

Towns County Middle School  
1400 U. S. Highway 76 East  
Hiawassee, Georgia 30546  
Phone 706-896-4131 Fax 706-896-9325

Name of Student \_\_\_\_\_ / / \_\_\_\_\_  
(Last, First, Middle) (Date of Birth) (Grade)  
\_\_\_\_\_  
(S. S. Number) (Ethnicity) (City, State of Birth)  
\_\_\_\_\_ Male \_\_\_\_\_ Female

Is either parent/guardian active duty in US Armed Forces, including National Guard or Reserve Forces? \_\_\_ Yes \_\_\_ No

\_\_\_\_\_  
(Name and address of school previously attended)

911 address: \_\_\_\_\_ Mailing address: \_\_\_\_\_

Your phone: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

Child lives with: \_\_\_ Both parents \_\_\_ One parent \_\_\_ One parent and step parent

Father's name: \_\_\_\_\_

(Last, First, Middle)

Where employed: \_\_\_\_\_ Phone: \_\_\_\_\_

Mother's name: \_\_\_\_\_

(Last, First, Middle)

Where employed: \_\_\_\_\_ Phone: \_\_\_\_\_

Child's doctor: \_\_\_\_\_ Phone \_\_\_\_\_

Hospital preference: \_\_\_\_\_

Any special health needs: \_\_\_\_\_

Any Special Education needs: \_\_\_\_\_

Other information concerning child: \_\_\_\_\_

Is student currently enrolled in an alternative school? Yes \_\_\_ No \_\_\_

Is student currently serving a suspension or expulsion from another school? Yes \_\_\_ No \_\_\_

Has student ever been adjudicated in Juvenile Court or Criminal Court? Yes \_\_\_ No \_\_\_

If emergency care becomes necessary, I give my permission for my child to receive such treatment as required by a physician.

\_\_\_\_\_  
(Parent's signature) \_\_\_ / \_\_\_ / \_\_\_ (Date)

**Towns County Middle School**  
**1400 U. S. Highway 76 East**  
**Hiawassee, Georgia 30546**  
**706 896-4131**  
**706 896-9325 FAX**  
**bthurman@townscountyschools.org**  
**Request for Records**  
\_\_\_\_/\_\_\_\_/\_\_\_\_

To: \_\_\_\_\_  
Name of last school attended

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Fax

The following student enrolled in Towns County Middle School:

Name of Student \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_\_  
(Last, First, Middle) (Date of Birth) (Grade)

In order to complete our student records, please send a copy of the following information contained in this student's record:

1. Certified copy of academic transcript (including grades to date if student withdrew before the end of the grading period)
2. Standardized test scores
3. Immunization record
4. Hearing, vision, and dental screening
5. FTE number
6. Certified copy of disciplinary record
7. Copy of birth certificate
8. Copy of Social Security card
9. Special Education records (if applicable), including psychological, eligibility report and current IEP
10. SST records
11. Gifted records

I give permission for the above information to be sent to Towns County Middle School.

\_\_\_\_\_  
Signature (Parent/Guardian)

### EMERGENCY STUDENT DATA FORM

STUDENT INFORMATION	
LAST NAME	
FIRST NAME	
BIRTH DATE	
GRADE LEVEL/HOMEROOM TEACHER	
BROTHERS/SISTERS IN SCHOOL AT TCCS	NAME TEACHER
	NAME TEACHER
	NAME TEACHER
	NAME TEACHER
BUS DRIVER	
BUS NUMBER	
911 ADDRESS	
CITY	
HOME PHONE	
EMERGENCY DROP OFF 911 ADDRESS	
MEDICAL INFORMATION: ALLERGIES, MEDICATIONS, OTHER IMPORTANT INFORMATION	
PARENT INFORMATION	
PARENT 1 LAST NAME	
PARENT 1 FIRST NAME	
RELATIONSHIP (MOTHER, FATHER, ETC.)	
DAYTIME PHONE 1	
DAYTIME PHONE 2	
PARENT 2 LAST NAME	
PARENT 2 FIRST NAME	
RELATIONSHIP (MOTHER, FATHER, ETC.)	
DAYTIME PHONE 1	
DAYTIME PHONE 2	
EMERGENCY CONTACT	
LAST NAME	
FIRST NAME	
RELATIONSHIP (AUNT, NEIGHBOR, ETC.)	
DAYTIME PHONE 1	
DAYTIME PHONE 2	
IF SCHOOL LETS OUT EARLY, MY CHILD IS TO RIDE BUS TO	PARENT SIGNATURE

- COPY 1 – STUDENT RECORD
- COPY 2 – HOMEROOM TEACHER
- COPY 3 – EMERGENCY BOX
- COPY 4 – SCHOOL BUS

## Health Information for School Year 2019-2020

Student: \_\_\_\_\_  male  female DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Grade: \_\_\_\_\_ Teacher / Homeroom: \_\_\_\_\_

\*\*\*Allergies: explain what kind of reaction and how to treat, such as Epi-pen or Benadryl\*\*\*

- no drug, food, seasonal or any known allergies
- Drug or Medication allergies \_\_\_\_\_
- Food allergies \_\_\_\_\_
- Seasonal allergies \_\_\_\_\_
- Bee or Insect allergies \_\_\_\_\_

### Health / Medical Issues

- Physical Handicaps (explain) \_\_\_\_\_
- Diabetes  Seizure Disorder  Hemophilia Disorder
- Asthma (Has your child ever needed **inhalers or breathing treatments**? Explain how often and possible triggers, like exercise, grasses, smoke, and such.) \_\_\_\_\_

Any other health concerns \_\_\_\_\_

Medications: (taken daily or frequently, dosage and why) \_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

Father / Guardian: \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Work phone \_\_\_\_\_

Mother / Guardian: \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Work phone \_\_\_\_\_

*If parents cannot be reached, list two nearby persons who will assume care of your child.*

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

\*\*Student's Doctor / Healthcare Provider \_\_\_\_\_ Phone \_\_\_\_\_

*\*\*School clinic personnel have my permission to contact my child's physician for further medical information. In case of serious illness / injury, the school will telephone 911 / Emergency Medical Services for immediate transportation to the closest hospital. I, the parent / legal guardian, authorize the transport of and treatment by the hospital emergency staff for my child, (as named above).*

Signature \_\_\_\_\_ Date \_\_\_\_\_

Health Form, for the School Nurse

Student: \_\_\_\_\_

Grade: \_\_\_\_\_ Teacher / Homeroom: \_\_\_\_\_

Dear parents / guardians,

In preparation for the 2019-2020 school year, it is very important to have accurate health information in order to best serve your child. Please fill out both sides of this school health form and return to the school.

**Parents of Head Start / Pre-K, Kindergarten and First grade:** Always send extra change of clothes in case of accidents or spillage. Please make these clothes available at all times.

**Special medications / prescription medications given to student at school is possible** but you must follow certain **guidelines:** 1) Student may not transport medication to school.

2) **Medication must be in original container**, no baggies, or foil.  
Your pharmacist can duplicate the prescription bottle for you, at no charge, one for home and one for school.

3) The parent/guardian must come to the clinic and **sign a form** to give us authorization to give the medication.

Towns County School District provides some over the counter medications/ generic brands in the clinic for use by the students. Indicate **yes** or **no** if you authorize for us to treat your child with these medications. The goal is to save time and prevent phone calls to you while giving them the best possible care while at school.

Tylenol \_\_\_\_\_ Tums antacid \_\_\_\_\_ Ibuprofen \_\_\_\_\_

Oragel (gum pain) \_\_\_\_\_ Benadryl \_\_\_\_\_ Cough drops \_\_\_\_\_

Neosporin / Aquaphor ointments \_\_\_\_\_ Burn cream \_\_\_\_\_

Caladryl (topical use for rash / insect bites) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Parent / guardian signature

date

U.S. Office of Personnel Management Guide to Personnel Data Standards	<b>ETHNICITY AND RACE IDENTIFICATION</b> (Please read the Privacy Act Statement and instructions before completing form.)	
Name (Last, First, Middle Initial)		Birthdate (Month and Year)
Agency Use Only		
<p><b>Privacy Act Statement</b></p> <p>Ethnicity and race information is requested under the authority of 42 U.S.C. Section 2000e-16 and in compliance with the Office of Management and Budget's 1997 Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. Providing this information is voluntary and has no impact on your employment status, but in the instance of missing information, your employing agency will attempt to identify your race and ethnicity by visual observation.</p> <p>This information is used as necessary to plan for equal employment opportunity throughout the Federal government. It is also used by the U. S. Office of Personnel Management or employing agency maintaining the records to locate individuals for personnel research or survey response and in the production of summary descriptive statistics and analytical studies in support of the function for which the records are collected and maintained, or for related workforce studies.</p> <p>Social Security Number (SSN) is requested under the authority of Executive Order 9397, which requires SSN be used for the purpose of uniform, orderly administration of personnel records. Providing this information is voluntary and failure to do so will have no effect on your employment status. If SSN is not provided, however, other agency sources may be used to obtain it.</p>		
<p><b>Specific Instructions:</b> The two questions below are designed to identify your ethnicity and race. Regardless of your answer to question 1, go to question 2.</p>		
<p><b>Question 1. Are You Hispanic or Latino?</b> (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)  <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
<p><b>Question 2.</b> Please select the racial category or categories with which you most closely identify by placing an "X" in the appropriate box. Check as many as apply.</p>		
<b>RACIAL CATEGORY</b> (Check as many as apply)	<b>DEFINITION OF CATEGORY</b>	
<input type="checkbox"/> 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.	
<input type="checkbox"/> 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.	
<input type="checkbox"/> Black or African American	A person having origins in any of the black racial groups of Africa.	
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.	
<input type="checkbox"/> White	A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.	

Standard Form 181  
 Revised August 2005  
 Previous editions not usable

42 U.S.C. Section 2000e-16

NSN 7540-01-099-3446



## Required Home Language Survey

Dear Parent or Guardian:

In order to provide your child with the best possible education, we need to determine how well he or she speaks and understands English. This survey assists school personnel in deciding whether your child may be a candidate for additional English language support. Final qualification for language support is based on the results of an English language assessment.

Thank You

Student Name (required information):

Language Background (required information):

1. Which language does your child best understand and speak?  
\_\_\_\_\_
2. Which language does your child most frequently speak at home?  
\_\_\_\_\_
3. Which language do adults in your home most frequently use when speaking with your child?  
\_\_\_\_\_

Language for School Communication (not required):

4. In which language would you prefer to receive all school information?  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian/Other

\_\_\_\_\_  
Date

## Township School System Student Residency Statement

Your child may be eligible for additional educational services through Title X, Part C, Federal McKinney-Vento Assistance Act. Eligibility can be determined by completing this questionnaire.

NOTE: Only one form needs to be completed per family!!!!

<p style="text-align: center;">Information provided on this form is confidential.</p> <p>Where does the <u>STUDENT</u> currently stay at night?</p> <ul style="list-style-type: none"> <li><input type="radio"/> Rent or own our own home</li> <li><input type="radio"/> Temporarily staying with another family because we can't find affordable housing</li> <li><input type="radio"/> Staying with another family due to convenient living arrangement.</li> <li><input type="radio"/> Staying with an adult that is not the parent or legal guardian, or staying alone without an adult.</li> <li><input type="radio"/> Staying in a hotel/motel, campground, or similar setting.</li> <li><input type="radio"/> Staying in emergency or transitional shelters such as domestic violence or homeless shelters or transitional housing.</li> <li><input type="radio"/> Has a primary nighttime residence that is a place that is not designed for or ordinarily used as a regular sleeping accommodation for humans.</li> <li><input type="radio"/> Staying in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar.</li> </ul>	<p style="text-align: center;"><u>For School Use Only:</u></p> <ul style="list-style-type: none"> <li><input type="radio"/> Doubled-Up</li> <li><input type="radio"/> Double-Up/ Unaccompanied Youth</li> <li><input type="radio"/> Hotel/Motel</li> <li><input type="radio"/> Unsheltered</li> <li><input type="radio"/> Sheltered</li> <li><input type="radio"/> Unknown</li> </ul>
---	---

Student Name		Grade
First	Last	

The undersigned certifies that the information provided above is accurate.

Parent of Record/Adult Caring for Student (Print)	Signature	Date
--	-----------	------

(Area Code) Phone Number	Street Address	City	State	Zip
--------------------------	----------------	------	-------	-----





Georgia Department of Education

Richard Woods, Georgia's School Superintendent

"Educating Georgia's Future"

School District: \_\_\_\_\_

Date: \_\_\_\_\_

Parent Occupational Survey

Please complete this form to determine if your child(ren) qualify to receive supplemental services under Title I, Part C

Name of Student(s)	Name of School	Grade
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- Has anyone in your household moved in order to work in another city, county, or state, in the last three (3) years?  Yes  No
- Has anyone in your household been involved in one of the following occupations, either full or part-time or temporarily during the last three (3) years?  Yes  No

If you answer "yes", check all that applies:

- 1) Planting/picking vegetables (such as tomatoes, squash, onions) or fruits (such as grapes, strawberries, blueberries)
- 2) Planting, growing, cutting, processing trees (pulpwood), or raking pine straw
- 3) Processing/packing agricultural products
- 4) Dairy/Poultry/Livestock
- 5) Meatpacking/Meat processing/Seafood
- 6) Fishing or fish farms
- 7) Other (Please specify occupation): \_\_\_\_\_

Names of Parent(s) or Legal Guardian(s) \_\_\_\_\_

Current Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone: \_\_\_\_\_

Thank You!

Please return this form to the school

Please maintain original copy in your files.

MEP funded school/district: Please give this form to the migrant liaison or migrant contact for your school/district.

Non-MEP funded (consortium) school/districts: When at least one "yes" and one or more of the boxes from 1 to 7 is/are checked, districts should fax occupational surveys to the Regional Migrant Education Program Office serving your district. For additional questions regarding this form, please call the MEP office serving your district:

GaDOE Region 1 MEP, P.O. Box 780, 201 West Lee Street, Brooklet, GA 30415  
Toll Free (800) 621-5217 Fax (912) 842-5440

GaDOE Region 2 MEP, 221 N. Robinson Street, Lenox, GA 31637  
Toll Free (866) 505-3182 Fax (229) 546-3251

Regional Office use only: