To Enroll at G.W. Long Elementary School

Please provide the following:

1. Copy of **birth certificate**
2. Copy of **social security card**
3. An up-to-date **Alabama immunization record**
4. **Withdrawal paperwork, transcript**, and/or **report card** from previous school
5. **Two proofs of residence** within the Skipperville school district, **one from each column:**

- *Column 1*
  - Insurance or Medicaid document with mailing address
  - Driver's license or gov't issued ID
  - Current utility bill showing address
  - Voter registration card
- *Column 2*
  - Rent receipt (numbered and signed by landlord)
  - Property tax record
  - Mortgage or property deed
  - Motor vehicle tag receipt

**Please call the Long Elementary School office at (334) 774-0021 if you have any questions regarding enrollment.

PLEASE PRINT

ALABAMA APPLICATION FOR STUDENT ENROLLMENT

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_____

*SOCIAL SECURITY NUMBER (voluntary) _____

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 to school system check-out procedures)

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

NAME AND ADDRESS OF LAST SCHOOL ATTENDED : _____

PARENT SIGNATURE _____

*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.

January 2015

Please list names of your student's brothers/sisters, the school they attend, and their grade level:

Brothers/Sisters:	School:	Grade:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Health Information:

Medical problems requiring attention (diabetes, epilepsy, allergies, etc...):_____

_____

In case of an emergency situation such as an accident or serious illness, I understand that the school shall make every effort to contact the parent/guardian and/or other emergency personnel as needed. I authorize the school to take whatever steps are necessary to provide the best medical care for my child. I will be responsible for any charges for medical assistance and/or ambulance service. I also give the school permission to contact a person listed as an emergency contact if I cannot be reached and they are to assume temporary care of my child. I authorize the school to share health history information as needed with all appropriate personnel in order to provide the best care for my child.

Signature of parent/guardian: _____ Date: _____

Medication Information

Will the child take medicine at school for an ongoing condition? Yes_____ No _____

Name of medication: _____ Dosage: _____ Time: _____

Name of prescribing doctor: _____

A **medication form** must be on file with the school nurse. The form must be completed and signed by the prescribing doctor and a parent. All medication must be in the properly labeled bottle from the pharmacist, and must be brought to school by a parent, not the student.

Transportation:

Bus #: _____ Bus Driver's Name: _____ Private Trans. _____Yes _____ No Walks _____

Unless the school has a written note from the parent/guardian stating a child should get off at a different location, he/she will be returned to the regular residence from which the child was picked up.

Prior School Attended:

School Name: _____ Phone #:_____

School Address: _____ City: _____ State: _____ Zip: _____

Grade: _____ Special services provided at previous school: _____

Does the student have a pending or unresolved discipline issue at his/her previous school? _____

Has the student been recommended for expulsion or alternative school by his/her previous school? _____

If you marked 'yes' to either of the previous questions, please explain:

_____

_____

Please read and sign the following:

*We do hereby certify that we **currently reside in the school's district, and will continue to reside in the district,** or have received permission from the Dale County Board of Education to attend this school. We also understand that students enrolling **must live with their parents or legal guardians (proof required).** If school officials determine this statement to be false the student(s) enrolled will be withdrawn immediately.

Signature of parent/guardian: _____ Relation:_____ Date: _____

DALE COUNTY SCHOOL SYSTEM

Residency Enrollment Application Form

An in-district student is defined by a student living in an established dwelling with the legal parent/guardian in Dale County; but outside of the city limits of Ozark and Daleville.

A. Background Information

Full Legal Name of Student: _____ Age _____ Grade _____

Name of Zoned Dale County School Applying for Enrollment: _____

Name of School and School System last attended: _____/_____

Name of Parent/Legal Guardian: _____

* Legal guardians and foster care parents must provide a court decree declaring him/her to be the legal guardian or the foster care parent of the student.

B. Residency Information

Residence Information

Location of Your Physical Residence/Complete Mailing Address (Including number and street – No PO Boxes)

_____

_____

_____

Phone Numbers: (Home) _____ (Work) _____ (Cell) _____

E-Mail Address: _____

C. Residency Verification

Please check one (1) item from each column that you will provide to verify your residence. Please attach the two (2) documents to this form.

Column One	*Column Two*
_____ Insurance or Medicaid mail with address	_____ Property tax record (tax appraisal postcard)
_____ Current utility bill showing residence address	_____ Rent Receipt: Numbered/signed by Landlord
_____ Voter Registration Card	_____ Mortgage documents or a property deed
_____ Driver's License or Government Issued ID	_____ Motor Vehicle Tag Receipt

Certification and Acknowledgement

I, *(full name)* _____, am the legal guardian of the above-named student, and do hereby certify that the information stated above on this form and in the supporting documentation are true. I consent and agree that the Dale County School System will have the right to verify the information provided above and that this form and any supporting documentation may be subject to review and/or verification by the Superintendent and/or his/her designee. **I fully understand that falsifying residency information will result in the immediate removal of the above-named student from school.**

I further agree that, if there is any change in my residence or the residence of the above-named student, I will notify the school administration within ten (10) days of the date of such change.

_____ _____

Signature: Parent/Legal Guardian Date:

Ethnicity and Race

Student's Name: _____ Grade: _____

Parent/Guardian Signature: _____ Date: _____

Please answer BOTH Question 1 AND Question 2

Question 1: Is this student Hispanic/Latino? CHOOSE ONLY ONE ETHNICITY:

□ **NO**, not Hispanic/Latino

□ **YES**, Hispanic/Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

The above question is about ethnicity, not race. No matter what you selected above, **please continue to answer the following Question 2 by marking one or more boxes to indicate what you consider your student's race to be.*

Question 2. What is the student's race? CHOOSE ONE OR MORE:

□ **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.

Office use only:	
Ethnicity – Choose only one: _____ NOT Hispanic/Latino _____ Hispanic/Latino	Race – Choose one or more: _____American Indian or Alaska Native _____Asian _____Black or African American _____Native Hawaiian or Other Pacific Islander _____White
Date:	Staff Signature:

Additional Requested Information:

MILITARY

Student connected to an Active Duty Military parent Circle One: YES NO

PRESCHOOL

Head Start Circle One: YES NO	First Class Funded Preschool – Circle One: Yes NO
Centered Based Child Care - Circle One: YES NO	Home Based Child Care – Circle One: YES NO
Home Visitation Program – Circle One: YES NO	Other Preschool – Circle One: YES NO
No Preschool – Check if no Preschool	Special Education Funded – Circle one: YES NO

SPECIAL EDUCATION SERVICES

Student currently receiving special education services Circle One: YES NO

Special Services Information

Student's Name: _____ Grade: _____

1. Has this student ever been referred for special services?
   _____Yes _____No

2. Has this student ever been tested for special services by either a public agency or a private agency?
   _____Yes _____No

3. If the answer to question number 2 is yes, was the student placed?

   _____Yes _____No

   Please check the type of disability impairment:

   ____ Autism

   ____ Deaf/Blindness

   ____ Developmental Delay

   ____ Emotional Disability

   ____ Hearing Impairment

   ____ Intellectual Disability

   ____ Multiple Disabilities

   ____ Orthopedic Impairment

   ____ Specific Learning Disability

   ____ Speech or Language Impairment

   ____Visual Impairment

   ____ Gifted

   ____ Other: _____

****Please provide a copy of the IEP if your child received special services****

_____ _____

Signature of Parent/Guardian Date

Federal and State regulations require school districts to have procedures in place to identify language needs of students and families to provide meaningful instruction for all students. This form will be used only for determining whether the student needs English Learner services.

Student Name:	**Gender (circle one) Male Female**	**Date:**
School:	**Grade:**	**Teacher:**
Parent/Guardian Name:		

Student Information	
Child's Date of Birth:	
Was your child born in the United States? (circle one) Yes No	If YES, what State?
If NO, what country?	If NO, date child entered the United States

Educational Background

Has your child attended school in the United States for any 3 years during their lifetime? **YES** **NO**

Previous schools attended starting with most recent

City and State_____School _____Dates attended_____
City and State_____School _____Dates attended_____
City and State_____School _____Dates attended_____

Language Background

1. What language is spoken by you and your family most of the time at home?_____

2. Parent Communication: Will you need an interpreter or a translator at Parent and Teacher conferences? **YES** **NO**
If you prefer written communication in a language other than English, in what language would you prefer?_____

3. What language is understood by your child? **(Check ONLY ONE)**

☐ **ONLY** English ☐ Only the home language and **NO** English ☐ Understands **MOSTLY** the home language and some English
☐ Understands **MOSTLY** English and **SOME** home language ☐ Understands home language and English **EQUALLY**

4. Is your child's first language or home language anything other than English? **YES** **NO**

IF YES	**What language did your child learn when he/she first begin to talk?**_____
IF YES	**What language(s) does your child most frequently speak at home?**_____
IF YES	**What other languages does your child speak?** _____
IF YES	**What language(s) do you most frequently speak to your child? Father**_____**Mother**_____

Parent Signature_____ **Date**_____

Counselor or EL office check box: Reviewed by (initials) Date: Notes:

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	

2022

ALABAMA STATE DEPARTMENT OF EDUCATION

HEALTH ASSESSMENT RECORD

School Year: _____-_____

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 confidential.

PLEASE complete both sides of this form (Return to the School Nurse)

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

Address (Street)

Home Telephone Number:	Cell Phone Number:	Additional Phone Number:	Grade	Teacher/Homeroom

Name of Parent/Guardian (Last, First Middle) | Work Phone Number:

Transportation

☐ Bus Rider Bus Number: ☐ Car Rider ☐ Special Needs Bus ☐ After School

Part I – Health Information

Place your child receives health care:

Physician's Name: _____

Address: _____

Phone: _____

☐ **Community Health Center**

☐ **Health Department**

☐ **Hospital Clinic**

☐ **No Regular Place**

☐ **Private Doctor /HMO**

Your child's Insurance Information:

☐ **ALL KIDS**

☐ **Medicaid**

☐ **No Insurance**

☐ **Other** _____

☐ **Private Insurance**

Place your child receives dental care:

Dentist's Name: _____

Address: _____

Phone: _____

☐ **Community Health Center**

☐ **Health Department**

☐ **Hospital Clinic**

☐ **No Regular Place**

☐ **Private Dentist /HMO**

Preferred Hospital: _____

Part II – Medical History Medical Equipment /Procedures Required at School

☐ Catheter ☐ Gastric Tube ☐ Nebulizer Treatments ☐ Oxygen Supplement ☐ Tracheostomy

☐ Vagal Nerve Stimulator (VNS) ☐ Ventilator ☐ Wheelchair ☐ Walker

☐ Other *Please explain:*

Medications and Procedures at School require a Prescriber/Parent Authorization Form (one for each medication or procedure) Please see your school nurse.

Please Complete Back of Form (Signature Required)

ALABAMA STATE DEPARTMENT OF EDUCATION

HEALTH ASSESSMENT RECORD

School Year: _____-_____

Name of Student

Part III – Medical History

□ YES □ NO	**KNOWN HEALTH PROBLEMS** If NO, go directly to the bottom of the page and provide parent/guardian signature If YES, and diagnosed by a physician, answer each question below.
□ YES □ NO □ YES □ NO	**Attention Deficit Disorder (ADD)** **Attention Deficit Hyperactivity Disorder (ADHD)** Requires medication □ At school □ At Home
□ YES □ NO	**Allergies:** □ **Food** _____ □ **Insects** _____ □ **Environmental** _____ □ **Medications** _____ □ Hives/rash □ Medications □ Breathing difficulty □ Epi-pen □ Other:
□ YES □ NO	**Asthma** □ Uses an inhaler at school □ Uses an inhaler at home
□ YES □ NO	**Blood/Bleeding Problems:** □**Hemophilia,** □**Von Willebrand's,** □**Other** □ **Requires medication** ***Please explain:***
□ YES □ NO	**Frequent Nose Bleeds:** *Please explain*
□ YES □ NO	**Cancer/Leukemia:** *Please explain*
□ YES □ NO	**Cerebral Palsy:** *Please explain*
□ YES □ NO	**Cystic Fibrosis:** *Please explain*
□ YES □ NO	**Dental Problems:** *Please explain:*
□ YES □ NO	**Diabetes** □ **Type 1 Diabetes** □ Monitors Blood Sugars at school □ Requires Insulin at school □ Insulin pump □ Glucagon order □ **Type 2 Diabetes** □ Managed with diet □ Oral medication
□ YES □ NO	**Emotional/Behavioral/Psychological:** *Please explain:*
□ YES □ NO	**Gastrointestinal/Stomach Problems:** *Please explain:*
□ YES □ NO	**Genetic / Rare Disorders:** *Please explain:*
□ YES □ NO	**Headaches:** *Please explain:*
□ YES □ NO	**Hearing Problems:** □ Right Ear □ Left Ear □ Both ears □ Hearing loss □ Hearing aid □ Tubes □ Cochlear Implant
□ YES □ NO	**Heart Condition:** □ ***Activity restrictions:*** □ **Medications taken at home:** *Please explain:*
□ YES □ NO	**Hypertension (High Blood Pressure):** *Please explain:*
□ YES □ NO	**Juvenile Arthritis/Bone-Joint Problems:** *Please explain:*
□ YES □ NO	**Kidney/ Bladder/ Urinary Problems:** *Please explain:*
□ YES □ NO	**Scoliosis:** □ No Treatment □ Wears Brace □ Surgery □ Family History
□ YES □ NO	**Seizures/Convulsions:** Type of seizure: _____ *Medications:* □ Diastat □ Klonopin □ Versed □ Medication taken at home □ Other _____ *Please explain:*
□ YES □ NO	**Sickle Cell:** □ Anemia □ **Trait**
□ YES □ NO	**Shunt:** □ VP shunt *Please explain:*
□ YES □ NO	**Spina Bifida:**
□ YES □ NO	**Special Diet:** *Please explain:*
□ YES □ NO	**Vision Problems:** □ Wears glasses □ Wears contacts □ Other
□ YES □ NO	**Other Medical Conditions:** *Please include **any** medications taken at home only.*

Required Signatures

(Electronic or Written) Parent(s) or Guardian Signature: _____ Date: _____

(Electronic or Written) School Nurse Signature: _____ Date: _____