gastric Tube ☐ Nebulizer Treatments ☐ Oxygen Supplement ☐ Tracheostomy
☐ Vagal Nerve Stimulator (VNS) ☐ Ventilator ☐ Wheelchair ☐ Walker

Required Signatures

Signature of parent(s) or guardian:_____ **Date:**_____

Signature of school nurse: _____ **Date:**_____