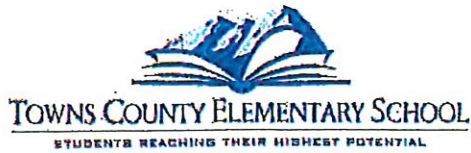




1150 Konahetah Road
Hiawassee, GA 30546

Documents **Required** with Registration Packet

- _____ Certificate of Immunization – GA Form 3231
(If out of state – must be converted to GA form)
- _____ Certificate of Vision, Hearing, Dental and Nutrition Form 3300
(If entering a GA school for the first time)
- _____ Certified copy of Birth Certificate
- _____ Social Security Card
- _____ Proof of Residency of Towns County
(Example: water, electric, gas bill or Lease Agreement with signature of landlord & renters)
- _____ Picture ID of parent/guardian registering the child
- _____ Custody or Guardianship papers issued by the court if student lives with anyone other than natural parents, as listed on the birth certificate



Enrollment Packet
1150 Konahetah Road
Hiawassee, GA 30546
Phone: 706-896-4131 Fax: 706-896-9872

Please Print Information

Enrollment Date _____

Student Legal Name _____
Last First Middle Suffix

Preferred Name _____ Age _____ Grade _____

SSN# _____ Male ___ Female ___ Date of Birth: _____

City of Birth: _____ County of Birth: _____ State of Birth: _____

Entry into US _____ Date entered US School _____

First Language learned: _____ Language Spoken at home: _____

Language Spoken most often: _____

Home Address: _____
Street City ST Zip Code County

Home Phone Number _____

Mailing Address: _____
Street/ PO # City ST Zip Code County

Is Parent/Guardian Active Military? Yes or No (Circle one)

Father's Name: _____ Employer: _____

Email Address: _____

Home Phone: _____ Work: _____ Cell: _____

Mother's Name: _____ Employer: _____

Email Address: _____

Home Phone: _____ Work: _____ Cell: _____

Marital Status of Parents: Single ___ Married ___ Divorced ___ Separated ___

Child lives with (give relationship): _____

Names of Step Parents if any: _____

Name of Child's Legal Guardian(s): _____ # of People living in household _____

Name and Grade of Brothers and Sisters attending Towns County School System:

ETHNICITY AND RACE IDENTIFICATION

(Please read the Privacy Act Statement and Instructions before completing form.)

Name (Last, First, Middle Initial)

Birthdate (Month and Year)

Agency Use Only

Privacy Act Statement

Ethnicity and race information is requested under the authority of 42 U.S.C. Section 2000e-16 and in compliance with the Office of Management and Budget's 1997 Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. Providing this information is voluntary and has no impact on your employment status, but in the instance of missing information, your employing agency will attempt to identify your race and ethnicity by visual observation.

This information is used as necessary to plan for equal employment opportunity throughout the Federal government. It is also used by the U. S. Office of Personnel Management or employing agency maintaining the records to locate individuals for personnel research or survey response and in the production of summary descriptive statistics and analytical studies in support of the function for which the records are collected and maintained, or for related workforce studies.

Social Security Number (SSN) is requested under the authority of Executive Order 9397, which requires SSN be used for the purpose of uniform, orderly administration of personnel records. Providing this information is voluntary and failure to do so will have no effect on your employment status. If SSN is not provided, however, other agency sources may be used to obtain it.

Specific Instructions: The two questions below are designed to identify your ethnicity and race. Regardless of your answer to question 1, go to question 2.

Question 1. Are You Hispanic or Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

Yes No

Question 2. Please select the racial category or categories with which you most closely identify by placing an "X" in the appropriate box. Check as many as apply.

RACIAL CATEGORY (Check as many as apply)	DEFINITION OF CATEGORY
<input type="checkbox"/> American Indian or Alaska Native	A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
<input type="checkbox"/> Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
<input type="checkbox"/> Black or African American	A person having origins in any of the black racial groups of Africa.
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
<input type="checkbox"/> White	A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Standard Form 181
Revised August 2005
Previous editions not usable

42 U.S.C. Section 2000e-16

NSN 7540-01-099-3446

Towns County Elementary School System

Emergency Student Data Form

Date: _____

Student's Name _____ Student goes by: _____

Birthdate _____ Grade _____ Age _____

Mailing Address _____
Street City State Zip Code

Physical Address _____
Street City State Zip Code

Home Phone Number _____

Mother's Name _____ Cell # _____ Work# _____

Email Address: _____

Father's Name _____ Cell # _____ Work# _____

Email: _____

Guardian (if different from parents) _____

Cell # _____ Work# _____

Address _____
Street City ST Zip Code

****Persons Authorized to HAVE LUNCH/ PICK UP/ SIGN OUT Student:
(PLEASE INCLUDE YOURSELF)****

The student will only be released to the following listed below:

Name

Phone Number

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(If more space is needed, please write on the back of this form)

If school lets out early due to inclement weather, please be sure the teacher has your dismissal information on file. Phone lines during this time are very busy.

Parent or Guardian Signature _____

Towns County Elementary School System

Student's name _____ Date _____

Medical Information: (PLEASE BE SURE TO FILL OUT BOTH SIDES OF SCHOOL HEALTH INFORMATION SHEET THAT'S INCLUDED IN THIS PACKET)

Allergies: _____ Medical Alerts: _____

Pre-K Program Student attended:

GA Pre-K _____ Head start _____ Did not attend a Pre-K _____

Name and Address of Pre-K School attended:

Has student ever been Home-Schooled? _____

Has student attended a Georgia School before _____ if yes..

Name and Address of School/s:

Has student ever attended Towns County Schools? _____ If yes, which grade and year? _____

Has student ever repeated a grade? _____ If yes, which grade _____ and why? _____

Is student enrolled in Special Ed Program (IEP)? _____

Has student ever had a psychological evaluation? _____ If yes, when was it completed? _____

Is student in gifted program? _____

Does student have any of the following? Speech (IEP) _____ 504 _____ RTI/MTSS _____ ESOL _____

Other _____

Any other information concerning your child will be greatly appreciated.

Health Form, for the School Nurse

Student: _____

Grade: _____ Teacher / Homeroom: _____

Dear parents / guardians,

In preparation for the 2022-2023 school year, it is very important to have accurate health information in order to best serve your child. Please fill out both sides of this school health form and return to the school.

Parent of Headstart / Pre-K, Kindergarten and First Grade: Always send extra change of clothes in case of accidents or spillage. Please make these clothes available at all times.

Special medications / prescription medications given to student at school is possible but you must follow certain guidelines: 1) Student may not transport medication to school.

2) **Medication must be in original container**, no baggies, or foil.

Your pharmacist can duplicate the prescription bottle for you, at no charge, one for home and one for school.

3) The parent / guardian must come to the clinic and **sign a form** to give us authorization to give the medication.

Towns County School District provides some over the counter medications / generic brands in the clinic for use by the students. Indicate **yes** or **no** if you authorize for us to treat your child with these medications. The goal is to save time and prevent phone calls to you while giving them the best possible care while at school.

Tylenol _____ Zyrtec _____ Tums antacid _____ Ibuprofen _____

Oragel (gum pain) _____ Benadryl _____ Cough Drops _____

Neosporin, Aquaphor topical ointments _____ Burn Cream _____

Caladryl (topical use for rash / insect bites) _____

Parent/Guardian Signature

Date

Health Information for School Year 2022-2023

High School Middle School Elementary School Head Start

Grade: _____ Teacher/Homeroom: _____

Student: _____ male female DOB: _____

Address: _____
*** Allergies: explain what kind of reaction and how to treat, such as Epi-pen or Benadryl***

- No drug; food, seasonal or any known allergies
- Drug or Medication allergies _____
- Food allergies _____
- Seasonal allergies _____
- Bee or Insect allergies _____

Health / Medical Issues

Physical Handicaps (explain) _____

Diabetes Seizure Disorder Hemophilia Disorder

Asthma (Has your child ever needed **inhalers** or **breathing treatments**? Explain how often and possible triggers, like exercise, grasses, smoke, and such.) _____

Any other health concerns _____

Medications: (taken daily or frequently, dosage and why) _____

EMERGENCY CONTACT INFORMATION

Father / Guardian: _____

Home phone _____ Cell phone _____ Work phone _____

Mother / Guardian: _____

Home phone _____ Cell phone _____ Work phone _____

If parents cannot be reached, list two nearby persons who will assume care of your child.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

**Student's Doctor / Healthcare Provider _____ Phone _____

School clinic personnel have my permission to contact my child's physician for further medical information. In case of serious illness / injury, the school will telephone 911 / Emergency Medical Services for immediate transportation to the closest hospital. I, the parent / legal guardian, authorize the transport of and treatment by the hospital emergency staff for my child (as named above).

Signature _____ Date _____



Required Home Language Survey

Dear Parent or Guardian:

In order to provide your child with the best possible education, we need to determine how well he or she speaks and understands English. This survey assists school personnel in deciding whether your child may be a candidate for additional English language support. Final qualification for language support is based on the results of an English language assessment.

Thank You

Student Name (required information):

Language Background (required information):

1. Which language does your child best understand and speak?

2. Which language does your child most frequently speak at home?

3. Which language do adults in your home most frequently use when speaking with your child?

Language for School Communication (not required):

4. In which language would you prefer to receive all school information?

Signature of Parent/Guardian/Other

Date

Towns County School System Student Residency Statement

Your child may be eligible for additional educational services through Title X, Part C, Federal McKinney-Vento Assistance Act. Eligibility can be determined by completing this questionnaire.

NOTE: Only one form needs to be completed per family!!!!

<p style="text-align: center;">Information provided on this form is confidential.</p> <p>Where does the STUDENT currently stay at night?</p> <ul style="list-style-type: none"> <input type="radio"/> We rent or own our own home <input type="radio"/> Temporarily staying with another family because we can't find affordable housing <input type="radio"/> Staying with another family due to convenient living arrangement. <input type="radio"/> Staying with an adult that is not the parent or legal guardian, or staying alone without an adult. <input type="radio"/> Staying in a hotel/motel, campground, or similar setting. <input type="radio"/> Staying in emergency or transitional shelters such as domestic violence or homeless shelters or transitional housing. <input type="radio"/> Has a primary nighttime residence that is a place that is not designed for or ordinarily used as a regular sleeping accommodation for humans. <input type="radio"/> Staying in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar. 	<p style="text-align: center;"><u>For School Use Only:</u></p> <ul style="list-style-type: none"> <input type="radio"/> Doubled-Up <input type="radio"/> Double-Up/ Unaccompanied Youth <input type="radio"/> Hotel/Motel <input type="radio"/> Unsheltered <input type="radio"/> Sheltered <input type="radio"/> Unknown
--	---

Student Name		Grade
First	Last	

The undersigned certifies that the information provided above is accurate.

Parent of Record/Adult Caring for Student (Print)	Signature	Date
--	-----------	------

(Area Code) Phone Number	Street Address	City	State	Zip
--------------------------	----------------	------	-------	-----



Richard Woods, Georgia's School Superintendent
"Educating Georgia's Future"

School District: _____

Date: _____

Parent Occupational Survey

Please complete this form to determine if your child(ren) qualify to receive supplemental services under Title I, Part C

Name of Student(s)	Name of School	Grade
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- Has anyone in your household moved in order to work in another city, county, or state, in the last three (3) years? Yes No
- Has anyone in your household been involved in one of the following occupations, either full or part-time or temporarily during the last three (3) years? Yes No
 If you answer "yes", check all that applies:
 - 1) Planting/picking vegetables (such as tomatoes, squash, onions) or fruits (such as grapes, strawberries, blueberries)
 - 2) Planting, growing, cutting, processing trees (pulpwood), or raking pine straw
 - 3) Processing/packing agricultural products
 - 4) Dairy/Poultry/Livestock
 - 5) Meatpacking/Meat processing/Seafood
 - 6) Fishing or fish farms
 - 7) Other (Please specify occupation): _____

Names of Parent(s) or Legal Guardian(s) _____

Current Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Thank You!
 Please return this form to the school

Please maintain original copy in your files.

MEP funded school/district: Please give this form to the migrant liaison or migrant contact for your school/district.

Non-MEP funded (consortium) school/districts: When at least one "yes" and one or more of the boxes from 1 to 7 is/are checked, districts should fax occupational surveys to the Regional Migrant Education Program Office serving your district. For additional questions regarding this form, please call the MEP office serving your district:

GaDOE Region 1 MEP, P.O. Box 780, 201 West Lee Street, Brooklet, GA 30415
 Toll Free (800) 621-5217 Fax (912) 842-5440

GaDOE Region 2 MEP, 221 N. Robinson Street, Lenox, GA 31637
 Toll Free (866) 505-3182 Fax (229) 546-3251

Regional Office use only:



Richard Woods, Georgia's School Superintendent
"Educating Georgia's Future"

Distrito Escolar: _____

Fecha: _____

Encuesta Ocupacional para Padres
Favor de completar este formulario para ayudarnos a determinar si su(s) hijo(s) califica(n) para recibir servicios suplementarios de parte del Programa de Título I, Parte C

Nombre del/los Estudiante(s)	Nombre de la Escuela	Grado
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

1. ¿Alguien en su casa se ha mudado para trabajar en otra ciudad, condado, o estado, en los últimos tres (3) años? Sí No
2. ¿Alguien en su casa trabaja, ha trabajado, o tiene la intención de trabajar en una de las siguientes actividades de forma permanente o temporaria, o ha hecho este tipo de trabajo en los últimos tres años? Sí No

Si la respuesta es "sí", marque todo trabajo que aplique:

- 1. Sembrando/cosechando vegetales (como tomates, calabazas, cebollas, etc.) o frutas (como uvas, fresas, arándanos, etc.)
- 2. Sembrando, cortando, procesando árboles, o juntando paja de pino (*pine straw*)
- 3. Procesando/empacando productos agrícolas
- 4. Trabajo en lechería o ganadería
- 5. Trabajo en empacadoras o procesadoras de carnes (como de res, pollo o mariscos)
- 6. Pesca o crianza de peces
- 7. Otra actividad. Por favor especifique en cuál: _____

Nombre de los padres o guardianes legales: _____

Dirección donde vive: _____

Ciudad: _____ Estado: _____ Código Postal: _____ Teléfono: _____

¡Muchas Gracias!
 Por favor regrese este formulario a la escuela

Please maintain original copy in your files.

MEP funded school/district: Please give this form to the migrant liaison or migrant contact for your school/district.

Non-MEP funded (consortium) school/districts: When at least one "yes" and one or more of the boxes from 1 to 7 is/are checked, districts should fax occupational surveys to the Regional Migrant Education Program Office serving your district. For additional questions regarding this form, please call the MEP office serving your district:

GaDOE Region 1 MEP, P.O. Box 780, 201 West Lee Street, Brooklet, GA 30415
 Toll Free (800) 621-5217 Fax (912) 842-5440

GaDOE Region 2 MEP, 221 N. Robinson Street, Lenox, GA 31637
 Toll Free (866) 505-3182 Fax (229) 546-3251

Regional Office use only:

WITHDRAWAL INFORMATION

Student's name _____ Date _____ Grade _____

The individual enrolling a student is the only person permitted to withdraw the student.

The person who enrolls a student during the school year assumes parental status; this can be mother or father, a legal guardian, or any other person who has assumed the role of parent. Pursuant of GA law, the enrolling parent(s) is the only individual(s) allowed to add to, delete from, or alter a student's pickup list.

I verify that all of the above information is correct and accurate. I understand that it shall be my responsibility to notify the school of any changes. Furthermore, I understand my signature below assigns me as the school system's enrolling parent for the above named student.

Enrolling Parent Signature

Enrolling Parent Printed Name

Date

Transportation and Lunch Visitors—Please read

*****Transportation is very important please make sure that your child's teacher has the information. At any time a transportation change needs to be made you have to come in person or send a note to school with your child. *** Sorry no changes can be made over the telephone, fax or emails.**

*****Lunch Visitors must sign in thru the front office *****

If at any time your child will have a visitor for lunch, please send a note to the office so that we are aware of their presence in the building.

Immunization Requirements for Towns County Elementary School

All Children entering Towns County Schools are required to meet the following:

NEW **A Hearing, Vision, Dental and Nutrition Screening must also be completed on Georgia Form 3300. All immunizations are required to be on Georgia Form 3231 and must be current in order for your child to be enrolled in Towns County Schools. **

1. Have the required doses of Hepatitis B, Diphtheria, Tetanus, and Pertussis (DTP) and polio vaccines.
2. Have two doses of Mumps, Measles, and Rubella (MMR) or two doses of Measles vaccine, two doses of Mumps vaccine, and one dose of Rubella vaccine or laboratory proof of immunity against Measles, Mumps or Rubella. If child is under four, at least one dose is required.
3. Have two doses of Varicella (chicken pox) vaccine or documentation of disease or laboratory proof of immunity. If child is under four, at least one dose is required.
4. If your child is under five years of age, he/she must have protection against pneumococcal disease. He/She will need the Pneumococcal Conjugate vaccine (PCV). The number of doses needed will depend on the child's age. Your child must have at least three doses of HIB.
5. If your child was born on or after January 1, 2006, he/she must have two doses of Hepatitis A (Hep A) vaccine or laboratory proof of immunity. The first dose must be given on or after the first birthday with spacing of six months or greater between doses.
6. If your child was born on or after January 1, 2006, he/she must have at least four doses of Polio (OPV and/or IPV). The final dose must be given on or after the fourth birthday and must be at least six months from the third dose.
7. **For students entering from out of state, please contact the Georgia Health Department or a Georgia licensed physician to have immunizations transferred to the Georgia Certificate form 3231.**

CERTIFICATE OF IMMUNIZATION

Child's Name (Last name, First name)

Birthdate

(Optional) Parent/Guardian Name (Last name, First name)

Unless specifically exempted by law, Georgia law (O.C.G.A. § 20-2-771) requires a certificate on file for each child in attendance in any school or child care facility in Georgia with penalties for failure to comply. Detailed instructions for this form and immunization requirements by age are spelled out in policy guides 3231INS and 3231REQ distributed by the Georgia Immunization Office.

(Fill in X)

Complete For K through 6th Grade
Child must be >= 4 years and have met all requirements for school attendance.

(Fill in X)

Complete For 7th through 10th Grade
Fulfills requirements K through 6th grade AND must have Tdap and MCV4 administered.

(Fill in X)

Complete For 11th Grade and higher
Fulfills requirements K through 10th grade AND must have MCV4 booster dose administered on or after 16th birthday.

VACCINE	DATE		DATE		DATE		DATE		DATE		Total Doses	Diagnosed	Serology+	History	Med. Exemption
	MM	DD	YY	MM	DD	YY	MM	DD	YY	MM					
Required Vaccines for School or Child Care Attendance															
DTP,DTaP,DT,Td															
Polio															
Hepatitis B															
Tdap															
MCV4															
HIB (Under Age 5)															
PCV (Under Age 5)															
Measles															
Mumps															
Rubella															
Hepatitis A (Born on/after 1/1/06)															
Varicella															
Recommended Vaccines (For Information Only)															
Rotavirus															
HPV															
Influenza															
Td (booster)															
Men-B															

SAMPLE

Notes:

A licensed Georgia physician, Advanced Practice Registered Nurse, Physician Assistant, qualified employee of a local Board of Health or the State Immunization Office is responsible for the content of this certificate. All dates must include month, day and year. In cases of natural immunity or Medical Exemption, the 4 digit year of infection, test or exemption must be filled in the appropriate box(es).

The certificate is NOT valid without name and birthdate of the child, date of expiration OR "X" in Complete for School Attendance box, legible name and address of the physician, Advanced Practice Registered Nurse, Physician Assistant or health department, certified by signature and a date of issue.

A school or facility official is responsible for keeping a current valid certificate on file for each child in attendance. A certificate must be replaced within 30 days after expiration. When a child leaves or transfers to another facility, the Certificate of Immunization should be given to a parent/guardian or sent to the new facility.

Printed, Typed or Stamped Name, Address and Telephone # of Licensed Physician or Health Department

Certified by (Signature/Signature Stamp) Date of Issue



Georgia Department of Public Health Form 3300

Certificate of Vision, Hearing, Dental, and Nutrition Screening

PLEASE SEE THE INSTRUCTIONS
ON THE BACK OF THIS FORM

FILE THIS FORM WITH THE SCHOOL WHEN YOUR CHILD IS FIRST ENROLLED IN A GEORGIA PUBLIC SCHOOL
SCREENER CONTACT INFORMATION IS REQUIRED

Parent/ Guardian Name: _____ first middle last
Parent/ Guardian Contact Information:
 Daytime phone number: _____
 Evening phone number: _____
 Cell phone number: _____

Child's Name: _____ first middle last
Date of Birth: ____/____/____
Gender: Male Female
Child's Home Address: _____

street city state zip code county

VISION	HEARING	DENTAL	NUTRITION
<input type="checkbox"/> Unable to screen (explain why below) <input type="checkbox"/> Uses corrective lenses <input type="checkbox"/> Worn for testing <input type="checkbox"/> Passed (20/30 in each eye for age 6 and above, 20/40 in each eye for below age 6) <input type="checkbox"/> Needs further evaluation <input type="checkbox"/> Under professional care (explain below) Screening completed by: <input type="checkbox"/> Physician <input type="checkbox"/> Local Health Department <input type="checkbox"/> Optometrist <input type="checkbox"/> "Prevent Blindness Georgia" employee <input type="checkbox"/> School Registered Nurse Screener's Signature Date <i>I certify that this child has received the above screening.</i> Contact Information:	<input type="checkbox"/> Unable to screen (explain why below) <input type="checkbox"/> Uses hearing aid / assistive device <input type="checkbox"/> Passed at 500, 1000, 2000, and 4000 Hz with audiometer at 20 or 25 dB <input type="checkbox"/> Needs further evaluation <input type="checkbox"/> Under professional care (explain below) Screening completed by: <input type="checkbox"/> Physician <input type="checkbox"/> Local Health Department <input type="checkbox"/> Audiologist <input type="checkbox"/> Speech-Language Pathologist <input type="checkbox"/> School Registered Nurse Screener's Signature Date <i>I certify that this child has received the above screening.</i> Contact Information:	<input type="checkbox"/> Unable to screen (explain why below) <input type="checkbox"/> Normal appearance <input type="checkbox"/> Needs further evaluation <input type="checkbox"/> Emergency problem observed <input type="checkbox"/> Under professional care (explain below) Screening completed by: <input type="checkbox"/> Physician <input type="checkbox"/> Dentist <input type="checkbox"/> Local Health Department Registered Nurse <input type="checkbox"/> Registered Dental Hygienist <input type="checkbox"/> School Registered Nurse Screener's Signature Date <i>I certify that this child has received the above screening.</i> Contact Information:	<input type="checkbox"/> Unable to screen (explain why below) Height: _____ Weight: _____ BMI: _____ BMI%: _____ <input type="checkbox"/> 5 th to 84 th percentile - Appropriate for age <input type="checkbox"/> < 5 th percentile - Needs further evaluation <input type="checkbox"/> ≥ 85 th percentile - Needs further evaluation <input type="checkbox"/> Under professional care (explain below) Screening completed by: <input type="checkbox"/> Physician <input type="checkbox"/> Local Health Department <input type="checkbox"/> Registered Dietician <input type="checkbox"/> School Registered Nurse Screener's Signature Date <i>I certify that this child has received the above screening.</i> Contact Information:

Screener's Comments:

FOR SCHOOL SYSTEM ONLY		Follow up for further evaluation
1 st attempt	2 nd attempt	Actions reported (if any)
Vision		
Hearing		
Dental		
Nutrition		

Student support services initiated on: _____

Georgia Department of Public Health Form 3300

Certificate of Vision, Hearing, Dental, and Nutrition Screening

Who is required to file this Form 3300? The parent or guardian of a child who is being admitted for the first time to a public school in Georgia must file a completed Form 3300 with the school when the child is enrolled.

What is the purpose of Form 3300? Form 3300 is intended to make sure that every child in Georgia is screened for possible problems with their vision, hearing, teeth and nutrition. The earlier these problems are detected, the earlier parents can seek professional help for the child.

What screenings are required? Four different screenings are required: vision, hearing, dental, and nutrition. All four screenings must be conducted and reported on the form before it can be filed with the school.

Who can conduct the screenings? Your child's doctor is authorized to conduct all four screenings, as is your local health department. In addition, the vision screening can be conducted by a Georgia licensed optometrist, an employee of Prevent Blindness Georgia trained to conduct vision screening, or a school registered nurse; the hearing screening can be conducted by a Georgia licensed speech-language pathologist or audiologist, or a school registered nurse; the dental screening can be conducted by a Georgia licensed dentist, dental hygienist, or a school registered nurse; and the nutrition screening can be conducted by a Georgia licensed dietitian or a school registered nurse. It is not necessary that the same person conduct all four screenings.

What does "BMI" and "BMI%" mean? "BMI" means "body mass index." BMI is a way to describe how much a child weighs in relation to height. "BMI percentile" is a way to compare the child's body mass index to the body mass index of a healthy child. If the child's BMI is less than 5% or more than 84% of what is appropriate for his or her age and height, then the child should be taken to a doctor or dietitian for a more detailed evaluation. For more information, visit the Centers for Disease Control and Prevention website on child and teen BMI at:
http://www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/about_childrens_bmi.html

What should a parent do if the "needs further evaluation" box is checked? "Needs further evaluation" means that the child may have a problem. If the "needs further evaluation" box is checked, then the parent should take the child to a professional for a more detailed evaluation. Your doctor or local health department may be able to help, or recommend someone who can help.

What if a Form 3300 was previously filed for the child at another school? It is only necessary to file the Form 3300 once. If the Form 3300 is filed at the child's first school, and the child later transfers to another school, then the original school is required to forward the Form 3300 to the new school.