Weddington Middle School
Marcus Leake, Principal
5903 Deal Road
Matthews, NC 28104
Phone 704-814-9772
Fax 704-814-9775
marcus.leake@ucps.k12.nc.us

Dear Parent(s) and Student:

Welcome to Weddington Middle School! Attached is a student informational packet that will need to be completed and returned to the school in order to start the enrollment process.

Along with the completed forms, please include a copy of the following documents:

- Birth Certificate
- Immunization Record
- Two proofs of residence, examples below:
    - Notarized rental agreements
    - Recent utility bills (electric, telephone, gas etc)
    - Current Driver's License
    - Current Car insurance or Property Insurance policies
- Previous report cards, test scores, and recommendations for placement
- Withdrawal Slip from previous school if enrolling during the school year

The above information must be obtained before we can enroll your child.

We look forward to working with you and your child at Weddington Middle School. Please feel free to call with any questions.

Warmest Regards,

Christie Haas

Data Manager

704-814-9772 ext. 1804

Christie.haas@ucps.k12.nc.us

Growing Possibilities...

In compliance with federal law, UCPS administers all educational programs, employment activities and admissions without discrimination against any person on the basis of gender, race, color, religion, national origin, age or disability.

STUDENT ENROLLMENT FORM

UNION COUNTY PUBLIC SCHOOLS

For Office Use Only:
Student ID ____________________ Enrollment Date ____________ Grade ____
Registration completed ____________ School ____________
Need ☐ Immunization Record ☐ Birth Certificate ☐ POR Transportation ____________
School Receiving Packet ____________ Teacher's Name ____________
Date Received ____________ Packet received by ____________

Please indicate the student's academic placement:

☐ New Kindergartener for the ____________ school year
☐ New Pre-Kindergartener for the ____________ school year
☐ New student entering grade ______ for the ____________ school year

Student Information

Birth certificate or other satisfactory evidence of age and official record of immunizations must be presented at time of enrollment. Copies of these documents are to be placed in folder and originals returned to parent/guardian.

Legal Name ______________________________ / ____________
Last First Middle Nickname

Physical address ______________________________
House/Apt. Number Street City State Zip

Mailing Address(if different) ______________________________
House/Apt. Number Street City State Zip

Home Phone ____________

☐ Male ☐ Female Date of Birth ____________ Place of Birth ____________
Month/Day/Year City/State/Country

Ethnicity: ☐ Hispanic ☐ Non-Hispanic
Race: (select all that apply) ☐ American Indian ☐ Black ☐ Asian ☐ Hawaiian/Pacific Islander ☐ White

Child resides with ______________________ ____________
Relationship to Student

Legal Custodian ____________ Legal paperwork provided to school ☐ Yes ☐ No

Family Information

Father's Full Name ______________________________

Place of Birth (City/State/Country) ____________ Deceased ☐ Yes ☐ No

Address ______________________________

Home Phone ____________ Cell Phone ____________

Employer ____________ Work Phone ____________

Highest Education level completed ____________ E-mail address ____________

Mother's Full Name (include maiden name) ______________________________

Place of Birth (City/State/Country) ____________ Deceased ☐ Yes ☐ No

Address ______________________________

Home Phone ____________ Cell Phone ____________

Employer ____________ Work Phone ____________

Highest Education level completed ____________ E-mail address ____________

Stepparent's, Legal Guardian's, or Sponsor's information (if applicable) Relationship to student ____________

Name ____________ Address ____________

Home/Cell Phone ____________ Employer ____________ Business Phone ____________

E-mail address ______________________________

STUDENT ENROLLMENT FORM

UNION COUNTY PUBLIC SCHOOLS

Other Information

Pick up Child

Emergency Contact ______________________________ ☐ Yes ☐ No
(Other than parent) Name Relationship Phone

Emergency Contact ______________________________ ☐ Yes ☐ No
(Other than parent) Name Relationship Phone

Emergency Contact ______________________________ ☐ Yes ☐ No
(Other than parent) Name Relationship Phone

If someone does **not** have your permission to pick up your child, please list name and relationship.

____

Other children in the family (please note if the sibling is a stepsibling)

Name ______________ School ______________ Grade ____
Name ______________ School ______________ Grade ____
Name ______________ School ______________ Grade ____

Give pertinent health or medical information and instructions (including any medicines prescribed and any physical restrictions)

____

____

Permission to obtain medical attention ☐ Yes ☐ No

Medical Provider ______________________________
Name Address Phone

Dentist ______________________________
Name Address Phone

Please indicate the student's previous academic placement (if applicable)

☐ Private School ______________ ______________
Name Street Address, City, State, Zip

☐ Charter School ______________ ______________
Name Street Address, City, State, Zip

☐ Public School ______________ ______________
Name Street Address, City, State, Zip

☐ Group Home/Institution ______________ ______________
Name Street Address, City, State, Zip

☐ Home School

Date last attended previous placement __________ Grade___ Homeroom teacher ______________
Month/Year

Has the student ever been enrolled in Union County Public Schools? ☐ Yes ☐ No

If yes, School Name ______________________________ School Year ____________

Is the student identified as a student with special needs and being served with a(n):

Individualized Education Program (IEP) ☐ Yes ☐ No If yes, has a copy of the plan been provided? ☐ Yes ☐ No
Section 504 Plan ☐ Yes ☐ No If yes, has a copy of the plan been provided? ☐ Yes ☐ No
Academically Gifted (AIG or TD) ☐ Yes ☐ No If yes, has a copy of the plan been provided? ☐ Yes ☐ No

Has the child ever been retained? ☐ Yes ☐ No If yes, what grade? ____________

Has the student ever left any school due to a Suspension or Expulsion? ☐ Yes ☐ No If yes, explain:

____

Transportation

Morning-student will arrive by ☐ Bus ☐ Car ☐ Walk Afternoon-student will leave by ☐ Bus ☐ Car ☐ Walk

Military Information

Does your child have any member of their immediate family serving in the US Armed Forces? ☐ Yes ☐ No

If yes, ______________________________
Name Relationship Branch of military service

____
Name Relationship Branch of military service

Parent/Legal Guardian ______________________________ ____________
Signature Date

Weddington Middle School

5903 Deal Road

Matthews, NC 28104

Phone: 704-814-9772

Fax: 704-814-9775

Request for Transcripts

Previous School Name and Address:

____

____

____

Student Name: **Date of Birth:**

____________________________ ____________________________

The above named student has enrolled in our school in the _____ grade and has informed us that your school is the last attended.

Please send the following:

- **Transcript of the student's school record including K-5 grades**
- **Grades at the date of withdrawal from your school**
- **Attendance records**
- **Standardized test results**
- **Immunization records**
- **Gifted/Advanced Records**
- **Exceptional Records including IEP or 504**

Please send to the attention of:
Christie Haas
Data Manager/Registrar
christie.haas@ucps.k12.nc.us

Union County Public Schools
North Carolina Immunization/Health Assessment Law Information

Every parent, guardian and person or agency, whether governmental or private, with legal custody of a child shall have the responsibility to ensure that the child has received the required immunizations at the age required by law. It shall be the responsibility of the parent to provide a complete immunization record of each school age child to the school not later than 30 calendar days after the child enters school *or the child will be suspended* from school until such time as a valid complete immunization record can be provided to the school. Please review your child's record to assure that it meets N.C. Immunization Law requirements.

General Statute 130A-152 through 130A-157 states in part that each child's immunization record must have the dates of each immunization and the specific immunizations. The following is a description of the requirements:

If a child enrolled in kindergarten or 1st grade for the first time after 7/1/94, but before7/1/99:

- 5 DTaP/DPT/Td — last dose on or after 4th birthday
- 4 Polio — 3 doses if last dose on or after 4th birthday
- 3 Hib — at least 1 Hib on or after 1st birthday (not given after age 5)
- 2 MMR — 1st dose on or after 1st birthday

If child enrolled in kindergarten for the 1st time after 7/1/99, but before 7/1/2015:

- 5 DTaP/DPT/Td — 4 doses if last dose on or after 4th birthday
- 4 Polio — 3 doses if last dose on or after 4th birthday
- 3 HIB — at least 1 HIB on or after 1st birthday (not given after age 5)
- 2 MMR — 1st dose on or after 1st birthday
- 3 Hepatitis B — last dose not before 24 weeks of age
- 1 Varicella — before school entry

If child enrolled in kindergarten for the first time after 7/1/15:

- 5 DTaP/DPT/Td — last dose required on or after 4th birthday. 4 doses if 4th is after 4th birthday.
- 4 Polio — last dose required on or after 4th birthday. 3 doses if 3rd is after 4th birthday.
- 3 Hib — at least 1 Hib on or after 1st birthday and before 5 years of age
- 2 MMR — 1st dose on or after 1st birthday
- 3 Hepatitis B — last dose not before 24 weeks of age
- 2 Varicella — before school entry (history of chickenpox disease must be documented by a provider)

Additional requirements beginning 7/1/2015:

- 1 Tdap — before entry into 7th grade (this booster dose is required if no Tdap given since age 10)
- 1 Meningococcal — before entry into 7th grade (this booster dose is required if no MCV given since age 10)

Any medical exemption must be in writing from a physician and must state the basis for the exemption pursuant to G.S. 130A-156.

North Carolina Health Assessment Law

G.S. 130A-440 states that every child in the State entering N.C. public schools for the first time shall receive a health assessment. The health assessment shall be made no more than 12 months prior to the day of school entry. The parent, guardian, or responsible person shall have 30 calendar days from the first day of school to present the required health assessment form for the child.

Please feel free to call the School Health Office @ 704-296-0845 to speak with a school nurse if you have questions about the North Carolina Immunization Law or Health Assessment Law.

I am aware that my child's complete immunization record/Health Assessment is due within 30 days of my child's first day of school or he/she will not be allowed to continue in school until such time as a valid immunization record and Health Assessment can be provided to the school. I realize that this responsibility is that of the parent/guardian, not that of the former school. A health assessment form is required for my child if he/she is entering NC public school for the first time.

____________________	____________	____________
Student's Name	Date of Birth	Enrollment Date

____________________	____________
Parent/Guardian Signature	Date

Original in File: copy to parent — revised 5/18 cs

This will be the only notification of health requirements.

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UNION COUNTY PUBLIC SCHOOLS

Request for Health Information

Date:________________

Must be completed annually

Please return the following form to your child's teacher **as soon as possible.** This information will be reviewed by the School Nurse.

Student Name:	Homeroom Teacher/Grade:	Bus#:
School:	**Date of Birth:**	Home Phone:
Parent/Guardian:	Daytime Phone:	
Parent/Guardian:	Daytime Phone:	
Emergency Contact:	Phone:	
Current Doctor/Practice:	Phone:	
Medication allergies and reaction(s): ☐ NONE KNOWN ☐ Yes (list):		
Current Medications:		
Does your child need medications at school: ☐ No ☐ Yes* (list):		

(*)Medication consent form is required to be signed by the health care provider and the parent/guardian. Medication cannot be given until consents have been received.

CHECK THE CONDITION(S) YOUR CHILD HAS BELOW, OR ☐ MY CHILD HAS NO KNOWN HEALTH CONDITIONS
(You may stop here if there are no known medical conditions. Please sign at the bottom and return form).

__ **ADD/ADHD** (See Below)	__ Cerebral Palsy	__ Hearing Aid/Loss	__ Neuromuscular Disease
__ Allergies, Seasonal	__ Crohn's Disease/IBS	__ **Head Injury/Concussion** Date Diagnosed: __________	__ Orthopedic Disability
__ **Allergies, Severe** (See Below)	__ Cystic Fibrosis	__ Heart Conditions Type: __________	__ Renal/Kidney Disease
__ **Asthma** (See Below)	__ **Diabetes** (See Below)	__ Hemophilia/Bleeding Disorder	__ Juvenile Rheumatoid Arthritis
__ Autism	__ Down's Syndrome	__ **Mental Health Diagnosis** (See Below)	__ Sickle Cell Anemia
__ Cancer/Leukemia Date Diagnosed:__________	__ **Epilepsy/Seizures** (See Below)	__ Migraine Headaches	__ Ulcers/Gastric Reflux
	__ Glasses/Contacts		__ Other:__________

FOR THE FOLLOWING CONDITIONS, PLEASE PROVIDE ADDITIONAL INFORMATION:

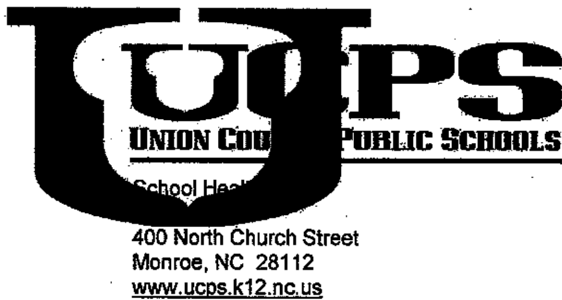
Severe Allergies Notify your School Nurse ***IMMEDIATELY*** If anaphylaxis may occur.	What is your child allergic to? ☐ Peanuts ☐ Tree Nuts ☐ Milk ☐ Eggs ☐ Insect Stings ☐ Other: __________ Is medication needed at school for allergies? ☐ No ☐ Yes* If yes, name: __________ Location of Medication: ☐ Carried by student* **(requires self-carry form)** ☐ Classroom ☐ Health Room Date/Type Last Reaction: __________ Check the type of allergic reaction that occurs: ☐ HIVES ☐ SWELLING ☐ DIFFICULTY BREATHING ☐ OTHER: __________
Asthma	Is medication needed at school for asthma? ☐ No ☐ Yes* If yes, name: __________ Location of Medication: ☐ Carried by student* **(requires self-carry form)** ☐ Classroom ☐ Health Room Date of last episode: __________ Triggers: ☐ Environmental ☐ Seasonal ☐ Exercise induced ☐ Upper respiratory infection ☐ Other:__________
Epilepsy/ Seizures	Type: ☐ Febrile Only ☐ Convulsive ☐ Non-Convulsive Date of last seizure: __________ Is emergency medication needed at school? ☐ No ☐ Yes* If yes, name: __________
Diabetes	Type I ☐ Type II ☐ Diagnosis Date: __________ * **Insulin** by: ☐ Pump ☐ Injections **CGM** (i.e.: Dexcom): ☐ No ☐ Yes, Type: __________ ***Please call to schedule Nurse Conference - Notify your school nurse immediately if newly diagnosed***
ADD/ADHD Mental Health	Type: ☐ ADD/ADHD ☐ Anxiety ☐ Depression ☐ Other: __________ Medication used for treatment: __________

Please be aware that the information you provide will be shared with staff on a need-to-know basis.

In the event of an emergency, and you cannot be reached, I give permission for the School Nurse to contact my doctor for further instructions on medications or care.

______________________________ ______________

Signature of Parent/Guardian **Date**



400 North Church Street
Monroe, NC 28112
www.ucps.k12.nc.us

Dear Parent/Guardian,

I am sending this letter to gather information about students who have health needs. Please fill out the reverse side of this form, "Request for Health Information," regardless of if your student has medical needs that could affect learning or might require emergency care during the school day. A health care provider's written diagnosis is required in order for an Individualized Healthcare Plan to be developed by the school nurse. Also, please let your school nurse know if your child participates in extracurricular school activities.

Chronic Health Conditions

- Please complete the reverse side of this form.
- If your child has a life-threatening condition/allergy, please notify the school nurse and any other staff members who will be in contact with your child (including afterschool care, cafeteria/bus driver/coach/extracurricular activities).
- Contact the school nurse if you need to schedule a conference to discuss details regarding the development of a health care plan for your child.
- Provide necessary changes that occur during the school year, either with contact numbers or your child's health condition.

Medication Administration

- Medication must be sent in the original container if it is an over-the-counter medicine or a prescription bottle if it is a prescription medicine.
- Please check expiration dates. School personnel are not allowed to give expired medications.
- The school does not provide any medications, including ointments, creams, pain relievers, eye drops, etc. Any medication given at school must be provided by the parent/guardian.
- A medication consent form is required for any medication given at school.
- **Signatures from a parent/guardian AND the student's health care provider are required for ANY medication to be given at school. This includes prescription as well as over the counter medications.**
- Faxed consents from parents and/or doctors are acceptable.
- The entire UCPS medication policy may be viewed online at www.ucps.k12.nc.us

If you have questions or concerns, please contact the school. I would be happy to speak with you.

Sincerely,

School Nurse

UCPS
UNION COUNTY PUBLIC SCHOOLS

Weddington Middle School
Steve Wray
5903 Deal Road
Matthews, NC 28104
Phone 704.814.9772
Fax 704.814.9775

Proof of Residence

Student's Name: ______________________________

Parent's Name : ______________________________

Address: ______________________________

City: ____________ State: ______ Zip: ____________

Student's Grade: ____________

Please attach a tangible proof of residence for the above address.

The following list of items will constitute proof of residence in Union County by individuals who are relocating to Union County as a homebuyer, a renter, or are living with a relative or a friend. Where items are linked by and, both items must be verified before proof or residence is granted.

1. A notarized rental agreement or purchase agreement for a house with a person's name and address on it.
2. An electric bill and a telephone bill with the person's name and address on it.
3. An automatic registration card and a driver's license with the person's name and address on it.
4. Car insurance and property insurance policy with the person's name on it.
5. Income tax W-2 form and property tax bill with the person's name and address on it.
6. A notarized statement from the owner of the house where the person is living, listing the names of the person and their child(ren) and a visit by the attendance counselor.

I understand that if I must take temporary housing outside of Union County before I locate permanently inside the boundary of Union County , I MUST pay a tuition charge of $35.00 per week per child and provide transportation until I obtain residence inside Union County . Contact Jonathon Moultrie at 704-292-2504 with any questions.

Parent Signature: ______________________ Date: ____________

Please respond in English

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UNION COUNTY PUBLIC SCHOOLS

English Home Language Survey

HOME LANGUAGE SURVEY

Date ____________ School ______________________________ Grade ________

Has the student ever attended a U.S. school before? ____yes ____no ____________
If yes Date of Entry

Student's Name ______________________________________ DOB ____________
First Name Middle Initial Last Name M/D/Y

Address ____
Street City State Zip

Phone Number ______________________________
Home Work

Parent or Guardian's Name ______________________________________
First Name Middle Initial Last Name

What is the student's country of origin <u>and</u> ethnicity? __________/__________
Origin Ethnicity

1. Is the student's first-learned or home language anything other than English? ______ Yes (Please continue survey) ______ No (Stop here and sign below)

2. Which language did your son/daughter learn when he/she first began to talk? ____________________

3. What language does your son/daughter speak most often? ____________________

4. What language is most often spoken in your home? ____________________

5. Other than languages studied in school, what Language(s) does your son/daughter speak? ____________________

** If the answer to questions 2-5 is a language other than English, the student will be assessed with the State-designated English language proficiency test to ensure appropriate placement and English language assistance if needed.*

______________________________ ______________
Parent or Guardian Signature Date

Phone 704-289-5460 **Fax 704-296-3107**