

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/ _____ Not Specified _____ Pacific Islander _____ Multi Race _____
Alaskan Native (Hispanic Students Only)

Birth Date: _____ Birthplace: _____
(Voluntary)

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

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)

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

Guardian's Name _____

Guardian's Name _____

Work Place _____

Work Place _____

Phone # _____

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

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

Troy City Schools
HOME LANGUAGE SURVEY

Date

School

Schools are required to determine the language(s) spoken at home by each student. This information is essential in order for schools to provide meaningful instruction for all students.

Your cooperation in helping us meet this important requirement is requested. Please answer the following questions and have your child return this form to his/her teacher.

Thank you for your help.

Name of student: _____

Last First Middle

Grade: _____ **Age:** _____

1. Which language did your son or daughter learn when he or she first began to talk?

2. What language does your son or daughter most frequently use at home?

3. What language do you use most frequently to speak to your son or daughter?

4. Name the language most often spoken by the adults at home.

Signature of Parent or Guardian



ALABAMA STATE DEPARTMENT OF EDUCATION

Parent Survey for Newly Enrolled Students



SCHOOL SYSTEM

SCHOOL NAME

DIRECTIONS

Please complete the following survey. Your child may be eligible for FREE additional educational services. If you answer yes to any of the questions below, an education representative may contact you to find out whether you, your child, or any member of your family is eligible for the migrant education program. All information will be kept confidential.

Please return the completed questionnaire to your child's school.

RELOCATION HISTORY

Have you ever traveled in or out of Alabama to work or find work in any of the pictures below in the past three (3) years?

☐ Yes

☐ No

Are you or your spouse currently working in agriculture, farming, fishing or any of the pictures below?

☐ Yes

☐ No

Mark all pictures of agriculture, farming, or fishing where you have worked in the past 3 years. See pictures below.

☐ Yes

☐ No

Other work you have done that is not shown in a picture below: _____

Fruit or Tomato Farms

☐ Yes



Fish or Shrimp Farms

☐ Yes



Nursery, greenhouse, sod farm

☐ Yes



Planting / Harvesting Crops

☐ Yes



Cattle Farms; Milk Products

☐ Yes



Hatchery; feeding, processing chickens, gathering eggs

☐ Yes



Working on a worm farm

☐ Yes



Growing, tending, felling trees

☐ Yes



PARENT INFORMATION

PARENT / GUARDIAN

ADDRESS

CITY

STATE

ZIP

PHONE NUMBER

PLACE OF EMPLOYMENT

NUMBER OF CHILDREN IN HOME

DATE OF MOVE



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 ☐ Asian ☐ Black, not of Hispanic origin ☐ White, not of Hispanic origin ☐ Hispanic/Latino ☐ Other		
(City and Zip code)			
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	Place where your child receives regular dental care: ☐ Health Department ☐ Hospital Clinic ☐ Community Health Center ☐ Private Doctor/HMO ☐ Other _____ ☐ No regular place	Type of Insurance your child has: ☐ Medicaid ☐ No Insurance ☐ Private Insurance ☐ ALLKIDS ☐ Other: _____
Physician's Name: _____	Dentist's Name: _____	
Address: _____	Address: _____	
Tel: _____	Tel: _____	

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? <i>(Requires medication authorization from physician)</i>
☐ Allergies: <i>Please Specify:</i> ☐ Food _____ ☐ Insects _____ ☐ Environmental _____ ☐ Medications _____	☐ To be given while at school? ☐ Hives/rash? ☐ Breathing difficulty? ☐ Epi-pen? <i>(Requires medication authorization from physician)</i>
☐ Asthma:	☐ He/She uses an inhaler at school? <i>(Requires authorization from physician)</i> ☐ He/She uses an inhaler at home?
☐ Bleeding Problems: (Hemophilia, Von Willebrand's, frequent nosebleeds)	☐ Requires medication? Please explain: <i>(Requires medication authorization from physician)</i>
☐ Cancer/Leukemia:	Please explain:
☐ Cerebral Palsy:	Please explain:
☐ Cystic Fibrosis:	Please explain:
☐ Dental Problems:	☐ Braces? OR Please explain:
☐ Diabetes: <i>(Requires medication and procedure authorization from physician)</i> ☐ 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: <i>Please explain:</i>	
☐ Gastrointestinal/Stomach Problems: <i>Please explain:</i>	
☐ Genetic Disorder: <i>Please explain:</i>	
☐ Headaches: <i>Please explain:</i>	
☐ Hearing Problems:	☐ Right Ear ☐ Left Ear ☐ Both ears ☐ Tubes ☐ Hearing loss? ☐ Hearing aid? ☐ Cochlear Implant
☐ Heart Condition: <i>Please explain: Are there any activity restrictions? Any medications taken at home only?</i>	
☐ Hypertension (High Blood Pressure):	
☐ Juvenile Arthritis/Bone-Joint Problems: <i>Please explain:</i>	
☐ Kidney Problems: <i>Please explain:</i>	
☐ Scoliosis:	☐ No Treatment ☐ Wears Brace ☐ Surgery
☐ Seizures/Convulsions: <i>Please explain:</i>	Type of seizure: _____ ☐ Diastat order
☐ Sickle Cell Anemia:	
☐ Spina Bifida:	
☐ Special Diet: <i>Please explain:</i>	
☐ Vision Problems:	☐ Wears glasses ☐ Wears contacts ☐ Other, _____
☐ Other Medical Conditions: <i>Please include <u>any</u> medications taken at home only.</i>	

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: _____



Student Residency Questionnaire

Please use one form per student. Return to school registration office within 14 days of receipt. If you require additional copies, please contact school.

Name of Student: _____
First Middle Last

Name of School: _____ Grade: _____ Birthdate: _____/_____/_____
Month Day Year Age: _____

Sex: _____ Male _____ Female _____

The answers to the following Questions can help determine the services this student may be eligible to receive under the McKinney-Vento Act 42 U.S.C. 11435.

1. Do you live in any of these following situations sharing the housing of others due to: (Check one)

_____ Loss of housing

_____ Economic hardship

_____ Long-term, cooperative living arrangement to save money or a similar reason

_____ Motel, car, campsite

_____ As a student are you living with someone other than your parents or legal guardian

2. If you answer YES to any of the above questions, please complete the remainder of this form

If you answer NO to all of the above questions, you may stop here.

ADDRESS /OR GENERAL ADDRESS _____

PHONE OR CONTACT NUMBER _____

3. Please list any other siblings/age in the household:
