STUDENT INFORMATION SHEET

STUDENT NAME_____/_____/_____
Last First Middle Name

ADDRESS_____

____/____/____ _____ _____ _____
Date of Birth Home Phone/ Emergency Phone No./Name of Person

_____
2nd Emergency Phone No./Name of person

1ST DAY OF SCHOOL____/____/____ **MALE**__ **FEMALE**__

SOCIAL SECURITY NUMBER_____/_____/_____

RACE White__ Black/African American__ Asian__ Indian__ Hispanic __

HOMEROOM TEACHER_____**GRADE**____

BUS DRIVERS NAME_____**BUS#**_____

SCHOOL LAST ATTENDED_____

_____/_____/_____/_____/_____
Street P.O. Box City State Zip Code

PARENT INFORMATION

FATHER'S NAME _____
Last First Middle Initial

MOTHER'S NAME_____
Last First Middle Initial

Parents Marital Status: (Circle One) SINGLE MARRIED DIVORCED
Parents Active Military: (Circle One) ACTIVE DUTY MILITARY, NATIONAL GUARD MILITARY, RESERVE MILITARY DEPENDENT

IF SINGLE OR DIVORCED WHO HAS CUSTODY?_____

_____ ____/____/____
PARENT OR GUARDIAN SIGNATURE DATE

Mother's Maiden Name_____ County Child Born In_____

City Child Born In _____

Person or persons allowed to pick up your child:

1._____ 2._____ 3._____

Charlotte Mullins
Director of Schools

Hancock County Schools

Immediate Enrollment and Records Transfer Students (Foster Students, Homeless Students, English Language Learners, Migrants, and Immigrant Enrollment)

Foster Students, homeless students, English learners, migrant, and immigrant students have the right to "immediate enrollment" when enrolling into the Hancock County School District. Any student placed in out of home care and into a home zoned for the Hancock County School District or a student who is identified as homeless will be granted immediate enrollment. Immediate enrollment means the student will be attending school as "soon as possible" -- within one school day of the notification of the intent to enroll from the child welfare agency. The child welfare agency will be responsible for getting the child to the school until collaboration can take place to set up transportation for school attendance. The final transportation plan should be in place within four working days.

The following information is needed to start the enrollment process for a child in foster care:

1) Legal documentation that the child has been placed in foster care.

2) The photo identification from the child welfare agency or other legal documentation of proof that the person enrolling the student is authorized to do so.

Students who are identified as homeless, English language learners, migrant or immigrant students will be enrolled immediately and documentation will be obtained at a later date when made available.

In addition to the above-mentioned items, the Hancock County School District will request documentation of residency and other necessary documents of the foster parents within three working days of the student's enrollment. If the foster student is transferring out of our school, Hancock County School District will send the student's educational records within 3 working days of the request. Designated staff will monitor the progress of our foster care students and homeless students monthly and will report to the Point of Contact. As needed, the Point of Contact will collaborate with the child welfare agency to determine strategies to support the academic success of the student.

418 Harrison Street, Sneedville, TN 37869 Phone: (423)733-2591 Fax: (423)733-8757

HANCOCK COUNTY ELEMENTARY SCHOOL
Ms. Valerie Harrison, Principal
373 Newman's Ridge Rd.
Sneedville, TN. 37869
Phone: (423)733-2534
Fax: (423)733-9820

Transfer From:

School Address:_____

_____

_____

_____whose date of birth is ___/___/___ has

Enrolled on this date ___/___/___ as a student in the ___ grade.

Please send a copy of his/her educational records. This request is for all records, including special education and entire confidential file, so that proper placement can be made and continuity of record keeping maintained.

_____ _____ _____

Parent/Guardian Signature Phone # Date

Thank you for your assistance and early attention to this request.

Sincerely,

Ms. Valerie Harrison, Principal

TEACHER COPY

Dear Parent,

In order that we may know how to assist your child in case of illness or accident, please give the following information:

Child's Name_____

Telephone No. - Home_____ Work_____

Place of work_____

Person to reach when not at home. *Must have 2 accurate reachable numbers*

1. _____ 2._____

Family physician or clinic preferred:

1. _____ 2._____

Hospital preference:

1. _____ 2. _____

Allergies or other health problems:

_____

_____

Any other special instructions:_____

_____

Insurance Co._____ TennCare_____

In case of a serious emergency when a parent cannot be reached please sign below so that a school official may act in behalf of your child.

_____ _____

Parent or Guardian Date

If none of the above people can be reached in an emergency situation, I hereby authorize the doctor on call at _____ to treat my child.

Parental Involvement Contract

Student's Name _____

Parents/Guardian's Name (s) _____ _____

Teacher's Name: _____

Principal: Ms. Valerie Harrison

School Name: HANCOCK COUNTY ELEMENTARY SCHOOL

School Year: 2020-2021

Parental Involvement Contract

Parent/Guardian Commitment:

In an effort to help my student reach his/her fullest academic potential I, _____, commit to do all of the following:*

- Ensure that my student attends school each day
- Arrives to school on time and ready to learn
- Review homework assignments and offer assistance when needed
- Demonstrate interest in my student's well-being by attending school functions and supporting the student's school activities
- Make every effort to attend parent-teacher conferences
- Personal goal (s): _____

Parent/Guardian Signature: _____

Date: _____

*If any obstacles or extenuating circumstances hinder and/or prevent me from a full commitment I will offer an explanation to the appropriate administrator (s) or staff member (s).

Teacher Commitment:

In an effort to help _____ reach his/her full academic potential. I will commit to do all of the following:

- Set high instructional standards for myself that will promote the development of the district's content standards and benchmarks.
- Teach effective study skills and strategies to ensure retention of learning.
- Notify the parent/guardian as soon as an attendance problem develops.
- Establish flexible scheduling and create a warm atmosphere for parents/guardians during classroom visits and participation in the activities, including parent-teacher conferences.

- Personal goal(s): _____

Teacher Signature: _____

Date: _____

School Administration Commitment:

We want all students to reach their full academic potential. Therefore, we commit to do all of the following:

- Consider accessing possible resources for all extenuating circumstances shared with appropriate staff by the parents/guardians to assist them to make a full commitment.

- Other goals(s): _____

Administrator Signature: Valerie Harrison

Date: 8/3/2020

HANCOCK COUNTY ELEMENTARY SCHOOL
Ms. Valerie Harrison, Principal
373 Newman's Ridge Road
Sneedville, TN 37869
PHONE: (423) 733-2534 FAX: 423-733-9820

SCHOOL/STUDENT/PARENT COMPACT
2020-2021

Hancock Elementary School and the parents of students participating in activities, services and programs funded by Title 1, Part A of the Elementary and Secondary Act (ESEA), agree that this compact outlines how the parents and the entire school staff will share the responsibility for improved student academic achievement and the means by which the school and parents will build and develop a partnership that will help children achieve the state's high performance standards.

This School-Parent Compact is in effect during the 2020-2021 school year.

School Responsibilities:

Hancock Elementary school will:

1. Provide high quality curriculum and instruction in a supportive and effective learning environment that enables the participating children to meet the states student academic achievement standards.
2. Have high expectations of ourselves, students, and other staff.
3. Display respect for all.
4. Determine the student's educational needs and adjust the instruction to accommodate those needs.
5. Provide a safe environment.
6. Hold teacher conferences twice per school year during which this compact will be discussed as it relates to the individual child's achievement. This school year sessions will be 10/29/20 & 3/18/21.
7. Provide parents with frequent reports on their child's progress.
8. Provide parents opportunities to volunteer and participate in their child's class, and to observe classroom activities in an appropriate manner.

Parent Responsibilities:

We, as parents, will support our children's learning in the following ways:

1. By monitoring attendance.
2. By making sure homework is completed.
3. By limiting the amount of television our children watch.
4. By volunteering in my child's classroom.
5. By participating, as appropriate, in decisions relating to my child's education.
6. By staying informed about my child's education and communication with the school by promptly reading all notices from the school and by responding by mail or some appropriate manner.

Signature:_____

Student Responsibilities:

1. Attend school regularly.
2. Take responsibility for own learning.
3. Come to school with needed materials (paper, pencils, etc).
4. Complete and return homework assignments.
5. Obey school rules.
6. Bring home all teachers notes, school letters, etc.

Signature:_____

Principal Agreement:

I support this form of parent involvement. Therefore, I shall strive to do the following:

1. Provide a safe environment that allows, for positive communication between the teacher, parent and student.
2. Encourage teachers to regularly provide homework assignments that will reinforce classroom instruction.

Signature: Valerie Harrison

HANCOCK COUNTY SCHOOLS

HOUSEHOLD INFORMATION SURVEY

2020-21 SCHOOL YEAR

Instructions: **Only <u>one form per household</u> is needed.** Please turn in to the school's front office at Hancock Elementary or Hancock Middle/High.

Parent(s)/Guardian(s):		
Street Address:		
City:	State:	Zip:
Home Phone:	Cell:	
Please list the first and last name of ALL STUDENTS residing in your household below	Date of Birth	Grade
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Total Number in Household _____ (please include ALL ADULTS & CHILDREN residing in your household)

Please check the box below that represents your Annual Gross Income:

☐ Less than $23,606	
☐ Between $23,607 and $31,894	☐ Between $73,335 and $81,622
☐ Between $31,895 and $40,182	☐ Between $81,623 and $89,910
☐ Between $40,183 and $48,470	☐ Between $89,911 and $98,198
☐ Between $48,471 and $56,758	☐ Between $98,199 and $106,486
☐ Between $56,759 and $65,046	☐ Between $106,487 and $114,774
☐ Between $65,047 and $73,334	☐ Over $114,775

Signature: An adult household member must sign this survey. I certify (promise) that all information on this survey is true and that all income is reported. I understand that the school will receive federal funding based on the information provided.

Sign here: Date:

ETSUHealth

Hancock County School-Based Health Centers
P.O. Box 723, Sneedville, TN 37869
Elementary Clinic Phone: (423)733-2121
High/Middle School Clinic Phone: (423)733-2819

SECTION I PATIENT INFORMATION

First Name	Middle Name	Last Name

Address	Zip code	City, State

Homeless Status [ ] Yes [ ] No
[ ] Not Homeless [ ] Doubling up [ ] Shelter [ ] Street [ ] Transitional [ ] Other_____

Phone 1 ( ) ▫Home ▫Cell ▫Work ▫Other_____
Ok to call [ ] Yes [ ] No Ok to leave message [ ] Yes [ ] No Ok to send text message [ ] Yes [ ] No

Phone 2 ( ) ▫Home ▫Cell ▫Work ▫Other_____
Ok to call [ ] Yes [ ] No Ok to leave message [ ] Yes [ ] No Ok to send text message [ ] Yes [ ] No

Date of Birth: mm/dd/yyyy	SSN:	Email:

Marital Status
[ ] Single [ ] Married [ ] Widowed [ ] Divorced
[ ] separated [ ]other/unknown

Student Status
[ ] Full Time
[ ] Part Time [ ] Not a Student

Gender Identity:
[ ] Male [ ] Female
[ ] Transgender M to F [ ] Transgender F to M
[ ]Other [ ]Prefer not to answer
Pronoun preference: [ ] He [ ] She

Sexual Preference:
[ ]Straight [ ]Lesbian or Gay [ ] Bi-sexual [ ]Transgender
[ ]Something else [ ]Don't Know [ ]Prefer not to answer

Employment status:
[ ] Employed [ ] Unemployed [ ] Self employed
[ ] Full time [ ] Part time
[ ] Retired [ ] Student [ ] Child [ ] Other

Employer:

Monthly income $_____

Family size _____
[ ] Decline to provide income

Agricultural Status [ ] Non Agricultural
[ ] Migrant *(A person\dependent whose principle employment has been in agriculture within the last 24 months and has had to establish a temporary home for the purpose of such employment)*
[ ] Seasonal *(A person\dependent whose principle employment has been in agriculture on a seasonal basis and has not had to establish a temporary home for the purpose of such employment)*
[ ] Employed year round [ ] Retired Farmworker

Veteran Status
[ ] YES
[ ] NO

Race check all that apply
[ ] Asian
[ ] Black\African-American
[ ] White
[ ] Other Pacific Islander
[ ] American Indian
[ ] Native-Hawaiian
[ ] Other _____

Ethnicity:
[ ]Hispanic or Latino
[ ]Not Hispanic or Latino

Housing Status
[ ] Public Housing
[ ] Not in public housing

Emergency Contact Name:

Address:

Emergency Contact Number
( )
Relationship to Patient

Language Spoken (mark all that apply)
[ ] English [ ] Spanish [ ] Other_____

Interpreter Status
[ ] YES [ ] NO

Please list your pharmacy preference:

Referral Source:
[ ] Relative\Friend\Patient [ ] Radio [ ]TV [ ]Yellow Pages
[ ] Church [ ] Website [ ] Health Fair [ ] Physician/Hospital
[ ] Other_____

ETSUHealth

SECTION II Guarantor Skip if different from Section I

RELATIONSHIP TO GUARANTOR [ ] Self (skip to next section [ ] Spouse [ ] Parent [ ] Other

First Name	Middle Name	Last Name

Address (if different from patient information above)	Zip Code	City State

Phone 1 ( ) ☐Home ☐Cell ☐Work ☐Other____
Ok to call [ ] Yes [ ] No Ok to leave message [ ] Yes [ ] No Ok to send text message [ ] Yes [ ] No

Phone 2 ( ) ☐Home ☐Cell ☐Work ☐Other____
Ok to call [ ] Yes [ ] No Ok to leave message [ ] Yes [ ] No Ok to send text message [ ] Yes [ ] No

Email:	Gender [ ] Male [ ] Female

Date of Birth:	SSN	Employment status: [ ] Employed [ ] Full time [ ] Part time [ ] Self employed [ ] Retired [ ] Unemployed

Employer Name and Address	Employer Phone ( )

SECTION III INSURANCE INFORMATION Please present all insurance information

PRIMARY INSURANCE [ ] No Insurance [ ]Medicaid\TennCare [ ] Medicare [ ] Other (Employer\Private\Commercial)	PATIENT'S RELATIONSHIP TO GUARANTOR [ ] Self [ ] Spouse [ ] Child [ ] Other

Plan Name	Policy Number	Group Number

Insured Name	Insured Date of Birth	Insured SSN

Insured Address	Insured Gender [ ] Male [ ] Female	Insured Phone ( ) ☐Home ☐Cell ☐Work ☐Other____

Employer Name and Address	Employer Phone ( )

Effective Date (if known)	Co-Pay $

DENTAL OR SECONDARY INSURANCE

[ ] Other Medical [ ] Dental [ ]Medicaid\TennCare [ ] Medicare [ ] Other (Employer\Private\Commercial)	Patient's relationship to the Insured [ ] Self [ ] Spouse [ ] Child [ ] Other _____

Plan Name	Policy Number	Group Number

Insured Name	Insured SSN	Insured Date of Birth

Effective Date (if known)	Co-Pay $

Employer Name	Employer Address	Employer Phone ( )

ETSU Health
Community Health Centers

PATIENT FINANCIAL & INSURANCE AGREEMENT
PLEASE READ THOROUGHLY AND SIGN BELOW

In consideration of receiving services from the ETSU College of Nursing, Office of Practice and Community Health Centers, you agree:

1. All services are provided to you with the understanding that you are responsible for the charges regardless of your insurance coverage. If you would like to know the charge of a service, please inquire prior to treatment. Please be aware that not all services are a covered benefit with different insurance companies. You are responsible for knowing what services are or are not covered. **KNOW YOUR BENEFITS.**

2. At check-in, we will collect your co-pay, deductible, and payment for uncovered services as well as the patient's portion as determined by insurance or sliding fee scale. We accept cash, check, and credit card of Master Card, Visa, and Discover.

3. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. **It is the patient's responsibility to inform our office immediately of insurance coverage or insurance company changes.**

4. You are responsible for knowing if a referral is required. Make sure you know what providers are in your plan, what facilities are covered and what ancillary services you must use. (Such as laboratory, hospitals, etc.) If we can be of assistance, please let us know.

5. We will bill your insurance company as a courtesy, but you are still ultimately responsible for payment of all services you receive. If your insurance company does not respond within 30 days we will follow up with an inquiry on your behalf. If, however, your insurance does not respond within 60 days of claim submission, a statement will be sent to you. You should call your insurance company to question why the claim is not paid. Our office will assist you only after you have contacted your insurance company.

6. If your medical claim has not been paid and your insurance company has not resolved your dispute, you may register a complaint with the Tennessee Department of Commerce and Insurance. Our office will do everything we can to assist you; however, you must understand you cannot delay payment while you are awaiting the outcome of your complaint.

7. Any unpaid charges over 90 days old will be sent to an outside collection agency with an additional agency fee. **You are responsible for any collection fees, legal fees, or court costs incurred in the collection process.** This agency will report your failure to pay to the THREE (3) national credit reporting agencies.

8. Returned checks are subject to a $40.00 return check fee.

We do understand that temporary financial problems may affect timely payment. We encourage you to communicate any such problems so that we can assist you in the management of your account.

I authorize the East Tennessee State University (ETSU) College of Nursing (CON) Office of Practice and Community Health Centers to examine, evaluate, and treat me, and/or my child, or ward. I authorize the ETSU CON to release any\all clinical information necessary in order to submit my insurance claims to my insurance companies. I also request that my insurance companies pay benefits directly to the ETSU CON for services rendered. I understand that the CHC will refund any overpayments on my account, in a timely manner.

Your signature below forms a binding agreement between the ETSU CON (the provider of service) and the Patient who is receiving services or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of any charges

Patient Printed Name	Patient/Guardian Signature	Date
ETSU CON Staff Signature	Date	

ETSUHealth
Community Health Centers

HIPAA AUTHORIZATION

I authorize East Tennessee State University (ETSU) College of Nursing (CON) Office of Practice and Community Health Centers to discuss and \or release my medical information including labs and test results, diagnosis, and treatment discussed to the following persons:

Name	Relationship to patient	Phone Number
Name	Relationship to patient	Phone Number
Name	Relationship to patient	Phone Number

ACKNOWLEDGEMENT OF PATIENT RIGHTS AND RESPONSIBILITIES
&
NOTICE OF PRIVACY PRACTICES

I acknowledge that the East Tennessee State University (ETSU) College of Nursing (CON) Office of Practice and Community Health Centers has provided me with a written copy of Patient Rights and Responsibilities. This information clearly defines my rights and responsibilities as a patient receiving services by a ETSU CON associated provider.

I have also been given the opportunity to review the East Tennessee State University (ETSU) Notice of Privacy Practices and understand that the Notice indicates how my protected health information may be used and disclosed and how I gain access to this information. I have also been given the opportunity to receive a copy of the ETSU Notice of Privacy Practices for further review

AUTHORIZATION AND RELEASE

I understand that the ETSU CON serves as a training center for students majoring in, but not limited to, Nursing, Audiology, Dental Hygiene, Nutrition, Radiology, and Speech-Language Pathology at ETSU. For this reason, I authorize the use of student observation, video recording, audio recording, pictures, client data, and discussion for professional research or educational purposes. I understand that no names or identifying information will be used in any of these procedures.

I understand that the evaluation and treatment procedures used by the Speech Language Pathologists\Audiologists are non-medical in nature. These procedures meet professional and ethical standards of the American Speech-Language-Hearing Association, and they offer no physical or psychological risk. Although the treatment procedures are expected to be beneficial, I understand that no guarantee of success can be expressed or implied.

By signing below, I agree to the above-mentioned statements.

Patient Printed Name	Patient/Guardian Signature	Date

ETSU CON Staff Signature _____ Date _____

ETSUHealth

SLIDING FEE DISCOUNT APPLICATION

It is the policy of ETSU Community Health Centers to provide essential services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return it to the front desk to determine if you or members of your family are eligible for a discount.

Discounts apply to services within the health center's federally approved scope of project only, and will not be applied to services purchased from outside, including reference laboratory testing, drugs, hearing aids, and other such services.* Discounts apply only to current, not future services.
*Additional charges may apply for these services.

If you do not wish to apply for the Sliding Fee Scale, please check the box below, sign and date. If you do wish to apply, then skip to the next section and sign at the end of the document.

☐ I do not wish to apply for the Sliding Fee Scale discount program at this time, and I understand I may apply at any time.

Signature: _____ Date: _____

Name of Head of Household	DOB	Phone Number	
Street	City	State	Zip code

Total Family Size **Please list ALL dependents**

Name	Date of Birth	Name	Date of Birth
Dependent		Dependent	
Dependent		Dependent	
Dependent		Dependent	

Annual/Monthly Household Income: You may report your income in an Annual or Monthly amount. Please circle which option you are reporting below.

Source of Income (Annual or Monthly)	Self	Spouse	Other	Total Amount
Gross wages, salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, 1040 tax form				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources				

ETSUHealth

SLIDING FEE DISCOUNT APPLICATION

*Gross income is before taxes and deductions				

NOTE: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

I certify that the family size and income information shown above is correct.

I understand this information must be provided within 3 business days of the date of visit to qualify for the discounted fee. If this information is not received, then I understand I will be responsible for the full fee for the visit.

Name (Print):	Signature:
Date:	

**********For office use only**********For office use only**********

Checklist	(✓)	Awaiting Proof of Income	(✓)
Verified Monthly Income: Total Amount:		Proof of income Requested: Date:	
Number in Household: Total:		Income Requirement Discussed with Patient: Date:	
Proof of Income Received: Type:		Notes:	
Sliding Fee Discussed with Patient: Sliding Scale Category:			
Recertification Date:		Staff Signature:	Date:

Health

PEDIATRIC HEALTH HISTORY FORM

Child's Name		Date			
Child's Previous doctor/ Primary Care Provider		DOB		Age	
Allergies/Reactions:					

Sexual Preference: ☐Straight ☐Lesbian or Gay ☐Bi-sexual ☐Transgender ☐Something else ☐Don't Know ☐Prefer not to answer

Gender Identity: ☐ M ☐F ☐Transgender M to F ☐Transgender F to M ☐Other ☐Prefer not to answer

PRESENT HEALTH CONCERNS	MEDICATIONS/VITAMINS	HERBS/HOME REMEDIES

PREGNANCY AND BIRTH

1.	Is this child your by: D Birth D Adoption D Stepchild D Other:
2.	Please indicate any medical problems during pregnancy: D None D Specify:
3.	Delivered by: D Vaginal Birth D Caesarean If caesarean, why:
4.	Birth Weight: Birth Length:
5.	Please indicate any medical problems during the baby's newborn period: D None If premature, how early?
	Other problems:

NUTRITION AND FEEDING

1.	Was your child breastfed? D No D Yes If so, how long?
2.	Has your child had any unusual feeding/dietary problems? D No D Yes If yes, specify:
3.	Milk intake now: Type D Cow milk (D non-fat D 1% fat D 2% fat D whole milk) D Soy milk D Rice milk
	Average ounces per day (Note: 8 ounces are in 1 cup):

SLEEP

Hours per night: Naps (number and length):

Any sleep problems: D No D Yes, explain:

DEVELOPMENT

At what age did your child: Sit alone: Walk alone: Say words: Toilet train (daytime):

Girls only: Age at first menstrual period:

DENTAL HISTORY

Has child been seen by a dentist? D No D Yes If so, how often: Date of last visit:

IMMUNIZATIONS/INFECTIOUS DISEASES: Please bring your child's immunization records to your appointment.

Has your child had chickenpox D No D Yes

EXPOSURES/HABITS: Any concerns about lead exposure (old home/plumbing/peeling paint)? D No D Yes

Do any household members smoke? D No D Yes

TV hours per day: Computer hours per day: Video games hours per day?

PAST MEDICAL HISTORY: Please describe any major medical problems and their dates:

ADDITIONAL HISTORY DISCUSSED: HOSPITALIZATIONS/OPERATIONS/BROKEN BONES/SEVERE SPRAINS (WITH DATES)

FAMILY HISTORY Please check off any family history of the following (indicate who has/had the condition)

D Alcoholism/Drug Abuse	D Heart Disease or Stroke before age 60	D Inherited/Genetic Diseases
D High Blood Pressure	D Thyroid Disease	D Psychiatric Disorders
D Asthma/Hayfever/Eczema	D Bleeding/Clotting Problems	D Seizures
D Kidney Disease	D Birth Defects	

SOCIAL HISTORY	Birthplace:	Current (or upcoming) grade:

Who lives at home:

Name:	Age:	Relationship:	Highest Education Level:
Name:	Age:	Relationship:	Highest Education Level:
Name:	Age:	Relationship:	Highest Education Level:
Name:	Age:	Relationship:	Highest Education Level:
Name:	Age:	Relationship:	Highest Education Level:

Are the child's parents: D Married D Unmarried D Separated D Divorced If divorced, when?

Parent's Occupation: Mother: Father:

Child care situation D Parents D Other (specify who and hours per day):

Concerns about your child: D Alcohol use D Tobacco D Sexual activity D Aggressive behavior

Is violence at home a concern: D No D Yes | Are there guns in the home? D No D Yes

SCHOOL HISTORY | Did/does your child attend preschool? D No D Yes Current Grade:

Name of school: | Any concerns about school performance?

Any concerns about relationships with: Teachers D No D Yes, explain:
Students D No D Yes, explain:

If over 4 years old, does your child have a best friend? D No D Yes

Sports/exercise: Type: How often? How long (minutes):

REVIEW OF ORGAN SYSTEMS: IF CHILD HAS MORE THAN ONE SYMPTOM IN A LINE, CIRCLE THE RELEVANT ONE(S).

Constitutional/Endocrine D Fevers/chills/excessive sweating D Unexplained weight loss/gain	Gastrointestinal D Nausea/vomiting/diarrhea D Constipation D Blood in bowel movement	Allergy D Hayfever/itchy eyes
Eyes D Squinting/"crossed" eyes/asymmetric gaze	Cardiovascular D Tires easily with exertion D Shortness of breath D Fainting	Skin D Rashes D Unusual moles
Ears/Nose/Throat D Unusually loud voice/hard of hearing D Mouth breathing/snoring D Bad breath D Frequent runny nose D Problems with teeth/gums	Genitourinary D Bedwetting D Pain with urination D Discharge: penis or vagina	Psychiatric D Speech problems D Anxiety/Stress D Problems with sleep/nightmares D Depression D Nail biting/thumbsucking D Bad temper/breath holding/jealousy
Respiratory D Cough/wheeze	Neurological D Headaches D Weakness D Clumsiness	Blood/Lymph D Unexplained lumps D Easy bruising/bleeding
Muscular D Muscle/join pain		

Hancock County Public Schools

Ms. Charlotte Mullins, Director of Schools
P.O. Box 629 – Sneedville, Tennessee 37869
Phone 1-423-733-2591 Fax 1-423-733-8757

HOME LANGUAGE SURVEY

Dear Parent(s):
In order to provide the best possible educational services for your child, please complete the Home Language Survey listed below. Survey should be returned to your child's classroom/homeroom and filed in permanent records.
Thank you.

Student Name:_____

School:_____

Grade:_____

Teacher_____

1. What is the first language your child learned to speak?

   _____

2. What language does your child speak most often outside of school?

   _____

3. What language do people usually speak in your child's home?

   _____

_____
Parent's Signature

ESPAÑOL (SPANISH)

1. ¿Se habla otro idioma que no sea el inglés en su casa? ____ No ____ Sí
2. ¿Habla el estudiante un idioma que no sea el inglés? ____No ____Sí
3. ¿Cuál fué el primer idioma que aprendió su hijo/a? _____

Parent or Guardian
Signature:_____Date:_____

Tennessee Migrant Education Program – Occupational Survey

Your child may qualify to receive FREE educational services. Please answer the following questions to help us determine their eligibility. Once completed, return this form to the school.

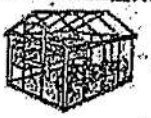
Student Name: (Last Name, First Name)	Grade:	Date:
Parent/Guardian Name:	School:	

1. Has your family moved within the last 3 years to another city, county, or state, in order to work in the agricultural and fishing industries? Yes☐ No☐

If yes, please indicate which family member: ☐Mother ☐Father ☐Children ☐Other

2. Do you or someone in your immediate family currently work in any of the occupations listed below? Yes☐ No☐

If yes, please indicate which occupation and which family member: ☐Mother ☐Father ☐Children ☐ Other

☐ **Meat and Food Processing/Packing**  Examples: Fruit, vegetables, chicken, pork, beef, etc.	☐ **Agriculture/Field Work**  Examples: Plant, pick and sort crops such as tomatoes, tobacco, cotton, strawberries, etc. Soil preparation, irrigation, fumigation, etc.	☐ **Dairy/Cattle Raising**  Examples: Feeding, milking, rounding up, etc.
☐**Nursery/Greenhouse**  Examples: Planting, potting, pruning, watering, etc.	☐ **Forestry**  Examples: Soil preparation, planting, growing, cutting trees, etc.	☐ **Fishing/Fish Processing**  Examples: catch, sort, pack, transport fish, etc.

3. If your current job is not in agriculture or fishing, did you or someone in your immediate family work in any of the occupations listed above in the last three years? Yes ☐ No☐

If yes, where? City:_____ State:_____

If you answered "YES" to any of the questions above, please answer the following questions.

How long have you been in this county in Tennessee? _____Weeks _____Months _____Years

Home Address City State Zip Code

Telephone number, please include area code. ( )

For school use only: Please send all surveys with at least one "YES" response to your district migrant liaison. All qualifying surveys should be uploaded to the TNMigrant site. Please notify the MEP that new surveys have been uploaded. Questions? Call (931)212-9539

SCHOOL DISTRICT:	STUDENT ID:	ENROLLMENT DATE:

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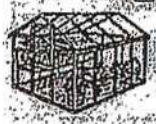
Programa de Educación Migrante en Tennessee – Encuesta de Ocupación

Sus hijos pueden ser elegibles para recibir servicios educativos **GRATUITOS**. Por favor, conteste las siguientes preguntas para determinar si califica y regrese esta encuesta a la escuela.

Nombre del Estudiante: (Apellidos, Nombre)	Grado:	Fecha:
Nombre del Padre / Guardián:	Escuela:	

1. ¿En los últimos 3 años su familia se ha mudado a otra ciudad, condado o estado, para trabajar en la agricultura o pesca?
   Sí ☐ No ☐
   Si su respuesta es "sí", indique el miembro de su familia se mudó ☐ Madre ☑ Padre ☐ Hijos ☐ Otro

2. ¿Usted o alguien en su familia actualmente trabajan en alguna de las actividades mencionadas abajo? Sí ☐ No ☐
   Si su respuesta es "sí", indique el miembro de su familia y qué actividad ☐ Madre ☐ Padre ☐ Hijos ☐ Otro

☐ **Procesamiento/Empaque de alimentos y carnes**  Ejemplos: vegetales y carne de res, pollo, cerdo, etc.	☐ **Trabajo de campo / Agricultura**  Ejemplos: sembrar, plantar, pizcar, cosechar, empacar, sortear; preparación de la tierra, irrigación, fumigación, etc.	☐ **Lechería / Ganadería**  Ejemplos: ordeñar, alimentar, acorralar, etc.
☐ **Vivero/ Invernadero**  Ejemplos: sembrar, cultivar, plantar, cosechar flores, plantas, etc.	☐ **Trabajo Forestal**  Sembrar, plantar, cultivar, cosechar árboles, etc.	☐ **Pesca/ Procesamiento de Pescado**  Ejemplos: Sortear, empacar, pescado o mariscos, etc.

3. Si su actual trabajo no es en la agricultura o la pesca, ¿Ha trabajado usted o algún miembro de su familia es este tipo de actividades, durante los últimos tres años? Sí ☐ No ☐

¿Dónde? Ciudad _____ Estado _____

Si respondió "Sí" a alguna de las 3 preguntas anteriores, responda las siguientes preguntas.

¿Cuánto tiempo lleva en este condado en Tennessee? ___ Semanas ___ Meses ___ Años

Domicilio _____ Ciudad _____ Estado _____ Código Postal

Número de teléfono, incluya el código de área. ( )

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