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, County, & State of Birth: _____ _____ _____

Entry into U.S. _____ Date entered U.S. School _____

First Language Learned: _____ Language Spoken at Home: _____

Language Spoken most often: _____

Home Address: _____ _____ _____ _____ _____

Street City State Zip Code County

Home Phone Number: _____

Mailing Address: _____ _____ _____ _____ _____

Street / PO # City State 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): _____Name of Step Parent(s) if any: _____

Name of Student's Legal Guardian: _____#of People living in household: _____

Name and Grade of Siblings attending Towns County Schools:

_____ _____

_____ _____

Towns County Elementary School

Request for Records

The student named below has entered our school district:

Student 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#:** _____

***Parental Consent*:**

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

_____ _____ _____

Parent / Guardian Printed Name **Signature of Parent / Guardian** **Date**

Please fax, email or mail ALL the following records for enrollment.

All Cumulative Records	Certified Birth Certificate	Social Security Card
Immunization Form #3231	Withdrawal Form	Current Transcript
Hearing, Vision, Dental, Nutrition Screening Form #3300		Attendance Summary
Gifted Records	MTSS/RTI/SST, 504 (active/inactive)	EIP/Title/Remedial Records
ESOL	Discipline Record	Custody Documents
Standardized Test Scores	Report Cards	

All Special Education Records:

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

Please send records to either of the following below:

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 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)	Social Security Number	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 Elementary School

2025-26

EMERGENCY STUDENT DATA FORM

Date: _____ Home Phone Number: _____

Student's Name: _____ Student Goes By: _____

DOB: _____ Grade: _____ Age: _____

Mailing Address: _____ _____ _____ _____

Street City State Zip

Physical Address: _____ _____ _____ _____

Street City State Zip

Mother's Name: _____ Cell #: _____ Work#: _____

Email Address: _____

Father's Name: _____ Cell #: _____ Work#: _____

Email Address: _____

Guardian (if different from parents)_____

Cell #_____ Work # _____

Address:_____ _____ _____ _____

Street City State Zip

****Persons Authorized to Pick Up / Sign Out Student****

PLEASE INCLUDE YOURSELF

The student will only be released to the following listed below:

Name	Phone Number
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

If school lets out early due to inclement weather, please be sure the teacher has your dismissal information on file. **Parent or Guardian Signature**: _____

Towns County Elementary School

Student's Name: _____ Date: _____

Medical Information: (Please be sure to complete both pages of the School Health Information sheets 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):_____

_____

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 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: _____

_____

_____

_____

Health Form for the School Nurse

Student Name: _____ **Date:** _____

Grade: _____ **Teacher / Homeroom:** _____

Dear Parents / Guardians,

In preparation for the **2025-26** school year, it is very important to have accurate health information in order to best serve your child. Please complete both pages of this school health form and return to your child's homeroom teacher.

Parent of Head Start / PreK, Kindergarten and First Grade: Always send an 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 are 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 school and someone from the clinic will have you 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 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 _____ Benedryl _____

Oragel (gum pain) _____ Cough Drops _____ Burn Cream _____

Neosporin, Aquaphor (topical ointments) _____

Caladryl (topical use for rash/insect bites) _____

_____ _____

Parent / Guardian Signature **Date**

Health Information for School Year 2025-26

___ High School ___Middle School ___Elementary School ___ Head Start / PreKGrade: _____
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[1] to collect your responses[2] 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
Communication Preferences This question helps the school provide you with an interpreter or translated documents, free of charge, should you want them. This question is for informational purposes only. It is **not** used to identify your child for English language proficiency screening.	**Parent Communication Language (Required)** • In which language would you prefer to receive school communication? _____
Identification of Potential English Learners These three questions help schools identify if your child should be screened for eligibility to participate in their language instruction educational program. 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.	**Home Language Survey (Required)** 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? _____
Additional Information from Multilingual Families If you indicated that your child and other adults in the home ***understand and use English and another language*** or languages, schools will ask you to provide additional information to decide if your child should be screened for English proficiency. 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.	**Additional Information from Multilingual Families.** ***Choose only one sentence that best describes your child's primary language.*** ☐ My child understands and uses only the home language and **no English**. ☐ My child understands and uses mostly the home language and **a little English**. ☐ My child understands and uses the home language and English **equally.** ☐ My child understands and uses **mostly English** and only a little of the home language. ☐ My child understands and uses **only English**.

Student Name: _____ **Parent Signature:**_____

[1] 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.*
[2] 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

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

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: ☐

Georgia Department of Education

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 "si", 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. Pezca 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 MEP office serving your district:

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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 phone, by fax, parent square, any social media or emails.

****Lunch Visitors****

At this time the school will not allow visitors in the building to have lunch with students.

Towns County Elementary School

Immunization Requirements

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

A hearing, vision, dental and nutrition screening must be completed prior on GA form 3300. All immunizations are required to be on GA 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 a 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 a 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.**

Rev. 07/2014

Georgia Department of Public Health

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 ≥ 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 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 (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

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

PLEASE SEE THE INSTRUCTIONS ON THE BACK OF THIS FORM

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

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 dietician 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 dietician 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

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.