OFFICE REFERRAL/REFERIDO A LA OFICINA

TEACHER/MAESTRO _____

_____

(Student's FIRST and LAST name/PRIMER nombre y APELLIDO del Estudiante)

First contact/Primer contacto _____

(FIRST and LAST name/PRIMER nombre y APELLIDO)

Number/Numeros (Home/Casa)_____ (Work/Abajo)_____ (Cell/Celular)_____

Second contact/Segundo contacto _____

(FIRST and LAST name/PRIMER nombre y APPELLIDO)

Number/Numeros (Home/Casa)_____(Work/Abajo)_____ (Cell/Celular)_____

Third contact/Tercer contacto _____

(FIRST and LAST name/PRIMER nombre y APPELLIDO)

Number/Numeros (Home/Casa) _____(Work/Abajo) _____ (Cell/Celular)_____

For teacher use only/para el uso de maestro solamente

He/she is experiencing or needs/El ella esta experimentando o necesita:

_____ vomiting/vomito
_____ ear ache/dolor de oido
_____ headache/dolor de cabeza
_____ needs lunch money/necesita dinero de almuerzo
_____ needs change of clothes/necesita cambio de ropa
_____ needs money for/necesita dinero para_____

▫ YES ▫ NO	Cerebral Palsy: *Please explain*
▫ YES ▫ NO	Cystic Fibrosis: *Please explain*
▫ YES ▫ NO	Dental Problems: *Please explain:*
▫ YES ▫ NO	Diabetes ▫ Type 1 Diabetes ▫ Monitors Blood Sugars at school ▫ Requires Insulin at school ▫ Insulin pump ▫ Glucagon order ▫ Type 2 Diabetes ▫ Managed with diet ▫ Oral medication
▫ YES ▫ NO	Emotional/Behavioral/Psychological: *Please explain:*
▫ YES ▫ NO	Gastrointestinal/Stomach Problems: *Please explain:*
▫ YES ▫ NO	Genetic / Rare Disorders: *Please explain:*
▫ YES ▫ NO	Headaches: *Please explain:*
▫ YES ▫ NO	Hearing Problems: ▫ Right Ear ▫ Left Ear ▫ Both ears ▫ Hearing loss ▫ Hearing aid ▫ Tubes ▫ Cochlear Implant
▫ YES ▫ NO	Heart Condition: ▫ Activity restrictions: ▫ Medications taken at home: *Please explain:*
▫ YES ▫ NO	Hypertension (High Blood Pressure): *Please explain:*
▫ YES ▫ NO	Juvenile Arthritis/Bone-Joint Problems: *Please explain:*
▫ YES ▫ NO	Kidney/ Bladder/ Urinary Problems: *Please explain:*
▫ YES ▫ NO	Scoliosis: ▫ No Treatment ▫ Wears Brace ▫ Surgery ▫ Family History
▫ YES ▫ NO	Seizures/Convulsions: Type of seizure: _____ *Medications:* ▫ Diastat ▫ Klonopin ▫ Versed ▫ Medication taken at home ▫ Other _____ *Please explain:*
▫ YES ▫ NO	Sickle Cell: ▫ Anemia ▫ Trait
▫ YES ▫ NO	Shunt: ▫ VP shunt *Please explain:*
▫ YES ▫ NO	Spina Bifida:
▫ YES ▫ NO	Special Diet: *Please explain:*
▫ YES ▫ NO	Vision Problems: ▫ Wears glasses ▫ Wears contacts ▫ Other
▫ YES ▫ NO	Other Medical Conditions: *Please include <u>any</u> medications taken at home only.*

Required Signatures

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

Signature of school nurse: _____ Date:_____

Oxford City Schools Check Out Authorization Form

Please Note: *<u>ONLY the Parent/Legal Guardian may complete this form</u>.

*Check outs will be allowed ONLY if all requested information is provided and the designated individual appears in the main office with Driver's License/Picture ID.

I (We) _____ the parent(s) of _____
(Parent/Legal Guardian) (Student Name)

Hereby authorize that our child may be checked out of school IN PERSON by the individuals listed below.

Parent email address: _____

Signed _____ Date _____
(Parent/Legal Guardian Signature)

Name of Person Authorized to Out	√	Relationship To Student	Phone Number	Work Phone Number	Driver's License #

Violations of this policy will terminate a student's checking out privileges by anyone other than a parent/legal guardian in person in the main office.

Parent/Legal Guardian: Please list any legal alerts that the school needs to be aware of in regards to your student checking out.

ALERT: _____

_____

_____

_____

RELEASE OF UTITLITY ACCOUNT INFORMATION TO OXFORD CITY SCHOOLS

To:_____(name of utility company)

I have authorized officials of Oxford City Schools to obtain my utility account information in order to verify whether I am a resident of the school district. I hereby authorize Alabama Power Company, Alabama Gas Corporation, and/or any other utility company to release information regarding my residential account(s), if any, to officials of Oxford City Schools, verbally or in writing, including but not limited to the address of any and all locations at which service is currently provided to me or has been provided to me within the last six months.

I understand that my signature releases Alabama Power Company, Alabama Gas Corporation, and/or any other utility service provided from any and all liability resulting from the release of this information. This authorization is good for 12 months to begin on the date shown below.

RELEASOR / CUSTOMER INFORMATION:

Print Full Name: _____ SS#_____ - _____ - _____

_____ _____

Date Signature

RELEASE INFORMATION TO:

School:	Oxford Elementary School	Phone:	256-241-3844
School Official:	Christi Gaskins	Fax:	256-835-3043
School Address:	1401 Caffey Drive, Oxford, AL 36203		

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This portion is to be completed by the utility service provider. Please mark and complete the one correct choice below.

1. _____ The Releasor / Customer identified above does not currently have an active account with this utility company AND has not had an active account within the last six months.

2. _____ The Releasor / Customer identified above does not currently have an active account, but the following account(s) have been closed / terminated within the last six months.

Account Number	Service Address	Termination Date

3. _____ The Releasor / Customer identified above currently has the following active accounts with this utility company:

Account Number	Service Address	Termination Date

NOTE: To obtain information from Alabama Power Company, school officials may FAX this form to (256) 231-3318

8/9/07