

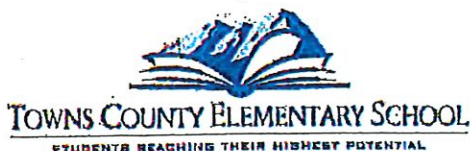


## *Towns County Elementary School*

### *Documents Required with Registration Packet*

- \_\_\_\_\_ Certificate of Immunization - Georgia Form 3231  
(If out of state - must be converted to GA form)
- \_\_\_\_\_ Certificate of Vision, Hearing, Dental and Nutrition Form 3300  
(If entering a GA school for the first time)
- \_\_\_\_\_ Certified Copy of Birth Certificate  
(Not the Hospital Copy)
- \_\_\_\_\_ Copy of Social Security Card
- \_\_\_\_\_ Proof of Residency of Towns County  
(Example: Water, Electric, Gas Bill or Lease Agreement with signature of landlord & renters)  
If proof of residency isn't with the registration packet a tuition fee will occur.  
Students will not be registered until this document is provided.  
Tuition fee is as follows per school year: \$1,000 - out of county, \$3,000 - out of state
- \_\_\_\_\_ Picture I.D. of parent/guardian registering the student
- \_\_\_\_\_ 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 \_\_\_\_\_

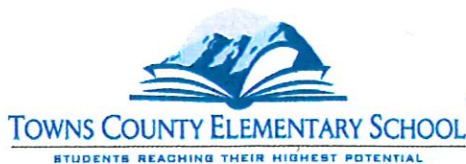
Name and Grade of Brothers and Sisters attending Towns County School System:

|       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |



**Principal:**  
Mr. Shannon Moss  
email: smoss@townscountyschools.org

**System Web Address:**  
www.townscountyschools.org



**Assistant Principal:**  
Mrs. LaTisha Usher  
email: lush@townscountyschools.org

**Counselor:**  
Mrs. Hailey Silvey-Burrell  
email: hsilvey@townscountyschools.org

## **REQUEST FOR RECORDS**

**The student named below has entered our school district:**

Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Current Grade Level: \_\_\_\_\_  
Did student receive any Special Education services: \_\_\_ Yes \_\_\_ No

Releasing School/Agency: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

County: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### **Please fax, mail, or email all the following records for enrollment.**

|                          |   |                            |
|--------------------------|---|----------------------------|
| Cumulative Records       | Certified Birth Certificate                               | Social Security Card       |
| Immunization Form#3231   | Hearing, Vision, Dental, & Nutrition Screening Form #3300 |                            |
| Withdrawal Form          | Current Transcript  | Attendance Summary         |
| Gifted Records           | SST (active/inactive)                                     | EIP/Title/Remedial Records |
| MTSS/RTI Records         | ESOL  | Discipline Record          |
| Standardized Test Scores | Report Cards  | Custody Documents          |

### **ALL Special Education Records:**

\* Speech Records \* Psychological \* Eligibility Report \* Current IEP

### **Parental Consent:**

My consent is given for my child's records and/or all other pertinent information to be released to the Towns County Elementary School. All information obtained will be kept strictly confidential. I give permission for Towns County Elementary School to obtain verbal clarification on any information received.

\_\_\_\_\_  
Parent/Guardian Printed Name

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**Please fax, mail, or email records to:**

**Towns County Elementary School**

**Attn: Registrar**

**1150 Konahetah Road**

**Hiawassee, GA 30546**

**Fax: 706-896-9872**

**Email: fshook@townscountyschools.org**





|   |  |  |                            |
|---|--|--|----------------------------|
| U.S. Office of Personnel Management<br>Guide to Personnel Data Standards  |  | <b>ETHNICITY AND RACE IDENTIFICATION</b><br>(Please read the Privacy Act Statement and instructions before completing form.)   |                            |
| Name (Last, First, Middle Initial)  |  | Social Security Number   | 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. <b>Regardless of your answer to question 1, go to question 2.</b></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.)<br/> <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>  |  |  |                            |
| <p><b>RACIAL CATEGORY</b><br/>(Check as many as apply)</p>  |  | <p><b>DEFINITION OF CATEGORY</b></p>   |                            |
| <input type="checkbox"/> American Indian or Alaska Native   |  | <p>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.</p>  |                            |
| <input type="checkbox"/> Asian  |  | <p>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.</p> |                            |
| <input type="checkbox"/> Black or African American  |  | <p>A person having origins in any of the black racial groups of Africa.</p>  |                            |
| <input type="checkbox"/> Native Hawaiian or Other Pacific Islander  |  | <p>A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.</p>  |                            |
| <input type="checkbox"/> White  |  | <p>A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.</p>   |                            |

Standard Form 181  
Revised August 2005  
Previous editions not usable

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

NSN 7540-01-099-3446





Towns County Elementary School System  
2024-2025

Emergency Student Data Form

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

Student's Name \_\_\_\_\_ Student goes by: \_\_\_\_\_

Birthdate \_\_\_\_\_ Grade \_\_\_\_\_ Age \_\_\_\_\_

Mailing Address \_\_\_\_\_  
Street City State Zip Code

Physical 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.**

Parents or Guardian Signature \_\_\_\_\_



## Towns County Elementary School

**Student's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Medical Information:** (Please be sure to complete both pages for School Health Information Sheet that is included in this packet)

**Allergies:** \_\_\_\_\_ **Medical Alerts:** \_\_\_\_\_

**PreK Program Information:**

**GA PreK** \_\_\_\_\_ **Head Start** \_\_\_\_\_ **Did Not Attend a PreK program:** \_\_\_\_\_

**Name and Address of PreK School Attended:** \_\_\_\_\_

**Has student ever been Home-Schooled?** \_\_\_\_\_

**Has student attended a Georgia School before?** \_\_\_\_\_ **if yes,**

**Name and Address of School(s):**

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**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?** \_\_\_\_\_

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**Is student enrolled in Special Education 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** \_\_\_\_\_ **MTSS/RTI** \_\_\_\_\_  
**ESOL** \_\_\_\_\_ **Other** \_\_\_\_\_

**Any other information concerning your child will be greatly appreciated.**

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## Health Form, for the School Nurse

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

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

Dear parents / guardians,

In preparation for the 2024-2025 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 \_\_\_\_\_ Zyrtec \_\_\_\_\_ 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 2024-2025**

☐ 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 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 \_\_\_\_\_





# Georgia Home Language Survey

## Notice to Parents and Guardians:

Georgia school systems are required<sup>1</sup> to collect your responses<sup>2</sup> to questions about your preferred language for school communication and your child's primary or home language. Information from the first question is used to identify your need for an interpreter or for translated documents. Information from the three *Home Language Survey questions* and the additional language information help us determine whether to screen your child's level of English language proficiency. The screening process will identify if your child qualifies for English learner status and services in our language instruction educational program.

| Purpose of Questions  | Questions & Parent/Guardians Responses  |
|---|---|
| <b>Communication Preferences</b><br><br>This question helps the school provide you with an interpreter or translated documents, free of charge, should you want them.<br><br>This question is for informational purposes only. It is <b>not</b> used to identify your child for English language proficiency screening.   | <b>Parent Communication Language (Required)</b><br><br><ul style="list-style-type: none"> <li>In which language would you prefer to receive school communication?<br/>_____</li> </ul>  |
| <b>Identification of Potential English Learners</b><br><br>These three questions help schools identify if your child should be screened for eligibility to participate in their language instruction educational program.<br><br>When the response to any of these questions is a language other than English, schools may be required to screen your child's level of English language proficiency. If you respond with more than one language, the school will need additional information from you before making this decision.  | <b>Home Language Survey (Required)</b><br><br>1. Which language does your child <u>best</u> understand and speak? _____<br><br>2. Which language does your child <u>most</u> frequently speak at home? _____<br><br>3. Which language do adults in your home <u>most</u> frequently use when speaking with your child?<br>_____   |
| <b>Additional Information from Multilingual Families</b><br><br>If you indicated that your child and other adults in the home <b>understand and use English and another language</b> or languages, schools will ask you to provide additional information to decide if your child should be screened for English proficiency.<br><br>If you respond that your child understands and uses English more than the other home language, or that your child understands and uses both English and the other home language equally, the school will not screen your child for English language proficiency. | <b>Additional Information from Multilingual Families. Choose <u>only one sentence</u> that best describes your child's primary language.</b><br><br><input type="checkbox"/> My child understands and uses only the home language and <b>no English</b> .<br><input type="checkbox"/> My child understands and uses mostly the home language and <b>a little English</b> .<br><input type="checkbox"/> My child understands and uses the home language and English <b>equally</b> .<br><input type="checkbox"/> My child understands and uses <b>mostly English</b> and only a little of the home language.<br><input type="checkbox"/> My child understands and uses <b>only English</b> . |

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

Parent Signature: \_\_\_\_\_

<sup>1</sup> [U.S. Department of Justice, Civil Rights Division, and U.S. Department of Education, Office for Civil Rights, 7 January 2015, Dear Colleague Letter: English Learner Students and Limited English Proficient Parents, p. 10.](#)

<sup>2</sup> The Home Language Survey should be given to first time enrollees to United States public schools.







## 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><b>Information provided on this form is confidential.</b></p> <p><u>Where does the <b>STUDENT</b> currently stay at night?</u></p> <ul style="list-style-type: none"><li><input type="radio"/> We 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 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>For School Use Only:</p> <ul style="list-style-type: none"><li><input type="radio"/> Doubled Up</li><li><input type="radio"/> Doubled 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/Audit Caring for Student | 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 |
|--------------------|----------------|-------|
| _____              | _____          | _____ |
| _____              | _____          | _____ |
| _____              | _____          | _____ |
| _____              | _____          | _____ |

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: ☐



*Richard Woods, Georgia's School Superintendent*  
*"Educating Georgia's Future"*

Distrito Escolar: \_\_\_\_\_

Fecha: \_\_\_\_\_

**Encuesta Ocupacional para Padres**

**Favor de completar este formulario para ayudarnos a determinar si su(s) hijo(s) califica(n) para recibir servicios suplementarios de parte del Programa de Título I, Parte C**

Nombre del/los Estudiante(s)

Nombre de la Escuela

Grado

|       |       |       |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

1. ¿Alguien en su casa se ha mudado para trabajar en otra ciudad, condado, o estado, en los últimos tres (3) años? ☐ Sí ☐ No

2.. ¿Alguien en su casa trabaja, ha trabajado, o tiene la intención de trabajar en una de las siguientes actividades de forma permanente o temporaria, o ha hecho este tipo de trabajo en los últimos tres años? ☐ Sí ☐ No

Si la respuesta es "sí", marque todo trabajo que aplique:

- ☐ 1. Sembrando/cosechando vegetales (como tomates, calabazas, cebollas, etc.) o frutas (como uvas, fresas, arándanos, etc.)
- ☐ 2. Sembrando, cortando, procesando árboles, o juntando paja de pino (*pine straw*)
- ☐ 3. Procesando/empacando productos agrícolas
- ☐ 4. Trabajo en lechería o ganadería
- ☐ 5. Trabajo en empacadoras o procesadoras de carnes (como de res, pollo o mariscos)
- ☐ 6. Pesca o crianza de peces
- ☐ 7. Otra actividad. Por favor especifique en cuál: \_\_\_\_\_

Nombre de los padres o guardianes legales: \_\_\_\_\_

Dirección donde vive: \_\_\_\_\_

Ciudad: \_\_\_\_\_ Estado: \_\_\_\_\_ Código Postal: \_\_\_\_\_ Teléfono: \_\_\_\_\_

¡Muchas Gracias!

Por favor regrese este formulario a la escuela

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 MBP office serving your district:

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

GaDOE Region 2 MBP, 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.**





## 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 years of age, 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 (706) 896-2265 or a Georgia licensed physician to have immunizations transferred to the Georgia Certificate form 3231.**





## CERTIFICATE OF IMMUNIZATION

Child's Name (Last name first)

Birthdate

(Optional) Parent/Guardian Name (Last name first)

Date of Expiration

(Next required immunization  
or review of medical  
exemption due.)☐ (Fill in X)

Complete For K through 6th Grade

Child must be  $\geq 4$  years and have met all  
requirements for school attendance.☐ (Fill in X)

Complete For 7th Grade or higher

Fulfills requirements K through 6th grade  
AND must have Tdap and MCV4 documented

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.

| VACCINE  | DATE |    |    | DATE |    |    | DATE |    |    | DATE |    |    | DATE |    |    | Total Doses | Diagnosed | Serology + | History | Med. Exemption |
|--|------|----|----|------|----|----|------|----|----|------|----|----|------|----|----|-------------|-----------|------------|---------|----------------|
|  | MM   | DD | YY | MM   | DD | YY | MM   | DD | YY | MM   | DD | YY | MM   | DD | YY |             |           |            |         |                |
| <b>Required Vaccines for School or Child Care Attendance</b> |      |    |    |      |    |    |      |    |    |      |    |    |      |    |    |             |           |            |         |                |
| 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  |      |    |    |      |    |    |      |    |    |      |    |    |      |    |    |             |           |            |         |                |
| <b>Recommended Vaccines (For Information Only)</b>           |      |    |    |      |    |    |      |    |    |      |    |    |      |    |    |             |           |            |         |                |
| Rotavirus  |      |    |    |      |    |    |      |    |    |      |    |    |      |    |    |             |           |            |         |                |
| HPV (3 doses)  |      |    |    |      |    |    |      |    |    |      |    |    |      |    |    |             |           |            |         |                |
| Influenza  |      |    |    |      |    |    |      |    |    |      |    |    |      |    |    |             |           |            |         |                |
| Td (booster)   |      |    |    |      |    |    |      |    |    |      |    |    |      |    |    |             |           |            |         |                |

## Notes:

A licensed Georgia physician, Advanced Practice Registered Nurse, Physician Assistant or 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 Dept.

Certified by (Signature/Signature Stamp)

Date of Issue







# 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

## 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

## 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

## NUTRITION

- ☐ Unable to screen (explain why below)

- Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
BMI: \_\_\_\_\_ BMI%: \_\_\_\_\_
- ☐ 5<sup>th</sup> to 84<sup>th</sup> percentile - Appropriate for age
  - ☐ < 5<sup>th</sup> percentile - Needs further evaluation
  - ☐ ≥ 85<sup>th</sup> 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: \_\_\_\_\_

Screener's Signature \_\_\_\_\_ Date \_\_\_\_\_

I certify that this child has received the above screening.

Contact Information: \_\_\_\_\_

Screener's Signature \_\_\_\_\_ Date \_\_\_\_\_

I certify that this child has received the above screening.

Contact Information: \_\_\_\_\_

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

1<sup>st</sup> attempt 2<sup>nd</sup> attempt Actions reported (if any)

Vision

Hearing

Dental

Nutrition

Screeners' Comments:

Student support services initiated on:



# Georgia Department of Public Health Form 3300

## Certificate of Vision, Hearing, Dental, and Nutrition Screening

**Who is required to file this Form 3300?** The parent or guardian of a child who is being admitted for the first time to a public school in Georgia must file a completed Form 3300 with the school when the child is enrolled.

**What is the purpose of Form 3300?** Form 3300 is intended to make sure that every child in Georgia is screened for possible problems with their vision, hearing, teeth and nutrition. The earlier these problems are detected, the earlier parents can seek professional help for the child.

**What screenings are required?** Four different screenings are required: vision, hearing, dental, and nutrition. All four screenings must be conducted and reported on the form before it can be filed with the school.

**Who can conduct the screenings?** Your child's doctor is authorized to conduct all four screenings, as is your local health department. In addition, the vision screening can be conducted by a Georgia licensed optometrist, an employee of Prevent Blindness Georgia trained to conduct vision screening, or a school registered nurse; the hearing screening can be conducted by a Georgia licensed speech-language pathologist or audiologist, or a school registered nurse; the dental screening can be conducted by a Georgia licensed dentist, dental hygienist, or a school registered nurse; and the nutrition screening can be conducted by a Georgia licensed dietitian or a school registered nurse. It is not necessary that the same person conduct all four screenings.

**What does "BMI" and "BMI%" mean?** "BMI" means "body mass index." BMI is a way to describe how much a child weighs in relation to height. "BMI percentile" is a way to compare the child's body mass index to the body mass index of a healthy child. If the child's BMI is less than 5% or more than 84% of what is appropriate for his or her age and height, then the child should be taken to a doctor or dietitian for a more detailed evaluation. For more information, visit the Centers for Disease Control and Prevention website on child and teen BMI at:  
[http://www.cdc.gov/healthyweight/assessing/bmi/childrens\\_bmi/about\\_childrens\\_bmi.html](http://www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/about_childrens_bmi.html)

**What should a parent do if the "needs further evaluation" box is checked?** "Needs further evaluation" means that the child may have a problem. If the "needs further evaluation" box is checked, then the parent should take the child to a professional for a more detailed evaluation. Your doctor or local health department may be able to help, or recommend someone who can help.

**What if a Form 3300 was previously filed for the child at another school?** It is only necessary to file the Form 3300 once. If the Form 3300 is filed at the child's first school, and the child later transfers to another school, then the original school is required to forward the Form 3300 to the new school.