School Year _____ TROY CITY SCHOOLS ☐ Please check if this is a new address

Residency Affidavit Form

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/ Alaskan Native____ Not Specified (Hispanic Students Only)____ Pacific Islander____ Multi Race____

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)

Guardian's Name_____

Work Place_____

Phone #_____

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

Guardian's Name_____

Work Place_____

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

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)

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
CONTACT _____
Relation_____ **Phone** _____

EMERGENCY #2
CONTACT _____
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

Question 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 on 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 (includin 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 €	**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) / (City and Zip code)	Race/Ethnicity	
	☐ American Indian	☐ White, not of Hispanic origin
	☐ Asian	☐ Hispanic/Latino
	☐ Black, not of Hispanic origin	☐ Other

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:
- □ Health Department
- □ Hospital Clinic
- □ Community Health Center
- □ Private Doctor/HMO
- □ Other _____
- □ No regular place

Physician's Name:_____

Address: _____

_____

Tel: _____

Place where your child receives regular dental care:
- □ Health Department
- □ Hospital Clinic
- □ Community Health Center
- □ Private Doctor/HMO
- □ Other _____
- □ No regular place

Dentist's Name: _____

Address: _____

_____

Tel: _____

Type of Insurance your child has:
- □ Medicaid
- □ No Insurance
- □ Private Insurance
- □ ALLKIDS
- □ Other:

_____

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

State of Alabama Department of Education
Health Assessment Record
School Year: _____ - _____

Part II – Medical History

☐ NO KNOWN HEALTH PROBLEMS

(If no, please go directly to the bottom of the page and provide parent/guardian signature.)

□**Attention Deficit Disorder (ADD)** **OR** □ **Attention Deficit Hyperactivity Disorder (ADHD)**	□Requires medication? *(Requires medication authorization from physician)* □To be given while at school?
□**Allergies:** *Please Specify :* □ **Food** _____ □ **Insects** _____ □ **Environmental** _____ □ **Medications** _____	□Hives/rash? □Breathing difficulty? □Epi-pen? *(Requires medication authorization from physician)*
□**Asthma:**	□He/She uses an inhaler at school?*(Requires authorization from physician)* □He/She uses an inhaler at home?
□**Bleeding Problems:** **(Hemophilia, Von Willebrand's, frequent nosebleeds)**	□Requires medication? Please explain: *(Requires medication authorization from physician)*
□**Cancer/Leukemia:**	Please explain:
□**Cerebral Palsy:**	Please explain:
□**Cystic Fibrosis:**	Please explain:
□**Dental Problems:**	□Braces? OR Please explain:
□**Diabetes:***(Requires medication and procedure authorization from physician)* □ **Type 1 Diabetic** □ **Type 2 Diabetic**	□Monitors Blood Sugars while at school? □Requires Insulin at school? □Glucagon order? □Insulin pump? □Managed with diet?

□**Emotional/Behavioral/Psychological:** *Please explain:*	
□**Gastrointestinal/Stomach Problems:** *Please explain:*	
□**Genetic Disorder:** *Please explain:*	
□**Headaches:** *Please explain:*	
□**Hearing Problems:**	□Right Ear □ Left Ear □ Both ears □ Tubes □Hearing loss? □Hearing aid? □ Cochlear Implant
□**Heart Condition:** *Please explain: Are there any activity restrictions? Any medications taken at home only?*	
□**Hypertension (High Blood Pressure):**	
□**Juvenile Arthritis/Bone-Joint Problems:** *Please explain:*	
□**Kidney Problems:** *Please explain:*	
□**Scoliosis:**	□No Treatment □ Wears Brace □ Surgery
□**Seizures/Convulsions:** *Please explain:*	Type of seizure: _____ □Diastat order
□**Sickle Cell Anemia:**	
□**Spina Bifida:**	
□**Special Diet:** *Please explain:*	
□**Vision Problems:**	□Wears glasses □ Wears contacts □ Other, _____
□**Other Medical Conditions:** *Please include **any** medications taken at home only.*	

Part III – Medical Equipment /Procedures Required at School

□ Catheter □ Gastric Tube □ Nebulizer Treatments □ Oxygen Supplement □ Tracheostomy
□ Vagal Nerve Stimulator (VNS) □ Ventilator □ Wheelchair □ Walker

Required Signatures

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

Signature of school nurse: _____ **Date:**_____

TROY CITY SCHOOL INTERNET USAGE CONTRACT

User Agreement (to be signed by all adult users and student users 2nd grade and above):

I,_____ (please print full name), hereby certify that I have received a copy of the Troy City Schools' Internet and IT Resources Acceptable Use Policy and that receipt of said Policy serves as a notice to me and my parents and/or legal guardian of the policy and its provisions. I understand and agree that it is my responsibility to fully inform myself of the provisions of this Policy, and I understand and agree that I will fully comply with and abide by all provisions of this Policy. I understand and agree that any violation of this Policy may result in disciplinary action against me which can include, but shall not be limited to, any disciplinary action authorized under the entire range of discipline provided for in the Student Code of Conduct up to and including expulsion, and, in addition, prohibition of use of the Internet. I hereby release and agree to hold harmless the Troy City Schools, the Troy City Board of Education and all other organizations and persons from any liability, loss, expense, claims, or damages, whether to person or property, arising from my use of the Internet. In addition, I hereby agree to accept full responsibility and liability for the consequences of my use of the Internet.

_____ _____

User Signature & Date Witness Signature & Date

Parent Agreement (to be signed by parents of all students):

I, _____ (please print full name), the parent/guardian of the above student hereby certify that I have read the Troy City School's Internet and Instructional Technology Use Policy. I agree and acknowledge that it is the responsibility of the above student to fully inform him/herself of the provisions of this Policy, and I agree with the requirement that the above student must fully comply with and abide by all provisions of this Policy. I understand and agree that any violation of this Policy by the above student may result in disciplinary action against him/her which can include, but shall not be limited to, any disciplinary action authorized under the entire range of discipline provided for in the Student Code of Conduct up to and including expulsion, and, on addition, prohibition of use of the Internet by that student. I hereby covenant and agree that I accept full responsibility for the use of the Internet by the above student, and I hereby agree to be responsible for all financial and legal liabilities and consequences which may result from the above student's use of the Internet and other technology services provided by the Troy City Schools. I hereby release and agree to indemnify and hold harmless the Troy City Board of Education, and all other organizations and persons from any liability, expense, loss, claims or damages, whether to person or property arising from the use of the Internet by the above student.

For my student in grades 2-12, I understand the Troy City School System will issue him/her and email account provided by Gaggle.net. I understand that the Troy City School System has determined what features my child has access to, which may include email, homework drop boxes, message boards, chat room, blogs, and digital storage lockers. I understand that all email messages and postings will be automatically filtered for inappropriate words and images, and that any messages determined to be questionable will be diverted to my student's email administrator for review. Consequences for misuse of email will be determined by the district, and may include restrictions, loss of privileges, or other disciplinary action. I further understand that my student's administrator or teacher can view my student's email account and digital locker at any time.

_____ € Check this box if you do NOT want your child

Parent Signature & Date to have an email address.

SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

STUDENT INFORMATION

Student's Name_____Date of Birth_____
School_____Grade_____ Teacher_____School Year____
List any known drug allergies/reactions_____Height (inches)____Weight(lbs)_____

PRESCRIBER AUTHORIZATION

Name of Medication_____ Reason for Taking_____
Dosage_____ Route _____Frequency /Time(s) to be given_____
Begin Medication _____Stop Medication _____
Date Date
Special Instructions:
Does medication require refrigeration? Yes € No €
Is the medication a controlled substance? Yes € No €
Is self-medication permitted and recommended for this student? Yes € No €
If yes, do you recommend this medication be kept "on person" by the student? Yes € No €

Potential Side Effects/Contradictions/Adverse Reactions _____

Treatment Order in the event of an adverse reaction: _____
(Attach additional sheet or use the back of this form if necessary)

I hereby affirm that this student has been instructed in the proper self-administration of the prescribed medication (s).

_____ _____ _____ _____
Signature of Prescriber (please print) **Date** **Phone** **Fax**

PARENT AUTHORIZATION

I authorize the School Nurse, the registered nurse (RN) or licensed practical nurse (LPN) to delegate to unlicensed school personnel the task of assisting my child in taking the above medication. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed. I also authorize the School Nurse to talk with the prescriber or pharmacist should a question come up about the medication.

Medication must be registered with the principal, his/her designee, or the school nurse. It must be in the original, unopened, sealed container and be properly labeled with the student's name, prescriber's name, date of prescription, name of medication, dosage, strength, time interval, route of administration and the date of drug expiration when appropriate.

_____ _____ _____ _____
Signature of Parent **Date** **Phone** **Cell**

SELF-ADMINISTRATION AUTHORIZATION

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in the proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).

_____ _____ _____ _____
Signature of Parent **Date** **Phone** **Cell**

Troy City Schools

Parent Permission for Publication of Student Photo/Video

Dear Parent/Guardian,

Troy City School District is including photographs and/or video recordings of students and teachers in school and classroom settings on our website. Also, these photographs/recordings will be utilized for professional development activities and for publications related to Troy City Schools. It is our practice to seek parent permission before including a student's photograph or video clip. We must have your signed permission in order to include your student in the media publications. Please review, sign, and return the consent form below.

Troy City School District has my permission to take photographs and/or video recordings of my child,

_____.

Print Student's Name

These photographs and/or video recordings may be used on the district website and in district publications for the 2016-2017 school term.

School_____

Student's Grade _____

Student's Homeroom Teacher_____

Parent/Guardian Signature _____

Print Parent/Guardian's Name _____

Date _____

Grade _____

ACKNOWLEDGMENT

I, _____ enrolled in
(Name of Student)

_____ and my
(Name of School)

parent(s) guardian hereby acknowledges by our signature that we have received and read, or had read to us, the forgoing Code of Student Conduct. We also acknowledge that we understand that it applies to all students enrolled in Troy City Schools and school sponsored activities and events, including but not limited to the following:

- Field trips
- Clubs or organization meetings
- School groups representing the school system in all types of events
- Persons in or on a vehicle located on school property
- Other school sponsored events including but not limiting to athletic events (football, baseball, basketball games, etc. on and off campus), dances, plays, etc.

-

(Signed) _____
Student

(Signed) _____
Parent/Guardian

Date: _____

NOTE: Students must return this form to their homeroom teacher. This ACKNOWLEDGMENT will become a part of the student's cumulative file.

Troy City Schools
HOME LANGUAGE SURVEY

_____ _____

Date School

Schools are required to determine the language(s) spoken at home by each student. This information is essential in order for schools to provide meaningful instruction for all students.

Your cooperation in helping us meet this important requirement is requested. Please answer the following questions and have your child return this form to his/her teacher.

Thank you for your help.

Name of student: _____

Last First Middle

Grade: _____ **Age:** _____

1. Which language did your son or daughter learn when he or she first began to talk?

   _____

2. What language does your son or daughter most frequently use at home?

   _____

3. What language do you use most frequently to speak to your son or daughter?

   _____

4. Name the language most often spoken by the adults at home.

   _____

_____

Signature of Parent or Guardian

ALABAMA STATE DEPARTMENT OF EDUCATION
EMPLOYMENT SURVEY

School System: _____ **School Year:** _____

School: _____ **Grade** _____

Dear Parents/Guardians,

Please complete the following survey. The results of this survey will be used to determine if you are possibly eligible for the *Migrant Education Program*.

Student Name: _____

Name of Parent or Guardian: _____

Address: _____

Telephone Number: _____

1. Have you moved during the last 3 years **to work or to seek work** even if it was for a short period of time?
   YES ____ **NO** ____

2. Are you or your spouse **working or have you worked** in an activity directly related to some of the following? Please check (√) all applicable:
   - □ The production or process of harvests, milk products, poultry farms, poultry plants, cattle farms
   - □ Fruit farms
   - □ The cultivation or cutting of trees
   - □ Work in nurseries or sod farms
   - □ Worm farms
   - □ Catching or processing sea food (shrimp, oysters, crabs, fish, etc…)

3. From what city, state or country did you come from? _____

   _____

4. What type of work did you or your spouse do before coming here? _____

   _____