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 (Other than parent) Name Relationship Phone ☐ Yes ☐ No

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

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

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

Sandy Ridge Elementary
Emily Kraftson, Principal
10101 Waxhaw Manor Dr.
Waxhaw, NC 28173
Phone 704.290.1505
Fax 704.243.3812
www.ucps.k12.nc.us/sandyridge

Proof of Residence Form

Student Name: _____
Parent/ Guardian Name: _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Phone Number: _____

In order for your child to enroll, please attach (2) Proofs of Residence for the above address from the list of acceptable documents listed below: (Where items are linked by ***and*** both items must be given to count as ONE proof of residence.)

- A notarized rental agreement or closing documents for a house with the above parent/guardian's name and address on it.
- Recent utility bills (electric, phone, gas, power, cable, etc.). If two utility bills are submitted, they will count AS (2) two proofs.
- A current driver's license **and** automobile registration card with parent/guardian's name and address on it.
- Current car insurance **and** property insurance policies with the parent/guardian's name and address on it.
- Income tax W-2 form **and** property Tax bill with the parent/guardian's name and address on it.
- A notarized Certificate of Residence form for the owner of the house, where the person is living, listing the names of the person and their child(ren). A visit by the Attendance Counselor will follow.

Parent/Guardian Signature: _____ Date: _____

****Temporary Residence****

Students living outside of Union County at a **temporary** residence, before locating inside the boundaries of Union County, must obtain approval from Union County Public Schools' Central Office.

Please go to https://ucpsncc.scriborder.com/ and apply for a student transfer.

Temporary Address: _____

City: _____ State: _____ Zip Code: _____

Growing Possibilities...

UCPS
UNION COUNTY PUBLIC SCHOOLS

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_____ Date of Birth _____
First Name Middle Initial Last name M/D/Y

Address_____
Street City State Zip Code

Phone Number_____
Phone No. (Home) (Work)

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

Parent or Guardian's Native Language_____

Do you need free translation services to understand school records and/or free interpretation services at conferences in your native language? Yes ___No____

What is the **student's** country of origin and ethnicity? _____/_____
Country Ethnicity

1. Is the student's first-learned or home language anything other than English? _____Yes **(Please continue the 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 foreign 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 may be assessed with the State-designated English language proficiency test to ensure appropriate placement and English language assistance if needed.

_____ _____
Parent/Guardian Signature Date

Phone 704-289-5460 Fax 704-296-3107 Revised 1/2017

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)
- 2 Meningococcal — 1st dose before entry into 7th grade (1st dose is required if no MCV given since age 10)
  2nd dose before entry into 12th grade.

Any medical exemption must be in writing from a physician per 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 1-2020 cs

This will be the only notification of health requirements.

UCPS
UNION COUNTY PUBLIC SCHOOLS

Request for Health Information

Must be completed annually

Date:_____

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**	__ Orthopedic Disability
__ **Allergies, Severe** (See Below)	__ Cystic Fibrosis	**Date Diagnosed:** _____	__ Renal/Kidney Disease
__ **Asthma** (See Below)	__ **Diabetes** (See Below)	__ Heart Conditions	__ Juvenile Rheumatoid Arthritis
__ Autism	__ Down's Syndrome	Type: _____	__ Sickle Cell Anemia
__ Cancer/Leukemia	__ **Epilepsy/Seizures** (See Below)	__ Hemophilia/Bleeding Disorder	__ Ulcers/Gastric Reflux
Date Diagnosed:_____	__ Glasses/Contacts	__ **Mental Health Diagnosis** (See Below)	__ Other:_____
		__ Migraine Headaches	

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**

Revised 03/2019 AH

January 2016

PUBLIC SCHOOLS OF NORTH CAROLINA
State Board of Education | Department of Public Instruction

NORTH CAROLINA HEALTH ASSESSMENT TRANSMITTAL FORM

This form and the information on this form will be maintained on file in the school attended by the student named herein and is confidential and not a public record.
(Approved by North Carolina Department of Public Instruction and Department of Health and Human Services)

PARENT to COMPLETE THIS SECTION

Student Name: ☐ M ☐ F

(Last) (First) (Middle)

Birthdate (M/D/YYYY): **School Name:**

Hispanic of Latino Origin: ☐ 1 Yes ☐ 2 No

Race: ☐ 1 Other Non-White ☐ 2 White ☐ 3 Black ☐ 4 American Indian ☐ 5 Chinese ☐ 6 Japanese ☐ 7 Hawaiian ☐ 8 Filipino ☐ 9 Other Asian ☐ 10 Unknown

Home Address: **City:** **State:** **County:**

Parent Information: Name of Parent, Guardian, or person standing in loco parentis:

Telephone(s)

Home:

Work:

Cell Phone:

Health Concerns to be shared with authorized persons (school administrators, teachers, and other school personnel who require such information to perform their assigned duties):

HEALTH CARE PROVIDER TO COMPLETE THIS SECTION

Medications prescribed for student:

Student's allergies, type, and response required:

Special diet instructions:

Health-related recommendations to enhance the student's school performance:

Vision screening information:
Passed vision screening: ☐ Yes ☐ No
Concerns related to student's vision:

Public Health
HEALTH AND HUMAN SERVICES

Hearing screening information:
Passed hearing screening: ☐ Yes ☐ No
Concerns related to student's hearing:

Recommendations, concerns, or needs related to student's health and required school follow-up:

School follow-up needed: ☐ Yes ☐ No

Medical Provider Comments:

Please attach other applicable school health forms:

Immunization record attached: ☐
School medication authorization form attached: ☐
Diabetes care plan attached: ☐
Asthma action plan attached: ☐
Health care plans for other conditions attached: ☐

Health Care Professional's Certification
I certify that I performed, on the student named above, a health assessment in accordance with G.S. 130A-440(b) that included a medical history and physical examination with screening for vision and hearing, and if appropriate, testing for anemia and tuberculosis. I certify that the information on this form is accurate and complete to the best of my knowledge.

Name: Title:

Signature: _____ Date (m/d/yyyy):

Practice/Clinic Name:			Practice/Clinic Address:	
Practice/Clinic City:	State:	Zip:	Phone:	Fax:

Provider Stamp Here:

Public Health
HEALTH AND HUMAN SERVICES

Sandy Ridge Elementary
Emily Kraftson, Principal
10101 Waxhaw Manor Dr.
Waxhaw, NC 28173
Phone 704.290.1505
Fax 704.243.3812
www.sres.ucps.k12.nc.us

2020-2021 PARENT INPUT FORM

Student's Name _____ **Grade (2020-21)** K **Male/ Female** (Please circle)

Please use the following form to provide the staff of Sandy Ridge Elementary some insight into the teaching style that you feel best fits your child.

If your child *requires* a peanut/nut protocol classroom, please check here. _____

The staff of Sandy Ridge Elementary will consider all information provided, but make no guarantees regarding classroom assignments.

Please describe your child's qualities and characteristics. Also, provide information that provides insight to the qualities and characteristics you believe the teacher should possess for your child to be successful. **Please do not list a specific teacher by name.**

Characteristics- Circle ONLY ONE!

All teachers possess a combination of qualities/styles as listed below; please identify the *ONE* most important characteristic you feel is beneficial for your child's teacher to demonstrate as a strength (this information is helpful in the placement process). If the characteristic does not appear below, please write in the "other" section.

Approachable/Flexible:	positive environment supporting expression/originality as they foster student well-being and confidence
Challenging:	encourages student to stretch and reach full potential by raising the bar with high expectations
Good Classroom Manager:	productive work environment promoting and maximizing on task behavior
Good Communicator:	environment that fosters relationships within the school community
Differentiates Instruction:	promotes opportunities to enhance success with multiple learning styles

Other: _____

Social

The staff of Sandy Ridge Elementary recognizes that some students should not be placed in class together due to personality conflicts and/or prior interactions. If there are students that you would prefer the staff to consider not placing your son/daughter with, please list those names below.

_____ _____

UCPS
UNION COUNTY PUBLIC SCHOOLS
Department Name
400 North Church Street
Monroe, NC 28112
Phone 704.296.9898 Fax 704.289.9182
www.ucps.k12.nc.us

Transportation Department
NEW BUS RIDER INFORMATION FORM

School Year: _____ Date: _____

Student Name: _____ Grade: _____

Parent(s) Name: _____

Primary Phone Number: _____

Home Address: _____

_____

Transportation Needs: AM only _____ PM only _____ or Both _____

Daily Bus Rider _____ Occasional Bus Rider _____

* Please keep in mind, it is the policy of Union County Public Schools Transportation that if your child does not ride 10 consecutive days, he/she will be removed from the bus roster, requiring you to reapply to ride the bus should you choose for your child to do so in the future.

****

Only fill out if an ALTERNATE ADDRESS is needed:

Please record the address in which the student will be picked up and/or dropped off, IF different from the HOME address stated above.

Morning Stop Address: _____

Name/Relationship to Student: _____

Afternoon Stop Address: _____

Name/Relationship to Student: _____

Growing Possibilities.