



Troy Elementary School
Hank Jones Early Childhood Center
KINDERGARTEN Registration Checklist
2021-2022

Student Name: _____

- _____ **1. Registration / Residency Affidavit**
- _____ **2. Alabama Enrollment Form**
- _____ **3. (2) Proofs of Residency**
- _____ **4. Home Language Survey**
- _____ **5. Employment Survey**
- _____ **6. Birth Certificate** (MUST BE BORN ON OR BEFORE SEPT. 1, 2016.)
- _____ **7. Social Security Card** (OPTIONAL)
- _____ **8. Alabama Immunization Record**
**Reminder: Immunizations must be complete BEFORE student can attend school. Make note of any incomplete record. Head Start will send information to ECC in May (write "Head Start" in Notes section).
- _____ **9. Health Assessment Form (ALSDE)**

NOTES:

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

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 _____	EMERGENCY #2 CONTACT _____
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Relation _____ Phone _____	Relation _____ Phone _____
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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 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 Center- Based Child Care - Circle One: YES NO Home Visitation Program – Circle One: YES NO No Preschool – Check if no Preschool <input type="checkbox"/>	First Class Funded Preschool – Circle One : YES NO Home- Based Child Care – Circle One: YES NO Other Preschool – Circle One: Yes NO Special Education Funded – Circle One: YES NO
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SPECIAL EDUCATION SERVICES

Student currently receiving special education services Circle One: Yes No

January 2015

Troy City Schools HOME LANGUAGE SURVEY

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? _____



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

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: _____	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"/> 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"/> Allergies: <i>Please Specify:</i> <input type="checkbox"/> Food _____ <input type="checkbox"/> Insects _____ <input type="checkbox"/> Environmental _____ <input type="checkbox"/> Medications _____	<input type="checkbox"/> To be given while at school? <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 any 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: _____