



STUDENT INFORMATION FORM

School	_____
Teacher	_____
Transfer	_____
Zone Exception	_____
Medical Alert	_____
Allergy	_____
EpiPen	_____

Student's Legal Name: _____
(Last) (First) (Middle)

Student's Preferred Name: _____ Gender: Male Female

Student's Social Security Number: _____ - _____ - _____
 Has your child ever attended Clinton City Schools? Yes No

Home Address: _____ Apt. _____

City: _____ State: _____ Zip: _____ County: _____

Mailing Address: _____ Apt.: _____
(If different)

City: _____ State: _____ Zip: _____ County: _____

Birthday (mm/dd/yyyy): _____ Registering for Grade: _____

Please choose one of the ethnic codes: Non-Hispanic Hispanic

Race: (Check all that apply):

- | | | |
|---|--------------------------------|---|
| <input type="checkbox"/> American Indian/Alaskan Native | <input type="checkbox"/> Asian | <input type="checkbox"/> Black/African American |
| <input type="checkbox"/> Native Hawaiian/Pacific Islander | <input type="checkbox"/> White | |

Home Language: _____ Translator Needed: Yes No

EMERGENCY CONTACTS

Please list phone numbers below where we can reach you during the hours of 7:30 AM until 4:00 PM.

Parent/Guardian <i>Person with whom the student is living</i>	Parent/Guardian <i>Can this parent be called to pick child up? Yes / No</i>
Name: _____	Name: _____
Relationship: _____ Custody: Yes / No	Relationship: _____ Custody: Yes / No
Address: _____ <small>(mailings will go to this address)</small>	Address: _____ <small>(if different from student)</small>
Driver's License Number: _____	Driver's License Number: _____
State Issued: _____	State Issued: _____
Home Phone: _____	Home Phone: _____
Cell Phone: _____	Cell Phone: _____
Employer: _____	Employer: _____
Work Phone: _____	Work Phone: _____
E-mail Address: _____	E-mail Address: _____

Parents must provide school with appropriate legal documentation from judicial system regarding divorce/custody restrictions and Orders of Protection.

Emergency Contacts (List in order to be contacted if parent or legal guardian cannot be reached.)
 Please be advised that by listing these individuals you are giving permission for the school to share emergency information regarding your child.

	Name	Relationship	Phone Number	May Pick Child Up
1.				
2.				
3.				

EMERGENCY INFORMATION

Medical Alert: List any Doctor diagnosed information that pertains to the health of your child that would be helpful for the school to know: (allergies, asthma, ADHD, Diabetes, heart condition, vision or hearing impairment, etc.)

Documentation must be provided to the school to support this diagnosis.

List any food items that your child is allergic to and the reaction it causes (Documentation required from Physician):

List any plant, vegetation or insect your child is allergic to and the reaction it causes (Documentation required from Physician): _____

List any medications your child is allergic to and the reaction it causes (Documentation required from Physician):

EpiPen prescribed: No _____ Yes _____

Albuterol Inhaler: No _____ Yes _____

Medical Conditions or Physical Limitations (Documentation required from Physician): _____

Medication(s): _____ Administered at Home / School / Both: (Circle one)

Doctor: _____ Telephone Number: _____

Hospital Preferred: _____

*Clinton City Schools cannot administer prescription or over-the-counter medication without prior written doctor approval. If your child takes medication at school, please obtain the appropriate form at your child's school or on the district website. *

Within the last two years has your child been served by:

Individual Education Program (IEP):

Speech/Language _____

Inclusion/Resource _____

CDC Placement _____

Other Support Services:

EL Program (English Learner) _____

504 Plan _____

Individual Health Plan _____

If yes to any of the above, please provide explanation or documentation. _____

Is your child currently under Discipline Action (suspension/expulsion) in another school system? ____ Yes ____ No

If yes explain: _____

Additional information you feel is relevant to the enrollment and services for your child. _____

List all brothers or sisters attending school:

- 1. _____ Grade _____ School _____
- 2. _____ Grade _____ School _____
- 3. _____ Grade _____ School _____
- 4. _____ Grade _____ School _____
- 5. _____ Grade _____ School _____

In order to attend Clinton City Schools a student must be a legal resident of Clinton or have been approved for a Transfer. Legal residence is defined as living with a legal custodial parent or legal guardian who is domiciled in Clinton. If the parent or legal guardian moves out of the Clinton city limits during the school year, a Transfer Request Form must be completed and submitted to the Director of Schools. Parents/guardians must notify Central Office immediately upon a change in residence.

Clinton City Schools utilizes an automated notification system to inform parents/guardians of important school and district information (i.e. school closures/delays, security alerts, school activities, etc.) The Telephone Communications Protection Act requires written permission to receive automated calls and SMS text messages on mobile device(s).

By providing a phone number below, you are giving CCS permission to contact you via the automated phone system.

Telephone Number: _____

I certify that all of the above information is true and correct and I understand that deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws. I certify that I am the parent or legal guardian of the child identified on this enrollment form. I further understand that the school must have permission from a parent or legal guardian for anyone including the individuals listed on this form to check a student out of school. I understand that Clinton City Schools participates in the state mandated assessment program, and my child will be participating as required.

Name of Parent/Guardians: _____

Signature of Parent/Legal Guardians: _____

Date of Application: _____

OTHER INFORMATION

What is the first language your child learned to speak? English _____ Other (specify) _____

What language does your child speak most often outside of school? _____

What language do people usually speak in your child's home? _____

US Entry Date _____ US School Entry Date _____

Where does your child stay at night? (Please check one)

Home/apartment owned or rented by the parent(s)/guardian(s)? _____

Are you temporarily living with another family member or friend? _____

Do you qualify as a migrant worker? _____ Yes _____ No

Is this child currently in Foster Care? _____ Yes _____ No

Additional Information: _____

FOR OFFICE USE ONLY

Code Entered: _____ Withdrawn Code: _____

Date: _____ Date: _____

Previous School: _____ New School: _____

Date Received: _____

Time Received: _____

Initials of Person Receiving Form: _____

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:
------------------	-------------------	------------------

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).



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

