

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)

Father, Step-Father, Mother, Step-Mother, Legal Guardian, Foster Care  
(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

<b>CHILD'S FULL NAME</b>	<b>SCHOOL ATTENDING</b>	<b>GRADE LEVEL</b>
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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 EMERGENCY #2 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

**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 (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:	
<b>Ethnicity – Choose only one:</b>  <input type="checkbox"/> NOT Hispanic/Latino  <input type="checkbox"/> Hispanic/Latino	<b>Race – Choose one or more:</b>  <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White
<b>Date:</b>	<b>Staff Signature:</b>

**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
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**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 <input type="checkbox"/> Bus Rider <input type="checkbox"/> Car Rider <input type="checkbox"/> Special Needs Bus <input type="checkbox"/> After School Program			

**Part I – Health Information**

<b>Place where your child receives regular health care:</b> <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	<b>Place where your child receives regular dental care:</b> <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	<b>Type of Insurance your child has:</b> <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: _____	Dentist's Name: _____	
Address: _____	Address: _____	
Tel: _____	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



**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.)**

<input type="checkbox"/> <b>Attention Deficit Disorder (ADD)</b> OR <input type="checkbox"/> <b>Attention Deficit Hyperactivity Disorder (ADHD)</b>	<input type="checkbox"/> Requires medication? <i>(Requires medication authorization from physician)</i> <input type="checkbox"/> To be given while at school?
<input type="checkbox"/> <b>Allergies: Please Specify :</b> <input type="checkbox"/> <b>Food</b> _____ <input type="checkbox"/> <b>Insects</b> _____ <input type="checkbox"/> <b>Environmental</b> _____ <input type="checkbox"/> <b>Medications</b> _____	<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"/> <b>Asthma:</b>	<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"/> <b>Bleeding Problems:</b> <b>(Hemophilia, Von Willebrand's, frequent nosebleeds)</b>	<input type="checkbox"/> Requires medication? Please explain: <i>(Requires medication authorization from physician)</i>
<input type="checkbox"/> <b>Cancer/Leukemia:</b>	Please explain:
<input type="checkbox"/> <b>Cerebral Palsy:</b>	Please explain:
<input type="checkbox"/> <b>Cystic Fibrosis:</b>	Please explain:
<input type="checkbox"/> <b>Dental Problems:</b>	<input type="checkbox"/> Braces? OR Please explain:
<input type="checkbox"/> <b>Diabetes:</b> <i>(Requires medication and procedure authorization from physician)</i> <input type="checkbox"/> <b>Type 1 Diabetic</b>  <input type="checkbox"/> <b>Type 2 Diabetic</b>	<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"/> <b>Emotional/Behavioral/Psychological:</b> <i>Please explain:</i>	
<input type="checkbox"/> <b>Gastrointestinal/Stomach Problems:</b> <i>Please explain:</i>	
<input type="checkbox"/> <b>Genetic Disorder:</b> <i>Please explain:</i>	
<input type="checkbox"/> <b>Headaches:</b> <i>Please explain:</i>	
<input type="checkbox"/> <b>Hearing Problems:</b>	<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"/> <b>Heart Condition:</b> <i>Please explain: Are there any activity restrictions? Any medications taken at home only?</i>	
<input type="checkbox"/> <b>Hypertension (High Blood Pressure):</b>	
<input type="checkbox"/> <b>Juvenile Arthritis/Bone-Joint Problems:</b> <i>Please explain:</i>	
<input type="checkbox"/> <b>Kidney Problems:</b> <i>Please explain:</i>	
<input type="checkbox"/> <b>Scoliosis:</b>	<input type="checkbox"/> No Treatment <input type="checkbox"/> Wears Brace <input type="checkbox"/> Surgery
<input type="checkbox"/> <b>Seizures/Convulsions:</b> <i>Please explain:</i>	Type of seizure: _____ <input type="checkbox"/> Diastat order
<input type="checkbox"/> <b>Sickle Cell Anemia:</b>	
<input type="checkbox"/> <b>Spina Bifida:</b>	
<input type="checkbox"/> <b>Special Diet:</b> <i>Please explain:</i>	
<input type="checkbox"/> <b>Vision Problems:</b>	<input type="checkbox"/> Wears glasses <input type="checkbox"/> Wears contacts <input type="checkbox"/> Other, _____
<input type="checkbox"/> <b>Other Medical Conditions:</b> <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**

<b>Signature of parent(s) or guardian:</b> _____	<b>Date:</b> _____
<b>Signature of school nurse:</b> _____	<b>Date:</b> _____

## TROY CITY SCHOOL INTERNET USAGE CONTRACT

User Agreement (to be signed by all adult users and student users 2<sup>nd</sup> 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 an email account provided by Gagle.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.

\_\_\_\_\_  
Parent Signature & Date

Check this box if you do NOT want your child 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	
<b>Special Instructions:</b>			
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>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).</i>			
_____ 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.

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

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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 \_\_\_\_\_

**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.