# Volunteer Pre-K Registration Process

## Registration Process

- **Children must be 4 years on or by August 15, 2020**
- Applications will be accepted at Clinton City Schools Central Office
- Pre-K IS NOT filled on a first-come/first-serve basis. Placement is based on highest need.
- Parents will be notified if their child is accepted into Pre-K before the third week of July.
- Parents need to prepare for an alternative day care arrangement in the event that your child does not receive a placement.
- All students will be kept on a waiting list. As positions become available throughout the school year, slots will be filled from this list. This list is based on need, not first-come/first-serve.
- Income eligible students will receive priority placement.

## Items to Bring for Registration (at the time the application is turned in)

- Proof of Residency (current CUB bill, lease, etc.)
- Proof of Income or case number verification for WIC or SNAP benefits
  - Tax returns or 12 consecutive pay stubs
- Certified Copy of Birth Certificate
- Up-to Date Shot Record
- Social Security Card
- Custody Papers (if applicable)
- Physical Exam (Upon enrollment)

******If you need help in completing these forms please contact Lori Collins at 865 457-0159 for assistance.*****

Department of **Education**

| For Office Use Only |
|---|
| Please Circle One<br>Income Eligible: Yes / No |
| If yes, and enrolled, student should be classified as (L) in student information system |

## 2020-21

## Application to Determine Income Eligibility for the Voluntary Pre-K Program

**Completion of this form DOES NOT qualify your child for the Free or Reduced Meal Program. Submission of this application is not a guarantee of acceptance into the VPK program.**

Name of Student: ______________________ Date of Application: ______________

SSN of Student: ______________________ Date of Birth of Student: ______________

Name of Applicant: ______________________ Relationship to Student: ______________

Mailing Address: ____________________________________________

City: ______________ State: ______________ Zip Code: ______________

Home Phone #: ( ) ______________ Work Phone #: ( ) ______________ Cell Phone #: ( ) ______________

## Part A - Family Information

**Please list information for all other household members**

**Section 1**

| | Name(s) of ALL OTHER CHILDREN in the Household | Date of Birth | School | Grade |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |

**Section 2**

| | Name(s) of ALL OTHER ADULTS in the Household | Relationship to Student |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |

**Total # of household members:** ______________

## Part B - Program Participation

**Please check (√) if Child /Family /Household member provides documentation of participation, in one or more of the following programs, currently or during past school year (*Documentation required-See Part D).**

| (√) | | (√) | | (√) | | (√) | | Case # |
|---|---|---|---|---|---|---|---|---|
| | Early Head Start | | Foster Care | | Migrant | | Families First (TANF) | |
| | Head Start | | Homeless | | Food Stamps / EBT | | | |
| | | | | | | | | |

***If submitting proof of qualifying for any of the above programs, you do NOT need to complete Part C.**

## Part C - Total Household Income

**Please list ALL INCOME of all household family members and how often income is received.**

Any falsification of information concerning income, residence, birth certificate and/or completion of this application and other forms may be reason for dismissal.

Income Instructions

From the list below, please write the Source of Income Code in the space provided to indicate the source(s) of income for each earning individual in the household. Also, please write the Monthly Payment or Wage Amount. Multiply the Payment or Wage amount by the number months you received the income and then calculate the Amount and the Total Annual Income.

| Source of Income Codes | | | | | | | |
|---|---|---|---|---|---|---|---|
| A. | GROSS work income | D. | Pension(s) | G. | Veteran's Benefits | J. | SSI Disability |
| B. | Unemployment | E. | Retirement | H. | Child Support | K. | Other - please list ↓ |
| C. | Workman's Comp | F. | Social Security | I. | Alimony | | |

| Name of Adult | Employer (if applicable) | Source of Income Code (See list above) | Monthly Payment or Wage Amount | Multiplied by (X) | How many months did you receive this income in the last year? | Total Amount |
|---|---|---|---|---|---|---|
| | | | $ - | X | | $ - |
| | | | $ - | X | | $ - |
| | | | $ - | X | | $ - |
| | | | $ - | X | | $ - |
| | | | $ - | X | | $ - |
| | | | | | Total Annual (Yearly) Income | $ - |

## Part D - INCOME VERIFICATION

| Please check (√) all documents submitted as Proof of Income or Program Participation. | | | | | |
|---|---|---|---|---|---|
| | Pay Stub / Verification of pay by employer | | Retirement Documentation | | Foster Care Reimbursement |
| | W-2 Form | | Social Security | | SSI Documentation |
| | Income Tax Form 1040A or 1040 | | Veteran's Benefit Letter | | TANF Documentation |
| | Unemployment Compensation | | Child Support | | AFDC / Public Assistance Payment |
| | Workman's Compensation Documentation | | Alimony Documentation | | TennCare Verification |
| | Pension Stubs | | Other (Specify): → | | |

**I certify that the above information in this application is correct. I further understand that any falsification of information concerning income, residence, birth certificate and/or completion of this application and other forms may be reason for dismissal from Tennessee's Voluntary Pre-K Program.**

Printed Name of Applicant: ______________________ SSN #: ______________

Signature of Applicant: ______________________ Date: ______________

Name and Signature of LEA employee reviewing this application

**I certify that I have examined the above income documentation and verification information. Completed forms must be maintained in accordance with FERPA.**

Printed Name / Title of LEA employee: ______________________

Signature of LEA employee: ______________________

Date Reviewed by LEA employee: ______________________

## Clinton City Schools
## Voluntary Pre-Kindergarten
## Application

DATE: ___/___/____

PUPIL'S LEGAL NAME ________________________ PREFERRED NAME ______________
LAST FIRST MIDDLE

Birth Date ___/ ___/ ____(Must be 4 years old on or before August 15)

Gender: ___ Male ___ Female

Race: (Mark all that apply) ___ Asian ___Black ___ White ___ Native American ___ Other

PUPIL'S PRIMARY ADDRESS ______________________
______________________

PRIMARY PHONE (____) ___________ SECOND PHONE (____) ___________

What is the first language this child learned to speak? ___ English ________ Other
What language does this child speak most often outside of school? __________
What language do people usually speak in this child's home? ______________

| PUPIL'S LEGAL GUARDIAN | 2ND LEGAL GUARDIAN |
|---|---|
| Name ______________________<br>Address______________________<br>Relationship to child ______________<br>(Own, Step, Foster, other)<br>Date of Birth ___/___/____ Race ___________<br>Highest level of education __HS diploma __ GED<br>____Tech School__Some College __AA/AS __BA/BS<br>__MA __DR<br>Employer ______________________<br>Work Phone (___) ___________<br>Email ______________________ | Name ______________________<br>Address______________________<br>Relationship to child ______________<br>(Own, Step, Foster, other)<br>Date of Birth ___/___/____ Race ___________<br>Highest level of education __HS diploma __ GED<br>__Some College __AA/AS __BA/BS __MA __DR<br>Employer ______________________<br>Work Phone (___) ___________<br>Email ______________________ |

**If there are custody arrangements that will affect the school, we must have a copy of the legal documentation stating those arrangements. If either parent is not permitted to pick up the child, the school must have legal documentation restricting that parent's right to the child.**

DO NOT Release my child to the following people:

| Last Name | First Name | Relationship |
|---|---|---|
| | | |
| | | |
| | | |

Please list 3 names and phone numbers of people to notify in the event of an emergency.

| Emergency Contact Name | Phone Number | Relationship to child |
|---|---|---|
| | (____) __________ | |
| | (____) __________ | |
| | (____) __________ | |

**Within the last two years, has your child been served by:**
An Individual Education Plan (IEP/IFSP) ____ 504 Plan ____ Early Head Start ____ A Speech Program ___
Other ____ If yes to any of the above, please provide explanation or documentation.

______________________________________________________________________

## FAMILY INFORMATION

Child lives with: Both parents___ One Parent___ Other (specify) ____________
Current Daycare (home, daycare, sitter, relative) ________________________
Is your child the dependent of an active duty military member? ___Y ___N
If a recent death of a close family member has occurred, please list relationship to child: ________________
Has family been homeless in the last 12 months (living in car, shelter, motel, campground, been evicted from housing)? __Y ___N
Check any of the following events which have occurred in your immediate family during the past 2 years:

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Death of Spouse | | Military Service | | Marriage | | Retirement | | Birth |
| | Substance Abuse | | Marital separation | | Divorce | | House fire | | Family moved |
| | Personal Injury | | Domestic violence | | Job Loss | | Jail Term | | Serious illness |

## BROTHERS AND SISTERS

| NAME | SEX | DATE OF BIRTH | SCHOOL | GRADE LEVEL | Does this child live in the home? Y/N | Did this child attend Clinton City Pre-K? Y/N |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

| Name(s) of ALL OTHER ADULTS in the Household | | Relationship to Child |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |

Total # of household members: _______

- I understand that submission of this application does not guarantee my child a spot into the Clinton City Pre-K Program.
- **NON-DISCRIMINATION POLICY**: No child will be discriminated against because of race, sex, color, national origin, religion, or disability.
- **STATEMENT OF CONFIDENTIALITY**: Any information shared with the school or your child's teacher will be kept confidential. This, and all information pertaining to students, will be kept in locked files.

I certify that all of the above information is true and correct. I certify that I am the legal custodian/legal guardian/legal parent of the child identified on this enrollment form.

**PARENT/LEGAL GUARDIAN SIGNATURE** ______________________________ **DATE**__________

# DEVELOPMENTAL AND FAMILY HISTORY

Child's Name________________________________ Today's Date________________

How did you hear about Clinton City Pre-Kindergarten?

Relative or friend____ Newspaper____ Other Agency____ Other ______________________

## PREGNANCY AND BIRTH HISTORY

Did mother have any health problems during pregnancy or delivery? Y___ N___ If yes, mark those that apply: ____Toxemia ____ Diabetes ____ Premature Labor ___ C-Section ___ Other Complications

Please explain_____________________________________________________________

Use of: ___Tobacco ____Alcohol ____Drugs Please explain___________________________

Did you child have any health problems during the first year? ___Y ___N If yes, make those that apply:

___Birth Injury ____Non-responsive ____Failure-to-Thrive ____Breathing Problems

___Feeding Problems ____Premature Birth ____Other Please Explain_______________________________

## CHILD'S HEALTH AND MEDICAL INFORMATION

Has your child ever been hospitalized? ____Y ____N If yes, please explain_______________________________

_____________________________________________________________________________

Does your child have any chronic medical/health problems? ____Y ____N If yes, mark that that apply:

___Chronic Ear Infections ___Sore Throats ___Urinary Infection ___High Temperatures

___Skin Disease ___Digestive Disorder ___Asthma ___Diabetes ___Rheumatic Fever ___ADD/ADHD

___Other________________ Please explain_________________________________________

_____________________________________________________________________________

Does your child have a diagnosed or suspected mental illness or developmental delay? ___Y ___N

If yes, please explain: Diagnosis____________________ Treatment___________________

Doctor/Therapist____________________

Does your child have allergies? ___Y ___N If yes, please explain:

Allergen__________Reaction__________ Allergen__________Reaction___________

Allergen__________Reaction__________ Allergen__________Reaction___________

Has your child ever had a seizure? ___Y ___N If yes, please explain_________________________________

Does your child have difficulty hearing? ___Y ____N If yes, please explain ______________________________

Does your child have difficulty seeing? ___Y ____N If yes, please explain______________________________

Does your child have difficulty speaking? ___Y ___N If yes, please explain______________________________

Does your child take any regular medications? ___Y ___N

What medication? ______________________ Will s/he be taking them at home or at school? ________

## CHILD'S PHYSICAL, PSCHOLOGICAL, AND SOCIAL DEVELOPMENT

### PHYSICAL DEVELOPMENT

At what age did you child: Crawl ____ Walk____ Talk____ Dress Self with Help___ Dress Self Alone___

### SLEEP HABITS

Does your child have a regular bedtime? ___Y ____N

At what time does your child go to bed? _____ What time does s/he wake? _____ Does s/he nap ___Y __N

### EATING

Do you have any nutritional concerns? ___Y ___N If yes, please explain______________________________

Has a doctor prescribed any dietary restrictions for your child? ___Y ___N

If yes, please explain______________________________________________________________________

### TOILETING

Is your child toilet trained? ___Y ___N Does s/he need assistance? ___Y ___N

### BEHAVIOR

Does your child exhibit any of the following behaviors on a regular basis (aside from occasional incidents)?

| | YES | NO | EXPLANATION |
|---|---|---|---|
| Aggressiveness | | | |
| Resistance to Authority | | | |
| Tantrums | | | |
| Destructiveness | | | |
| Hyperactivity | | | |
| Short attention span | | | |
| Daydream | | | |
| Discipline | | | |
| Nervousness | | | |
| Depression/Sadness | | | |
| Fears/Anxiety | | | |
| Frequent crying | | | |
| Difficulty getting along with others | | | |
| Difficulty expressing himself | | | |

Is there any additional information you would like us to know about your child?

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

CLINTON CITY SCHOOL SYSTEM

212 NORTH HICKS STREET, CLINTON TN 37716 · (865) 457-0159 FAX · (865) 463-0668

# RECORDS REQUEST

______________________________________________

**Principal's Name** (school moving from)

______________________________________________

**Name of School** (school moving from)

______________________________________________

**Street**

______________________________________________

**City** **State** **Zip Code**

______________________________________________

**Student's Name** **Birth Date** **Grade Level**

**The above referenced student has enrolled in the Clinton City School System. Please forward copies of all pertinent school records including, but not limited to:**

- **Cumulative Record information**
- **Test scores**
- **Attendance**
- **Special Education Records (IEP, Psychological, Counseling)**
- **RTI information/Data points**

**Please forward to:**

**Clinton City Schools**
**Attn: Lori Smith**
**Student Services**
**212 North Hicks Street**
**Clinton, Tennessee 37716**

**I do hereby authorize the Clinton City Schools to request all pertinent school records in accordance with the policy of said organization for the purpose of determining proper educational placement of my child. I hereby release the Clinton City Schools from all liability that may arise from the release of the information obtained.**

______________________ ______________________________

Date Signature of Parent or Guardian

Clinton City
SCHOOLS

TRADITION OF EXCELLENCE

# Home Language Survey

## Grades Pre-K -6

Name of Child:________________________ Date of Birth: ______________

Address: ________________________ Telephone Number: ______________

School:________________________ Grade: ______________

Country of Birth: ________________________________________

Date first enrolled in ANY U.S. School: ______________ Date first entered U.S. ______________

## Questions for Parents/Guardians

1. What is the first language this child learned to speak? ______________
2. What language does this child speak most often outside of home? ______________
3. What language do people usually speak in this child's home? ______________
4. Has this child ever received ELL (ESL) classes in another school? ______________
5. Will you require an interpreter/translator at Parent/Teacher meetings? ______________

If yes, what language? ________________________________________

Parent/Guardian Signature: ________________________ Date: ______________

*A copy of this form is to be kept in the student's permanent/cumulative file.*

# Tennessee Migrant Education Program – Occupational Survey

Your child may qualify to receive **free** educational services. Please answer the following questions to help us determine their eligibility. Once completed, return this form to the school.

| STUDENT FIRST NAME: | STUDENT LAST NAME: | DATE: |
|---|---|---|
| SCHOOL: | | GRADE: |
| PARENT/GUARDIAN NAME: | | |

**1) In the past three years, has your family moved to another city, state, and/or county?**

☐ Yes ☐ No

**2) Do you or anyone in your immediate family currently work or have worked (in the past three years) in any of the following occupations?**

☐ Yes ☐ No

**a. If yes, please circle all that apply:**

**Processing & Packing** (fruit, vegetables, chicken, eggs, pork, beef, etc.)

**Agriculture/Field Work** (planting, picking, and sorting crops; soil preparation; irrigation; fumigation; etc.)

**Dairy/Cattle Raising** (feeding, milking, rounding up, etc.)

**Nursery/Greenhouse** (planting, potting, pruning, watering, etc.)

**Forestry** (soil preparation, planting, growing, cutting trees, etc.)

**Fishing/Fish Processing** (catching, sorting, packing, transporting fish, etc.)

*If you answered "yes" to the questions above, please continue. Otherwise, your form is complete.*

**3) How long have you been in this county in Tennessee?**

| WEEKS: | MONTHS: | YEARS: |
|---|---|---|

| HOME ADDRESS: | | |
|---|---|---|
| CITY: | STATE: | ZIP: |
| TELEPHONE (WITH AREA CODE): | | |

| **For school use only:** If questions 1 and 2 are "yes," please send the survey to your district migrant liaison. If you have questions, call (931) 212-9539 to speak with the Tennessee Migrant Education Program. | | |
|---|---|---|
| School District: | Student State ID: | Enrollment Date: |

This project is funded under a Grant Contract with the State of Tennessee

VACCINE INFORMATION STATEMENT

# Meningococcal ACWY Vaccines—MenACWY and MPSV4: *What You Need to Know*

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de Información Sobre Vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

## 1 Why get vaccinated?

Meningococcal disease is a serious illness caused by a type of bacteria called *Neisseria meningitidis*. It can lead to meningitis (infection of the lining of the brain and spinal cord) and infections of the blood. Meningococcal disease often occurs without warning—even among people who are otherwise healthy.

Meningococcal disease can spread from person to person through close contact (coughing or kissing) or lengthy contact, especially among people living in the same household.

There are at least 12 types of *N. meningitidis*, called "serogroups." Serogroups A, B, C, W, and Y cause most meningococcal disease.

Anyone can get meningococcal disease but certain people are at increased risk, including:
- Infants younger than one year old
- Adolescents and young adults 16 through 23 years old
- People with certain medical conditions that affect the immune system
- Microbiologists who routinely work with isolates of *N. meningitidis*
- People at risk because of an outbreak in their community

Even when it is treated, meningococcal disease kills 10 to 15 infected people out of 100. And of those who survive, about 10 to 20 out of every 100 will suffer disabilities such as hearing loss, brain damage, kidney damage, amputations, nervous system problems, or severe scars from skin grafts.

**Meningococcal ACWY** vaccines can help prevent meningococcal disease caused by serogroups A, C, W, and Y. A different meningococcal vaccine is available to help protect against serogroup B.

## 2 Meningococcal ACWY Vaccines

There are two kinds of meningococcal vaccines licensed by the Food and Drug Administration (FDA) for protection against serogroups A, C, W, and Y: meningococcal conjugate vaccine (**MenACWY**) and meningococcal polysaccharide vaccine (**MPSV4**).

Two doses of MenACWY are routinely recommended for adolescents 11 through 18 years old: the first dose at 11 or 12 years old, with a booster dose at age 16. Some adolescents, including those with HIV, should get additional doses. Ask your health care provider for more information.

In addition to routine vaccination for adolescents, MenACWY vaccine is also recommended for certain groups of people:
- People at risk because of a serogroup A, C, W, or Y meningococcal disease outbreak
- Anyone whose spleen is damaged or has been removed
- Anyone with a rare immune system condition called "persistent complement component deficiency"
- Anyone taking a drug called eculizumab (also called Soliris®)
- Microbiologists who routinely work with isolates of *N. meningitidis*
- Anyone traveling to, or living in, a part of the world where meningococcal disease is common, such as parts of Africa
- College freshmen living in dormitories
- U.S. military recruits

Children between 2 and 23 months old, and people with certain medical conditions need multiple doses for adequate protection. Ask your health care provider about the number and timing of doses, and the need for booster doses.

**MenACWY** is the preferred vaccine for people in these groups who are 2 months through 55 years old, have received MenACWY previously, or anticipate requiring multiple doses.

**MPSV4** is recommended for adults older than 55 who anticipate requiring only a single dose (travelers, or during community outbreaks).

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

## 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 have ever had a life-threatening allergic reaction after a previous dose of meningococcal ACWY vaccine, or if you have a severe allergy to any part of this vaccine, you should not get this vaccine. Your provider can tell you about the vaccine's ingredients.

- **If you are pregnant or breastfeeding.**

  There is not very much information about the potential risks of this vaccine for a pregnant woman or breastfeeding mother. It should be used during pregnancy only if clearly needed.

If you have a mild illness, such as a cold, you can probably get the vaccine today. If you are moderately or severely ill, you should probably wait until you recover. Your doctor can advise you.

## 4 Risks of a vaccine reaction

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

As many as half of the people who get meningococcal ACWY vaccine have **mild problems** following vaccination, such as redness or soreness where the shot was given. If these problems occur, they usually last for 1 or 2 days. They are more common after MenACWY than after MPSV4.

A small percentage of people who receive the vaccine develop a mild fever.

### 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—usually within 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 to the nearest hospital. Otherwise, call your doctor.
- Afterward, the reaction 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 health care 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/vaccines**

Vaccine Information Statement
Meningococcal ACWY Vaccines

03/31/2016

42 U.S.C. § 300aa-26

Office Use Only