School Year _____ TROY CITY SCHOOLS ☐ Please check if this is a new address

Residency Affidavit Form

Grade _____ This registration form should not be considered a barrier to enrollment

I. STUDENT INFORMATION: DATE: _____

Full Legal Name of Child _____ Male_____ Female_____

Race: Black____ White____ Asian____ American Indian/ Alaskan Native____ Not Specified (Hispanic Students Only)____ Pacific Islander____ Multi Race____

Birth Date: _____ (Voluntary) Birthplace: _____

*Child's Social Security # _____ (Voluntary) Home Telephone #_____

Complete Mailing Address _____

_____

Parent/Guardian E-mail Address: _____Student's E-mail Address: _____

Parent/Guardian Cell Number: _____ Parent/Guardian Cell Number: _____

The following individuals have permission to check-out this student.

Emergency Name: _____ Emergency Number: _____

II. FAMILY INFORMATION:

Child Lives With: Father____ Step-Father____ Mother____ Step-Mother____ Legal Guardian____ Foster Care____
(Check all that apply)

Father, Step-Father, Mother, Step-Mother, Legal Guardian, Foster Care (Circle One)

Guardian's Name_____
Work Place_____
Phone #_____

Father, Step-Father, Mother, Step-Mother, Legal Guardian, Foster Care (Circle One)

Guardian's Name_____
Work Place_____
Phone # _____

III. TRANSFER INFORMATION:

Transferring From: Name of School _____ School Phone # _____
Was your child in any Exception Child programs (special education/gifted education)? If Yes, Please List _____

Has your Child Previously Attended Troy City Schools? Yes____ No ____ When? _____
Has your Child Been Retained? Yes____ No ____ What Grade? _____

IV. I certify that I have the responsibility of providing for the needs of this student and that I am in charge and control of his/her actions.

_____ _____
PARENT/LEGAL GUARDIAN/FOSTER CARE SIGNATURE **DATE**

***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.**

V. MEDICAL HISTORY:

1. List all current medical problems (allergies, diabetes, etc.)_____

_____

2. Does your child take any medication? Please list all prescriptive and non-prescriptive drugs he/she takes _____

_____

3. Is he/she allergic to any medication? _____

4. Please include any additional information you feel would be helpful to the school nurse and other personnel._____

_____

VI. STATE OF ALABAMA
COUNTY OF PIKE

RESIDENCY AFFIDAVIT UNDER OATH

I, _____, am the _____of
Parent/Legal Guardian/Foster Care **(Print Full Name)** Mother, Father, Legal Guardian, Foster Care

CHILD'S FULL NAME **SCHOOL ATTENDING** **GRADE LEVEL**

_____ _____ _____

Do hereby certify, under oath that our residence and domicile is presently within the city limits of the City of Troy, Pike County, Alabama; that we have our permanent address in the city limits of the City of Troy, Pike County, Alabama; and that said permanent address is

---

I further certify, under penalty of perjury, that my child spends weekdays, weeknights, and weekends at the above permanent address, and that I have notified the District if my child spends nights during the week or weekends outside of the Troy City Limits with any regularity.
I understand that the purpose of this affidavit is to induce the Troy City Board of Education to allow my/our child to attend the public schools in the City of Troy, Alabama. I further consent and agree that the Troy City Board of Education shall have the right to verify this affidavit as to our residence and that this affidavit may be submitted to a Federal Court or other authority as proof of our residence, and I consent to the use of this affidavit by the Troy City Board of Education as proof of our residence. I understand fully and completely that the execution of a false affidavit will result in the removal of my/our child from school rolls.

I further hereby agree that if there is any change whatsoever in my residence or in the residence of the above named child, I will notify the Troy City Board of Education immediately and will sign a new affidavit stating the correct residence. Failure to report a change will result in the withdrawal of your child.

Sworn to and subscribed before me this _____day of _____, 20_____

_____ _____

Notary Public **Parent/Legal Guardian/Foster Care Signature**

Troy City Schools
HOME LANGUAGE SURVEY

_____ _____

Date School

Schools are required 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.

Your cooperation in helping us meet this important requirement is requested. Please answer the following questions and have your child return this form to his/her teacher.

Thank you for your help.

Name of student: _____

Last First Middle

Grade: _____ **Age:** _____

1. Which language did your son or daughter learn when he or she first began to talk?

   _____

2. What language does your son or daughter most frequently use at home?

   _____

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

   _____

4. Name the language most often spoken by the adults at home.

   _____

_____

Signature of Parent or Guardian

ALABAMA STATE DEPARTMENT OF EDUCATION

Parent Survey

for Newly Enrolled Students

SCHOOL SYSTEM
SCHOOL NAME

DIRECTIONS

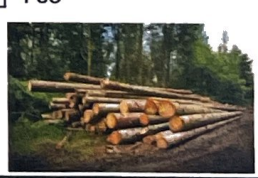
Please complete the following survey. Your child may be eligible for FREE additional educational services. If you answer yes to any of the questions below, an education representative may contact you to find out whether you, your child, or any member of your family is eligible for the migrant education program. All information will be kept confidential.

Please return the completed questionnaire to your child's school.

RELOCATION HISTORY

Have you ever traveled in or out of Alabama to work or find work in any of the pictures below in the past three (3) years?	☐ Yes	☐ No
Are you or your spouse currently working in agriculture, farming, fishing or any of the pictures below?	☐ Yes	☐ No
Mark all pictures of agriculture, farming, or fishing where you have worked in the past 3 years. See pictures below.	☐ Yes	☐ No

Other work you have done that is not shown in a picture below: _____

Fruit or Tomato Farms ☐ Yes 	Fish or Shrimp Farms ☐ Yes 	Nursery, greenhouse, sod farm ☐ Yes 	Planting / Harvesting Crops ☐ Yes 
Cattle Farms; Milk Products ☐ Yes 	Hatchery; feeding, processing chickens, gathering eggs ☐ Yes 	Working on a worm farm ☐ Yes 	Growing, tending, felling trees ☐ Yes 

PARENT INFORMATION

PARENT / GUARDIAN

ADDRESS	CITY	STATE	ZIP
PHONE NUMBER	PLACE OF EMPLOYMENT		
NUMBER OF CHILDREN IN HOME		DATE OF MOVE	

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 strictly confidential.

To be completed by parent/guardian.

PLEASE PRINT. Return to the School Nurse.

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

Address (Street)	Race/Ethnicity	
	☐ American Indian	☐ White, not of Hispanic origin
(City and Zip code)	☐ Asian	☐ Hispanic/Latino
	☐ Black, not of Hispanic origin	☐ Other

Home Telephone Number	Cell Telephone Number	School	Grade

Name of Parent/Guardian (Last, First, Middle)

Transportation

☐ Bus Rider ☐ Car Rider ☐ Special Needs Bus ☐ After School Program

Part I – Health Information

Place where your child receives regular health care:
- ☐ Health Department
- ☐ Hospital Clinic
- ☐ Community Health Center
- ☐ Private Doctor/HMO
- ☐ Other _____
- ☐ No regular place

Physician's Name: _____

Address: _____

_____

Tel: _____

Place where your child receives regular dental care:
- ☐ Health Department
- ☐ Hospital Clinic
- ☐ Community Health Center
- ☐ Private Doctor/HMO
- ☐ Other _____
- ☐ No regular place

Dentist's Name: _____

Address: _____

_____

Tel: _____

Type of Insurance your child has:
- ☐ Medicaid
- ☐ No Insurance
- ☐ Private Insurance
- ☐ ALLKIDS
- ☐ Other:

_____

Authorizations:

☐ **I authorize the school nurse, the registered nurse (RN) or licensed practical nurse (LPN), to talk with the physician(s) should a question come up about my child's medical conditions.**

☐ **I do NOT authorize the school nurse, the RN or LPN, to talk with the physician(s) should a question come up about my child's medical conditions.**

☐ **I authorize for my child to participate in all school health screenings, such as vision, hearing and scoliosis.**

☐ **I authorize the yearly review of my child's Certificate of Immunization (Blue Slip) by the local Public Health Department.**

FOR OFFICE USE ONLY Acuity Scale:			
Level A Nursing Dependent	Level B Medically Fragile	Level C Medically Complex	Level D Health Concerns

State of Alabama Department of Education
Health Assessment Record
School Year: _____ - _____

Part II – Medical History

☐ **NO KNOWN HEALTH PROBLEMS**

(If no, please go directly to the bottom of the page and provide parent/guardian signature.)

☐Attention Deficit Disorder (ADD) OR ☐ Attention Deficit Hyperactivity Disorder (ADHD)	☐Requires medication? *(Requires medication authorization from physician)* ☐To be given while at school?
☐Allergies: *Please Specify :* ☐ Food _____ ☐ Insects _____ ☐ Environmental _____ ☐ Medications _____	☐Hives/rash? ☐Breathing difficulty? ☐Epi-pen? *(Requires medication authorization from physician)*
☐Asthma:	☐He/She uses an inhaler at school?*(Requires authorization from physician)* ☐He/She uses an inhaler at home?
☐Bleeding Problems: (Hemophilia, Von Willebrand's, frequent nosebleeds)	☐Requires medication? Please explain: *(Requires medication authorization from physician)*
☐Cancer/Leukemia:	Please explain:
☐Cerebral Palsy:	Please explain:
☐Cystic Fibrosis:	Please explain:
☐Dental Problems:	☐Braces? OR Please explain:
☐Diabetes:*(Requires medication and procedure authorization from physician)* ☐ Type 1 Diabetic ☐ Type 2 Diabetic	☐Monitors Blood Sugars while at school? ☐Requires Insulin at school? ☐Glucagon order? ☐Insulin pump? ☐Managed with diet?

☐Emotional/Behavioral/Psychological: *Please explain:*	
☐Gastrointestinal/Stomach Problems: *Please explain:*	
☐Genetic Disorder: *Please explain:*	
☐Headaches: *Please explain:*	
☐Hearing Problems:	☐Right Ear ☐ Left Ear ☐ Both ears ☐ Tubes ☐Hearing loss? ☐Hearing aid? ☐ Cochlear Implant
☐Heart Condition: *Please explain: Are there any activity restrictions? Any medications taken at home only?*	
☐Hypertension (High Blood Pressure):	
☐Juvenile Arthritis/Bone-Joint Problems: *Please explain:*	
☐Kidney Problems: *Please explain:*	
☐Scoliosis:	☐No Treatment ☐ Wears Brace ☐ Surgery
☐Seizures/Convulsions: *Please explain:*	Type of seizure: _____ ☐Diastat order
☐Sickle Cell Anemia:	
☐Spina Bifida:	
☐Special Diet: *Please explain:*	
☐Vision Problems:	☐Wears glasses ☐ Wears contacts ☐ Other, _____
☐Other Medical Conditions: *Please include **any** medications taken at home only.*	

Part III – Medical Equipment /Procedures Required at School

☐ Catheter ☐ Gastric Tube ☐ Nebulizer Treatments ☐ Oxygen Supplement ☐ Tracheostomy
☐ Vagal Nerve Stimulator (VNS) ☐ Ventilator ☐ Wheelchair ☐ Walker

Required Signatures

Signature of parent(s) or guardian:_____ Date:_____

Signature of school nurse: _____ Date:_____

Troy City Schools
Stewart B. McKinney Program
ATTACHMENT A

Student Residency Questionnaire

Please use one form per student. Return to school registration office within 14 days of receipt. If you require additional copies, please contact school.

Name of Student:_____ _____ _____
First Middle Last

Name of School:_____Grade:____Birthdate:____/____/____ Age:_____
Month Day Year

Sex: _____Male_____Female_____

The answers to the following Questions can help determine the services this student may be eligible to receive under the **McKinney-Vento Act 42 U.S.C. 11435.**

1. **Do you live in any of these following situations sharing the housing of others due to: (Check one)**

_____Loss of housing

_____Economic hardship

_____Long-term, cooperative living arrangement to save money or a similar reason

_____Motel, car, campsite

_____As a student are you living with someone other than your parents or legal guardian

2. **If you answer YES to any of the above questions, please complete the remainder of this form**

If you answer NO to all of the above questions, you may stop here.

ADDRESS /OR GENERAL ADDRESS_____

PHONE OR CONTACT NUMBER_____

3. Please list any other siblings/age in the household:

_____

_____

_____

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_____

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 with school system check-out procedures)

1. _____ Relation _____ Phone _____
2. _____ Relation _____ Phone _____
3. _____ Relation _____ Phone _____

NAME AND ADDRESS OF LAST SCHOOL ATTENDED: _____

_____

PARENT SIGNATURE _____

RACE AND/OR ETHNICITY

Student's Name: _____ Grade: _____

Parent/Guardian Signature: _____Date: _____

What is the student's race and/or ethnicity? SELECT ALL THAT APPLY:

□ **AMERICAN INDIAN OR ALASKA NATIVE**
For example, Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow lnupiat Traditional Government, Nome Eskimo Community, Aztec, Maya, etc.

□ **ASIAN**
For example, Chinese, Asian Indian, Filipino, Vietnamese, Korean, Japanese, etc.

□ **BLACK OR AFRICAN AMERICAN**
For example, African American, Jamaican, Haitian, Nigerian, Ethiopian, Somali, etc.

□ **HISPANIC OR LATINO**
For example, Mexican, Puerto Rican, Salvadoran, Cuban, Dominican, Guatemalan, etc.

□ **MIDDLE EASTERN OR NORTH AFRICAN**
For example, Lebanese, Iranian, Egyptian, Syrian, Iraqi, Israeli, etc.

□ **NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER**
For example, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, Marsha/Iese, etc.

□ **WHITE**
For example, English, German, Irish, Italian, Polish, Scottish, etc.

Office use only:	
	Race – Choose one or more: _____American Indian or Alaska Native _____Asian _____Black or African American _____Hispanic or Latino _____Middle Eastern or North African _____Native Hawaiian or Other Pacific Islander _____White
Date:	Staff Signature: