



Please write the school year in the box →

# Pre-K Registration Form

2023-2024

# School Year

|   |  |
|---|--|
| PROVIDER LEGAL NAME: <b>NEWTON COUNTY SCHOOL SYSTEM</b> | (this section to be entered by the provider) |
| SCHOOL/SITE NAME:                                       |  |

| CHILD INFORMATION <span style="float: right; font-size: small;">(Please print name exactly as it appears on the birth certificate.)</span> |                    |                        |             |
|--|--------------------|------------------------|-------------|
| CHILD'S LAST NAME:   |                    |                        |             |
| CHILD'S FIRST NAME:  |                    |                        |             |
| CHILD'S MIDDLE NAME:   | NAME SUFFIX:       | (i.e. Jr, Sr, II, III) |             |
| CHILD'S SOCIAL SECURITY#:  | D.O.B. (MM/DD/BY): | SEX:                   | M    F      |
| HOME ADDRESS (Do not enter PO Box Info):   |                    | COUNTY:                |             |
| CITY:  | STATE: GA          | ZIP:                   | HOME PHONE: |

**If the Student is transferring from another Pre-K, please provide the following:**  
 Previous School Name: \_\_\_\_\_ Last Date in Attendance: \_\_\_\_\_

| PARENT/GUARDIAN INFORMATION             |                 |                 |  |
|---|-----------------|-----------------|--|
| MOTHER'S LAST NAME:                     | FIRST:          | MIDDLE INITIAL: |  |
| HOME ADDRESS (If different from child): |                 |                 |  |
| CITY:                                   | STATE:          | ZIP:            |  |
| HOME PHONE:                             | DAY TIME PHONE: | EMAIL:          |  |
| PLACE OF EMPLOYMENT:                    |                 |                 |  |
| ADDRESS:                                |                 |                 |  |
| CITY:                                   | STATE:          | ZIP:            |  |
| FATHER'S LAST NAME:                     | FIRST:          | MIDDLE INITIAL: |  |
| HOME ADDRESS (If different from child): |                 |                 |  |
| CITY:                                   | STATE:          | ZIP:            |  |
| HOME PHONE:                             | DAY TIME PHONE: | EMAIL:          |  |
| PLACE OF EMPLOYMENT:                    |                 |                 |  |
| ADDRESS:                                |                 |                 |  |
| CITY:                                   | STATE:          | ZIP:            |  |

| EMERGENCY CONTACT INFORMATION <span style="float: right; font-size: small;">(Person to contact in the event that either parent/guardian cannot be contacted)</span> |                 |
|---|-----------------|
| NAME:   | DAY TIME PHONE: |
| DAY TIME ADDRESS:   |                 |
| CITY:   | STATE:    ZIP:  |

I verify the above information to be correct, and I understand that completion of this form does not guarantee placement in a Pre-K class. If my child is placed in Georgia's Pre-K Program, I agree that my child will attend the program for the required number of hours and days as prescribed by the Georgia Department of Early Care and Learning and outlined by the center where my child is enrolled. I understand that failure to comply with these attendance requirements could result in disenrollment. I understand that I cannot register my child without appropriate age documentation. I have attached a copy of appropriate age documentation to this registration form.

**SIGNATURE (Parent/Guardian):** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**CHILD MAINTENANCE**

CHILD'S LIVING ARRANGEMENTS:                      BOTH PARENTS      MOTHER      FATHER      OTHER

CHILD'S LEGAL GUARDIAN:                      BOTH PARENTS      MOTHER      FATHER      OTHER

**THE CHILD MAY BE RELEASED TO THE PERSON(S) SIGNING THIS AGREEMENT OR TO THE FOLLOWING:**

NAME    ADDRESS    RELATIONSHIP

**CHILD'S PHYSICIAN OR CLINIC'S NAME (CHILD'S PRIMARY HEALTH SOURCE):**

DATE OF LAST FULL HEALTH SCREENING:    PHONE:

**MY CHILD HAS THE FOLLOWING SPECIAL NEED(S):**

**THE FOLLOWING SPECIAL ACCOMMODATION(S) MAY BE REQUIRED TO MOST EFFECTIVELY MEET MY CHILD'S NEEDS WHILE AT THIS CENTER:**

**MY CHILD IS CURRENTLY ON MEDICATION(S) PRESCRIBED FOR LONG-TERM CONTINUOUS USE AND/OR HAS THE FOLLOWING PRE-EXISTING ALLERGIES, ILLNESS, OR HEALTH CONCERNS:**

**GENERAL RELEASE**

I verify the above information to be correct and true. I hereby grant permission for the information provided in the preceding Registration Form to be distributed to Pre-K providers, the Department of Early Care and Learning (DECAL), and certain agencies or those entities contracted by Pre-K providers or DECAL which shall include, but not be limited to, the Georgia Department of Education, and colleges/universities.

**SIGNATURE (Parent/Guardian):** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**PHOTOGRAPH/VIDEOTAPE RELEASE**

I hereby grant permission for the Pre-K provider specified below, the Georgia Department of Early Care and Learning (DECAL) and certain agencies or entities contracted by the Pre-K provider or DECAL which shall include, but not be limited to, the Georgia Department of Education, and colleges/universities, to record the participation and appearance of my child,

\_\_\_\_\_, by photograph and/or videotape in connection with daily Pre-K

activities for the purposes of news releases, reporting, and assessing the progress of children and the program. DECAL and its contractors are authorized to exhibit or distribute such photograph(s) and/or videotape in whole or in part without restrictions or limitations for any educational or promotional purpose that DECAL deems appropriate. Such photograph(s) and/or videotape may, for example, appear in printed or visual materials for DECAL and/or on DECAL's web site.

The undersigned hereby jointly and severally releases, acquits, forgives, and discharges the Pre-K provider, DECAL, and other entities contracted by the Pre-K provider or DECAL, from any actions, agreements, claims, controversies, demands, judgments, liabilities, proceedings, and suits, whether arising in equity or in law regarding such participation and appearance by said child.

This release shall remain binding upon all successors in interest and personal representatives of the parties, to the extent permitted by law.

PRE-K PROVIDER NAME/ADDRESS: \_\_\_\_\_

SIGNATURE (Parent/Guardian): \_\_\_\_\_

DATE: \_\_\_\_\_



Georgia Department of Early Care and Learning

## Waiting List Information Form

Please clearly print the name as it appears on the birth certificate

|                                    |                                      |   |     |
|------------------------------------|--------------------------------------|---|-----|
| Child's Last Name                  |                                      |   |     |
|                                    |                                      |   |     |
| Child's First Name                 |                                      |   |     |
|                                    |                                      |   |     |
| Child's Middle Name                |                                      | Name Suffix (Jr, Sr, II, III)                         |     |
|                                    |                                      |   |     |
| Last 4 Digits of SSN (if provided) | Date of Birth (M/D/Y)                | Gender  |     |
|                                    |                                      | <input type="checkbox"/> M <input type="checkbox"/> F |     |
| Home Address                       | City                                 | State   | Zip |
|                                    |                                      | GA  |     |
| County of Residence                | Date Started on Waiting List (M/D/Y) |   |     |
|                                    |                                      |   |     |
| Parent/Guardian Name               | Phone Number                         |   |     |
|                                    |                                      |   |     |

\*\* Directory information on this form may be shared with  
Bright from the Start: Georgia Department of Early Care and Learning

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date



**Newton County School System**  
**PRE-K STUDENT REGISTRATION PACKET**

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## Registration Checklist



The following documents are required in order for Pre-k registration packet to be considered complete.

Two Proofs of Residency:

(Electric, gas, garbage or water bill in the name of the person enrolling the child; **AND** a mortgage statement or lease agreement.) \*Please note: If the child does not live with one or both parents, guardianship or custody documents must be presented.

Utility Bill, AND

Lease Agreement OR Mortgage Statement

Certified Birth Certificate-- **The child must be 4 years old on or before September 1, 2023.**

Child's Immunization Record – GA Form 3231 (obtain from your child's Physician or Health Department)

Eye, Ear, Dental (EED) and Nutrition Screening– GA Form 3300 (obtain from your child's physician or Health Department). Only needed for students entering a Georgia public school for the first time or re-entering a Georgia school after being gone for one entire school year

Child's Social Security Card, or signed waiver request

*Bright from the Start* Pre-K Registration Form

*Newton County* Pre-K Registration Form

Proof of Custody/Guardianship (if applicable)



# Newton County School System

## PRE-K STUDENT REGISTRATION PACKET

Student's Legal Name: \_\_\_\_\_  
Last Name First Name Middle Name Suffix (Jr, Sr, II, III, etc)

Gender:  Male  Female Date of Birth: \_\_\_\_\_  
mm dd yyyy

Student's Social Security Number: \_\_\_\_\_

Last school attended: \_\_\_\_\_ Grade: \_\_\_\_\_

Services received (check if applicable):  EL  Gifted  SPED  EBIS  RTI  504

### **Previous Newton County School**

Yes  No Has this student ever been enrolled in a Newton County School?

If Yes: \_\_\_\_\_  
School Name Grade Year

### **Ethnicity / Race Information** - New Federally Mandated Questions. Please answer both parts.

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

No, not Hispanic/Latino

Yes, Hispanic/Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race).

*The above part of the question is about ethnicity, not race. No matter what you selected above, please continue to answer the following by marking one or more boxes to indicate what you consider this student's race to be.*

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

**American Indian or Alaska Native** (A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.)

**Asian** (A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)

**Black or African American** (A person having origins in any of the black racial groups of Africa.)

**Native Hawaiian or Other Pacific Islander** (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)

**White** (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)



# Newton County School System

## PRE-K STUDENT REGISTRATION PACKET

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

Student's **Residence** Address: \_\_\_\_\_  
Number Street Name Apt #  
GA  
City State Zip code

Household **Mailing** Address: \_\_\_\_\_  
(if different from above) Number Street Name Apt #  
GA  
City State Zip Code

**Preferred phone number** the school should normally use to contact you: \_\_\_\_\_

### **PRIMARY HOUSEHOLD INFORMATION** - Where student *normally* sleeps on a nightly basis.

**Parent/Guardian:** \_\_\_\_\_  
Last Name First Name Middle Name

Parent/Guardian Date of Birth: \_\_\_\_\_  
mm dd yyyy

Relationship to Student: (Mother, Father, Grandparent, Guardian, etc) \_\_\_\_\_

Email Address: \_\_\_\_\_

Residence Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Place of Work: \_\_\_\_\_

**Parent/Guardian:** \_\_\_\_\_  
Last Name First Name Middle Name

Parent/Guardian Date of Birth: \_\_\_\_\_  
mm dd yyyy

Relationship to Student: (Mother, Father, Grandparent, Guardian, etc) \_\_\_\_\_

Email Address: \_\_\_\_\_

Residence Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Place of Work: \_\_\_\_\_

**Does the child have a parent or guardian who is currently on active duty in the U.S. Armed Forces, including the National Guard or Reserve Forces?** No Yes



# Newton County School System

## PRE-K STUDENT REGISTRATION PACKET

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

**SECONDARY HOUSEHOLD INFORMATION** - Where student sleeps on a part time basis. Leave blank if this does not apply to your family situation.

**Parent/Guardian:** \_\_\_\_\_  
Last Name
First Name
Middle Name

Parent/Guardian Date of Birth: \_\_\_\_\_  
mm
dd
yyyy

Relationship to Student: (Mother, Father, Grandparent, Guardian, etc) \_\_\_\_\_

Email Address: \_\_\_\_\_

**Residence** Address: \_\_\_\_\_  
Number
Street Name
Apt #

---

City State Zip Code

Residence Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Place of Work: \_\_\_\_\_

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

| Last Name | First Name | Date of Birth | Relation to Student | School |
|-----------|------------|---------------|---------------------|--------|
| _____     | _____      | _____         | _____               | _____  |
| _____     | _____      | _____         | _____               | _____  |
| _____     | _____      | _____         | _____               | _____  |
| _____     | _____      | _____         | _____               | _____  |
| _____     | _____      | _____         | _____               | _____  |





**Newton County School System**  
**PRE-K STUDENT REGISTRATION PACKET**

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

**Emergency Contact Information** - Please list at least two family members or friends who could assume temporary care of your child in the event that you cannot be reached.

Emergency Contact #1: \_\_\_\_\_  
Name Phone Relation to Student

Emergency Contact #2: \_\_\_\_\_  
Name Phone Relation to Student

**Student Residency Statement** - Do you live in any of the following situations? Please mark as appropriate.

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

How long do you anticipate living at this location? \_\_\_\_\_



**Newton County School System**  
**PRE-K STUDENT REGISTRATION PACKET**

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

***Home Language Survey***

**Home Language Survey** - In order to comply with state guidelines, we are required to have a Home Language Survey on file **for ALL students**.

**Student's Legal Name:** \_\_\_\_\_

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

**Student's Address:** \_\_\_\_\_

Number                      Street Name                      Apt #

City                      State                      Zip Code

**Telephone:** \_\_\_\_\_

**Parent/Guardian:** \_\_\_\_\_

Last Name                      First Name                      Middle Name

Where was this student born (in what country)? \_\_\_\_\_

Date this student entered the USA (if applicable): \_\_\_\_\_  
mm      dd      yyyy

Date this student first started school in the USA: \_\_\_\_\_  
mm      dd      yyyy

1. Which language does your child **most frequently** speak at home? \_\_\_\_\_
2. Which language do adults in your home **most frequently** use when speaking with your child? \_\_\_\_\_
3. Which language(s) does your child currently understand or speak? \_\_\_\_\_
4. If possible, would you prefer notice of school activities in a language **other** than English?      Yes      No

If yes, which \_\_\_\_\_

Language? \_\_\_\_\_

Parent signature \_\_\_\_\_ Date \_\_\_\_\_

PLACE IN PERMANENT RECORD FOLDER

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



**Newton County School System**  
**PRE-K STUDENT REGISTRATION PACKET**

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

***Kindergarten and Pre-Kindergarten***  
***Parent Questionnaire***

**(Complete this section ONLY if registering a student for Pre-Kindergarten or Kindergarten for THE 2023-2024 SCHOOL year.) Form SHOULD ONLY BE COMPLETED ONCE—AT THE BEGINNING OF PRE-KINDERGARTEN OR AT THE BEGINNING OF KINDERGARTEN (if child did not attend Pre-K in the Newton County School System)**

Which of the following services are you presently receiving, if any? Check all that apply.

\_\_\_ Medicaid \_\_\_ TANF \_\_\_ Food Stamps \_\_\_ SSI \_\_\_ PeachCare \_\_\_ CAPS

Have you applied for pre-kindergarten anywhere else? \_\_\_ If so, where? \_\_\_\_\_

Do you have guardianship or custody of the child who you are registering for pre-kindergarten? \_\_\_

If so, how is this child related to you? \_\_\_\_\_

Do you get your child's immunizations at the Newton County Health Department? \_\_\_\_\_

If not, where do you get your child's immunizations? \_\_\_\_\_

Any problems during pregnancy or delivery? \_\_\_\_\_

At birth was the child \_\_\_ Full Term \_\_\_ Premature Birth weight \_\_\_ pounds \_\_\_ ounces

Do you have special concerns about this child? \_\_\_\_\_

**BEHAVIOR AND FAMILY INTERACTION**

How is the child disciplined? \_\_\_\_\_ For what is he/she disciplined? \_\_\_\_\_

Are there any family problems which might affect your child's school success? \_\_\_\_\_

Has your child ever attended pre-school? \_\_\_ Head Start? \_\_\_ Nursery? \_\_\_

Where? \_\_\_\_\_



**Newton County School System**  
**PRE-K STUDENT REGISTRATION PACKET**

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

***Kindergarten and Pre-Kindergarten***  
***Parent Questionnaire*** (continued)

**DEVELOPMENTAL HISTORY**  
***(If guess, label as such)***

Give Age:

When did this child: Sit? \_\_\_\_\_ Crawl? \_\_\_\_\_ Walk? \_\_\_\_\_ Use Words? \_\_\_\_\_

Talk in sentences? \_\_\_\_\_ Feed self? \_\_\_\_\_ Dress self? \_\_\_\_\_ When was the child weaned? \_\_\_\_\_

Is the child toilet trained? \_\_\_\_\_ When was child toilet trained? \_\_\_\_\_

Does the child perform the following? Mark one by placing an "X" under the best answer:

Often      Sometimes      Rarely

1. Talks a lot?
2. Seems to speak as well as other children the same age?
3. Speaks so you can understand him or her?
4. Speaks so other adults understand him or her?
5. Speaks so other children understand him or her?

If the child does not talk, does he or she (mark one):

1. Make any sounds?
2. Use gestures to communicate?

What language(s) is spoken most frequently in the home? \_\_\_\_\_



**Newton County School System**  
**PRE-K STUDENT REGISTRATION PACKET**

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

***Kindergarten and Pre-Kindergarten***  
***Parent Questionnaire*** (continued)

**Medical Information**

- |                         |                     |                          |                         |
|-------------------------|---------------------|--------------------------|-------------------------|
| _____ Asthma            | _____ Sinus trouble | _____ Thumb sucking      | _____ Heart trouble     |
| _____ Indigestion       | _____ Allergies     | _____ Nail biting        | _____ Frequent fevers   |
| _____ Diarrhea          | _____ Vomiting      | _____ Headaches          | _____ Nightmares        |
| _____ Constipation      | _____ Bed wetting   | _____ Nose bleeding      | _____ Difficulty seeing |
| _____ Epilepsy/seizures |                     | _____ Difficulty hearing |                         |

\_\_\_\_\_ Overtired or lacking pep

\_\_\_\_\_ Other physical problems (Explain): \_\_\_\_\_

Hearing problems: \_\_\_\_\_

Vision problems: \_\_\_\_\_

Childhood diseases: \_\_\_\_\_

Hospitalization: \_\_\_\_\_

Serious injuries: \_\_\_\_\_

Allergies: \_\_\_\_\_

Family Doctor: \_\_\_\_\_

(Name)

(Telephone Number)

(Address)

Is this child currently on medication? \_\_\_\_\_ No \_\_\_\_\_ Yes (If yes, describe) \_\_\_\_\_

**I UNDERSTAND THAT WITHIN 30 DAYS OF ENROLLMENT, I MUST SUBMIT MY CHILD'S HEALTH SCREENING.**

**DATE:** \_\_\_\_\_ **SIGNATURE:** \_\_\_\_\_

**I UNDERSTAND THAT THIS APPLICATION DOES NOT GUARANTEE MY CHILD'S PLACEMENT IN THE PRE-KINDERGARTEN PROGRAM.**

**DATE:** \_\_\_\_\_ **SIGNATURE:** \_\_\_\_\_



**Newton County School System**  
**PRE-K STUDENT REGISTRATION PACKET**

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

***EMERGENCY CLOSING INSTRUCTIONS***

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

Child's Name: \_\_\_\_\_

Address: \_\_\_\_\_

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

**CHECK ONE:**

\_\_\_\_ Ride regular bus home

\_\_\_\_ Ride bus to neighbor/friend/relative:

Name: \_\_\_\_\_ Bus Number: \_\_\_\_\_

\_\_\_\_ Day Care:

Name: \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_ Parent Pickup

\_\_\_\_ Other (please explain): \_\_\_\_\_

Parent/Guardian signature \_\_\_\_\_ Date: \_\_\_\_\_

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



**Newton County School System**  
**PRE-K STUDENT REGISTRATION PACKET**

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

***SCHOOLWIDE E-MAIL OPTION***

Dear Parents,

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

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

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

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

Student Name: \_\_\_\_\_

Homeroom Teacher: \_\_\_\_\_

**Please write clearly and case sensitive.**

Preferred E-mail: \_\_\_\_\_  
(the above is for Parent/guardian name \_\_\_\_\_)

Secondary E-mail: \_\_\_\_\_  
(the above is for Parent/guardian name \_\_\_\_\_)

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

Student name \_\_\_\_\_

Homeroom Teacher \_\_\_\_\_

Home Telephone # \_\_\_\_\_



# Newton County School System

## PRE-K STUDENT REGISTRATION PACKET

### CLINIC INFORMATION CARD

Gender:  Male  Female      Student's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_      Grade \_\_\_\_\_      HmRm Teacher \_\_\_\_\_

mm      dd      yyyy

Name of siblings enrolled in this school: \_\_\_\_\_

### **HEALTH HISTORY (If yes, please explain)**

|  |  |  |                    |
|--|--|--|--------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Allergies (LIST ALL)   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Problem     |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine Headache  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Physical Handicaps |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Condition     |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizure  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems     |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Menstrual  |  |                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Drug Allergies/Reaction  |  |                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Other  |  |                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | My child needs an inhaler/nebulizer available at school (if YES, provide medication to keep at school) |  |                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | My child requires an Epi-Pen for severe allergic reaction (if YES, provide Epi-Pen to keep at school)  |  |                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | My child received immunizations this past year<br>If YES list type and date:                           |  |                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | My child takes prescribed medications routinely/occasionally<br>If YES please list:                    |  |                    |

### **EMERGENCY INFORMATION**

Parent/Guardian #1: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_  
 Residence Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_ Cell Ph: \_\_\_\_\_

Parent/Guardian #2: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_  
 Residence Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_ Cell Ph: \_\_\_\_\_

If parents cannot be reached, list two (2) Emergency Contacts who will assume care of your child:

Emerg.Contact #1: \_\_\_\_\_ Relationship \_\_\_\_\_ Ph: \_\_\_\_\_  
 Emerg.Contact #2: \_\_\_\_\_ Relationship \_\_\_\_\_ Ph: \_\_\_\_\_

|  |  |
|--|--|
| <b>Please Note</b>                                       | In the event that Emergency Medical care is deemed necessary, the school will immediately attempt to make contact using phone numbers provided on the clinic card and will contact Emergency Medical Services (911) to respond to the school for evaluation and possible transport.  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Medical information, as indicated above, may be shared with appropriate staff as needed.   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | In an <b>emergency</b> , I give the principal, or designee, permission to administer Tylenol or Benadryl in the event the parent or contact person cannot be reached.  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | In non-emergency health concerns I authorize the school nurse/school personnel to utilize the following medications: anti-itch medication (caladryl, cortisone cream/lotion), antiseptic sprays, cough drops or the generic of these. I understand that it is the <b>parents'</b> responsibility to provide non-prescription medications to have available at school such as Motrin, Tylenol, Benadryl, etc. All medication must be labeled and <b>must be</b> in the original container. School Nurses are prohibited by their license restrictions to dispense prescription medication without the prescribing doctor's signature. |

Should there be a need for school personnel to dispense prescription/nonprescription medication to my child, I will contact the school for the appropriate medication form that must accompany medication. I understand that **all medication must be provided by the parent/guardian** and that no personnel can dispense without parent/guardian signature.

Parent/Legal Guardian Signature



School District: \_\_\_\_\_

Date: \_\_\_\_\_

**Parent Occupational Survey**

**Please complete this form to determine if your child(ren) qualify to receive supplemental services under Title I, Part C**

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

1. Has anyone in your household moved in order to work in another city, county, or state, in the last three (3) years?  Yes  No
2. Has anyone in your household been involved in one of the following occupations, either full or part-time or temporarily during the last three (3) years?  Yes  No

**If you answer "yes", check all that applies:**

- 1) Planting/Picking vegetables (tomatoes, squash, onions, etc.) or fruits (grapes, strawberries, blueberries, etc.)
- 2) Planting, growing, cutting, processing trees (pulpwood), or raking pine straw
- 3) Processing/Packing agricultural products
- 4) Dairy/Poultry/Livestock
- 5) Packing/Processing meats (beef, poultry, or seafood)
- 6) Commercial fishing or fish farms
- 7) Other (Please specify occupation): \_\_\_\_\_

Names of Parent(s) or Legal Guardian(s) \_\_\_\_\_

Current Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Thank You! Please return this form to the school

Please maintain original copy in your files.

MEP funded school/district: Please give this form to the migrant liaison or migrant contact for your school/district.

Non-MEP funded (consortium) school/districts: When at least one "yes" and one or more of the boxes from 1 to 7 is/are checked, districts should fax occupational surveys to the Regional Migrant Education Program Office serving your district. For additional questions regarding this form, please call the MEP office serving your district:

GaDOE Region 1 MEP, 201 West Lee Street, Brooklet, GA 30415  
Toll Free (800) 621-5217 Fax (912) 842-5440

GaDOE Region 2 MEP, 221 N. Robinson Street, Lenox, GA 31637  
Toll Free (866) 505-3182 Fax (229) 546-3251

Family Contacted/Attempt Date: \_\_\_\_\_

Sent to Regional Office on: \_\_\_\_\_

1854 Twin Towers East • 205 Jesse Hill Jr. Drive • Atlanta, GA 30334 • [www.gadoe.org](http://www.gadoe.org)

Richard Woods, Georgia's School Superintendent

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