CUTHBERTSON HIGH SCHOOL
1400 Cuthbertson Road
Waxhaw, NC 28173
704-296-0105 704-843-3591 (fax)

Dear Parent and Student:

Welcome to Cuthbertson High School. Enclosed is a packet of information that needs to be completed and returned to the high school to assist in registering your child. Please fill out the information and return it as soon as possible.

The forms that are included in this packet that need to be completed and returned are:

- Student information form
- Proof of residence (2 from list)
- Record of schools attended
- Home language survey
- Request for transcript
- UCPS NC immunization law information form

Complete the following information **only as necessary:**

- **Certificate of residence** – This form is only needed if **you and the student** will be residing with another family already living in the Cuthbertson attendance area. The form must be **notarized.**
- **Request for health information** – This form needs to be completed if the student has a medical need that may affect learning or require emergency care during the school day.
- **Medications consent form** – This only needs to be completed if the student will need to take any medication(s) at school, a **doctor's signature is required**.
- **Exception children's records request form** – This only needs to be completed if your student has been identified as an EC student.

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

- Birth Certificate
- Official immunization record
- Final report card (or grades as of time of withdrawal from previous school)
- Unofficial transcript
- Exceptional Children / Special Ed / English as second language records (if applicable)
- Standardized test scores
- Photo ID for parent

All of the above information **MUST BE** presented before your child can be enrolled

We look forward to meeting with you and your family.

Sincerely,
Guidance Department.

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 _____

S**tepparent's, Legal Guardian's, or Sponsor's** information (if applicable) Relationship to student_____

Name _____Address_____

Home/Cell Phone _____Employer _____ Business Phone_____

E-mail address _____

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

PROOF OF RESIDENCE

Student name:_____ Grade: _____

Parent names:_____

Home address:_____

Subdivision name:_____

Telephone number:_____

PLEASE ATTACH TWO (2) PROOFS OF RESIDENCE FOR THE ABOVE ADDRESS, FROM THE LIST BELOW:

List of acceptable documents include:

- ***Notarized*** rental/purchase **agreement** for a house with the person's name and address on it
- Recent **Utility** bills (electric, telephone, gas, power, cable, etc.) *If two utility bills are submitted, they will count as your 2 proofs of residence*
- Current **Driver's license** *and* **automobile registration** (as long as the address is the same) These documents are considered ONE
- Current **Car insurance** *and* **property insurance** policies (as long as the address is the same) These documents are considered ONE
- Recent **Income tax W-2** form *and* **property tax bill** These documents are considered ONE

NOTE: *While attending Cuthbertson High School the student and a parent MUST reside at the address listed above and on the proof of residence documents. If you have questions about this Union County Public School's Board policy, please see a guidance counselor.*

I have read and understand the above attendance area policy. The documents I am submitting as proof of the student's residence are true and accurate.

_____

STUDENT SIGNATURE DATE

_____

PARENT SIGNATURE DATE

If you reside in a home other than your own and the homeowner resides with you, then you will need to complete the CERTIFICATION OF RESIDENCE form. The homeowner is responsible for signing this document in front of a notary and providing proof of residency to the Cuthbertson High School.

CERTIFICATION OF RESIDENCE

This certification must be signed in the presence of a notary public after all information has been completed. This certification is valid only accompanied by two (2) proofs of residence from the list below.

THIS IS TO CERTIFY THAT (list names of ALL family members)

_____

_____

_____

_____

ARE PRESENTLY RESIDING IN MY HOME (give full address)

_____

_____

_____

EFFECTIVE DATE

_____

Signature

_____

Print Name _____ Date _____

State of North Carolina
County of Union

I, _____, a Notary Public for said County and State, do hereby certify that

_____, personally appeared before me this day and

acknowledged the due execution of the foregoing instrument.

Witness my hand and official seal this _____ day of _____, 20_____

(Official Seal)

_____
NOTARY PUBLIC
My Commission Expires

_____

Acceptable documents to prove residence:

Notarized rental/purchase agreement
Utility bills (electric, telephone, gas, etc.)
Driver's license and automobile registration
Car insurance and property insurance policies
Income tax W-2 form and property tax bill

RECORD OF SCHOOLS ATTENDED

Student Name _____

Date of Birth _____

The State of North Carolina requires that we document and obtain records from ALL schools attended by each student from Kindergarten through the current grade. Your assistance in filing out the following information will be most helpful and is greatly appreciated.

YEAR	GRADE	SCHOOL	CITY / STATE	NC PUBLIC SCHOOL?
	K			**NC Public School?** **Y N**
	1			**NC Public School?** **Y N**
	2			**NC Public School?** **Y N**
	3			**NC Public School?** **Y N**
	4			**NC Public School?** **Y N**
	5			**NC Public School?** **Y N**
	6			**NC Public School?** **Y N**
	7			**NC Public School?** **Y N**
	8			**NC Public School?** **Y N**
	9			**NC Public School?** **Y N**
	10			**NC Public School?** **Y N**
	11			**NC Public School?** **Y N**
	12			**NC Public School?** **Y N**

HOME LANGUAGE SURVEY
CUTHBERTSON HIGH SCHOOL

Student Name_____

Date_____ DOB _____ Grade _____

Address _____

Phone Number Home _____ Cell/Work _____

Parent/Guardian Name _____

Has the student ever attended a U.S. school? Yes _____ No _____
If yes – Date of Entry _____

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 survey)

   No _____ (Stop here & sign below)

2. Which language did your student learn when he/she first began to talk? _____

3. What language does your student 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 student 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/Guardian Signature Date

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

CUTHBERTSON HIGH SCHOOL
1400 Cuthbertson Road
Waxhaw, NC 28173
704-296-0105
FAX: 704-843-3591
SCHOOL CODE: 900311

REQUEST FOR RECORDS

Name of Student:_____

Date of Birth:_____

I give permission for official records to be sent to Cuthbertson High School.

Parent Signature:_____ Date:_____

School Name:_____

School Address:_____

School Phone #:_____ School Fax #:_____

The above named student has enrolled in Cuthbertson High School and has advised us that your school is the last one the student attended. Please send us the following information as soon as possible:

- Official Transcript
- Grades as of date of withdrawal from your school
- Attendance record for this year
- Standardized test results
- Discipline Records
- Immunization records
- ALL records pertaining to **504 Plan/ EC-Exception Children/ ESL – English as second language (ex. *current* Dec. 4, Dec. 5, Psychological Testing, Educational Testing, etc.)**

Please include any course description that might not be obvious for transferring credits.

TO BE COMPLETED BY PREVIOUS SCHOOL:

Student was / was not in good standing at the time of withdrawal. If not, please indicate the reason, including suspension, expulsion, books/fees, other.

_____

Signature of School Official Title Date

*As per Family Education Rights and Privacy Act (FERPA) parents (or students over the age of 18) have the right to inspect and review any and all official school records directly relating to their child.

** The agency or individual agrees not to permit any other party access to such information without parent/guardian or eligible student consent.

***As per Family Education Rights and Privacy Act (FERPA) parents may have a copy of the information to be released if desired.

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

UCPS 3-2019 AH

Union County Public Schools
North Carolina Immunization 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 130-A-152 through 130-A 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 child enrolled in kindergarten or 1st grade for the first time after 7/1/94, but before 7/1/99:

- 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 — first dose after 1st birthday

If child enrolled in kindergarten for the 1st time after 7/1/99, but before7/1/2015:

- 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 before age 5)
- 2 MMR — 1st dose on or after 1st birthday
- 3 Hepatitis B — last does 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 does 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 Menigiococcal — 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. 130-A-156.

North Carolina Health Assessment Law
G.S. 130-A-440 states that every child in the State entering N.C. public schools 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 is due at my child's school within 30 calendar days of today's date or he/she will not be allowed to continue in school until such time as a valid immunization record 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 N.C. public school for the first time.

_____

Student Name Date of Birth Enrollment Date

_____

Parent/Guardian Signature Date

THIS WILL BE THE ONLY NOTIFICATION OF HEALTH REQUIREMENTS

UNION COUNTY PUBLIC SCHOOLS
Exceptional Children's Programs
400 North Church Street
Monroe, NC 28112

RECORDS REQUEST
Confidential and Privileged

The student named below has enrolled in Union County Public Schools and has listed your school as the last school he/she attended. We are requesting the Special Education information for this student.

Student's full name:_____

Date of birth:_____ Grade:_____

Please forward records to:

Cuthbertson High School
EC Department
1400 Cuthbertson Road
Waxhaw, NC 28173
704-296-0105
FAX: 704-843-3591

Please send the following information:

- Referral for initial evaluation
- Permission to evaluate
- Permission for placement
- Individual Education Plan (IEP)
- Most current evaluation or re-evaluation information including – summary of assessments, psychological reports, education, medical, multidisciplinary team documentation, etc.
- Related services information including written evaluation reports
- Any other pertinent information which will assist in the service delivery

I give permission for records to be sent to Union County Public Schools. I understand that this information will be handled in accordance with confidentiality requirements.

_____

Parent/Guardian Signature Date

COMPARABLE SERVICES FORM
FOR
TRANSFER STUDENTS

Note: May be used **only** with previously identified EC students who have transferred to Union County Public Schools. An IEP meeting must be held within 2 weeks of the date of enrollment. The meeting is set for

_____

(Date) (Time) (Place)

Name of Student:_____

Date of birth:_____

Parent/Guardian:_____

School: Cuthbertson High School

1. Former school:_____
   School system:_____
   Phone number:_____
   Former teacher:_____
   (a) Disability:_____
   (b) Direct Special Education Services received:
   (c) Related services received:_____

2. Attach a copy of IEP if available from parent/guardian. If not, note parent's/guardian's opinion of student's present level of functioning (i.e. can student subtract with borrowing or can write a simple sentence)

3. Comparable Exceptional Children Services to be provided:_____
   _____

4. Comparable related services to be provided:_____
   _____

PARENT CONSENT FOR COMPARABLE SERVICE DELIVERY

I give consent for the comparable service delivery to my child through the Exceptional Children's Program as specified above. I understand that this service is not a formal placement in the Exceptional Children's Program and depends upon substantiated confirmation of previous special education services. The IEP team will meet within 2 weeks to make decisions regarding my child's eligibility for EC services

_____ _____

Parent/Guardian signature Date

To expedite Exceptional Children's eligibility, parents/guardians should be given the following:

1. Consent for Release of Information (Form B)
2. Handbook on Parent's Rights
3. Invitation to Conference

Copies of this form to: SNA, Data Manager and EC Case Manager to be placed in EC folder.

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: