# 2019-2020

## Lanett City Schools

## APPLICATION FOR STUDENT ENROLLMENT

PLEASE PRINT — Must be completed by Parent/Legal Guardian — PLEASE PRINT

DATE:_____ SCHOOL: W. O. Lance Elementary _____ 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 CONTACTS: (PLEASE LIST NUMBERS OTHER THAN YOUR OWN)

EMERGENCY CONTACT #1_____ EMERGENCY CONTACT #2 _____

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/GUARDIAN 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.*

# Lanett City Schools
## 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 | • FirstClass 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 |

# Lanett City Schools
## 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 students 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 origina l 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:<br>_____NOT Hispanic/Latino<br>_____Hispanic/Latino | Race - Choose one or more:<br>_____American Indian or Alaska Native<br>_____Asian<br>_____Black or African American<br>_____Native Hawaiian or Other Pacific Islander<br>_____White |
| Date: | Staff Signature: |

W.O. Lance Elementary School
200 South 8th Avenue
Lanett, AL 36863
Phone (334) 644-5915 Fax (334) 644-5926

TO THE PARENTS OR GUARDIANS OF STUDENTS ENROLLING IN LANETT CITY SCHOOLS:

The Lanett City Board of Education is under order from the United States Department of Justice to determine the residence of all students (those who live in Lanett and those outside of the city limits), who enroll in the Lanett City School System.

Phillip Johnson, Superintendent
Lanett City Schools

**********

# AFFIDAVIT

I _____, the parent/legal guardian of

_____ do solemnly state and affirm that my

permanent principal place of residence is at the following address:

_____

Street City State Zip

Further, I solemnly state and affirm that the above named student actually resides at my place of residence.

This document will be made available to investigative officers of the United States Department of Justice.

_____ _____

Date Signature of Parent/Legal Guardian

Routes and Post Office Boxes are not acceptable addresses. Please use road or street numbers or names. Landmarks may be given to pinpoint your area.

_____ This address is inside the Lanett city limits.

_____ This address is outside the Lanett city limits.

We reside in the _____school district.

Rev. 08-01-12

LANETT CITY SCHOOLS
EL PROGRAM
HOME LANGUAGE SURVEY

Name_____Age_____Date_____

School_____Teacher_____Grade_____

Federal and state laws require schools 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.

Please answer the following questions and return the form to the school office. Thank you for your help.

1. Is a language other than English spoken at home?

   Yes _____ No _____

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

   Yes _____ No _____

3. What language did your child learn when he/she first began to talk?

   English _____ Spanish _____ Other _____

4. What language does your child most frequently speak at home?

   English _____ Spanish _____ Other _____

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

   English _____ Spanish _____ Other _____

6. What language is most often spoken by the adults at home?

   English _____ Spanish _____ Other _____

_____
STUDENT'S SIGNATURE (GRADES 5-12)

_____
PARENT'S SIGNATURE (GRADES K-4)

A copy of this document is filed in the student's cumulative folder.

Appendix A

# LANETT CITY SCHOOLS
# RESIDENCY QUESTIONNAIRE

CHOOL: W. O. Lance Elementary Lanett Junior High School Lanett High School GRADE: _____

tudent Name: _____ Male / Female Birth Date: _____

) Where is the student currently living?

____ With only parent(s)/legal guardian(s) and siblings (if any) in a house or apartment

* If you checked the above box, please skip to section 3.**

____ In a shelter

____ With more than one family in a house or apartment

____ In a motel, car, or campsite

____ With friends or family members (other than parent/guardian)

* If you checked one of the last four boxes, please complete sections 2 and 3.**

The student lives with:

___ 1 parent

___ 2 parents

___ 1 parent and another adult

_____ A relative, friend(s) or other adult(s)

_____ Alone with no adult(s)

_____ An adult that is not the parent or the legal guardian

Name of Parent(s)/Legal Guardian(s) _____

Address _____
Street Address City State Zip Code

hone Number: _____

gnature of Parent(s)/Legal Guardian(s)/Person Completing Form _____

School Office: Please send to District Homeless Liaison for review.

_____ Reviewed by District Homeless Liaison

Action Needed/Taken: _____

_____

_____

# 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: _____

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
   - ☐ 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

## HEALTH ASSESSMENT RECORD

School Year: 2019 - 2020

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: 2019 - 2020

Name of Student

Part III – Medical History

| | |
|---|---|
| ☐ YES ☐ NO | KNOWN HEALTH PROBLEMS<br>If NO, go directly to the bottom of the page and provide parent/guardian signature<br>If YES, and diagnosed by a physician, answer each question below. |
| ☐ YES ☐ NO<br>☐ YES ☐ NO | Attention Deficit Disorder (ADD)<br>Attention Deficit Hyperactivity Disorder (ADHD)<br>Requires medication ☐ At school ☐ At Home |
| ☐ YES ☐ NO | Allergies:<br>☐ Food _____ ☐ Hives/rash ☐ Medications<br>☐ Insects _____ ☐ Breathing difficulty ☐ Epi-pen<br>☐ Environmental _____<br>☐ 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<br>☐ 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<br>☐ Insulin pump<br>☐ Glucagon order<br>☐ 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<br>☐ Tubes ☐ Cochlear Implant |
| ☐ YES ☐ NO | Heart Condition: ☐ Activity restrictions: ☐ Medications taken at home:<br>*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: _____<br>*Medications:* ☐ Diastat ☐ Klonopin ☐ Versed ☐ Medication taken at home ☐ Other _____<br>*Please explain:* |
| ☐ YES ☐ NO | Sickle Cell: ☐ Anemia ☐ Trait |
| ☐ 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 <u>any</u> medications taken at home only.* |

## Required Signatures

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

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

# Lanett City Schools
## Medication Procedures Summary

Dear Parents/Guardians,

This letter is to inform you of the requirements of the medication procedures, should your child require Prescription or Over-the-counter (OTC) medications while attending school.

- All medications, whether Prescription or Over-the Counter, must be turned into the school Nurse by the student's parent/ guardian or other responsible adult.
- Medications cannot be transported on the bus (except emergency medications and approved medications prescribed for self-administration).
- No student will be permitted to carry or possess any type of medications, whether Prescription or Over-the-Counter, on his/her person at any time (except emergency medications and approved medications prescribed for self administration).
- Controlled Substances cannot be approved for self administration by a licensed prescriber.
- The parent/guardian must sign a School Medication Physician/Prescriber/Parent Authorization Form before any medication, Prescription or Over-the-Counter, can be administered at school.
- Over-the-Counter medications will require the parent/guardian signature only on the medication authorization form and is valid for the entire school year.
- Prescription medication will require the parent physician/prescriber signature on the authorization form as well as the parent /guardian signature.
- If the Prescription medication order is changed during the school year, a new authorization form is required. Both physician/prescriber and parent/guardian must sign the form.
- For Prescription medications, a current pharmacy labeled container is required which includes the student's name, physician name, name of medication, strength, dosage, time interval, route and date of drug's discontinuation when appropriate.
- For Over-the Counter medications, an unexpired, unopened, age appropriate, original manufacturer's container is required and all manufacturer's labeling must be clearly legible. The student's name must be written on the container.
- The school will not supply any Prescription or Over-the Counter medication to staff or students.
- All unused medications not picked up by the parents/guardians by the last day of each school year will be discarded according to appropriate disposal guidelines.

These medication procedures were developed with your child's safety in mind. If you have any questions concerning these medication procedure's, please contact your school nurse.

_____ _____

Parent Signature Student's Name

# When to Keep a Sick Child Home from School

## KEEP HOME FROM SCHOOL

Seek medical advice if symptoms persist or gets worse.

- Diarrhea
- Vomiting
- Fever, headache, muscle ache, fatigue
- Congestion, cough, runny nose
- Watery eyes, sneezing, with or without sore throat or cough

## SEEK MEDICAL ADVICE

- Temperature over 100.5
- Vomiting that last more than 1 day
- Diarrhea that last more than 1 day
- Coughing that is repeated, that last for weeks and is often accompanied by thick mucus and vomiting
- Stiff neck
- White spots inside of the mouth or back of the throat
- A sore throat in which swallowing hurts
- Skin rash that spreads from the face to the trunk or limbs

**Child should not return to school until they are symptom free for 24 hours without medication**

---

Parent Signature Date

---

Student Name

VACCINE INFORMATION STATEMENT

# Influenza (Flu) Vaccine (Inactivated or Recombinant): *What you need to know*

## 1 Why get vaccinated?

Influenza ("flu") is a contagious disease that spreads around the United States every year, usually between October and May.

Flu is caused by influenza viruses, and is spread mainly by coughing, sneezing, and close contact.

Anyone can get flu. Flu strikes suddenly and can last several days. Symptoms vary by age, but can include:

- fever/chills
- sore throat
- muscle aches
- fatigue
- cough
- headache
- runny or stuffy nose

Flu can also lead to pneumonia and blood infections, and cause diarrhea and seizures in children. If you have a medical condition, such as heart or lung disease, flu can make it worse.

Flu is more dangerous for some people. Infants and young children, people 65 years of age and older, pregnant women, and people with certain health conditions or a weakened immune system are at greatest risk.

Each year thousands of people in the United States die from flu, and many more are hospitalized.

Flu vaccine can:

- keep you from getting flu,
- make flu less severe if you do get it, and
- keep you from spreading flu to your family and other people.

## 2 Inactivated and recombinant flu vaccines

A dose of flu vaccine is recommended every flu season. Children 6 months through 8 years of age may need two doses during the same flu season. Everyone else needs only one dose each flu season.

Some inactivated flu vaccines contain a very small amount of a mercury-based preservative called thimerosal. Studies have not shown thimerosal in vaccines to be harmful, but flu vaccines that do not contain thimerosal are available.

There is no live flu virus in flu shots. They cannot cause the flu.

There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against three or four viruses that are likely to cause disease in the upcoming flu season. But even when the vaccine doesn't exactly match these viruses, it may still provide some protection.

Flu vaccine cannot prevent:

- flu that is caused by a virus not covered by the vaccine, or
- illnesses that look like flu but are not.

It takes about 2 weeks for protection to develop after vaccination, and protection lasts through the flu season.

## 3 Some people should not get this vaccine

Tell the person who is giving you the vaccine:

- If you have any severe, life-threatening allergies. If you ever had a life-threatening allergic reaction after a dose of flu vaccine, or have a severe allergy to any part of this vaccine, you may be advised not to get vaccinated. Most, but not all, types of flu vaccine contain a small amount of egg protein.
- If you ever had Guillain-Barré Syndrome (also called GBS).
  Some people with a history of GBS should not get this vaccine. This should be discussed with your doctor.
- If you are not feeling well.
  It is usually okay to get flu vaccine when you have a mild illness, but you might be asked to come back when you feel better.

## 4 Risks of a vaccine reaction

With any medicine, including vaccines, there is a chance of reactions. These are usually mild and go away on their own, but serious reactions are also possible.

Most people who get a flu shot do not have any problems with it.

Minor problems following a flu shot include:

- soreness, redness, or swelling where the shot was given
- hoarseness
- sore, red or itchy eyes
- cough
- fever
- aches
- headache
- itching
- fatigue

If these problems occur, they usually begin soon after the shot and last 1 or 2 days.

More serious problems following a flu shot can include the following:

- There may be a small increased risk of Guillain-Barré Syndrome (GBS) after inactivated flu vaccine. This risk has been estimated at 1 or 2 additional cases per million people vaccinated. This is much lower than the risk of severe complications from flu, which can be prevented by flu vaccine.
- Young children who get the flu shot along with pneumococcal vaccine (PCV13) and/or DTaP vaccine at the same time might be slightly more likely to have a seizure caused by fever. Ask your doctor for more information. Tell your doctor if a child who is getting flu vaccine has ever had a seizure.

Problems that could happen after any injected vaccine:

- People sometimes faint after a medical procedure, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting, and injuries caused by a fall. Tell your doctor if you feel dizzy, or have vision changes or ringing in the ears.
- Some people get severe pain in the shoulder and have difficulty moving the arm where a shot was given. This happens very rarely.
- Any medication can cause a severe allergic reaction. Such reactions from a vaccine are very rare, estimated at about 1 in a million doses, and would happen within a few minutes to a few hours after the vaccination.

As with any medicine, there is a very remote chance of a vaccine causing a serious injury or death.

The safety of vaccines is always being monitored. For more information, visit: www.cdc.gov/vaccinesafety/

## 5 What if there is a serious reaction?

What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or unusual behavior.

  Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a severe allergic reaction or other emergency that can't wait, call 9-1-1 and get the person to the nearest hospital. Otherwise, call your doctor.
- Reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor should file this report, or you can do it yourself through the VAERS web site at www.vaers.hhs.gov, or by calling 1-800-822-7967.

*VAERS does not give medical advice.*

## 6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling 1-800-338-2382 or visiting the VICP website at www.hrsa.gov/vaccinecompensation. There is a time limit to file a claim for compensation.

## 7 How can I learn more?

- Ask your healthcare provider. He or she can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call 1-800-232-4636 (1-800-CDC-INFO) or
  - Visit CDC's website at www.cdc.gov/flu



08/07/2015

42 U.S.C. § 300aa-26

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