Checklist for enrollment for the Grundy County High School:

(All items are required for new students and students reenrolling)

- Birth Certificate
- Social Security Card
- Proof of Immunization
- Proof Of Legal Custodial Guardian
- Copy of current physical if the student is enrolling for the first time in a TN school
- Two documents that verify proof of residence in Grundy County (ex. Current water, electric bill)

********Records for enrollment will not be requested until all items on list have been turned in.***

Grundy County High School

24970 SR 108

Coalmont, TN 37313

Phone: 931-3042333 Fax: 931-259-4767

School Counselor Donna Jones

School Counselor Kimberly Grogan

Guidance Secretary Jessica Huntley

Release of Information for Enrollment

Date:_____

Student Name:_____ Grade:_____

Birthdate:_____ Previous School:_____

Previous School Phone:_____ Previous School Fax:_____

The student listed above has enrolled at Grundy County High School.

Please provide the following by fax, email or mail to the information above.

- Complete Withdrawal Grades
- Official Transcript
- Behavioral/Discipline Records
- TCAP/EOC Scores
- TN Health Records/Shot Record
- Attendance Report
- Birth Certificate
- Social Security Card
- Special Education Records, Psychological Report & IEP
- 504

***Please check if any of the following items are applicable to this student:**

____**This student is currently suspended**

____**This student is currently expelled**

____**This student is currently attending Alternative School**

Parent Signature: _____ Date:_____

Updated June 2019

School:
Grade:
Homeroom Teacher:
Enrollment Date:

GRUNDY COUNTY SCHOOLS

Registration Form

Transportation

BUS # AM _____ PM _____
CAR AM _____ PM _____

Last School Attended _____

STUDENT INFORMATION

Student Name (as it appears on Birth Certificate) _____
First Middle Last

Student's Preferred Name: _____ **Gender :** ☐ Male ☐ Female **Social Security #** _____

Birth Date (MM/DD/YYYY) __ __ /__ __ /__ __ __ __ **Mother's Maiden Name** _____ **Birth Country:** _____

Birth City: _____ **Birth County:** _____ **Birth State:** _____

ETHNICITY: (check one) ☐ Hispanic/Latino ☐ Not Hispanic/Latino

RACE: (check all that apply)
☐ American Indian/ Alaskan Native ☐ Asian ☐ White/Caucasian ☐ Black/African-American ☐ Hawaiian/Other Pacific Islander

Military: Check the appropriate box if this student has a parent/guardian that is:
☐ Active Military ☐ Military National Guard ☐ Reserve Military

Internet Connection: Do you have internet connection in your home? ☐ Yes ☐ No

List Other Children in Family _____

GUARDIAN/CUSTODIAL INFORMATION and POWERSCHOOL INFORMATION

Are there Legal/Custody issues we should be aware of?: Yes____ No_____ What? _____

CUSTODY: ☐ Both Parents ☐ Father ☐ Mother ☐ State Custody ☐ Sibling ☐ Other-Legal Guardian _____

1. **Parent/Guardian:** _____ **Relationship:** _____
   ☐ Custodial Parent ☐ Emergency Contact ☐ Can Pick Child up ☐ PowerSchool Access
   Physical Address: _____
   Number & Street City State Zip
   Mailing Address: _____
   (If different) Number & Street City State Zip
   Phone # ( ) _____ ☐ Home ☐ Work ☐ Cell
   Phone # ( ) _____ ☐ Home ☐ Work ☐ Cell **Occupation:** _____
   E-mail Address _____ (Required for PowerSchool Access)

2. **Parent/Guardian:** _____ **Relationship:** _____
   ☐ Custodial Parent ☐ Emergency Contact ☐ Can Pick Child up ☐ PowerSchool Access
   Physical Address: _____
   Number & Street City State Zip
   Mailing Address: _____
   (If different) Number & Street City State Zip
   Phone # ( ) _____ ☐ Home ☐ Work ☐ Cell
   Phone # ( ) _____ ☐ Home ☐ Work ☐ Cell **Occupation:** _____
   E-mail Address _____ (Required for PowerSchool Access)

I give my permission for the numbers listed below to be used by PowerSchool, the automatic dialing equipment, regarding information from Grundy County Schools and understand that I may opt-out at any time.

(_____) _____ (_____) _____

I would like the PowerSchool automatic phone calls in: (Choose one) ☐ English ☐ Spanish

The Grundy County School System does not discriminate on the basis of race, sex, color, religion, national origin, age, handicap in the provision of educational opportunities, activities, or administered programs.

EMERGENCY INFORMATION

Please list Emergency Contacts other than those listed on page 1

Name	Relationship	Phone

STUDENT HEALTH INFORMATION

Does your student have health problems we should be aware of (including any allergies)?
☐ Yes ☐ No If yes, please fill out medication form with the School Nurse.

Please mark all that you give the school permission to do for your student ☐ Call Doctor ☐ Call Ambulance ☐ Treat

STUDENT PICKUP INFORMATION

Please list anyone allowed to pick your student up from school.

Parent/Guardian Signature:_____ Date: _____

attendance MATTERS
in
Grundy County Schools

Thank you for helping keep your student's information current.

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STUDENT HEALTH INFORMATION

Students Name _____ School _____ Teacher _____ Gr _____ School Year _____

Birthdate _____ Parent/Guardian's Name _____ Phone _____ Cell _____

Emergency Contact Name/Number if unable to reach Parent/Guardian _____

Family Doctor Name/Number _____ Does student wear glasses? _____ hearing aids? _____

Does your child have any of the following? YES_____ (check in box and complete all that apply) NO_____

Please sign/date at the bottom. Then read the back of this page sign/date and return to school.

_____Asthma Age of diagnosis _____
What causes asthma attacks _____
Name of Regular Asthma Medication _____
Name of emergency medication (Inhaler) _____
Does student need help with inhaler? _____ Will student keep inhaler with him/her at school? _____ or leave with the school secretary or nurse? _____
Nebulizer @ home _____ Nebulizer @ school _____
Does student have a Peak Flow Meter? _____ Has doctor completed an Asthma Action Plan for school? _____
Name of Doctor treating asthma _____
Phone Number ( ) _____
Expiration Date on Inhaler _____

SEVERE ALLERGY TO:
_____Food Name of food _____ Reaction _____

SEVERE ALLERGY TO:
_____Insect Bites/ Stings
_____Itching & swelling of lips, tongue or mouth
_____Itching of throat _____Itchy rash, whelps
_____Difficulty breathing _____Nausea, vomiting, diarrhea
_____SWELLING AT STING/BITE SITE ONLY?
Is an Epipen prescribed for school use? _____
If so, what is the expiration date on Epipen? _____

Is student allergic to medication(s)? _____ Which one? _____
_____Describe reaction. _____

_____Allergy to Latex Reaction _____

_____High Blood Pressure (Age diagnosed _____)
Medication for high blood pressure _____

_____Migraine Headache (Medication _____)

_____ADD _____ADHD Medication _____
Does this medication have to be given at school? _____
When was ADD or ADHD diagnosed? _____

_____Hemophilia _____Sickle Cell Anemia _____Shunt
_____Other Health Problems _____

_____Heart Type of Heart Problem _____
Diagnosed at what age _____ Medication _____
Does the student require antibiotics before dental work? _____ If yes what medication and what dosage? _____
Any restrictions on activities? _____
Last doctor's visit for heart problem _____
List signs/symptoms which require emergency action and what action should be taken. _____
Name of Doctor treating heart problem _____
Phone Number ( ) _____

_____Diabetes _____Type I _____Type II Age of Diagnosis _____
_____Insulin @ school. Type of insulin _____
_____Pump Type of insulin _____
_____Blood Glucose checks @ school _____
_____Check Ketones @ school _____
_____Glucagon ordered? If so, what is the expiration date? _____
Is student on a sliding scale? _____
Have you provided a container of snacks for school and bus to treat lo blood sugar? _____ This is strongly recommended.
Name of Doctor treating diabetes _____
Phone Number ( ) _____

_____Seizures/Epilepsy Age of Diagnosis _____
Type of Seizures _____
What causes Seizures? _____
Date of last seizure _____
Medication _____ Dosage _____
Length of Seizures _____
What happens before and during a seizure _____
Is any emergency medication (Diastat) ordered for school use? _____
Expiration Date for Diastat _____
Name of Doctor treating seizures _____
Phone Number ( ) _____

List medication student takes regularly at home. _____
Is it necessary for any meds to be taken at school? _____ If so, What? _____
If medication must be taken during school hours, a medication authorization form must be complete by parent/guardian.
If students medication changes during the school year or you have any questions, please contact the school.
I understand this information will be kept at school in nurses office. Other school personnel will be given this information on a need to know basis. I authorize the School Nurse to talk with the physician should a question come up regarding this student's health information.

PARENT/GUARDIAN signature _____ DATE _____

MEDICATION USED BY SCHOOL

Hydrogen Peroxide: cleansing minor cuts, abrasions, etc.
propyl Alcohol: cleansing minor cuts, abrasions, ,etc
White Petroleum Jelly: minor skin irritations and chapped lips.
Eye Wash: for cleansing and minor dry eyes.
Antibacterial Soap: cleansing minor cuts ,scrapes and burns.
Antibiotic Ointment: to help prevent infection in minor cuts and burns.
Hydrocortisone/Benadryl Cream: minor skin irritation from insect bites, poison ivy etc.
Burn Gel: for minor burns
Tums: indigestion
Cough drops: coughing

MEDICATION TAKEN AT SCHOOL

If your child has to take medication at school, the legal has to bring it. (if not on the above list) Students ARE NOT allowed To transport ANY medication to or from school. This includes prescription medication, over the counter meds such as Tylenol, etc. Parent/guardian must bring these meds to school.

WHEN PARENTS/GUARDIANS ARE NOTIFIED OF HEALTH INCIDENTS AT SCHOOL:

Students are instructed to tell parents of ALL incidents whether minor or major. The school will only notify you of major Incidents, unless otherwise stated by parent/guardian.

MINOR INCIDENTS

Headaches (less than once per week)
Minor cuts or scrapes
Minor bruising
Minor cold/allergies/sinus
Minor counseling or instruction visit
Minor foreign bodies (splinter, etc.)

MAJOR INCIDENTS

Headaches (more than once a week)
any probable infection
large cuts or scrapes
large bruising
major counseling or instruction visit
any minor incident not resolved in expected amount of time

EMERGENCY contacts to 911

Acute respiratory distress
Severe bleeding
Shock/ anaphylactic reaction
Cardiac distress
Serious, extensive burns
Poisoning
Unconsciousness
Seizure lasting longer than 5 minutes
Severe injury involving large bones of leg pelvic
Severe head, neck, or back trauma
Psychiatric emergency

PARENT/GUARDIAN signature_____**Date**_____