Hancock County Middle/High School

New Student Enrollment Form

Enrollment Date____Grade__________

Legal Name____

DOB___________________________SS#_________________________________

Gender: ____Male____Female Special Education/IEP: _____yes____no

Ethnic Category (Please check one)

______American Indian ______White_____ Hispanic/Latine

______Black/AfricanAmerican _______Asian ________Other

Discipline Issues____

Last School Attended____

City___________________State_______________Zip_____________________

Parent/Guardian________________________Relationship___________________

Address____

Home Phone__________________ Cell Phone_____________________________

Proof of Custody: _____Married______Divorced______Copy of Custody

______Birth Certificate ______Immunizations ____Social Security Card

Hancock County Resident _____yes ____no (proof of residence/mail)

Do you have a parent/guardian who is enlisted in the military (Army, Navy, Air Force, Marine Corps, Coast Guard, Active Guard Reserve)?

_____Full-time Active Duty _____Part-time National Guard _____Part-time Reserves

Emergency Contacts:

Name____Phone #_________________

Name____Phone #_________________

Permission to Pick-Up:

Name____

Name____

Charlotte Mullins
Director of Schools

Hancock County Schools

Hancock County
Board of Education
Jack Mullins, Chairman
David Jones, Vice Chairman
Dennis Holt
Jerry Hopkins
Kyle Livesay
Freddie Mullins
Jamie Stanifer

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.

Student Information

Name:____

Address:____

Home Phone:_________________________________ DOB:____________________

Parent/Guardian Name:	Parent/Guardian Name:
Work Place:	Work Place:
Work Phone:	Work Phone:
Cell Phone:	Cell Phone:
Email:	Email:

Student Lives with:____

Emergency Contacts:

Name:______________________________ Phone Number:____________________

Name:______________________________ Phone Number:____________________

Permission to Pick-Up Student:

Name:______________________________ Phone Number:____________________

Name:______________________________ Phone Number:____________________

Name:______________________________ Phone Number:____________________

Name:______________________________ Phone Number:____________________

Allergies/Medical
Concerns:____

____

Choose the transportation that your child will use unless you send a note.

_____ Bus Rider #___ _____ Student Driver _____ Car Rider

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:

21ST CENTURY CLASSROOM LEARNING CENTER
AFTER SCHOOL PROGRAM

My child ______________________ has my permission to participate in the 21st CCLC After School Program sponsored by Clinch-Powell Educational Cooperative, Hancock County Board of Education, or any other agency representing the after school program. My child has my permission to participate in any or all activities associated with any event including recreation, music, art, dancing, drama, tutoring, etc. Realizing that the directors and teachers will take all normal care but that accidents and injuries can nonetheless occur during participation, I hereby waive any claim, action, cause of action or suit for damages or other remedies arising from any injury or injuries sustained by my child during participation in after school activities or travel to and from activities. I further release the directors, teachers, and assistants from liability for injuries and/or damages sustained by my child. I execute this waiver and release in consideration of Clinch-Powell Educational Cooperative, Hancock County Board of Education, and all after school staff allowing my child to participate.
In case of an emergency illness or injury, I also give my consent to the program directors to secure emergency medical aid as quickly as possible at the nearest medical facility.
In case of an accident enroute to or from the event location or during the event, I agree to accept responsibility for the payment of all medical bills incurred.
I also agree to accept any financial responsibilities for damages to any vehicle, building, or furniture that has been caused by the above-mentioned child.

I give my consent to the sponsors of the 21st CCLC After School Program to use videos and/or photographs to display in photo albums, advertisements, social media and/or for other publicity purposes.

____
Hospitalization Insurance Carrier

____
Parent or guardian signature

____
Date

Grade your child is in this school year__________

(other side)

Meningococcal vaccine is not required by the state to attend school in Tennessee. State law requires schools to inform all parents about the rare and serious illness caused by meningococcal bacteria and the availability of a vaccine that can reduce the risk of it. The vaccine is recommended for all preteens and teens. If you have questions, talk to your child's healthcare provider.

VACCINE INFORMATION STATEMENT

Meningococcal Vaccines

What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis.

Hojas de Información Sobre Vacunas están disponibles en Español y en muchos otros idiomas. Visite http://www.immunize.org/vis

1 What is meningococcal disease?

Meningococcal disease is a serious bacterial illness. It is a leading cause of bacterial meningitis in children 2 through 18 years old in the United States. Meningitis is an infection of the covering of the brain and the spinal cord.

Meningococcal disease also causes blood infections.

About 1,000 – 1,200 people get meningococcal disease each year in the U.S. Even when they are treated with antibiotics, 10-15% of these people die. Of those who live, another 11%-19% lose their arms or legs, have problems with their nervous systems, become deaf or mentally retarded, or suffer seizures or strokes.

Anyone can get meningococcal disease. But it is most common in infants less than one year of age and people 16-21 years. Children with certain medical conditions, such as lack of a spleen, have an increased risk of getting meningococcal disease. College freshmen living in dorms are also at increased risk.

Meningococcal infections can be treated with drugs such as penicillin. Still, many people who get the disease die from it, and many others are affected for life. This is why preventing the disease through use of meningococcal vaccine is important for people at highest risk.

2 Meningococcal vaccine

There are two kinds of meningococcal vaccine in the U.S.:

- Meningococcal conjugate vaccine (MCV4) is the preferred vaccine for people 55 years of age and younger.
- Meningococcal polysaccharide vaccine (MPSV4) has been available since the 1970s. It is the only meningococcal vaccine licensed for people older than 55.

Both vaccines can prevent 4 types of meningococcal disease, including 2 of the 3 types most common in the United States and a type that causes epidemics in Africa. There are other types of meningococcal disease; the vaccines do not protect against these.

3 Who should get meningococcal vaccine and when?

Routine Vaccination

Two doses of MCV4 are recommended for adolescents 11 through 18 years of age: the first dose at 11 or 12 years of age, with a booster dose at age 16.

Adolescents in this age group with HIV infection should get three doses: 2 doses 2 months apart at 11 or 12 years, plus a booster at age 16.

If the first dose (or series) is given between 13 and 15 years of age, the booster should be given between 16 and 18. If the first dose (or series) is given after the 16th birthday, a booster is not needed.

Other People at Increased Risk

- College freshmen living in dormitories.
- Laboratory personnel who are routinely exposed to meningococcal bacteria.
- U.S. military recruits.
- Anyone traveling to, or living in, a part of the world where meningococcal disease is common, such as parts of Africa.
- Anyone who has a damaged spleen, or whose spleen has been removed.
- Anyone who has persistent complement component deficiency (an immune system disorder).
- People who might have been exposed to meningitis during an outbreak.

Children between 9 and 23 months of age, and anyone else with certain medical conditions need 2 doses for adequate protection. Ask your doctor about the number and timing of doses, and the need for booster doses.

MCV4 is the preferred vaccine for people in these groups who are 9 months through 55 years of age. MPSV4 can be used for adults older than 55.

Meningococcal vaccine is not required by the state to attend school in Tennessee. State law requires schools to inform all parents about the rare and serious illness caused by meningococcal bacteria and the availability of a vaccine that can reduce the risk of it. The vaccine is recommended for all preteens and teens. If you have questions, talk to your child's healthcare provider.

4 Some people should not get meningococcal vaccine or should wait.

- Anyone who has ever had a severe (life-threatening) allergic reaction to a previous dose of MCV4 or MPSV4 vaccine should not get another dose of either vaccine.
- Anyone who has a severe (life threatening) allergy to any vaccine component should not get the vaccine. *Tell your doctor if you have any severe allergies.*
- Anyone who is moderately or severely ill at the time the shot is scheduled should probably wait until they recover. Ask your doctor. People with a mild illness can usually get the vaccine.
- Meningococcal vaccines may be given to pregnant women. MCV4 is a fairly new vaccine and has not been studied in pregnant women as much as MPSV4 has. It should be used only if clearly needed. The manufacturers of MCV4 maintain pregnancy registries for women who are vaccinated while pregnant.

Except for children with sickle cell disease or without a working spleen, meningococcal vaccines may be given at the same time as other vaccines.

5 What are the risks from meningococcal vaccines?

A vaccine, like any medicine, could possibly cause serious problems, such as severe allergic reactions. The risk of meningococcal vaccine causing serious harm, or death, is extremely small.

> Brief fainting spells and related symptoms (such as jerking or seizure-like movements) can follow a vaccination. They happen most often with adolescents, and they can result in falls and injuries.
>
> Sitting or lying down for about 15 minutes after getting the shot – especially if you feel faint -- can help prevent these injuries.

Mild problems

As many as half the people who get meningococcal vaccines have mild side effects, such as redness or pain where the shot was given.

If these problems occur, they usually last for 1 or 2 days. They are more common after MCV4 than after MPSV4.

A small percentage of people who receive the vaccine develop a mild fever.

Severe problems

Serious allergic reactions, within a few minutes to a few hours of the shot, are very rare.

6 What if there is a moderate or severe reaction?

What should I look for?

Any unusual condition, such as a severe allergic reaction or a high fever. If a severe allergic reaction occurred, it would be within a few minutes to an hour after the shot. Signs of a serious allergic reaction can include **difficulty breathing, weakness, hoarseness or wheezing, a fast heart beat, hives, dizziness, paleness, or swelling of the throat.**

What should I do?

- Call a doctor, or get the person to a doctor right away.
- Tell your doctor what happened, the date and time it happened, and when the vaccination was given.
- Ask your provider to report the reaction by filing a Vaccine Adverse Event Reporting System (VAERS) form. Or you can file this report through the VAERS website at **www.vaers.hhs.gov**, or by calling **1-800-822-7967.**

VAERS does not provide medical advice.

7 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) was created in 1986.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling **1-800-338-2382** or visiting the VICP website at **www.hrsa.gov/vaccinecompensation.**

8 How can I learn more?

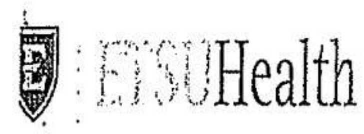
- Your doctor can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)** or
  - Visit CDC's website at **www.cdc.gov/vaccines**

Vaccine Information Statement (Interim)

Meningococcal Vaccines

10/14/2011

42 U.S.C. § 300aa-26



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 [ ] American Indian
[ ] Black\African-American [ ] Native-Hawaiian
[ ] White [ ] Other ______
[ ] Other Pacific Islander

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

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

Emergency Contact Name:

Address:

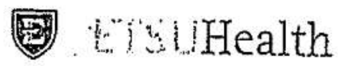
Emergency Contact Number
( )
Relationship to Patient

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 ________



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 $

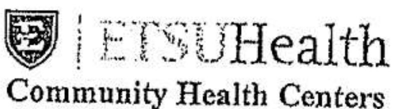
DENTAL OR SECONDARY INSURANCE

[ ] 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 ( )



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	

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

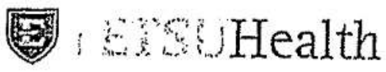
I understand that the ETSU CON serves as a training center for students majoring in, but not limited to, Nursing, Audiology, Dental Hygiene, Nutrition, Radiology, and Speech-Language Pathology at ETSU. For this reason, I authorize the use of student observation, video recording, audio recording, pictures, 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 ________



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 <u>reference laboratory testing, drugs, hearing aids, and other such services.*</u> 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: ______________

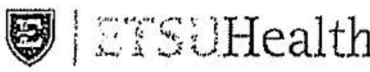
Name of Head of Household		DOB	Phone Number	
Street	City		State	Zip code

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				



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.

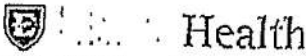
I certify that the family size and income information shown above is correct.

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:



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

This project is funded under a Grant Contract with the State of Tennessee

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	☐ Trabajo de campo / Agricultura	☐ Lechería / Ganadería
Ejemplos: vegetales y carne de res, pollo, cerdo, etc.	Ejemplos: sembrar, plantar, pizcar, cosechar, empacar, sortear; preparación de la tierra, irrigación, fumigación, etc.	Ejemplos: ordeñar, alimentar, acorralar, etc.
☐ Vivero/ Invernadero	☐ Trabajo Forestal	☐ Pesca/ Procesamiento de Pescado
Ejemplos: sembrar, cultivar, plantar, cosechar flores, plantas, etc.	Sembrar, plantar, cultivar, cosechar árboles, etc.	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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SCHOOL DISTRICT:	STUDENT ID:	ENROLLMENT DATE:
	- –	

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