Towns County Elementary School

1150 Konahetah Road
Hiawassee, GA 30546
(706) 896-4131
Fax: (706) 896-9872

Required Documents for Registration:

_____ *Certificate of Immunization GA Form 3231*
(If out of state- must be converted over to GA)

_____ *Certificate of Vision, Hearing, Dental and Nutrition Form 3300 (If entering a GA school for the first time)*

_____ *Certified Copy of Birth Certificate*

_____ *Social Security Card*

_____ *Proof of Residency of Towns County*
(Ex: water, electric, gas bill or Lease Agreement with signature of landlord/renters)

_____ *Picture ID of parent/guardian registering the child.*

_____ *Custody or Guardianship papers issued by the court if student lives with anyone other than natural parents, as listed on the birth certificate.*

Enrollment Packet

1150 Konahetah Road
Hiawassee, GA 30546
Phone: 706-896-4131 Fax: 706-896-9872

Please Print Information

Enrollment Date ________________

Student Legal Name ______________ ______________ ____________ __________
Last First Middle Suffix

Preferred Name ______________ Age ______ Grade______

SSN# ______________ Male ___ Female ___ Date of Birth: _____________

City of Birth: ______________ County of Birth: ______________ State of Birth: ____________
Entry into US ___________ Date entered US School __________
First Language learned: _______________ Language Spoken at home: _____________
Language Spoken most often: _____________

Home Address: ____________________ ________________ ______ _______ ________
Street City ST Zip Code County
Home Phone Number ________________

Mailing Address: __________________ _________________ ______ _______ ________
Street/ PO # City ST Zip Code County

Is Parent/Guardian Active Military? Yes or No (Circle one)

Father's Name: ____________________________ Employer: _____________________
Email Address: __________________________________
Home Phone: ______________________ Work: ___________________ Cell: ______________

Mother's Name: ___________________________ Employer: _____________________
Email Address: __________________________________
Home Phone: ______________________ Work: ___________________ Cell: ______________

Marital Status of Parents: Single ___ Married ____ Divorced _____ Separated ______
Child lives with (give relationship): _________________________________
Names of Step Parents if any: _________________________________
Name of Child's Legal Guardian(s): __________________ # of People living in household____
Name and Grade of Brothers and Sisters attending Towns County School System:

__________________________________ ____________________________
__________________________________ ____________________________
__________________________________ ____________________________
__________________________________ ____________________________

REQUEST FOR RECORDS

Date __________

To: ____
Name of last school attended

____
Address

____
City, State, Zip Code

______________________________ ______________________________
Telephone Number Fax Number

The following student enrolled in Towns County Elementary School
Name of Student ____
Date of Birth ____________ Grade _________

In order to complete our student records, please send a copy of all pertinent information that will help in serving this student.

- Copy of academic transcript (including grades to date if student withdrew before the end of the grading period)
- Standardized Test Scores/ Report Cards
- Attendance Records
- Immunizations Record 3231
- Hearing, Vision, Dental and Nutrition Screening Form 3300
- Copy of disciplinary record(s)
- Copy of Birth Certificate
- Copy of Social Security Card
- Special Education Records, including psychological, eligibility report and current IEP
- Speech Records
- MTSS/RTI/SST Records, ESOL, Gifted Records
- Custody Documents

****All that applies to this enrolling student*****

I give permission for the above information to be transferred to Towns County Elementary School.

____________________________________ ____________________________________
Parent/Guardian Signature Parent/Guardian Printed Name

Send records to:
1150 Konahetah Road; Hiawassee, Georgia 30546 Phone: (706) 896-4131 Fax: (706) 896-9872

Towns County Elementary School System

2021-2022

Emergency Student Data Form

Date: ______________________ Student's Name ________________________________

Birthdate _____________________ Grade ______ Age _____

Home Address ___________________ _____________ _____ _______

Street City State Zip Code

Home Phone Number _________________________

Mother's Name ______________________ Cell # ________________ Work# _______________

Email Address: __________________________________

Father's Name ______________________ Cell # ________________ Work# _______________

Email: ____

Guardian (if different from parents) __________________________________

Cell # ___________________ Work# __________________

Address ___________________ _____________ _______ ________

Street City ST Zip Code

****Persons Authorized to HAVE LUNCH / PICK UP / SIGN OUT Student:**
(PLEASE INCLUDE *YOURSELF*)**
The student will only be released to the following listed below:

Name	Phone Number
___________________________________	__________________________
___________________________________	__________________________
___________________________________	__________________________
___________________________________	__________________________
___________________________________	__________________________

(if more space is needed, please write on the back of this form)

If school lets out early due to inclement weather, please be sure the teacher has your dismissal information on file. Phone lines during this time are very busy.

Signature of Parent/Guardian: ___________________________

Towns County Elementary School System

Student's name ______________________ Date ____________

Medical Information: (PLEASE BE SURE TO FILL OUT BOTH SIDES OF SCHOOL HEATLH INFORMATION SHEET THAT'S INCLUDED IN THIS PACKET)

Allergies: ______________________ Medical Alerts: ________________________

Pre-K Program Student attended:

GA Pre-K _____ Head start ____ Did not attend a Pre-K _____

Name and Address of Pre-K School attended:

____

Has student ever been Home-Schooled? _________

Has student attended a Georgia School before _____ if yes..

Name and Address of School/s:

____

____

Has student ever attended Towns County Schools? ______ If yes, which grade and year? _____

Has student ever repeated a grade? ______ If yes, which grade _____ and why? ____________

Is student enrolled in Special Ed Program (IEP)? ______

Has student ever had a psychological evaluation? ______ If yes, when was it completed? _____

Is student in gifted program? _______

Does student have any of the following? Speech (IEP) _____504 ____ RTI/MTSS ____

Other _______

Any other information concerning your child will be greatly appreciated.

____

____

Health Form, for the School Nurse

Student: ____

Grade: __________________ Teacher / Homeroom: ________________________________

Dear parents / guardians,

In preparation for the 2021-2022 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.

Parent of Headstart / 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 topical ointments ___________ **Burn Cream**______________

Caladryl (topical use for rash / insect bites) ______________

_____________________________ _________________

Parent/Guardian Signature *Date*

Health Information for School Year 2021-2022

☐ High School ☐ Middle School ☐ Elementary School ☐ Head Start

Grade: __________ Teacher/Homeroom: ____________________

Student: ____________________________ ☐ male ☐ female DOB: ______________

Address: ____

*** 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 closet 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** ________________________

U.S. Office of Personnel Management Guide to Personnel Data Standards	**ETHNICITY AND RACE IDENTIFICATION** (Please read the Privacy Act Statement and instructions before completing form.)	
Name (Last, First, Middle Initial)		Birthdate (Month and Year)
Agency Use Only		

Privacy Act Statement

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.

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.

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.

Specific Instructions: The two questions below are designed to identify your ethnicity and race. **Regardless of your answer to question 1, go to question 2.**

Question 1. Are You Hispanic or Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

☐ Yes ☐ No

Question 2. 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.

RACIAL CATEGORY (Check as many as apply)	DEFINITION OF CATEGORY
☐ 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 original 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.

Standard Form 181
Revised August 2005
Previous editions not usable

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

NSN 7540-01-099-3446

TOWNS COUNTY SCHOOLS

STUDENTS REACHING THEIR HIGHEST POTENTIAL

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**

All Rights Reserved

Towns County 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!!!!

Information provided on this form is confidential.

Where does the **STUDENT** currently stay at night?

- o We rent or own our own home
- o Temporarily staying with another family because we can't find affordable housing
- o Staying with another family due to convenient living arrangement.
- o Staying with an adult that is not the parent or legal guardian, or staying alone without an adult.
- o Staying in a hotel/motel, campground, or similar setting.
- o Staying in emergency or transitional shelters such as domestic violence or homeless shelters or transitional housing.
- o Has a primary nighttime residence that is a place that is not designed for or ordinarily used as a regular sleeping accommodation for humans.
- o Staying in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar.

For School Use Only:

- o Doubled-Up
- o Double-Up/ Unaccompanied Youth
- o Hotel/Motel
- o Unsheltered
- o Sheltered
- o Unknown

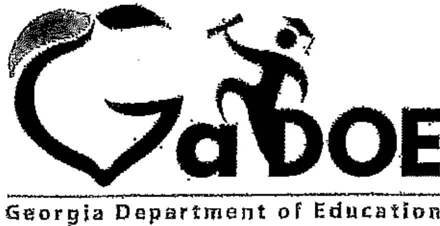
Student Name First / Last	Grade

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

Form August 2013



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

1. Has anyone in your household moved in order to work in another city, county, or state, in the last three (3) years? ☐ Yes ☐ No

2. 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: ☐

WITHDRAWAL INFORMATION

Student's name ______________________________ Date ____________ Grade ______

The individual enrolling a student is the only person permitted to withdraw the student.

The person who enrolls a student during the school year assumes parental status; this can be mother or father, a legal guardian, or any other person who has assumed the role of parent. Pursuant of GA law, the enrolling parent(s) is the only individual(s) allowed to add to, delete from, or alter a student's pickup list.

I verify that all of the above information is correct and accurate. I understand that it shall be my responsibility to notify the school of any changes. Furthermore, I understand my signature below assigns me as the school system's enrolling parent for the above named student.

______________________________ ______________________________ ____________

Enrolling Parent Signature **Enrolling Parent Printed Name** **Date**

Transportation and Lunch Visitors—Please read

******Transportation is very important please make sure that your child's teacher has the information. At any time a transportation change needs to be made you have to come in person or send a note to school with your child. *** Sorry no changes can be made over the telephone, fax or emails.**

*****Lunch Visitors must sign in thru the front office *****

If at any time your child will have a visitor for lunch, please send a note to the office so that we are aware of their presence in the building.

System Web Address:
www.towns.k12.ga.us

TOWNS COUNTY ELEMENTARY SCHOOL
STUDENTS REACHING THEIR HIGHEST POTENTIAL

Immunization Requirements for Towns County Elementary School

All Children entering Towns County Schools are required to meet the following:

NEW **A Hearing, Vision, Dental and Nutrition Screening must also be completed on Georgia Form 3300. All immunizations are required to be on Georgia Form 3231 and must be current in order for your child to be enrolled in Towns County Schools. **

1. Have the required doses of Hepatitis B, Diphtheria, Tetanus, and Pertussis (DTP) and polio vaccines.
2. Have two doses of Mumps, Measles, and Rubella (MMR) or two doses of Measles vaccine, two doses of Mumps vaccine, and one dose of Rubella vaccine or laboratory proof of immunity against Measles, Mumps or Rubella. If child is under four, at least one dose is required.
3. Have two doses of Varicella (chicken pox) vaccine or documentation of disease or laboratory proof of immunity. If child is under four, at least one dose is required.
4. If your child is under five years of age, he/she must have protection against pneumococcal disease. He/She will need the Pneumococcal Conjugate vaccine (PCV). The number of doses needed will depend on the child's age. Your child must have at least three doses of HIB.
5. If your child was born on or after January 1, 2006, he/she must have two doses of Hepatitis A (Hep A) vaccine or laboratory proof of immunity. The first dose must be given on or after the first birthday with spacing of six months or greater between doses.
6. If your child was born on or after January 1, 2006, he/she must have at least four doses of Polio (OPV and/or IPV). The final dose must be given on or after the fourth birthday and must be at least six months from the third dose.
7. **For students entering from out of state, please contact the Georgia Health Department or a Georgia licensed physician to have immunizations transferred to the Georgia Certificate form 3231.**

1150 Konahetah Road; Hiawassee, Georgia 30546 Phone: (706) 896-4131 Fax: (706) 896-9872

Georgia Department of Public Health
Form 3300

PLEASE SEE THE INSTRUCTIONS ON THE BACK OF THIS FORM

Certificate of Vision, Hearing, Dental, and Nutrition Screening

FILE THIS FORM WITH THE SCHOOL WHEN YOUR CHILD IS FIRST ENROLLED IN A GEORGIA PUBLIC SCHOOL
SCREENER CONTACT INFORMATION IS REQUIRED

Parent/ Guardian Name: ______________________
first middle last

Parent/ Guardian Contact Information:
Daytime phone number: ______________________
Evening phone number: ______________________
Cell phone number: ______________________

Child's Name: ______________________
first middle last

Date of Birth: ____/____/____ **Gender:** ☐Male ☐Female

Child's Home Address:
____
street city state zip code county

VISION
☐ Unable to screen (explain why below)
☐ Uses corrective lenses
☐ Worn for testing

☐ Passed (20/30 in each eye for age 6 and above, 20/40 in each eye for below age 6)
☐ Needs further evaluation
☐ Under professional care (explain below)

Screening completed by:
☐ Physician
☐ Local Health Department
☐ Optometrist
☐ "Prevent Blindness Georgia" employee
☐ School Registered Nurse

____
Screener's Signature **Date**
I certify that this child has received the above screening.
Contact Information:

HEARING
☐ Unable to screen (explain why below)
☐ Uses hearing aid / assistive device

☐ Passed at 500, 1000, 2000, and 4000 Hz with audiometer at 20 or 25 dB
☐ Needs further evaluation
☐ Under professional care (explain below)

Screening completed by:
☐ Physician
☐ Local Health Department
☐ Audiologist
☐ Speech-Language Pathologist
☐ School Registered Nurse

____
Screener's Signature **Date**
I certify that this child has received the above screening.
Contact Information:

DENTAL
☐ Unable to screen (explain why below)

☐ Normal appearance
☐ Needs further evaluation
☐ Emergency problem observed
☐ Under professional care (explain below)

Screening completed by:
☐ Physician
☐ Dentist
☐ Local Health Department Registered Nurse
☐ Registered Dental Hygienist
☐ School Registered Nurse

____
Screener's Signature **Date**
I certify that this child has received the above screening.
Contact Information:

NUTRITION
☐ Unable to screen (explain why below)

Height: ________ Weight: ________
BMI: ________ BMI%: ________

☐ 5th to 84th percentile - Appropriate for age
☐ < 5th percentile - Needs further evaluation
☐ ≥ 85th percentile - Needs further evaluation
☐ Under professional care (explain below)

Screening completed by:
☐ Physician
☐ Local Health Department
☐ Registered Dietician
☐ School Registered Nurse

____
Screener's Signature **Date**
I certify that this child has received the above screening.
Contact Information:

FOR SCHOOL SYSTEM ONLY: Follow up for further evaluation

	1st attempt	2nd attempt	Actions reported (if any)
Vision			
Hearing			
Dental			
Nutrition			

Student support services initiated on:

Screeners' Comments:

DPH Form 3300 Rev. 2013

Rev. 07/2020

Georgia Department of Public Health

Form 3231

CERTIFICATE OF IMMUNIZATION

Child's Name (Last name, First name)

Birthdate

(Optional) Parent/Guardian Name (Last name, First name)

Unless specifically exempted by law, Georgia law (O.C.G.A. § 20-2-771) requires a certificate on file for each child in attendance in any school or child care facility in Georgia with penalties for failure to comply. Detailed instructions for this form and immunization requirements by age are spelled out in policy guides 3231INS and 3231REQ distributed by the Georgia Immunization Office.

Date of Expiration

(Next required immunization or review of medical exemption due.)

(Fill in X) **Complete For K through 6th Grade**
Child must be >= 4 years and have met all requirements for school attendance.

(Fill in X) **Complete For 7th through 10th Grade**
Fulfills requirements K through 6th grade AND must have Tdap and MCV4 administered.

(Fill in X) **Complete For 11th Grade and higher**
Fulfills requirements K through 10th grade AND must have MCV4 booster dose administered on or after 16th birthday.

VACCINE	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	Total Doses	Diagnosed	Serology+	History	Med. Exemption
Required Vaccines for School or Child Care Attendance											
DTP,DTaP,DT,Td											
Polio											
Hepatitis B											
Tdap											
MCV4											
HIB (Under Age 5)											
PCV (Under Age 5)											
Measles											
Mumps											
Rubella											
Hepatitis A (Born on/after 1/1/06)											
Varicella											
Recommended Vaccines (For Information Only)											
Rotavirus											
HPV											
Influenza											
Td (booster)											
Men-B											

SAMPLE

Notes:

A licensed Georgia physician, Advanced Practice Registered Nurse, Physician Assistant, qualified employee of a local Board of Health or the State Immunization Office is responsible for the content of this certificate. All dates must include month, day and year. In cases of natural immunity or Medical Exemption, the 4 digit year of infection, test or exemption must be filled in the appropriate box(es).

The certificate is NOT valid without name and birthdate of the child, date of expiration OR "X" in Complete for School Attendance box, legible name and address of the physician, Advanced Practice Registered Nurse, Physician Assistant or health department, certified by signature and a date of issue.

A school or facility official is responsible for keeping a current valid certificate on file for each child in attendance. A certificate must be replaced within 30 days after expiration. When a child leaves or transfers to another facility, the Certificate of Immunization should be given to a parent/guardian or sent to the new facility.

Printed, Typed or Stamped Name, Address and Telephone # of Licensed Physician or Health Department

Certified by (Signature/Signature Stamp)

Date of Issue

PRINTED BY GEORGIA IMMUNIZATION REGISTRY (GRITS)