

Weldon City Schools



Weldon Elementary Global Academy
"Baby Chargers"

Weldon Middle School
"Junior Chargers"

Roanoke Valley Early College
"Chargers"

Weldon Stem High School Career Academies
"Chargers"

Enrollment Packet

_____ Proof of Residence – (recent utility bill, rent/mortgage receipt with parent/guardian name and address, or a house closing document.)

_____ Student must be living with biological parent or **legal guardian** if under the age of 18. (Proof of **legal guardianship** must be in writing.)

_____ Birth Certificate

_____ Copy of Social Security Card

_____ Copy of last report card from former school (if enrolling during the summer) OR withdrawal form from last school (if enrolling during the school year).

_____ Immunization Record

_____ An appointment must be made to see the principal or designee before a student can be registered.

_____ After a conference with the principal or designee, the student will then be referred to the counselor or designee for registration.

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Contents of Student Folder *(For New Enrollment Purposes)*

Please place a check by each item which is currently located in the student's file. Leave blank if item is not in file.

Permission for Release of Records

Enrollment Application

Home Language Survey

Copy of Birth Certificate

Social Security Number

Student Emergency Card

McKinney Vento Eligibility

Immunization Records

Other Health Records

Transcript of Grades

Copy of grades from previous school term

End-of-Grade/End-of-Course Test Scores (must have previous year)

If a student is in the Exceptional Children's Program or has a 504, the folder should contain a sheet stating: "Look for my EC Records" or "Look for my 504 Records."

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OFFICE OF THE PRINCIPAL

PERMISSION FOR RELEASE OF RECORDS

Date

TO: _____

FROM: _____

I hereby give permission for the records of

Name of Student

DOB

Date

to be sent to the address indicated above. Please send the following records:

_____ Cumulative File
_____ Transcript
_____ Grades to Date of Withdrawal
_____ Test Scores
_____ Scores of Semester Exams
_____ Confidential Records (including IEP, if available)

_____ Exceptional Children's Records
_____ 504 Accommodation Plans
_____ ESL Records
_____ AIG Records
_____ Health Record
_____ Explanation of your Grading System

Please forward records to: _____
Counselor, Principal, Data Manager

I understand that I may examine these records, if I desire to do so

Signature of Parent/Guardian

Date

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RELEASE OF RECORDS, continued

Student Name: _____ DOB: _____ Grade: _____

Previous School: _____ Teacher: _____

Address of Previous School: _____

My child, _____ did receive services in the Programs for Exceptional Children.

My child, _____ did **NOT** receive services in the Programs for Exceptional Children.

CONSENT:

I hereby authorize WELDON CITY SCHOOLS to receive information about the above-mentioned student, for the purpose of contributing to individual educational planning for him/her. Specific information requested is checked below:

_____ Educational _____ Psychological _____ Occupational Therapy
_____ Medical _____ Counseling _____ Physical Therapy
_____ Speech/Language _____ Other: _____

I understand that the information to be received will not be released to other agencies without prior written consent. I acknowledge that I have been informed to the type of information being requested and that there are statues and regulations protecting the confidentiality of authorized information. I acknowledge that this consent is voluntary and is valid until such request is fulfilled. I understand that I may revoke this consent at any time except to the extent that action based upon this consent has been taken.

Parent/Guardian Signature

Relationship to Student

Witness

Date

School

(Information for Enrollment) Page 2

Place of Birth:

County: _____ **City:** _____ **State:** _____

Family Dentist: _____

Address: _____ **Phone:** _____

Family Physician:

Address: _____ **Phone:** _____

Hospital Preference: _____

Name

Address

State

Zip

Significant Facts Concerning Student (Health Problems, etc.):

Name of Last School Attended: _____

Address: _____

Parent Information:

Father's Name: _____ **Place of Birth:** _____

Employer: _____ **Business Phone:** _____

Occupation: _____

_____ **High School Graduate** _____ **College Graduate**

Mother's Name: _____ **Place of Birth:** _____

Employer: _____ **Business Phone:** _____

Occupation: _____

_____ **High School Graduate** _____ **College Graduate**

Directions to Child's Home:

NOTE: SPECIAL INSTRUCTIONS (CONCERNING STUDENT)

**Weldon City Schools
Student Emergency Card**

Name of Student _____
(Last) (First) (Middle)

Date: _____

Physical Address: _____

School: _____

Mailing Address: _____

Home Phone: _____ Grade: _____

DOB: _____

Cell Phone: _____

Text#: Yes _____ No _____

Teacher/Homeroom: _____

Bus #: _____

Where can parents be reached if not at home: _____

Mother's Name: _____

Work Phone: _____

Cell Phone: _____

Text#: Yes _____ No _____

Father's Name: _____

Work Phone: _____

Cell Phone: _____

Text#: Yes _____ No _____

Address (if different from above) _____

List two neighbors or relatives who can assume temporary care of your child if you cannot be reached.

1. Name: _____

Phone: _____

Address: _____

2. Name: _____

Phone: _____

Address: _____

In case of a medical emergency, injury or serious illness, I hereby authorize school personnel to take or send my child to the family physician or the hospital. I understand that I, the parent or legal guardian, am responsible for the cost of any and all treatment provided by the treating facility.

Parent/Guardian's Signature

Date: _____

Doctor: _____

Phone: _____

Hospital Preference: _____

Serious Healthy Condition: _____

List any medications taken daily or medications needed in a medical emergency: _____

Dear parents,

The following is a brief health from which must be returned to your child's teacher as soon as possible. This information will be reviewed by the school nurse and used to meet your child's health needs at school and PE. Please use a pen and write firmly.

School: _____ Homeroom Teacher/Grade: _____

Student Name: _____ DOB: _____ Phone: _____

Parent/Guardian Name: (Mother) _____ Daytime Phone: _____

(Father) _____ Cell Phone: _____

Daytime Phone: _____

Cell Phone: _____

Name of Doctor: _____ Phone#: _____

Name of Dentist: _____ Phone#: _____

Does your child have health insurance? **Yes No** Is your child on a special diet? **Yes No**

Does your child take regular medication? **Yes No** Is your child able to participate in Physical Education? **Yes No**

Has your child experienced a head injury of any kind (e.g., concussion) in the past year? **Yes No**

CHECK CONDITION(S) YOUR CHILD HAS

1. Asthma	7. Convulsions/Seizures	13. Hemophilia	19. Skin Problems
2. ADD/ADHD	8. Cystic Fibrosis	14. Heart Problems	20. Speech Problems
3. Bone/Muscle Problems	9. Cerebral Palsy	15. Hearing Problems	21. Kidney/Bladder
4. Bowel Problems	10. Dizziness/Fainting	16. Physical Disability	22. Vision Problems
5. Cancer/Leukemia	11. Diabetes	17. Severe Allergies	Other _____
6. Nose Bleeds	12. Emotional/Behavioral	18. Sickle Cell Anemia	None _____

For those illnesses or developmental problems checked above, please provide additional information:

Severe Allergies

What is your child allergic to? _____

Is emergency medication needed at school for allergies? **Yes No**

Circle the type of allergic reactions that occurs. **Hives Swelling Difficult Breathing Other:** _____

Asthma

What triggers an episode? _____

Circle when medication is needed at school. **Daily Before PE Never When Symptoms Occur**

Diabetes

Is insulin needed at school? **Yes No** Are snacks needed at school? **Yes No**

Will blood sugar checks be needed at school? **Yes No**

Vision Problems

Does your child wear glasses or contacts? **Yes No** Is special seating needed? **Yes No**

Hearing Problems

Does your child have a known loss? **Yes No** Is special seating needed? **Yes No**

Does your child have a hearing aid? **Yes No**

Heart Problems

Circle Type: Heart Murmur Heart Valve Condition Other: _____

Is exercise limited? **Yes No** Is medication needed at school? **Yes No**

Bone/Orthopedic Problems – Name of problem: _____

Other Health Problem or Learning Problem: _____

If your child needs medication, a special diets, or PE restrictions at school, please contact the school nurse. Additional forms signed by the doctor will be necessary.

I give permission for routine health screenings to be performed (height, weight, vision, hearing and dental). I understand that I will be notified of any possible problems detected.

Parent or Guardian Signature: _____

Date: _____

Notification of Possible Media Visits / Photo Release Form

Weldon City Schools uses photographs, slides, videos, or illustrations of students for many purposes related to WCS business. This form allows you to grant or deny permission to WCS to release your child’s image for display or publication. This form also allows a parent or guardian to choose whether or not their child may be identified by name on the school or district’s websites. Student names may be released unless a parent or guardian has expressly contacted the school and requested their child’s “directory information” not be shared. However, as a safeguard, the district does not directly publish student names to the Internet unless given permission by a parent or guardian.

Parents have two options for granting or denying consent:

- Parents may deny permission for any display or publication of their child’s image. You should select this option if you do not want your child’s photograph to be used on the WCS or individual school websites, in WCS or school publications, or in release to external organizations (such as PTA) or the media.
- Parents also may grant permission for their child’s image to be published or displayed in print, video, and/or digital media. Selecting this option means that your child’s photograph and name may appear in WCS or school publications, on the WCS or individual school websites, and may be released to external organizations (such as PTA) or the media.

Please complete this form and have your child return it to his or her school. This consent form remains valid throughout your child’s K-12 experience with the Weldon City Schools or until a new form is completed and signed by a parent / guardian or eligible student.

I deny permission to use my child’s image for display, publication or release to external organizations.

I grant permission for use of my child’s image in print, video and/or digital media. I understand that my child’s image may be used or released by WCS without additional notification and that my child’s name may appear along with his or her photograph.

Student’s Name: _____

Student’s grade and school: _____

Parent/Guardian Name: _____

Phone Number: _____

Date: _____

Weldon City Schools
“Charging Into Excellence”

Home Language Survey

Date: _____

Name of Student: _____
(Last) (First) (Middle)

Birth Date: _____ **Gender:** _____

School: _____ **Grade:** _____

Homeroom Teacher: _____

Place of Birth: _____ **Country of Origin:** _____

Time in United States Schools: _____

What School Did the Student Last Attend? _____

1. What is the first language the student learned to speak?

2. What language is primarily spoken in the student’s home?

3. What language does the student speak most often?

4. Other than languages studied in school, does the student speak any language other than English?
Yes _____ No _____
(If yes, list the language)

Name of Person Completing the Survey: _____

Relationship to Student: _____

This survey is administered once to ALL students enrolling in Weldon City Schools for the first time. The survey is used to identify National Origin Minority Students and Limited English Proficient (LEP) students according to state and federal law.

If the answer to ANY of the questions indicates a language other than English, the student must be referred to the Testing Coordinator for language proficiency testing and to the English as a Second Language (ESL) Administrator of determination of placement in the ESL program.

CC: Data Manager
ESL Administrator
Cumulative/Permanent Folder

Medical Statement for Students with Special Nutritional Needs for School Meals

When completed fully, this form gives schools the information required by the U.S. Department of Agriculture (USDA), U.S. Office for Civil Rights (OCR), and U.S. Office of Special Education and Rehabilitative Services (OSERS) for meal modifications at school. See "Guidance for Completing Medical Statement for Students with Special Nutritional Needs for School Meals" for help in completing this form.

PART A (To be completed by Parent/Guardian)

Name of Student: (Last) _____ (First) _____ (Middle) _____

Date of Birth _____ Student ID # _____ School _____ Grade _____

Will student eat breakfast provided by the school cafeteria? Will student eat lunch provided by the school cafeteria? Will the student eat a snack provided by the After School Snack Program?

Yes No

Yes No

Yes No

Printed Name of Parent/Guardian: _____

Mailing Address: _____ City: _____ State/Zip: _____

Phone number(s): _____

(Work)

(Home)

(Cell)

Email Address: _____

What concerns do you have about your student's nutritional needs at school?

What concerns do you have about your student's ability to safely participate in mealtime at school?

Does the student have an identified disability and an Individualized Education Program (IEP) or 504 Plan?

Yes No

If *Yes* and you have concerns about nutritional needs, have a licensed physician complete Part B, page 2, of this form and sign it. Return completed form to _____.

If *No* and you have concerns about nutritional needs, have a licensed physician or recognized medical authority complete Part B, page 2, of this form and sign it.

Return completed form to _____.

NOTE: Special dietary needs for students without an IEP or 504 Plan are accommodated at the discretion of the Child Nutrition Administrator and policies of the school district.

Parental/Guardian Consent: I agree to allow my child's health care provider and school personnel to discuss information on this form.

Parent/Guardian Signature: _____

Date: _____

PART B (To be completed by Licensed Physician)

Student Diagnosis or condition:

Check major life activities affected:

- Walking Seeing Hearing Speaking
 Breathing Working Learning Other _____
 Performing manual tasks Caring for self (including eating)

Specify any dietary restrictions or special diet instructions for school meals:

Designate consistency requirements for food:

- Clear Liquid Pureed
 Full Liquid Mechanical Soft
 Blenderized liquid No change needed

Designate consistency requirement for liquids:

- Thin Spoon-thick
 Nectar-like No change needed
 Honey-like

List any foods causing food *intolerance* that should be avoided: _____

List any foods causing food *allergies* that should be avoided: _____

If student has **life threatening** allergies*, check appropriate box(es): ingestion contact inhalation

* Students with life threatening food allergies must have an emergency action plan in place at school.

For *any* special diet, list specific foods to be omitted and substitutions; you may attach a separate care plan.

a. Foods To Be Omitted

b. Recommended Substitutions

a. Foods To Be Omitted	b. Recommended Substitutions

Indicate any other comments about the child's eating or feeding patterns, including tube feeding if applicable:

If a nutritional/feeding care plan has not been developed prior to completion of this form an additional assessment is required, please refer student for feeding and nutritional assessment in your community. School-based personnel do not routinely have instrumentation and/or training for a comprehensive nutrition and feeding assessment.

Signature of Physician/Medical Authority*

Printed Name

Phone Number

Date

* A licensed physician's signature is required for students with a disability. For students without a disability, a licensed physician or recognized medical authority must sign the form.

PART C (To be completed by Child Nutrition Services)

Child Nutrition Services Notes:

CN Administrator Signature: _____ **Date:** _____

Guidance for Completing the Medical Statement for Students with Special Nutritional Needs for School Meals

Parent/Guardian:

The *Medical Statement for Students with Special Nutritional Needs for School Meals* helps schools provide meal modifications for students who require them. Completion of all items will allow your child's school to create a plan with you for providing safe, appropriate meals to your child while at school.

Your participation in this process is very important. The sooner you provide this signed and completed form to your child's school, the sooner the Child Nutrition Program or school staff can prepare the food your child requires. Your signature is required for your school to take action on the medical statement. The school staff cannot change food textures, make food substitutions, or alter your child's diet at school without all the information filled in on this form.

Please follow the steps below to get started:

- 1) Complete all items of **PART A** of the Medical Statement.
- 2) Take the Medical Statement to your child's pediatrician or family doctor and have him/her complete **PART B**.
- 3) Return the properly signed Medical Statement to your child's teacher, principal, nurse, Special Education case manager, or Section 504 case manager, Child Nutrition Administrator, or the school staff person who gave you the blank form.
- 4) Ask the school when a team, including you and the school system's Child Nutrition Administrator, will meet to consider the information provided on the form. You may invite people from the community who are knowledgeable about your child's feeding and nutrition issues to the meeting. These would be people who could help school staff design a school mealtime plan for your child, like your child's pediatrician, nurse, speech-language pathologist, occupational therapist, registered dietitian or personal care aide.

Physicians and Medical Authorities:

This form helps schools provide meal modifications for students who require them. Completion of all items will streamline efficient care of the student.

The school cannot change food textures, make food substitutions, or alter a student's diet at school without a proper statement from you. Meal modifications are implemented based on medical assessment and treatment planning and must be ordered by a licensed physician or recognized medical authority.

Please consider the following as you complete **PART B** of the Medical Statement:

- 1) Complete all items of **PART B**. (*Note: A licensed physician's signature is required for students with a disability. For students without a disability, a licensed physician or recognized medical authority must sign the form. Recognized medical authorities include physicians, physician assistants, and nurse practitioners.*)
- 2) Be as specific as possible about the nature of the child's disability and life activities that the disability limits. In the case of food allergy, please indicate if the student's condition is a food intolerance, an allergy that would affect performance and participation at school (e.g., severe rash, swelling, and discomfort), or a life-threatening allergy (e.g., anaphylactic shock).
- 3) If your assessment of the child does not yield sufficient data to make a determination about food substitutions, consistency modifications, or other dietary restrictions, please refer the child/family to the appropriate feeding, nutrition, or allergy specialists for completion of the Medical Statement. Schools do not routinely have instrumentation and/or staff trained for a comprehensive nutrition and feeding assessment and must partner with community providers to meet a student's special feeding and nutrition needs.
- 4) Attach any previous and/or existing feeding/nutrition evaluations, care plans, or other pertinent documentation housed in the student's medical records to the Medical Statement for parent/guardian delivery to the school.
- 5) Consider being available to consult with the child's school team as it implements the feeding/nutrition care plan.

Declaración médica para estudiantes con necesidades especiales de nutrición en comidas servidas en la escuela

Quando se llena completamente, este formulario les da a las escuelas información requerida por el Departamento de Agricultura de Estados Unidos (U.S. Department of Agriculture, USDA), la Oficina de los Derechos Civiles de Estados Unidos (U.S. Office for Civil Rights, OCR) y la Oficina de Servicios de Rehabilitación y Educación Especial de Estados Unidos (U.S. Office of Special Education and Rehabilitative Services, OSERS) para modificar comidas servidas en la escuela. Vea el documento "Guía de llenado de la declaración médica para estudiantes con necesidades especiales de nutrición en comidas servidas en la escuela" si necesita ayuda para llenar este formulario.

PARTE A (Debe ser llenada por el padre, la madre o el tutor legal)		
1 ^{er} apellido del estudiante: _____ (1 ^{er} nombre) _____ (Inicial 2 ^o nombre) _____		
Fecha de nacimiento _____	N° de identificación _____	Escuela _____ Grado _____
¿Va el estudiante a consumir el desayuno en la cafetería de la escuela?	¿Va el estudiante a consumir el almuerzo en la cafetería de la escuela?	¿Va el estudiante a consumir bocadillos del Programa de bocadillos después del horario escolar?
<input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Sí <input type="checkbox"/> No	<input type="checkbox"/> Sí <input type="checkbox"/> No
Nombre del padre, la madre o el tutor legal: _____		
Dirección postal: _____ Ciudad: _____ Estado/C.P.: _____		
Teléfonos: _____ (Casa)	_____ (Trabajo)	_____ (Celular)
Correo electrónico: _____		
¿Qué inquietudes tiene con respecto a las necesidades nutritivas del estudiante en la escuela?		
¿Qué inquietudes tiene con respecto a la capacidad del estudiante de comer con seguridad en la escuela?		
¿Tiene el estudiante una discapacidad identificada y un Programa de Educación Individualizada (Individualized Education Program, IEP) o un Plan 504?		
<input type="checkbox"/> Sí <input type="checkbox"/> No		
Si la respuesta es "sí" y usted tiene inquietudes sobre necesidades de nutrición, pídale a un médico licenciado que llene la Parte B, Página 2, de este formulario y que lo firme y lo envíe a _____.		
Si la respuesta es "no" y usted tiene inquietudes sobre necesidades de nutrición, pídale a un médico licenciado o a una autoridad médica reconocida que llene la Parte B, Página 2 de este formulario y que lo firme y lo envíe a _____.		
NOTA: Las necesidades dietéticas especiales de los estudiantes sin IEP ni Plan 504 se satisfacen a discreción del administrador de nutrición infantil y las normas del distrito escolar.		
Consentimiento de los padres o el tutor legal: Acepto que el proveedor de asistencia médica de mi estudiante y el personal de la escuela hablen sobre la información que se presenta en este formulario.		
Firma del padre, la madre o el tutor legal: _____		Fecha: _____

De acuerdo con las leyes federales y las normas del Departamento de Agricultura de los Estados Unidos (USDA), se le prohíbe a esta institución discriminar según la raza, color de la piel, origen nacional, género sexual, edad o discapacidad. Para presentar una queja de discriminación, escriba a USDA, Director, Office of Adjudication, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 o llame gratuitamente al (866) 632-9992 (voz). Las personas con impedimentos auditivos o discapacidades de habla pueden ponerse en contacto con el USDA por el Servicio Federal de Repetición (Federal Relay Service) llamando al (800) 877-8339; o al (800) 845-6136 (español). La institución USDA es un empleador y proveedor de igualdad de oportunidades.

Guía de llenado de la declaración médica para estudiantes con necesidades especiales de nutrición en comidas servidas en la escuela

Padre, madre o tutor legal:

La *Declaración médica para estudiantes con necesidades especiales de nutrición en comidas servidas en la escuela* les permite a la escuela modificar las comidas para los estudiantes que lo requieren. Llenar el formulario en su totalidad le permite al equipo del estudiante formular un plan con usted para darle comidas seguras y apropiadas al estudiante mientras se encuentre en la escuela.

Su participación en este proceso es muy importante. Se necesita su firma para que la escuela del estudiante pueda tomar medidas con respecto a la declaración médica. El personal de la escuela no puede cambiar la textura de la comida ni sustituir alimentos ni alterar la dieta del estudiante en la escuela sin toda la información que se solicita en este formulario.

Siga los pasos que se presentan a continuación para comenzar:

- 1) Llene completamente la **Parte A** de la declaración médica.
- 2) Lleve la declaración médica al pediatra o al doctor de cabecera del estudiante y pídale que llene completamente la **Parte B**.
- 3) Envíele la declaración médica correctamente firmada al maestro, director, enfermera, administrador de casos de educación especial, administrador de casos de la sección 504 o administrador de nutrición de alumnos, o al integrante del personal del establecimiento que le dio el formulario en blanco.
- 4) Pregúntele a la escuela cuándo va a reunirse a considerar la información presentada en este formulario el equipo en que se encuentran usted y el administrador de nutrición del sistema escolar del estudiante. Puede invitar a la reunión a personas de su comunidad con conocimientos sobre los problemas de alimentación y nutrición de su estudiante. Estas serían personas que podrían ayudar al personal de la escuela a diseñar un plan de comidas servidas en la escuela a su estudiante, tales como el pediatra, la enfermera, el patólogo del lenguaje y el habla, el terapeuta ocupacional, el dietista registrado o el ayudante de asistencia personal del estudiante.

Médicos y autoridades médicas:

Este formulario le permite a la escuela modificar las comidas para los estudiantes que lo requieren. Responder todas las preguntas agiliza el cuidado eficiente del estudiante.

La escuela no puede cambiar la textura de la comida ni sustituir alimentos ni alterar la dieta del estudiante sin una declaración apropiada de parte suya. Las modificaciones de comidas se implementan según evaluación médica y planificación de tratamiento, y deben ser ordenadas por un médico licenciado o una autoridad médica reconocida.

Considere lo siguiente cuando llene la **Parte B** de la declaración médica:

- 1) Llene todos los recuadros de la **Parte B** (*Nota: Se requiere la firma de un médico licenciado para los estudiantes con discapacidades. Para estudiantes sin discapacidades, un médico o autorizado o una autoridad médica reconocida debe firmar el formulario. Las autoridades médicas reconocidas son médicos, asistentes médicos y profesionales de enfermería.*)
- 2) Sea lo más específico posible sobre la naturaleza de la discapacidad del estudiante y las actividades diarias que la discapacidad limita. En caso de alergias alimenticias, indique si la afección es una intolerancia a la comida, una alergia que afectaría el rendimiento y la participación en las actividades escolares (p. ej., urticaria grave, hinchazón o molestia) o una alergia con peligro de muerte (p. ej., shock anafiláctico).
- 3) Si su evaluación del estudiante no produce suficientes datos para tomar una decisión respecto a sustitutos alimenticios, modificaciones de consistencias u otras restricciones dietéticas, remita al estudiante o a los familiares a los especialistas apropiados de alimentación, nutrición o alergias para que llenen la declaración médica. Las escuelas por lo general no tienen los instrumentos y/o el personal capacitado para hacer evaluaciones integrales de nutrición y alimentación, y deben asociarse a proveedores de la comunidad para satisfacer las necesidades especiales de alimentación y nutrición del estudiante.
- 4) Adjunte todas las evaluaciones de alimentación o nutrición, planes de asistencia previos o actuales y otros documentos pertinentes contenidos en los registros médicos del estudiante a la declaración médica para que el padre, la madre o el tutor legal los envíen a la escuela.
- 5) Considere estar a disposición del equipo de la escuela del estudiante para consultas a medida que se implementa el plan de asistencia de alimentación y nutrición.



Weldon City Schools

“Charging Into Excellence”

McKinney Vento
April Whitaker
School Social Worker
Homeless Liaison

Weldon Elementary School
“Baby Chargers”

Weldon Middle School
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Roanoke Valley Early College
“Chargers”

Weldon High School
“Chargers”

McKinney-Vento Eligibility

This questionnaire is in compliance with the McKinney-Vento Act, U.S.C. 42 § 11431 et seq. Your answers will help determine if the student meets eligibility requirements for services under the McKinney-Vento Act.

Student _____ Parent/Guardian _____
School _____ Phone _____
Age _____ Grade _____ D.O.B. _____ Retained Previous Year: _____ Yes _____ No
Address _____ City _____ Zip Code _____

Please list the names and ages of all your children: (**For any child not enrolled in school (Age 4 and under), please include First and Last Name, Date of Birth, Ethnicity, and Gender**):

Child 1: _____
Child 2: _____
Child 3: _____

Is the address above a temporary living arrangement? Yes _____ No _____

Please choose which of the following situations the student currently resides in (you can choose more than one):

- _____ House or apartment with parent or guardian
- _____ Motel, car, or campsite
- _____ Shelter or other temporary housing
- _____ With friends or family members (other than or in addition to parent/guardian)

If you are living in shared housing, please check all of the following reasons that apply:

- _____ N/A
- _____ Loss of housing
- _____ Economic situation
- _____ Temporarily waiting for house or apartment
- _____ Provide care for a family member
- _____ Living with boyfriend/girlfriend
- _____ Loss of employment
- _____ Parent/Guardian is deployed
- _____ Other (Please explain) _____

Are you a student under the age of 18 and living apart from your parents or guardians? Yes _____ No _____



Residency and Educational Rights

Students without fixed, regular, and adequate living situations have the following rights:

- 1) Immediate enrollment in the school they last attended or the local school where they are currently staying even if they do not have all of the documents normally required at the time of enrollment without fear of being separated or treated differently due to their housing situations;
- 2) Transportation to the school of origin for the regular school day;
- 3) Access to free meals, Title I and other educational programs, and transportation to extra-curricular activities to the same extent that it is offered to other students.

Services requesting (check all that apply):

- NONE
- Tutoring
- Other instructional services
- Expedited evaluations
- Medical referral
- Dental referral
- Other health service
- Transportation
- Early childhood programs
- Assistance with participation in school programs
- After-school mentoring
- Summer programs
- Record transfer
- Parent education related to rights and resources for children
- Coordination between schools and agencies
- Counseling
- Addressing needs related to domestic violence
- Clothing to meet a school requirement
- School supplies
- Referral to other programs and services
- Emergency assistance related to school attendance
- Other: _____

Barriers Reported (check all that apply):

- NONE Transportation Immunizations Other enrollment issues
- School Selection School records Other medical records

Any questions about these rights can be directed to the local McKinney-Vento Liaison at 252-536-4829 or the State Coordinator at 336-574-8724



Weldon City Schools

“Charging Into Excellence”

McKinney Vento
April Whitaker
School Social Worker
Homeless Liaison

PLEASE READ BEFORE YOU SIGN:

I understand that this application pertains to the child’s placement in Weldon City Schools for the current school year only. I further understand that if the information provided is false, the child may be removed from the school. The district will give a notice of opportunity to appeal the removal in accordance to district policy.

By signing below, I acknowledge that I have received and understand the above rights.

Signature of Parent/Guardian/Person Enrolling Student/Unattached Youth Date

Signature of Witness (School Employee) Date

Signature of Principal Date

Signature of McKinney-Vento Liaison Date

To be completed by school personnel

Transportation request sent to _____ by _____ on _____.
Central Office / Bus Garage initials date

Free/Reduced Lunch Form Submitted by _____ on _____.
initials date



**To be completed by school personnel only:
Please send copy to April Whitaker, Homeless Liaison**

Homeless Database

LEA ID 422 STUDENT ID _____

Name _____
Last First Middle

Mother’s Name _____
Last First

Father’s Name _____
Last First

Residency Type _____
(Enter any of the following types: Shelter, Double Up, Hotel, Motel, Unsheltered (cars, parks, van, camper, etc.)

Address _____

City _____ State _____ Zip Code _____

Phone Number _____

School Name _____

School ID _____

Grade _____ (K-12, UG, OS-Out of school Youth, PK3, PK4, PK5)

Enroll Date _____ Withdraw Date _____

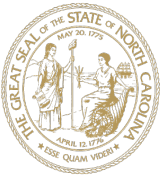
Circle all services provided for this student during this school year: Clothing, medical, dental, transportation, after-school care, DV counseling, attendance related, food, school supplies, referral to other programs-EC, AIG, DSS, etc.)

Circle all barriers that have been waived for this student: School selection, transportation, school records, immunizations, other medical records, other enrollment issues

Absences _____ Days Enrolled/Days Present _____

Promoted to Next Grade _____
Y/N

Database Completed by _____ Date _____



PUBLIC SCHOOLS OF NORTH CAROLINA

DEPARTMENT OF PUBLIC INSTRUCTION | Catherine Truitt, Superintendent of Public Instruction

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Occupational Survey

Student Name : _____
Last Name First Name

School: _____ Grade: _____

The Migrant Education Program, through the North Carolina Department of Public Instruction, provides support and instructional services to children and families who have moved in the past three years and who have done agriculture or fishing work. We appreciate your help in determining if your children or relatives qualify to receive services in this program. Please answer the following questions and return the survey to the school.

<p>1. Have you or someone in your family worked in any of the following areas below in the last three years? No _____ Yes _____ (Select all that apply and continue to question number 2)</p>			
<p>2. Have you or your family moved to another school district or to another city or county in the last three years? No _____ Yes _____</p>			
 Work in the harvest of fruits and vegetables, tobacco, sweet potatoes, nuts, cotton, or in agricultural farms, ranches, fields, and vineyards <input type="checkbox"/>	 Working in a fruit or vegetable cannery or in a fruit or vegetable packing plant <input type="checkbox"/>	 Working in a dairy <input type="checkbox"/>	 Working in a fishery or on a shrimp or catfish farm <input type="checkbox"/>
 Working in a slaughter house (chicken, cow, or pig) <input type="checkbox"/>	 Working on a poultry or hog farm <input type="checkbox"/>	 Working in a plant nursery or orchard; growing or harvesting trees <input type="checkbox"/>	 Other similar work in agriculture, please explain: _____ _____ _____
<p>3. How long ago did you arrive to this school district? Month _____ Year _____</p>			
<p>4. Parent(s)' Name(s) _____</p>			
<p>5. What is your current address?</p> <p>Address _____</p> <p>City _____ State _____ Zip Code _____</p>			
<p>6. Phone Number(s): _____</p>			

FEDERAL PROGRAM MONITORING & SUPPORT DIVISION

6351 Mail Service Center, Raleigh, North Carolina 27699-6351 | (984) 236-2786 | Fax (984) 236-2099

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PUBLIC SCHOOLS OF NORTH CAROLINA

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Encuesta Ocupacional



Nombre del Estudiante: _____

Apellido

Nombre

Escuela: _____ Grado: _____

El Programa de Educación para estudiantes migrantes a través del Departamento de Instrucción Pública del Estado provee servicios de apoyo a los niños y familias que se han mudado en los últimos 3 años y que han trabajado en agricultura o pesca. Agradecemos que nos ayuden a determinar si su niño o pariente califica para recibir servicios en este programa. **Por favor, conteste las siguientes preguntas y entréguelas a la escuela**

<p>1. ¿Usted o alguien en su familia ha trabajado en alguno de los siguientes trabajos en los últimos tres años? No _____ Sí _____ (Seleccione todos los que aplican en el cuadro de abajo)</p>			
 Trabajo en los campos de agricultura cosechando frutas, verduras, nueces, melones, algodón, o en el silaje de zacate, paja, etc <input type="checkbox"/>	 Trabajo en el enlatado de frutas o verduras o en una planta empacadora <input type="checkbox"/>	 Trabajo en las lecherías <input type="checkbox"/>	 Trabajo en la pesca, granjas de camarón o peces <input type="checkbox"/>
 Trabajo en el corte de carnes crudas (pollos, reses, puercos) <input type="checkbox"/>	 Trabajo en granjas avícolas <input type="checkbox"/>	 Trabajo en huertas, viveros, talando árboles o limpiando la tierra) <input type="checkbox"/>	 Otro trabajo similar, favor explicar: Como cercando ranchos, fincas o huertas _____ _____ _____
<p>2. ¿Usted o su familia se ha mudado a otro distrito escolar, o a una ciudad o condado en los últimos tres años? No _____ Si _____</p>			
<p>3. ¿Hace cuánto tiempo se mudó a este distrito escolar o condado? Mes _____ Año _____</p>			
<p>4. Nombre de uno de los padres _____</p>			
<p>5. ¿Cuál es su dirección actual? _____ Dirección _____ Ciudad Estado Código Postal</p>			
<p>6. Teléfono: _____</p>			

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