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.

January 2015

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	Yes ☐	No ☐
Student Connected to Guard or Reserve Military	Yes ☐	No ☐

PRESCHOOL

Heat Start Yes ☐ No ☐	First Class Funded Preschool Yes ☐ No ☐
Center-Based Child Care Yes ☐ No ☐	Home-Based Child Care Yes ☐ No ☐
Home Visitation Program Yes ☐ No ☐	Preschool Yes ☐ No ☐
Preschool – Check if no Preschool ☐	

Please list any relatives that will be enrolled in Kindergarten at MCS for the 20-21 academic school year.

_____

_____

_____

_____

MARENGO COUNTY SCHOOLS

Home Language Survey

Student' name:_____ Date:_____

Age:_____ Date of birth_____ Last grade attended:_____

Parent's name:_____ Country of origin:_____

Is a language other than English spoken at home? _____

Is your child's first language a language other than English?_____

What language did your child learn when her/she first began to talk?_____

What language does your child most frequently speak at home?_____

_____ _____

Student's signature (If in grades 9-12) Parent/guardian's signature

Encuesta del lenguaje materno

Nombre del/a estudiante_____Fecha_____

Edad_____Fecha de nacimiento_____ Año escolar_____

Nombre del padre_____ Nombre de la madre_____
País de

origen_____ Idioma de la infancia_____ Idioma
que el/la

estudiante usa más frecuentemente_____Idioma hablado en

casa_____ El/la estudiante lee, habla y escribe en los siguientes
idiomas _____

Los padres leen, hablan y escriben en los siguientes
idiomas_____

_____ _____

Firma de/la estudiante (Si están en grados 9-12) Firma de los padres

SIGNED COPY MUST BE RETAINED IN STUDENT'S CUM FOLDER, IF ANOTHER LANGUAGE IS INDICATED ANYWHERE, PLEASE CALL STEPHANIE POPE, 334 295-2233 FOR TESTING.

MARENGO COUNTY SCHOOL SYSTEM
EMPLOYMENT SURVEY

SCHOOL SYSTEM: _____ SCHOOL YEAR: _____

SCHOOL: _____ GRADE: _____

Dear Parents or 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 three 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
- ☐ Fish or shrimp farms
- ☐ Worm farms
- ☐ Catching or processing seafood (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?

_____

ALABAMA STATE DEPARTMENT OF EDUCATION
EMPLOYMENT SURVEY

SCHOOL SYSTEM: _____ SCHOOL YEAR: _____

SCHOOL: _____ GRADE:_____

Dear Parents or 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: _____

Home Telephone No: _____ Cell Telephone No: _____

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** ☐

   If so, what type work are you or **your spouse doing now:**

   _____

2. If you marked "**yes**" on question number 1, what city, state, or country did you move from?

   _____

3. Have you or your spouse **ever worked** in an activity directly related to any of the following? Please **check (√)** all that apply:

   - ☐ 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
   - ☐ Fish or shrimp farms
   - ☐ Worm farms
   - ☐ Catching or processing seafood (shrimp, oysters, crabs, fish, etc.....)

SECRETARIA DE EDUCACION DEL ESTADO DE ALABAMA
ENCUESTA DE EMPLEO

SISTEMA ESCOLAR: _____ AÑO ESCOLAR: _____

ESCUELA: _____ GRADO DE LA ESCUELA: _____

Estimado Padre o Guardián:

Por favor de completar la siguiente encuesta. Los resultados de ésta encuesta serán usados para determinar si son posiblemente elegibles para el Programa de Educación para Migrantes.

Nombre del niño: _____

Nombre del padre o guardián: _____

Dirección: _____

Teléfono: _____

1. ¿Se ha mudado usted en los últimos tres años **para trabajar o buscar trabajo** aunque haya sido por un tiempo corto? **SI** _____ **NO** _____

2. ¿Usted o su cónyugue **trabajan o han trabajado** en una actividad directamente relacionada an algunas de las siguientes? Por favor de marcar (√) los aplicables:

   ☐ La producción o proceso de cosechas, productos de lechería, aves, polleras o ganado.
   ☐ Huertas de frutas.
   ☐ La cultivación o corte de árboles.
   ☐ Trabajo en Invernaderos o granjas de Césped
   ☐ Granjas de pescados o camarones
   ☐ Granjas de gusanos
   ☐ La pesca o proceso de mariscos (camarones, ostiones, cangrejos, pescados, etc.)

3. ¿De que ciudad, estado o país se mudaron? _____

   _____

4. ¿Que tipo de trabajo hizo usted o su cónyugue antes de mudarse aquí?

   _____

Additional Requested Information:

MILITARY

Student Connected to an Active Duty Military Family	Circle One: Yes ☐ No ☐
Student Connected to Guard or Reserve Military	Circle One: Yes ☐ No ☐

PRESCHOOL

Heat 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 ☐	

Please list any relatives that will be enrolled in Kindergarten at MHS for the 20-21 academic school year.

_____

_____

_____

_____

ALABAMA STATE 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 confidential.

PLEASE complete both sides of this form (Return to the School Nurse)

Name of Student (Last, First, Middle)	Birth Date	Sex	School

Address (Street)

Home Telephone Number:	Cell Phone Number:	Additional Phone Number:	Grade	Teacher/Homeroom

Name of Parent/Guardian (Last, First Middle) | Work Phone Number:

Transportation

☐ Bus Rider Bus Number: ☐ Car Rider ☐ Special Needs Bus ☐ After School

Part I – Health Information

Place your child receives health care:

Physician's Name: _____

Address: _____

Phone:_____

- ☐ **Community Health Center**
- ☐ **Health Department**
- ☐ **Hospital Clinic**
- ☐ **No Regular Place**
- ☐ **Private Doctor /HMO**

Your child's Insurance Information:

- ☐ **ALL KIDS**
- ☐ **Medicaid**
- ☐ **No Insurance**
- ☐ **Other** _____
- ☑ **Private Insurance**

Place your child receives dental care:

Dentist's Name: _____

Address: _____

Phone:_____

- ☐ **Community Health Center**
- ☐ **Health Department**
- ☐ **Hospital Clinic**
- ☐ **No Regular Place**
- ☐ **Private Dentist /HMO**

Preferred Hospital: _____

Part II – Medical History Medical Equipment /Procedures Required at School

☐ Catheter ☐ Gastric Tube ☐ Nebulizer Treatments ☐ Oxygen Supplement ☐ Tracheostomy

☐ Vagal Nerve Stimulator (VNS) ☐ Ventilator ☐ Wheelchair ☐ Walker

☐ Other *Please explain:*

Medications and Procedures at School require a Prescriber/Parent Authorization Form (one for each medication or procedure) Please see your school nurse.

Please Complete Back of Form (Signature Required)

ALABAMA STATE DEPARTMENT OF EDUCATION

HEALTH ASSESSMENT RECORD

School Year: _____-_____

Name of Student **Part III – Medical History**

□ YES ■ NO	**KNOWN HEALTH PROBLEMS** If **NO**, go directly to the bottom of the page and provide parent/guardian signature If **YES**, and diagnosed by a physician, answer each question below.
□ YES □ NO □ YES □ NO	**Attention Deficit Disorder (ADD)** **Attention Deficit Hyperactivity Disorder (ADHD)** Requires medication □ At school □ At Home
□ YES □ NO	**Allergies:** □ Hives/rash □ Medications □ **Food** _____ □ **Insects** _____ □ Breathing difficulty □ Epi-pen □ **Environmental** _____ □ **Medications** _____ □ Other:
□ YES □ NO	**Asthma** □ Uses an inhaler at school □ Uses an inhaler at home
□ YES □ NO	**Blood/Bleeding Problems:** □**Hemophilia,** □**Von Willebrand's,** □**Other** □ **Requires medication** ***Please explain:***
□ YES □ NO	**Frequent Nose Bleeds:** *Please explain*
□ YES □ NO	**Cancer/Leukemia:** *Please explain*
□ YES □ NO	**Cerebral Palsy:** *Please explain*
□ YES □ NO	**Cystic Fibrosis:** *Please explain*
□ YES □ NO	**Dental Problems:** *Please explain:*
□ YES □ NO	**Diabetes** □ **Type 1 Diabetes** □ Monitors Blood Sugars at school □ Requires Insulin at school □ Insulin pump □ Glucagon order □ **Type 2 Diabetes** □ Managed with diet □ Oral medication
□ YES □ NO	**Emotional/Behavioral/Psychological:** *Please explain:*
□ YES □ NO	**Gastrointestinal/Stomach Problems:** *Please explain:*
□ YES □ NO	**Genetic / Rare Disorders:** *Please explain:*
□ YES □ NO	**Headaches:** *Please explain:*
□ YES □ NO	**Hearing Problems:** □ Right Ear □ Left Ear □ Both ears □ Hearing loss □ Hearing aid □ Tubes □ Cochlear Implant
□ YES □ NO	**Heart Condition:** □ ***Activity restrictions****:* □ **Medications taken at home***:* *Please explain:*
□ YES ■ NO	**Hypertension (High Blood Pressure):** *Please explain:*
□ YES □ NO	**Juvenile Arthritis/Bone-Joint Problems:** *Please explain:*
□ YES □ NO	**Kidney/ Bladder/ Urinary Problems:** *Please explain:*
□ YES □ NO	**Scoliosis:** □ No Treatment □ Wears Brace □ Surgery □ Family History
□ YES □ NO	**Seizures/Convulsions:** Type of seizure: _____ *Medications:* □ Diastat □ Klonopin □ Versed □ Medication taken at home □ Other _____ *Please explain:*
□ YES □ NO	**Sickle Cell:** □ Anemia □ T**rait**
□ YES □ NO	**Shunt:** □ VP shunt *Please explain:*
□ YES □ NO	**Spina Bifida:**
□ YES □ NO	**Special Diet:** *Please explain:*
□ YES □ NO	**Vision Problems:** □ Wears glasses □ Wears contacts □ Other
□ YES □ NO	**Other Medical Conditions:** *Please include* ***any*** *medications taken at home only****.***

Required Signatures

(Electronic or Written) Parent(s) or Guardian Signature: _____ **Date:**_____

(Electronic or Written) School Nurse Signature: _____ **Date:**_____