

**Items Needed For Enrollment**  
**Daleville City Schools**

Name: \_\_\_\_\_ Grade: \_\_\_\_\_

\_\_\_\_\_ Birth Certificate

\_\_\_\_\_ Social Security Card

\_\_\_\_\_ Current Alabama Immunizations Certificate  
(Exception: migrants and victims of disaster rendering the student homeless)\*  
Must be obtained ASAP

\_\_\_\_\_ Withdrawal Papers from former school to include most  
recent report card or progress report/transcript and  
discipline records

\_\_\_\_\_ Legal Child Custody Papers

\_\_\_\_\_ Special Education Paperwork (provide copies of IEP, 504, Gifted Plan, EL Plan)

\_\_\_\_\_ 2 Proofs of Residency  
Daleville City School Board policy 5.20- The following items are the acceptable  
forms of proof of residency needed for enrollment:  
-Utility bills or deposit receipts: Electricity, water, gas ONLY  
-Mortgage Documents or property deed  
-Residential Lease

\_\_\_\_\_ Picture ID of parent /guardian

Upon completion of the enrollment packet, please call Mrs. Nabinger at 334-598-2456  
ext. 2208 to schedule an appointment to complete the registration.

**Daleville City School District**  
**APPLICATION FOR STUDENT ENROLLMENT**

**PLEASE PRINT**

**Must be completed by Parent/Legal Guardian**

**PLEASE PRINT**

DATE: \_\_\_\_\_ SCHOOL: \_\_\_\_\_ GRADE: \_\_\_\_\_  
LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ MIDDLE NAME: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_ SEX - Circle One: MALE FEMALE HOME PHONE: \_\_\_\_\_  
PHYSICAL ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_  
MAILING ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_  
STUDENT LIVES WITH - Circle One: PARENTS MOTHER FATHER GUARDIAN RELATION \_\_\_\_\_  
\*SOCIAL SECURITY NUMBER (voluntary): \_\_\_\_\_  
PARENT(S) / GUARDIAN: (verification shall be in accordance with local school board policy)

|                                                                                                                             |
|-----------------------------------------------------------------------------------------------------------------------------|
| <b>MOTHER/GUARDIAN:</b> _____ Address: _____<br>Email Address: _____ Cell Phone: _____<br>EMPLOYER: _____ Work Phone: _____ |
|-----------------------------------------------------------------------------------------------------------------------------|

|                                                                                                                             |
|-----------------------------------------------------------------------------------------------------------------------------|
| <b>FATHER/GUARDIAN:</b> _____ Address: _____<br>Email Address: _____ Cell Phone: _____<br>EMPLOYER: _____ Work Phone: _____ |
|-----------------------------------------------------------------------------------------------------------------------------|

**SPECIAL INFORMATION ABOUT CUSTODY:** \_\_\_\_\_

**EMERGENCY CONTACTS:** (PLEASE LIST NUMBERS OTHER THAN YOUR OWN)

**EMERGENCY #1**

**EMERGENCY CONTACT #2**

|                              |                              |
|------------------------------|------------------------------|
| Contact _____                | Contact _____                |
| Relation: _____ Phone: _____ | Relation: _____ Phone: _____ |

**THESE PEOPLE HAVE PERMISSION TO CHECK MY CHILD OUT OF SCHOOL**  
**(In accordance to school system check-out procedures)**

|          |                 |              |
|----------|-----------------|--------------|
| 1. _____ | Relation: _____ | Phone: _____ |
| 2. _____ | Relation: _____ | Phone: _____ |
| 3. _____ | Relation: _____ | Phone: _____ |

**MILITARY**

|                                                         |                    |
|---------------------------------------------------------|--------------------|
| Student connected to an Active Duty Military Family     | Circle One: Yes No |
| Student connected to a Guard or Reserve Military Family | Circle One: Yes No |

**PRE-SCHOOL**

|                                      |                    |                             |                    |
|--------------------------------------|--------------------|-----------------------------|--------------------|
| Head Start                           | Circle One: Yes No | FirstClass Funded Preschool | Circle One: Yes No |
| Center-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 |

**NAME AND ADDRESS OF LAST SCHOOL ATTENDED:** \_\_\_\_\_

**PARENT/GUARDIAN 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.*

**Daleville City Schools**  
**Race and/or Ethnicity**

Student's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

What is the student's race and/or ethnicity? SELECT ALL THAT APPLY:

☐ **AMERICAN INDIAN OR ALASKA NATIVE**

For example, Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, Maya, etc.

☐ **ASIAN**

For example, Chinese, Asian Indian, Filipino, Vietnamese, Korean, Japanese, etc.

☐ **BLACK OR AFRICAN AMERICAN**

For example, African American, Jamaican, Haitian, Nigerian, Ethiopian, Somali, etc.

☐ **HISPANIC OR LATINO**

For example, Mexican, Puerto Rican, Salvadoran, Cuban, Dominican, Guatemalan, etc.

☐ **MIDDLE EASTERN OR NORTH AMERICAN**

For example, Lebanese, Iranian, Egyptian, Syrian, Iraqi, Israeli, etc.

☐ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER**

For example, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, Marsh/lese, etc.

☐ **WHITE**

For example, English, German, Irish, Italian, Polish, Scottish, etc.

**Office use only:**

Race - Choose one or more:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

Date: \_\_\_\_\_ Staff Signature: \_\_\_\_\_



# ALABAMA STATE DEPARTMENT OF EDUCATION

## Parent Survey

### for Newly Enrolled Students



|                                         |              |
|-----------------------------------------|--------------|
| SCHOOL SYSTEM<br>Daleville City Schools | STUDENT NAME |
|-----------------------------------------|--------------|

|             |
|-------------|
| 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? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you or your spouse currently working in agriculture, farming, fishing or any of the pictures below?                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Mark all pictures of agriculture, farming, or fishing where you have worked in the past 3 years. See pictures below.       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

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

|                                                                                                                                                           |                                                                                                                                                                                      |                                                                                                                                                             |                                                                                                                                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Fruit or Tomato Farms</b><br><input type="checkbox"/> Yes<br>        | <b>Fish or Shrimp Farms</b><br><input type="checkbox"/> Yes<br>                                    | <b>Nursery, greenhouse, sod farm</b><br><input type="checkbox"/> Yes<br> | <b>Planting / Harvesting Crops</b><br><input type="checkbox"/> Yes<br>      |
| <b>Cattle Farms; Milk Products</b><br><input type="checkbox"/> Yes<br> | <b>Hatchery; feeding, processing chickens, gathering eggs</b><br><input type="checkbox"/> Yes<br> | <b>Working on a worm farm</b><br><input type="checkbox"/> Yes<br>       | <b>Growing, tending, felling trees</b><br><input type="checkbox"/> Yes<br> |

#### PARENT INFORMATION

|                          |                     |       |     |
|--------------------------|---------------------|-------|-----|
| <b>PARENT / GUARDIAN</b> |                     |       |     |
| ADDRESS                  | CITY                | STATE | ZIP |
| <b>PHONE NUMBER</b>      | PLACE OF EMPLOYMENT |       |     |

**Daleville City Schools**

**626 N. Daleville Ave**

**Daleville, AL 36322**

**334-598-2456**

**Home Language Survey**

Date: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Student's name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: ☐ Male ☐ Female

Parent/Guardian Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

1. Was your child born in the United States: ☐ Yes ☐ No

If yes, which state? \_\_\_\_\_

If no, what country: \_\_\_\_\_

If no, date child entered the United States: \_\_\_\_\_

2. Has your child attended any school in the United States for any three years during their lifetime? ☐ Yes ☐ No

If yes, please provide school name(s), state, and dates attended.

Name of School \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Dates attended \_\_\_\_\_

Name of School \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Dates attended \_\_\_\_\_

Name of School \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Dates attended \_\_\_\_\_

3. What language is spoken by you and your family most of the time? \_\_\_\_\_

4. Parent communication:

If you prefer written communication in a language other than English, in what language would you prefer to received communication? \_\_\_\_\_

Will you need an interpreter/translator at Parent-Teacher meetings? ☐ Yes ☐ No

5. Is your child's native language anything other than English? ☐ Yes ☐ No

Native Language: \_\_\_\_\_

6. What is the language the Student first acquired? \_\_\_\_\_

\*\*\* Only if you responded "Yes" to question # 6 above, please answer the following\*\*\*

Please describe the language understood by your child. (Check only one)

☐ Understands ONLY English.

☐ Understands only our home language and NO English.

☐ Understands mostly the home language and some English.

☐ Understands our home language and English equally.

☐ Understands mostly English and some of our home language.

\_\_\_\_\_  
Parent Signature Date: \_\_\_\_\_

*In order to comply with state and federal guidelines, we are required to have a Home Language Survey on file for each student. The parent(s) or legal guardian(s) should complete this form.*

**Daleville City Schools**  
**Office of the School Nurse**

Dear Parents/Guardians,

Welcome back! Please take a moment and read this reminder of some of the health policies from our local school board and the State Dept. of Education.

First, if your child has been sick, whether it is **FEVER, VOMITING, OR DIARRHEA**, or any other **ILLNESS, KEEP THEM HOME**. It is unfair to your child and the others in their classroom to be sent to school sick. It is **MANDATORY** that they be without **FEVER OR VOMITING FOR 24 HOURS** before returning to school. We know that this is often inconvenient, but this will keep a virus from sweeping through our students.

Also, we **MUST** have a phone number where either you or someone you have assigned authority may be reached if your child becomes sick or is hurt at school. I do not have the facilities to care for several children at one time and the only other option is to return the sick child to the classroom. **If your phone numbers change, please call or send a note to the Front Office.**

If your child should ever need to take medication during the school day, I will be happy to help. We have very strict guidelines as to how these medications are handled and dispensed. EVERY medication given, whether by a physician or over the counter, **MUST** have a signed permission on file before it can be given. All prescribed medications must have the form signed by both you and the doctor. All prescribed medications must be counted and signed in. All of these forms are available at school. **UNDER NO CIRCUMSTANCES ARE STUDENTS ALLOWED TO TRANSPORT MEDICATION ON THE BUS.** The exception to this is inhalers. A student may lose their bus privileges if medication is sent on the bus. Medication **cannot** be received without the paperwork.

If your child has any **NEW** medication, they **MUST** stay home with you the first day this medication is given. This way you can make sure they tolerate the medication and have no reaction to it.

If you have any questions, please do not hesitate to ask. Please complete both the **FRONT** and **BACK** of the attached **HEALTH** form and return it to your child's teacher **TOMORROW**. We are required to have a new one each year on file for each student, along with any other medical paperwork you may have provided the school last year. If you list any **Food Type Allergy**, please make sure we have a signed form from your child's doctor (Diet Prescription for Meals at School Form).

Respectfully,

Lindsey Moore, BSN-RN, Lead Nurse

Missy Holloway, Nurse



## 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

|                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|----------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> YES <input type="checkbox"/> NO                                                             | <b>KNOWN HEALTH PROBLEMS</b><br>If <b>NO</b> , go directly to the bottom of the page and provide parent/guardian signature<br>If <b>YES</b> , and diagnosed by a physician, answer each question below.                                                                                                                                                                                                                               |
| <input type="checkbox"/> YES <input type="checkbox"/> NO<br><input type="checkbox"/> YES <input type="checkbox"/> NO | <b>Attention Deficit Disorder (ADD)</b><br><b>Attention Deficit Hyperactivity Disorder (ADHD)</b><br>Requires medication <input type="checkbox"/> At school <input type="checkbox"/> At Home                                                                                                                                                                                                                                          |
| <input type="checkbox"/> YES <input type="checkbox"/> NO                                                             | <b>Allergies:</b><br><input type="checkbox"/> Food _____<br><input type="checkbox"/> Insects _____<br><input type="checkbox"/> Environmental _____<br><input type="checkbox"/> Medications _____<br><input type="checkbox"/> Hives/rash _____<br><input type="checkbox"/> Breathing difficulty _____<br><input type="checkbox"/> Other: _____<br><input type="checkbox"/> Medications _____<br><input type="checkbox"/> Epi-pen _____ |
| <input type="checkbox"/> YES <input type="checkbox"/> NO                                                             | <b>Asthma</b> <input type="checkbox"/> Uses an inhaler at school <input type="checkbox"/> Uses an inhaler at home                                                                                                                                                                                                                                                                                                                     |
| <input type="checkbox"/> YES <input type="checkbox"/> NO                                                             | <b>Blood/Bleeding Problems:</b> <input type="checkbox"/> Hemophilia, <input type="checkbox"/> Von Willebrand's, <input type="checkbox"/> Other<br><input type="checkbox"/> Requires medication <i>Please explain:</i>                                                                                                                                                                                                                 |
| <input type="checkbox"/> YES <input type="checkbox"/> NO                                                             | <b>Frequent Nose Bleeds:</b> <i>Please explain</i>                                                                                                                                                                                                                                                                                                                                                                                    |
| <input type="checkbox"/> YES <input type="checkbox"/> NO                                                             | <b>Cancer/Leukemia:</b> <i>Please explain</i>                                                                                                                                                                                                                                                                                                                                                                                         |
| <input type="checkbox"/> YES <input type="checkbox"/> NO                                                             | <b>Cerebral Palsy:</b> <i>Please explain</i>                                                                                                                                                                                                                                                                                                                                                                                          |
| <input type="checkbox"/> YES <input type="checkbox"/> NO                                                             | <b>Cystic Fibrosis:</b> <i>Please explain</i>                                                                                                                                                                                                                                                                                                                                                                                         |
| <input type="checkbox"/> YES <input type="checkbox"/> NO                                                             | <b>Dental Problems:</b> <i>Please explain:</i>                                                                                                                                                                                                                                                                                                                                                                                        |
| <input type="checkbox"/> YES <input type="checkbox"/> NO                                                             | <b>Diabetes</b> <input type="checkbox"/> Type 1 Diabetes <input type="checkbox"/> Monitors Blood Sugars at school <input type="checkbox"/> Requires Insulin at school<br><input type="checkbox"/> Type 2 Diabetes <input type="checkbox"/> Managed with diet <input type="checkbox"/> Insulin pump<br><input type="checkbox"/> Glucagon order<br><input type="checkbox"/> Oral medication                                             |
| <input type="checkbox"/> YES <input type="checkbox"/> NO                                                             | <b>Emotional/Behavioral/Psychological:</b> <i>Please explain:</i>                                                                                                                                                                                                                                                                                                                                                                     |
| <input type="checkbox"/> YES <input type="checkbox"/> NO                                                             | <b>Gastrointestinal/Stomach Problems:</b> <i>Please explain:</i>                                                                                                                                                                                                                                                                                                                                                                      |
| <input type="checkbox"/> YES <input type="checkbox"/> NO                                                             | <b>Genetic / Rare Disorders:</b> <i>Please explain:</i>                                                                                                                                                                                                                                                                                                                                                                               |
| <input type="checkbox"/> YES <input type="checkbox"/> NO                                                             | <b>Headaches:</b> <i>Please explain:</i>                                                                                                                                                                                                                                                                                                                                                                                              |
| <input type="checkbox"/> YES <input type="checkbox"/> NO                                                             | <b>Hearing Problems:</b> <input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> Both ears <input type="checkbox"/> Hearing loss <input type="checkbox"/> Hearing aid<br><input type="checkbox"/> Tubes <input type="checkbox"/> Cochlear Implant                                                                                                                                               |
| <input type="checkbox"/> YES <input type="checkbox"/> NO                                                             | <b>Heart Condition:</b> <input type="checkbox"/> Activity restrictions: <input type="checkbox"/> Medications taken at home:<br><i>Please explain:</i>                                                                                                                                                                                                                                                                                 |
| <input type="checkbox"/> YES <input type="checkbox"/> NO                                                             | <b>Hypertension (High Blood Pressure):</b> <i>Please explain:</i>                                                                                                                                                                                                                                                                                                                                                                     |
| <input type="checkbox"/> YES <input type="checkbox"/> NO                                                             | <b>Juvenile Arthritis/Bone-Joint Problems:</b> <i>Please explain:</i>                                                                                                                                                                                                                                                                                                                                                                 |
| <input type="checkbox"/> YES <input type="checkbox"/> NO                                                             | <b>Kidney/ Bladder/ Urinary Problems:</b> <i>Please explain:</i>                                                                                                                                                                                                                                                                                                                                                                      |
| <input type="checkbox"/> YES <input type="checkbox"/> NO                                                             | <b>Scoliosis:</b> <input type="checkbox"/> No Treatment <input type="checkbox"/> Wears Brace <input type="checkbox"/> Surgery <input type="checkbox"/> Family History                                                                                                                                                                                                                                                                 |
| <input type="checkbox"/> YES <input type="checkbox"/> NO                                                             | <b>Seizures/Convulsions:</b> Type of seizure: _____<br>Medications: <input type="checkbox"/> Diastat <input type="checkbox"/> Klonopin <input type="checkbox"/> Versed <input type="checkbox"/> Medication taken at home <input type="checkbox"/> Other _____<br><i>Please explain:</i>                                                                                                                                               |
| <input type="checkbox"/> YES <input type="checkbox"/> NO                                                             | <b>Sickle Cell:</b> <input type="checkbox"/> Anemia <input type="checkbox"/> Trait                                                                                                                                                                                                                                                                                                                                                    |
| <input type="checkbox"/> YES <input type="checkbox"/> NO                                                             | <b>Shunt:</b> <input type="checkbox"/> VP shunt <i>Please explain:</i>                                                                                                                                                                                                                                                                                                                                                                |
| <input type="checkbox"/> YES <input type="checkbox"/> NO                                                             | <b>Spina Bifida:</b>                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <input type="checkbox"/> YES <input type="checkbox"/> NO                                                             | <b>Special Diet:</b> <i>Please explain:</i>                                                                                                                                                                                                                                                                                                                                                                                           |
| <input type="checkbox"/> YES <input type="checkbox"/> NO                                                             | <b>Vision Problems:</b> <input type="checkbox"/> Wears glasses <input type="checkbox"/> Wears contacts <input type="checkbox"/> Other                                                                                                                                                                                                                                                                                                 |
| <input type="checkbox"/> YES <input type="checkbox"/> NO                                                             | <b>Other Medical Conditions:</b> <i>Please include <u>any</u> medications taken at home only.</i>                                                                                                                                                                                                                                                                                                                                     |

### Required Signatures

(Electronic or Written) Parent(s) or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Electronic or Written) School Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Former School Name: \_\_\_\_\_

Former School Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**State of Alabama**  
**Department of Education**  
**Official Request for Student Records**

Date requested: \_\_\_\_\_ Faxed: \_\_\_\_\_ Emailed: \_\_\_\_\_

2nd request: \_\_\_\_\_ Faxed: \_\_\_\_\_ Emailed: \_\_\_\_\_

The Alabama Department of Education and Daleville City Schools request that you transmit the following student records as soon as possible. If the student is currently receiving special education and related services, the records must be transferred to the requesting school. (Alabama Administrative Code 290-080-090.03)

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| Last | First | MI | Grade |
|------|-------|----|-------|
|------|-------|----|-------|

---

| Last | First | MI | Grade |
|------|-------|----|-------|
|------|-------|----|-------|

Please fax or email the checked information:

- ☐ All records listed below
- ☐ Birth certificate
- ☐ SSN
- ☐ Immunization Certificate
- ☐ Legal custody papers
- ☐ Report card or withdraw papers  
with grades
- ☐ Attendance records
- ☐ Discipline records
- ☐ Progress Monitoring Data
- ☐ IEP/504 Plan/Eligibility/Referral
- ☐ Standardized Testing
- ☐ WIDA/Access reports
- ☐ Transcript(s)
- ☐ CCR or ACT reports

Registrar: Janet Nabinger  
Daleville City Schools  
625 N. Daleville Ave  
Daleville, Al. 36322  
334-598- 2456  
Fax: 334-598-9006  
Email:  
registrar@daleville.k12.al.us

