Twiggs County Public Schools Returning Student Package

Together We Inspire Great Gains for Students!

Dr. Mack Bullard, Superintendent of Schools

2021-2022 School Year

Returning at:

[__] **Jefferson Elementary School**
675 Bullard Rd., Jefferson, GA 31044
478-945-3114

[__] Twiggs **County Middle School**
375 Watson Drive, Jeffersonville, GA 31044
478-945-3113

[__] **Twiggs County High School**
375 Watson Drive, Jeffersonville, GA 31044
478-945-3112

[__] **Jeffersonville Alterative Program**
375 Watson Drive, Jeffersonville, GA 31044
478-945-3112

Enrollment Status: [__] Enrolled [__] Provisional *

Date Entered Into IC:

Date: _____

Initials: _____

_____ _____
Central Office Enrollment Date

{*The parent / legal guardian has 30 Days from the date of entry to complete the necessary paperwork to be maintained in the student's file.}

STUDENT INFORMATION FORM

Student's Legal Name: _____ _____ _____
Last **First** **Middle** **(Called by)**

Male: _____ Female: _____ Birth Date: ___ /___ /_____ *Social Security #: _____
MM DD YEAR

[*A parent or Guardian* who objects to incorporation of the social security number into the school records of a child may have the requirements waived by signing a statement objecting to the requirement. O.C.G.A.20-2-150]

Ethnic Group: American Indian: _____ Asian: _____ African American: _____ Hispanic/Latino: _____ Multiracial: ____ White: ____

Birth Place: _____
City **State** **Country**

PRIMARY LEGAL GUARDIAN(S) – with whom the child PRIMARILY lives

Parent/Guardian 1: _____ _____ _____ **Relationship:** _____
Last Name **First Name** **Middle Name**

Physical Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Mailing Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Ethnic Group: American Indian: _____ Asian: _____ African American: _____ Hispanic/Latino: _____ Multiracial: ____ White: ____

Employer: _____

Phone 1: Day ( )_____ _____Home

Email Address:

Parent/Guardian 2: _____ _____ _____ **Relationship:** _____
Last Name **First Name** **Middle Name**

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Employer: _____

Ethnic Group: American Indian: _____ Asian: _____ African American: _____ Hispanic/Latino: _____ Multiracial: ____ White: ____

Does student live with you Yes ( ) No ( )

Phone 1: Day ( )_____ _____Work Ext:_____

Phone 2: Day ( )_____ _____Cell ( ) Pager ( )

EMERGENCY CONTACT INFORMATION

The following person(s) may pick up:_____ from school and may be called in cases of emergency if I cannot be reached

1. _____ Relationship: _____ Phone: ( )_____Cell: ( )_____

2. _____ Relationship: _____ Phone: ( )_____Cell: ( )_____

3. _____ Relationship: _____ Phone: ( )_____Cell: ( )_____

In the event of a medical emergency, the District will have the student transported to the closest doctor or medical facility for treatment. Parents/guardians will assume full responsibility for all charges incurred. I prefer that my student be transported to_____ Hospital for treatment.

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

HEALTH CARD

Student's Name
_____DOB_____
Race_____ Age_____ Grade_____ Teacher
_____
Doctor _____ Dentist
_____
Parent(s)_____ Phone (H)_____
(W)_____
Home Address _____ Cell #
_____
Insurance Information: _____Medicaid _____ Peach Care _____Other _____No Insurance
Policy # _____
Emergency Contacts: If a parent cannot be reached, I authorize Twiggs County Schools to call the persons listed below. I also give permission for those listed below to sign my child out of school.
Name _____ Relationship _____ Phone
_____
Name _____ Relationship_____ Phone
_____

MEDICAL HISTORY:
Allergies (i.e. Medication, Food, Bug Bites/Bee Stings)_____
_____**REQUIRES EPI-PEN? _____**
Does your child have any of the following conditions? _____Asthma _____ADD/ADHD _____Cancer
_____Kidney Disease _____Arthritis _____Heart Problems _____ Seizures _____Diabetes _____Lupus
_____Migraine Headaches _____Sickle Cell Anemia _____Other: (Explain) _____
MEDICATIONS: List **ALL** medications that your child takes. Include inhalers/nebulizer treatments or insulin:
_____
_

Basic First Aid will be provided by the nurse or designated staff in the event of an injury. Select over-the-counter medications, listed below, will be kept at school and administered according to the manufacturer's recommendations based upon age and/or weight. **All stocked medications will be given only with signed parental permission.** Parents will be contacted to pick up students with potentially contagious or serious conditions.

CHECK "YES" OR "NO" NEXT TO THE MEDICATION/TREATMENTS THAT YOU GIVE PERMISSION FOR YOUR CHILD TO RECEIVE AT SCHOOL:

YES	NO	MEDICATION/TREATMENT	COMPLAINTS/REASON FOR ADMINISTRATION
		TYLENOL (ACETAMINOPHEN)	Pain/Headaches without fever, not relieved by comfort measures
		MOTRIN (IBUPROFEN)	To be substituted if allergic to Tylenol, Sickle Cell pain
		BENADRYL	Allergic reactions
		TUMS	Indigestion/Heartburn
		HYDROCORTISONE CREAM	Insect bites/Non-Contagious rashes
		NEOSPORIN/FIRST AID SPRAY	Minor cuts and scrapes
		ORAJEL	Tooth/Mouth pain – NOT to take the place of Dental Care
		VISINE	Non-Contagious red or irritated eyes
		CHLORASEPTIC SPRAY AND/OR COUGH DROPS	Minor sore throat pain or cough without fever
		VASELINE	Chapped lips

As Parent/Guardian of the above named student, I give permission for the nurse or designated persons to administer basic first aid and the medications above that I have checked "YES". School Clinic personnel have my permission to contact my child's MD (doctor) and/or dentist to discuss medical information relevant to my child's health. In case of serious illness/injury, the school will telephone 911 for immediate transport to an emergency treatment facility. I authorize the transport and treatment by EMS and the hospital emergency staff for my child. Fees for transport and medical services will be the responsibility of the Parent/Guardian.

Parent/Guardian Signature _____
Date _____

Twiggs County Public Schools
REQUEST FOR ADMINISTRATION OF MEDICATION
(LONG TERM MEDICATION – MORE THAN TWO WEEKS)

Twiggs County Public Schools recommends and encourages parents to medicate their children at times other than regularly scheduled school hours. However, if it is necessary for students to receive medication during school hours, the nurse or designee may assist parents if this form is properly completed and returned to school.

****** Medication will only be accepted from the parent/guardian in the original bottle labeled appropriately by a pharmacist. All dates must be current. It is the responsibility of the parent to inform the school of ANY changes in medication. New medications and/or doses will not be given unless a new form is completed and a newly labeled bottle is provided. Unused medications will be disposed of one week after medication is discontinued unless picked up by the parent/guardian.******

Student _____ D.O.B._____

Teacher _____ Grade _____

STATEMENT OF PHYSICIAN

Physician's Name _____ Physician's Phone _____

Medication: _____ Date of Prescription: _____

Dosage:_____ Time of Administration:_____

Route: _____ Discontinue Date: _____

Possible Side Effects: _____

Medicine/ Food Contraindications while taking this medication _____

Physician's Signature _____Date _____

STATEMENT OF PARENT/GUARDIAN

I do hereby request the nurse or designated personal to administer medication as outlined above. I understand that any school system personnel are not legally obligated to administer this medication. I will notify the school nurse or designee immediately and fill out a new form if the medication, dosage, or directions change.

Parent/Guardian Signature _____ Date_____

Home Phone _____ Work phone _____ Cell _____

_____

Date