

School Year _____

**TROY CITY SCHOOLS
Residency Affidavit Form**

Please check if this is
a new address

Grade _____ This registration form should not be considered a barrier to enrollment

I. STUDENT INFORMATION:

DATE: _____

Full Legal Name of Child _____ Male _____ Female _____

Race: Black _____ White _____ Asian _____ American Indian/ _____ Not Specified _____ Pacific Islander _____ Multi Race _____
Alaskan Native (Hispanic Students Only)

Birth Date: _____ Birthplace: _____
(Voluntary)

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

Complete Mailing Address _____

Parent/Guardian E-mail Address: _____ Student's E-mail Address: _____

Parent/Guardian Cell Number: _____ Parent/Guardian Cell Number: _____

The following individuals have permission to check-out this student.

Emergency Name: _____ Emergency Number: _____

II. FAMILY INFORMATION:

Child Lives With: Father _____ Step-Father _____ Mother _____ Step-Mother _____ Legal Guardian _____ Foster Care _____
(Check all that apply)

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

Guardian's Name _____ Guardian's Name _____

Work Place _____ Work Place _____

Phone # _____ Phone # _____

III. TRANSFER INFORMATION:

Transferring From: Name of School _____ School Phone # _____

Was your child in any Exception Child programs (special education/gifted education)? If Yes, Please List _____

Has your Child Previously Attended Troy City Schools? Yes _____ No _____ When? _____

Has your Child Been Retained? Yes _____ No _____ What Grade? _____

IV. I certify that I have the responsibility of providing for the needs of this student and that I am in charge and control of his/her actions.

PARENT/LEGAL GUARDIAN/FOSTER CARE SIGNATURE

DATE

*Disclosure of your child's social security number (SSN) is voluntary. If you elect not to provide a SSN, a temporary identification number will be generated and utilized instead. Your child's SSN is being requested for use in conjunction with enrollment in school as provided in Ala. Admin. Code §290-3-1-02(2)(b) (2). It will be used as a means of identification in the statewide student management system.

V. MEDICAL HISTORY:

1. List all current medical problems (allergies, diabetes, etc.) _____

2. Does your child take any medication? Please list all prescriptive and non-prescriptive drugs he/she takes _____

3. Is he/she allergic to any medication? _____
4. Please include any additional information you feel would be helpful to the school nurse and other personnel. _____

VI. STATE OF ALABAMA

COUNTY OF PIKE

RESIDENCY AFFIDAVIT UNDER OATH

I, _____, am the _____ of
 Parent/Legal Guardian/Foster Care (Print Full Name) Mother, Father, Legal Guardian, Foster Care

CHILD'S FULL NAME

SCHOOL ATTENDING

GRADE LEVEL

Do hereby certify, under oath that our residence and domicile is presently within the city limits of the City of Troy, Pike County, Alabama; that we have our permanent address in the city limits of the City of Troy, Pike County, Alabama; and that said permanent address is

I further certify, under penalty of perjury, that my child spends weekdays, weeknights, and weekends at the above permanent address, and that I have notified the District if my child spends nights during the week or weekends outside of the Troy City Limits with any regularity.

I understand that the purpose of this affidavit is to induce the Troy City Board of Education to allow my/our child to attend the public schools in the City of Troy, Alabama. I further consent and agree that the Troy City Board of Education shall have the right to verify this affidavit as to our residence and that this affidavit may be submitted to a Federal Court or other authority as proof of our residence, and I consent to the use of this affidavit by the Troy City Board of Education as proof of our residence. I understand fully and completely that the execution of a false affidavit will result in the removal of my/our child from school rolls.

I further hereby agree that if there is any change whatsoever in my residence or in the residence of the above named child, I will notify the Troy City Board of Education immediately and will sign a new affidavit stating the correct residence. Failure to report a change will result in the withdrawal of your child.

Sworn to and subscribed before me this _____ day of _____, 20_____

 Notary Public

 Parent/Legal Guardian/Foster Care Signature

ALABAMA APPLICATION FOR STUDENT ENROLLMENT
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)

MOTHER/GUARDIAN _____	Address _____
Email Address _____	Cell Phone _____
EMPLOYER _____	Work Phone _____

FATHER/GUARDIAN _____	Address _____
Email Address _____	Cell Phone _____
EMPLOYER _____	Work Phone _____

SPECIAL INFORMATION ABOUT CUSTODY _____

EMERGENCY CONTACT: (PLEASE LIST NUMBERS OTHER THAN YOUR OWN)

EMERGENCY #1 _____ EMERGENCY #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 _____

NAME AND ADDRESS OF LAST SCHOOL ATTENDED: _____

Parent 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.

Ethnicity and Race

Student's Name: _____ Grade: _____

Parent/Guardian Signature: _____ Date: _____

Please answer BOTH Question 1 AND Question 2

1: Is this student Hispanic/Latino? CHOOSE ONLY ONE ETHNICITY:

- 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 question is about ethnicity, not race. No matter what you selected above, **please continue to answer the following Question 2** by marking one or more boxes to indicate what you consider your student's race to be.

Question 2. What is the student's race? CHOOSE ONE OR MORE:

- 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.

Office use only:	
Ethnicity – Choose only one: _____ NOT Hispanic/Latino _____ Hispanic/Latino	Race – Choose one or more: _____ American Indian or Alaska Native _____ Asian _____ Black or African American _____ Native Hawaiian or Other Pacific Islander _____ White
Date:	Staff Signature:

Additional Requested Information:

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

PRESCHOOL

Head Start Circle One: YES NO	First Class 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 <input type="checkbox"/>	Special Education Funded – Circle One: YES NO

SPECIAL EDUCATION SERVICES

Student currently receiving special education services Circle One: Yes No



**State of Alabama 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 strictly confidential.
To be completed by parent/guardian.
PLEASE PRINT. Return to the School Nurse.

Name of Student (Last, First, Middle)		Birth Date	Sex
Address (Street)		Race/Ethnicity <input type="checkbox"/> American Indian <input type="checkbox"/> White, not of Hispanic origin <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Black, not of Hispanic origin <input type="checkbox"/> Other	
(City and Zip code)			
Home Telephone Number	Cell Telephone Number	School	Grade

Name of Parent/Guardian (Last, First, Middle) _____

Transportation

Bus Rider Car Rider Special Needs Bus After School Program

Part I – Health Information

Place where your child receives regular health care: <input type="checkbox"/> Health Department <input type="checkbox"/> Hospital Clinic <input type="checkbox"/> Community Health Center <input type="checkbox"/> Private Doctor/HMO <input type="checkbox"/> Other _____ <input type="checkbox"/> No regular place	Place where your child receives regular dental care: <input type="checkbox"/> Health Department <input type="checkbox"/> Hospital Clinic <input type="checkbox"/> Community Health Center <input type="checkbox"/> Private Doctor/HMO <input type="checkbox"/> Other _____ <input type="checkbox"/> No regular place	Type of Insurance your child has: <input type="checkbox"/> Medicaid <input type="checkbox"/> No Insurance <input type="checkbox"/> Private Insurance <input type="checkbox"/> ALLKIDS <input type="checkbox"/> Other: _____
Physician's Name: _____ Address: _____ Tel: _____	Dentist's Name: _____ Address: _____ Tel: _____	

Authorizations:

I authorize the school nurse, the registered nurse (RN) or licensed practical nurse (LPN), to talk with the physician(s) should a question come up about my child's medical conditions.

I do NOT authorize the school nurse, the RN or LPN, to talk with the physician(s) should a question come up about my child's medical conditions.

I authorize for my child to participate in all school health screenings, such as vision, hearing and scoliosis.

I authorize the yearly review of my child's Certificate of Immunization (Blue Slip) by the local Public Health Department.

FOR OFFICE USE ONLY Acuity Scale:			
Level A Nursing Dependent	Level B Medically Fragile	Level C Medically Complex	Level D Health Concerns



Part II – Medical History

<input type="checkbox"/> NO KNOWN HEALTH PROBLEMS	
(If no, please go directly to the bottom of the page and provide parent/guardian signature.)	
<input type="checkbox"/> Attention Deficit Disorder (ADD) OR <input type="checkbox"/> Attention Deficit Hyperactivity Disorder (ADHD)	<input type="checkbox"/> Requires medication? <i>(Requires medication authorization from physician)</i> <input type="checkbox"/> To be given while at school?
<input type="checkbox"/> Allergies: Please Specify : <input type="checkbox"/> Food _____ <input type="checkbox"/> Insects _____ <input type="checkbox"/> Environmental _____ <input type="checkbox"/> Medications _____	<input type="checkbox"/> Hives/rash? <input type="checkbox"/> Breathing difficulty? <input type="checkbox"/> Epi-pen? <i>(Requires medication authorization from physician)</i>
<input type="checkbox"/> Asthma:	<input type="checkbox"/> He/She uses an inhaler at school? <i>(Requires authorization from physician)</i> <input type="checkbox"/> He/She uses an inhaler at home?
<input type="checkbox"/> Bleeding Problems: (Hemophilia, Von Willebrand's, frequent nosebleeds)	<input type="checkbox"/> Requires medication? Please explain: <i>(Requires medication authorization from physician)</i>
<input type="checkbox"/> Cancer/Leukemia:	Please explain:
<input type="checkbox"/> Cerebral Palsy:	Please explain:
<input type="checkbox"/> Cystic Fibrosis:	Please explain:
<input type="checkbox"/> Dental Problems:	<input type="checkbox"/> Braces? OR Please explain:
<input type="checkbox"/> Diabetes: <i>(Requires medication and procedure authorization from physician)</i> <input type="checkbox"/> Type 1 Diabetic <input type="checkbox"/> Type 2 Diabetic	<input type="checkbox"/> Monitors Blood Sugars while at school? <input type="checkbox"/> Requires Insulin at school? <input type="checkbox"/> Glucagon order? <input type="checkbox"/> Insulin pump? <input type="checkbox"/> Managed with diet?
<input type="checkbox"/> Emotional/Behavioral/Psychological: <i>Please explain:</i>	
<input type="checkbox"/> Gastrointestinal/Stomach Problems: <i>Please explain:</i>	
<input type="checkbox"/> Genetic Disorder: <i>Please explain:</i>	
<input type="checkbox"/> Headaches: <i>Please explain:</i>	
<input type="checkbox"/> Hearing Problems:	<input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> Both ears <input type="checkbox"/> Tubes <input type="checkbox"/> Hearing loss? <input type="checkbox"/> Hearing aid? <input type="checkbox"/> Cochlear Implant
<input type="checkbox"/> Heart Condition: <i>Please explain: Are there any activity restrictions? Any medications taken at home only?</i>	
<input type="checkbox"/> Hypertension (High Blood Pressure):	
<input type="checkbox"/> Juvenile Arthritis/Bone-Joint Problems: <i>Please explain:</i>	
<input type="checkbox"/> Kidney Problems: <i>Please explain:</i>	
<input type="checkbox"/> Scoliosis:	<input type="checkbox"/> No Treatment <input type="checkbox"/> Wears Brace <input type="checkbox"/> Surgery
<input type="checkbox"/> Seizures/Convulsions: <i>Please explain:</i>	Type of seizure: _____ <input type="checkbox"/> Diastat order
<input type="checkbox"/> Sickle Cell Anemia:	
<input type="checkbox"/> Spina Bifida:	
<input type="checkbox"/> Special Diet: <i>Please explain:</i>	
<input type="checkbox"/> Vision Problems:	<input type="checkbox"/> Wears glasses <input type="checkbox"/> Wears contacts <input type="checkbox"/> Other, _____
<input type="checkbox"/> Other Medical Conditions: <i>Please include <u>any</u> medications taken at home only.</i>	

Part III – Medical Equipment /Procedures Required at School

<input type="checkbox"/> Catheter	<input type="checkbox"/> Gastric Tube	<input type="checkbox"/> Nebulizer Treatments	<input type="checkbox"/> Oxygen Supplement	<input type="checkbox"/> Tracheostomy
<input type="checkbox"/> Vagal Nerve Stimulator (VNS)	<input type="checkbox"/> Ventilator	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Walker	

Required Signatures

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