

Student Name _____

Last, First & Middle

STUDENT RESIDENCY QUESTIONNAIRE



The information requested on this form fulfills one requirement of the McKinney-Vento Act 42 U.S.C. 11434a(2), which is also known as the Title X, Part C, of the No Child Left Behind Act. The answers you give will help determine the services your student may be eligible to receive. **No student(s) will be discriminated against based upon any of this confidential information provided.**

School: _____ Grade: _____ Date of Birth: _____ Age: _____

Gender: M or F Ethnicity: _____ Parent/Guardian Name: _____

Phone Number: _____ Current Street Address: _____

Today's Date: _____ City, State, Zip _____

Complete Section A... IF you are living in a TEMPORARY RESIDENCE. If you have a **PERMANENT residence** (such as a house, an apartment, or a condo), please **only** complete **Section C** below.

Section A.

1. Is the student living in a temporary place such as: motel/hotel, car, camper, emergency shelter, friend's house, relative's house? YES _____ NO _____
2. Was the student forced into a temporary place due to loss of housing from eviction, foreclosure, financial hardship, domestic violence, fire or natural disaster, death or incarceration of parent/guardian, or other crisis situation? YES _____ NO _____

If either question above is answered Yes, please explain further: _____

If you answered **Yes to BOTH QUESTIONS** in **Section A**, please **complete Section B** below. **Otherwise**, you may **skip to Section C** below and **sign** the form.

Section B. Please check the box that best describes where the student is presently living:

- In the home/apartment of a friend or relative (sharing someone else's home because you have nowhere else to live)
- In a shelter or transitional housing program (examples: family shelter, domestic violence shelter, youth shelter, etc.)
- In a hotel or motel because of economic hardship, eviction, foreclosure, fire, lack of deposits for permanent housing, etc.
- In a tent, car, van, abandoned building, on the streets, at a campground, in the park, or at another unsheltered location
- Moving from place to place

Check the box that best describes with whom the student resides. (Please note: legal guardianship may be granted only by a court; students living on their own or with friends or relatives who do not have legal guardianship are allowed to enroll in and attend school. The school cannot require proof of guardianship for enrollment or continued attendance.)

Parent(s) Legal Guardian(s) Caregiver(s) who are not legal guardian(s) (example: relatives, friends, parent of friends, etc.)

Other, please specify: _____

Is this student awaiting foster care placement? If so, please explain: _____

Please list all student(s) and their age(s) of this family under your care: _____

Section C. I understand that the information provided above is correct, true and current. I also understand that enrolling a child in a Tennessee public school under false pretense is punishable by law.

Signature of Parent/Guardian or Other Person completing form

Relationship to Student

Date

Indian Lake Elementary

Student Name _____ Date _____ Grade _____

Birthdate _____ Last _____ First _____ Middle _____ Nickname _____
Age _____ Sex _____ City of Birth _____ County of Birth _____ State of Birth _____ Country of Birth _____

Race: White _____ American Indian _____ Asian _____ Black/African American _____ Pacific Islander/Native Hawaiian _____ Check all that apply

Ethnicity: Hispanic _____ Not Hispanic _____

List sibling(s) currently attending the SCS: 1) _____ 2) _____ 3) _____ 4) _____

School Last Attended _____ Address _____ Phone _____ Dates _____

Custody: Mother _____ Father _____ Both _____ Other _____ Custody Papers On File In Office? Y or N _____ Non Custodial Parent May Pick Child Up From School? Y or N _____

Visitation Restrictions: _____ Non Custodial Parent May Attend School Functions and Join Child For Lunch? Y or N _____

Please List Any Person(s) Your Child Should NEVER Be Allowed Contact With. You Must Provide A Valid No-Contact Order For Us To Deny Contact With A Non-Custodial Parent.

Name _____ Relationship _____
Name _____ Relationship _____
Name _____ Relationship _____

Father/Guardian _____ Mother/Guardian _____

Address _____ Address _____

Primary Phone _____ Secondary _____ Primary Phone _____ Secondary _____

Employer _____ Work Phone _____ Employer _____ Work Phone _____

Email _____ Email _____

Primary Residential Parent Child Lives At This Address Primary Residential Parent Child Lives At This Address

List Persons (over 18) Who Have Permission To Sign Out & Transport Your Child If You Cannot Be Reached. Parents Are Required To Notify The School Office In Writing If Any Pick Up Information Changes.

Name _____ Relationship _____ Home Phone _____ Cell Phone _____

Name _____ Relationship _____ Home Phone _____ Cell Phone _____

Name _____ Relationship _____ Home Phone _____ Cell Phone _____

I affirm that all information given is complete and accurate, and that the home address provided is the legal residence of the student and the student's primary custodian. I understand that the student's assignment to a school is based on the legal residence of the primary custodian.
Parent or Guardian Signature _____ Date _____

Car Rider AM / PM / BOTH Bus Rider AM / PM / BOTH

Daycare AM / PM / BOTH

SUMNER COUNTY SCHOOLS STUDENT HEALTH INFORMATION FORM

School Year 2022-23

Dear Parents/Guardians: Please complete the following information, **FRONT & BACK**, and return it as soon as possible. This information will only be shared with the necessary school personnel to maintain and promote the student's health/wellbeing.

Student Name: _____ Sex: Male / Female Date of Birth: _____

School: _____ Grade: _____ Homeroom or 1st Period Teacher: _____

School attended last year: _____

Student is a: Bus rider _____ (Bus number-AM _____ PM _____) Car rider _____ Drives _____ Other _____

Parents/guardians are responsible for providing ALL medications, including over the counter (OTC) medicines, for their children. All medications must be delivered to the school in person by the parent, guardian, or parent/guardian's adult designee.

Check and explain in space below if your child, CURRENTLY or IN THE LAST 2 YEARS ONLY, has had any of the following conditions:

Disease/Condition	Yes	No	Please explain/elaborate here:
Diabetes			If yes, Type I or Type II? (please circle) Any medications?
Heart Problems			
Significant Kidney or Urinary Problems			
Asthma (in last 2 years)			Is a rescue inhaler used? Y / N Other medications?
Psychological Concerns			If yes, please list current medications:
Stomach/Intestinal Problems			
Seizure Disorder			Type: _____ Date of last seizure: _____ Medications: _____
			Is Diastat prescribed? Y / N Has it ever been given? Y / N Date last given: _____
Life-Threatening Allergies			To what? _____
			Is an EpiPen® prescribed? Y / N Has it ever been used? Y / N Date last used: _____
			Is Benadryl given with the EpiPen®? Y / N
List All Other Known Allergies (i.e. Meds, Foods, Nuts, Bee Stings, etc.):			
Other Significant Health Concerns:			

Does your child have a physical or mental impairment that significantly limits one or more major life activities? Y / N If Yes, please explain: _____

Does your child take medication regularly, not listed above? Y / N If Yes, what? _____

Student's primary doctor: _____ Phone: _____

Student's Specialist (if applicable): _____ Phone: _____

Your signature is an informed consent to share health history information with school staff on a need-to-know basis for emergency plans & health plans. Student health information, within the school setting, is limited to the information necessary to serve the student's education and health interests. Your signature gives the school nurse permission to communicate with your student's health care provider(s) regarding health concerns.

Parent/Guardian Name: _____ Signature: _____ Date: _____

Home Phone: _____ Cell: _____ Work/Ext: _____

Parent e-mail address(es): _____

STUDENT'S NAME: _____

SUMNER COUNTY SCHOOLS
MEDICATION ADMINISTRATION PROTOCOL

NEVER SEND MEDICINE OF ANY TYPE TO SCHOOL WITH YOUR CHILD. Only medications required to maintain student's attendance will be given. All students must have prescription and non-prescription forms completed before the school can administer medication to the student. **Over the counter/non-prescription medications will be given according to package directions only**, unless accompanied by a physician's order with alternate directions. All prescription medications require physician and parent signature. The pharmacy label **MUST** match the physician's written order. Non-prescription medications require a parent's signature only and must be sent in a sealed, unopened bottle. **No Ziploc baggies, unlabeled bottles, or expired medications will be accepted.**

Please note: alternative medicines and/or treatments such as herbal supplements, homeopathic medicines, vitamins, nutritional supplements, essential oils and any other products that are not regulated by the FDA will not be administered at school. The actions and potential side effects of these products are not readily available to health care providers and will not be given by school staff.

- ◆ Morning & "1-time a day" medications should be given at home. This includes over-the-counter medications such as Advil & Tylenol.
- ◆ Antibiotics ordered **less than 4 times** a day will not be given during school hours.
- ◆ Narcotics will not routinely be given during school hours.
- ◆ A new medication form must be completed **each school year**. This includes insulin and emergency medication orders.
- ◆ Medication guidelines for Sumner County Schools does not allow aspirin or products containing aspirin to be given without a doctor's order (BC Powder, Pamprin, Excedrin Migraine, Bayer Aspirin, Midol, Goody's Powder, Pepto-Bismol, etc.). If you are not certain if a product contains aspirin, please check the list of active ingredients for "**salicylate**" or "**salicylic acid**" or consult your pharmacist. If these products must be given during school hours, it will require a physician's order.
- ◆ Any changes in medication must be accompanied by a new form, with the changes noted, and signed by the physician. This includes discontinuing a daily medication.
- ◆ All unused medication will only be returned to the parent/guardian/parent's adult designee. If medication is not picked up within two weeks of the request being made, or the medication being discontinued **the medication will be discarded**. No medication will be stored over the summer; **medications left at the end of the school year will be discarded after dismissal on the last full day of instruction.**
- ◆ **No student should ever transport or possess medications on school property, aside from medications permitted by state law & physician order (i.e. EpiPen, rescue inhaler, Glucagon, Cystic Fibrosis enzymes).**
- ◆ **When relocating from another state**, parents will have 30 days to convert existing orders to a Tennessee physician (proof of appointment will also be accepted for specialists and others that may be more difficult to schedule).

I have read and understand the above information and I am aware that my child will not receive medications at school unless my designee or I bring it in. I understand that I will be notified to come to school to sign for any medication that is not brought in correctly.

Parent / Guardian Signature

Date

PARENT/GUARDIAN PLEASE COMPLETE BOTH SIDES OF THIS FORM

Nurse/Staff Notes Only: _____

Entregado a los padres: IHP _____ (IHP Declined _____) Med Form _____ 504 Letter _____

Fecha: _____

El estudiante tiene un: 504 _____ IEP _____

Añadido a Skyward _____

ESCUELAS DEL CONDADO DE SUMNER FORMULARIO DE INFORMACIÓN DE SALUD DEL ESTUDIANTE
Año Escolar 2022-23

Estimados padres/tutores: Complete la siguiente información, **FRENTE Y REVERSO**, y devuélvala lo antes posible. Esta información solo se compartirá con el personal escolar necesario para mantener y promover la salud/bienestar del estudiante.

Nombre del estudiante: _____ Sexo: Masculino/Femenino Fecha de Nacimiento: _____

Escuela: _____ Grado: _____ Aula/profesora de 1er periodo: _____

Escuela a la que asistió el año pasado: _____

El estudiante es usara: el autobús _____ (Número de autobús -AM _____ PM _____) Carro _____ Otro _____

Los padres/tutores son responsables de proporcionar TODOS los medicamentos, incluidos los medicamentos de venta libre (OTC), para sus hijos. Todos los medicamentos deben ser entregados a la escuela en persona por el padre, tutor o el adulto designado por el padre/tutor.

Marque y explique en el espacio a continuación si su hijo, ACTUALMENTE o SÓLO EN LOS ÚLTIMOS 2 AÑOS, ha tenido alguna de las siguientes condiciones:

Enfermedad/Condición	Si	No	Por favor explique/elabore aquí:
Diabetes			En caso afirmativo, ¿Tipo I o Tipo II? (encierre en un círculo) ¿Algún medicamento?
Problemas del corazón			
Problemas renales o urinarios significativos			
Asma (en los últimos 2 años)			¿Se utiliza un inhalador de rescate? S/N ¿Otros medicamentos?
Preocupaciones psicológicas			En caso afirmativo, indique los medicamentos actuales:
Problemas estomacales/intestinales			
Trastorno convulsivo			Tipo: _____ Fecha de la última convulsión: _____ Medicamentos: _____
			¿Se prescribe Diastat? S/N ¿Se ha dado alguna vez? S / N Fecha de último dato: _____
Alergias potencialmente mortales			¿A qué?
			¿Se receta un EpiPen®? S/N ¿Se ha usado alguna vez? S/N Fecha de último uso: _____
			¿Se administra Benadryl con el EpiPen®? S/N
Enumere todas las demás alergias conocidas (es decir, medicamentos, alimentos, nueces, picaduras de abeja, etc.):			
Otras preocupaciones de salud significativas:			

¿Su hijo tiene un impedimento físico o mental que limita significativamente una o más actividades importantes de la vida? S / N En caso afirmativo, explique:

¿Su hijo toma medicamentos con regularidad, no mencionados anteriormente?

S/N En caso afirmativo, ¿qué? _____

Doctor primario del estudiante: _____ Teléfono: _____

Especialista del estudiante (si corresponde): _____ Teléfono: _____

Su firma es un consentimiento informado para compartir información del historial de salud con el personal de la escuela según sea necesario para planes de emergencia y planes de salud. La información de salud del estudiante, dentro del entorno escolar, se limita a la información necesaria para atender los intereses educativos y de salud del estudiante. Su firma le da permiso a la enfermera de la escuela para comunicarse con los proveedores de atención médica de su estudiante con respecto a problemas de salud.

Nombre del Padre de Familia / Guardian: _____ Firma: _____ Fecha: _____

Teléfono de casa: _____ Celular _____ Trabajo/Ext: _____

Dirección(es) de correo electrónico de los padres: _____

ESCUELAS DEL CONDADO DE SUMNER

PROTOCOLO DE ADMINISTRACIÓN DE MEDICAMENTOS

NUNCA ENVÍE MEDICAMENTOS DE NINGÚN TIPO A LA ESCUELA CON SU HIJO. Solo se administrarán los medicamentos necesarios para mantener la asistencia del estudiante. Todos los estudiantes deben tener formularios de prescripción y de venta libre completos antes de que la escuela pueda administrarle medicamentos al estudiante. Los medicamentos de venta libre/sin receta se administrarán según las instrucciones del paquete únicamente, a menos que vayan acompañados de una orden médica con instrucciones alternativas. Todos los medicamentos recetados requieren la firma del médico y de los padres. La etiqueta de la farmacia DEBE coincidir con la orden escrita del médico. Los medicamentos sin receta solo requieren la firma de los padres y deben enviarse en una botella sellada y sin abrir. No se aceptarán bolsas Ziploc, botellas sin etiquetar o medicamentos vencidos.

***Tenga en cuenta: no se administrarán en la escuela medicamentos y/o tratamientos alternativos como suplementos a base de hierbas, medicamentos homeopáticos, vitaminas, suplementos nutricionales, aceites esenciales y cualquier otro producto que no esté regulado por la FDA. Las acciones y los posibles efectos secundarios de estos productos no están fácilmente disponibles para los proveedores de atención médica y no serán proporcionados por el personal escolar. ***

- ◆ Los medicamentos de la mañana y “1 vez al día” deben administrarse en casa. Esto incluye medicamentos de venta libre como Advil y Tylenol.
- ◆ Los antibióticos ordenados menos de 4 veces al día no se administrarán durante el horario escolar.
- ◆ No se administrarán narcóticos de forma rutinaria durante el horario escolar.
- ◆ Se debe completar un nuevo formulario de medicamentos cada año escolar. Esto incluye órdenes de insulina y medicamentos de emergencia.
- ◆ Las pautas de medicamentos para las escuelas del condado de Sumner no permiten que se administren aspirinas o productos que contengan aspirinas sin una orden médica (BC Powder, Pamprin, Excedrin Migraine, Bayer Aspirin, Midol, Goody's Powder, Pepto-Bismol, etc.). Si no está seguro de si un producto contiene aspirina, consulte la lista de ingredientes activos para "salicilato" o "ácido salicílico" o consulte a su farmacéutico. Si estos productos deben administrarse durante el horario escolar, se requerirá una orden médica.
- ◆ Cualquier cambio en la medicación debe ir acompañado de un nuevo formulario, con los cambios anotados y firmados por el médico. Esto incluye suspender un medicamento diario.
- ◆ Todos los medicamentos no utilizados solo se devolverán a los padres/tutores/persona adulta designada por los padres. Si no se recoge el medicamento dentro de las dos semanas posteriores a la solicitud, o si se suspende el medicamento, se desechará el medicamento. No se almacenará ningún medicamento durante el verano; los medicamentos que queden al final del año escolar se desecharán después de la salida del último día completo de instrucción.
- ◆ Ningún estudiante debe transportar o poseer medicamentos en la propiedad escolar, aparte de los medicamentos permitidos por la ley estatal y la orden médica (es decir, EpiPen, inhalador de rescate, glucagón, enzimas de fibrosis quística).
- ◆ Al mudarse de otro estado, los padres tendrán 30 días para convertir las órdenes existentes a un médico de Tennessee (también se aceptará prueba de cita para especialistas y otros que pueden ser más difíciles de programar).

He leído y entiendo la información anterior y sé que mi hijo no recibirá medicamentos en la escuela a menos que su doctor lo designe o yo traiga los medicamentos. Entiendo que se me notificará para que venga a la escuela a firmar por cualquier medicamento que no se administre correctamente

Firma del Padre / Tutor

Fecha

PADRE/TUTOR POR FAVOR COMPLETE AMBOS LADOS DE ESTE FORMULARIO

Solo notas de enfermera/personal:
