



MEDIA RELEASE FORM

School _____

Date _____

Dear Parent or Guardian:

Throughout the school year, the media may visit your school to cover special events. Shelby County Schools may also wish to use your child's photograph, likeness, voice or student work for promotional and educational reasons, such as in publications, posters, brochures and newsletters; on the district website, radio station or Cable TV channel; or at community fairs or other special district events.

Before your child's photograph, likeness, voice or student work can be used by the media or by the school district, you must give your permission.

Please sign and return this form to your child's school, indicating your preference. Thank you for your cooperation.

- I give my permission** for my child to be filmed/photographed/interviewed by the media during school events and for the district to use my child's photograph/work/voice for promotional and educational purposes.

Parent/Guardian signature _____ Date _____

- I do not give my permission** for my child to be filmed/photographed/interviewed by the media during school events and for the district to use my child's photograph/work/voice for promotional and educational purposes.

Parent/Guardian signature _____ Date _____

Student's Name (please print) _____

If you have any questions about this form, please call your school or the Shelby County Schools Office of Communications and Broadcast Services at 416-5628.



Household Information Survey

(Please provide only one survey per household)



ADDRESS

Parent Name: _____

Street: _____

City: _____ State: _____ Zip: _____

STUDENT NAME(S)

ATTENDING SCHOOL(S)

Do not fill out this section. For School Use Only:

Student ID: _____ Y N
 Student ID: _____ Y N
 Student ID: _____ Y N
 Student ID: _____ Y N
 Student ID: _____ Y N
 Student ID: _____ Y N

Please check **TWO** boxes below:

- 1) Column 1 that indicates the number of people in your household; and
- 2) Column 2 that represents your annual income.
- 3) Both check marks must be in the same row.

Household Size	Annual Gross Income:		
<input type="checkbox"/> 1	<input type="checkbox"/> Between \$0 - \$21,590	OR	<input type="checkbox"/> Above \$21,590
<input type="checkbox"/> 2	<input type="checkbox"/> Between \$0 - \$29,101	OR	<input type="checkbox"/> Above \$29,101
<input type="checkbox"/> 3	<input type="checkbox"/> Between \$0 - \$36,612	OR	<input type="checkbox"/> Above \$36,612
<input type="checkbox"/> 4	<input type="checkbox"/> Between \$0 - \$44,123	OR	<input type="checkbox"/> Above \$44,123
<input type="checkbox"/> 5	<input type="checkbox"/> Between \$0 - \$51,634	OR	<input type="checkbox"/> Above \$51,634
<input type="checkbox"/> 6	<input type="checkbox"/> Between \$0 - \$59,145	OR	<input type="checkbox"/> Above \$59,145
<input type="checkbox"/> 7	<input type="checkbox"/> Between \$0 - \$66,656	OR	<input type="checkbox"/> Above \$66,656
<input type="checkbox"/> 8	<input type="checkbox"/> Between \$0 - \$74,167	OR	<input type="checkbox"/> Above \$74,167

SIGNATURE An adult household member must sign the application.

I certify (promise) that all information on this application is true and that all income is reported. I understand that the school will receive federal and state funding based on the information provided. I understand that school officials may verify (check) the information.

Sign here: _____ Date: _____



Department of Coordinated School Health
Confidential Student Health Information

PLEASE PRINT
 Student Name: _____
 Gender: M or F _____
 Date of Birth: _____
 Race: _____
 School: _____
 Grade: _____

General Information:

- The request for identifiable health information will enable us to provide safe and appropriate health care if your child becomes ill or injured at school or on the bus. The information that you provide will be maintained confidentially and is limited to individuals that work with your child within the school setting with a legitimate need to know. If you have any questions or would like to discuss specific health issues with Health Services staff, please call your school directly during school hours or call the Department of Coordinated School Health at (901) 473-2693.

RELEASE OF HEALTH INFORMATION: (PLEASE INITIAL)

	Parent gives permission to release health information to appropriate school system staff for medical alert notification and health care management
	Parent prohibits disclosure of sensitive health information to school staff unless medically necessary without specific request and school nurse involvement

PARENT/GUARDIAN INFORMATION (PLEASE PRINT)

Last Name	First Name	Relationship	Phone

EMERGENCY CONTACTS (PLEASE PRINT)

Last Name	First Name	Relationship	Phone

PHYSICIAN CONTACTS (PLEASE PRINT)

Physician Name or Office	Clinic/Practice Name & Address	Phone

PLEASE REVIEW THE FOLLOWING LIST AND CHECK ANY AND ALL THAT APPLY.

<input type="checkbox"/>	ADHD	<input type="checkbox"/>	Cystic Fibrosis	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	Sickle Cell anemia
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	Sinus Problems
<input type="checkbox"/>	Anxiety attack	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Dialysis	<input type="checkbox"/>	Meningitis	<input type="checkbox"/>	Vision Problems
<input type="checkbox"/>	Artificial joints	<input type="checkbox"/>	Fractures (Skull)	<input type="checkbox"/>	Menstrual cramps	<input type="checkbox"/>	Vomiting
<input type="checkbox"/>	Artificial valves (heart)	<input type="checkbox"/>	Glasses	<input type="checkbox"/>	Migraine Headache	<input type="checkbox"/>	Procedure:
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	Catheterization **
<input type="checkbox"/>	Back Problems	<input type="checkbox"/>	Hearing Problems	<input type="checkbox"/>	Panic attacks	<input type="checkbox"/>	Tube Feeding **
<input type="checkbox"/>	Broken bones	<input type="checkbox"/>	Heart Problems	<input type="checkbox"/>	Reflux	<input type="checkbox"/>	Equipment:
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Crutches
<input type="checkbox"/>	Contact lenses	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Scoliosis	<input type="checkbox"/>	Walker
<input type="checkbox"/>	Concussion	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Wheelchair

ALLERGY INFORMATION: IS YOUR CHILD ALLERGIC TO ANY OF THE FOLLOWING?

Medication (name)	Environmental - (Trees - Grass)-	Does your child require an epinephrine for an allergic reaction? Y or N If Yes, what type and dose level:	Name of medications your child takes in addition to the Epinephrine to treat an allergic reaction:
Food (Tree nuts - Peanuts - Fish - Milk)	Dyes (Red - Yellow)		
Insects (Bees - Wasps)	Other		
Latex			

MEDICATION INFORMATION: DOES YOUR CHILD ROUTINELY TAKE MEDICINE AT HOME OR SCHOOL? Y OR N

IF YES, PLEASE PROVIDE INFORMATION BELOW:

DIAGNOSIS FOR WHICH MEDICINE IS GIVEN	NAME OF MEDICATION	FORM (PILL, LIQUID, INHALER)	DOSAGE	SPECIFIC TIME (S) TO BE GIVEN	G I V	GIVEN AT SCHOOL

PARENT/ GUARDIAN ACKNOWLEDGEMENT: I understand that my child may be allowed to take his/her medication according to SCS Health Care Management Policy #6043. I also understand that I must personally bring all medications that are deemed medically necessary for administration during the school day to the school and complete a Parent Authorization Form for Administration of Medication. This document will be placed on file in the school office.

I understand that although a reasonable attempt will be made to remind the student about medications, it is expected that the student will be responsible for obtaining his/her medication if required for self-administration during the school day.

I agree to indemnify and hold harmless SACS and its employees from claims relating to the possession or self-administration of asthma inhalers or oral medications, and understand that SACS, its employees and agents shall incur no liability as a result of injury to a student or any other person as a result of possession or self-administration of asthma inhalers or oral medications.

I also authorize the school nurse and district health services staff to consult with the prescribing physician to clarify medication orders, or, in the interest of the student's health, to discuss his/her response to the prescribed medication. All health information will be kept confidential.

Parent/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 FIRST NAME:	STUDENT LAST NAME:	DATE:
SCHOOL:		GRADE:
PARENT/GUARDIAN NAME:		

1) In the past three years, has your family moved to another city, state, and/or county?

Yes No

2) Do you or anyone in your immediate family currently work or have worked (in the past three years) in any of the following occupations?

Yes No

a. If yes, please circle all that apply:



Processing & Packing
(fruit, vegetables, chicken, eggs, pork, beef, etc.)



Agriculture/Field Work
(planting, picking, and sorting crops; soil preparation; irrigation; fumigation; etc.)



Dairy/Cattle Raising
(feeding, milking, rounding up, etc.)



Nursery/Greenhouse
(planting, potting, pruning, watering, etc.)



Forestry
(soil preparation, planting, growing, cutting trees, etc.)



Fishing/Fish Processing
(catching, sorting, packing, transporting fish, etc.)

If you answered "yes" to the questions above, please continue. Otherwise, your form is complete.

3) How long have you been in this county in Tennessee?

WEEKS:	MONTHS:	YEARS:
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HOME ADDRESS:		
CITY:	STATE:	ZIP:
TELEPHONE (WITH AREA CODE):		

For school use only: If questions 1 and 2 are "yes," please send the survey to your district migrant liaison. If you have questions, call (931) 212-9539 to speak with the Tennessee Migrant Education Program.

School District:	Student State ID:	Enrollment Date:
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Southern Avenue Charter Elementary School
Emergency Transportation Consent Form

Dear Parents:

If your child suddenly becomes ill or needs medical attention during school hours, we will contact you to make arrangements for emergency care. If we are unable to reach you (either parent or guardian) or the emergency contact person listed on file, permission to transport your child via emergency personnel or ambulance will be necessary.

I give my consent for Southern Avenue Charter School to contact emergency services and or emergency transportation for my child _____ in the event emergent care is warranted. I understand that the school and school personnel will always work to ensure the safety of my child and I release the school and school personnel from any responsibility in the event of any aforementioned emergent incident or situation.

Parent / Guardian Signature: _____

Date: _____



**Southern Avenue Charter School
Of Academic Excellence and Creative Arts**

STUDENT – PARENT HANDBOOK

Please read the Student – Parent handbook and discuss the policies and procedures with your child to ensure that each of you understands what is expected. Sign this form to verify that you and your child have received the handbook and have your child return this form to the school.

Student: I, _____, will read the Student – Parent handbook to review my responsibilities and the expectations as outlined in the handbook.

Student Signature: _____ **Date:** _____

Parent / Guardian: I, _____, will read the Student – Parent handbook, discuss the policies, procedures and expectations with my child and understand my responsibilities as outlined in the handbook.

Parent / Guardian Signature: _____
Date: _____

SHELBY COUNTY SCHOOLS STUDENT RESIDENCY QUESTIONNAIRE/HOMELESS AFFIDAVIT

This document is intended to address the McKinney-Vento Homeless Assistance Act. Your answers will help determine documents necessary to enroll your student.

Student: _____ Sex: M F Birth Date: ____/____/____ Grade: _____
Last Name First Name Day Month Year

Do you and your student live in a fixed, regular adequate nighttime residency? (If "Yes" stop here. You must provide proof of homeownership or rental documents along with two current utility bills in your name as proof of residency.) declare that my family meets one of the following conditions for the McKinney-Vento Homeless Assistance Act: (Please check all that apply).

1. Lack a fixed, regular nighttime residence temporarily live with another family in a house, mobile home, or apartment because I cannot afford housing (Shared Resident Affidavit required.):

- Live in a Motel/Hotel (Hotel/Motel Receipt required.)
- Live in an emergency shelter, transitional shelter, or domestic violence shelter.
- Live in a car, trailer, park, or campground.
- Other location: _____

2. The student lives with:

- One Parent
- Two Parents
- Legal Guardian (Proof of Guardianship required)
- Unaccompanied Youth

3. I am:

- The parent/legal guardian of the above-named student
- Other: _____

- The district will actively investigate all cases where it has reason to believe false information has been provided on an affidavit; including the use of private investigators/SCS Security to verify residency status (verification may include home visits).
- The district may refer cases in which false information has been provided to counsel for Shelby County Schools for further actions and/or file civil action to recover damages incurred as a result of providing false information.
- Investigations that reveal students have enrolled on the basis of providing false information will lead to **immediate withdrawal** from the district.

I declare under penalty of perjury under the laws of this state that the information provided here is true and correct and of my own personal knowledge.

Signature: _____ Printed Name: _____ Date: _____

Address/Current Location: _____

Street City Zip

Mailing Address: _____

Street City Zip

Telephone: _____ Cell Phone: _____ Other Phone: _____

For Office Use Only:

School Assigned: _____

Information Verified by: _____ Date: _____

Shelby County Schools offers educational and employment opportunities without regard to race, color, creed, national origin, religion, age, gender, or disability.

Shelby County Schools Shared Residence Affidavit

This form is to be completed if residency requirements cannot be provided due to the fact that the parent and child(ren) are sharing a home with another person SEVEN DAYS A WEEK YEAR ROUND. This affidavit must be re-certified through Student Services annually.

All sections must be completed and signatures notarized. DO NOT SIGN THIS FORM IF ANY OF THE STATEMENTS ARE INCORRECT. Evidence of false information will result in immediate withdrawal of the student(s) from school

To be completed by Parent(s)/ Guardian(s):

Student: _____ Sex: M F Birth Date: ___/___/___ Grade: _____
Last Name First Name

Student: _____ Sex: M F Birth Date: ___/___/___ Grade: _____
Last Name First Name

(Please list additional students on a separate sheet.)

Parent (s) Name: _____
Last Name First Name

Address: _____
Last Name First Name

Telephone: _____ Cell Phone _____ Other Phone _____

This living arrangement is: Temporary Duration: _____ Permanent

This address listed above is my only residence. I agree to notify Shelby County Schools if there is any change in the status of my residence. I understand that home visitation and/or residency verification is part of the process when residency is established by an Affidavit of Shared Residence

Signature of Parent/Legal Court Appointed Guardian

TN Driver's License/ID Card Number

Date

TO BE COMPLETED BY HOMEOWNER:

I, _____, declare/certify that I am the primary resident/owner at
(Owner, Lease Holder, Qualified Relative, Friend, Neighbor, etc.)

_____ and that the above mentioned adult(s) and student(s) reside with me on a full-
(Street) (City) (Zip)
time basis (seven days a week year round.)

I agree to notify Shelby County Schools if there is any change in the status of residence of the persons listed above. I understand that home visitation and/or residence verification is part of the process when residency is established by a Shared Residence Affidavit. I further agree to provide proof of my residence to Shelby County Schools.

Signature of Primary Resident/Owner(s)

TN Driver's License/ID Card Number

Date

State of Tennessee, County Of _____

On _____ before me _____ Personally

appeared _____
Name(s) of Signer(s)

Place Notary Seal below

who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of Tennessee that the foregoing paragraph is true and correct.

WITNESS my hand and official seal

Signature _____
Signature of Notary Public

Southern Avenue Charter School
Parental Involvement / Family Support Program

Parent participation is a cornerstone of Southern Avenue Charter School

- Parents are required to volunteer ten (10) hours (per family) each semester in the school. Parents are encouraged to participate in school fundraising activities and or corporate contribution. Volunteer hours will be recorded and maintained in the main office of each building.
 - Parents can schedule and perform volunteer hours daily between the hours of:
 - a) 7:00 a.m. - 8:00 a.m.
 - b) 10:30 a.m. – 4:00 p.m.
- Teachers will provide each volunteer with a list of areas of need and or tasks.
- Parents are responsible for ensuring their child attends school each day, arrives on time and is dressed in school uniform.
 - Parents are responsible for ensuring their child gets the proper amount of sleep each night to make sure the student is rested and ready to learn each day.
 - Parents are responsible for reading to their child a minimum of 30 minutes a night, 5 nights a week. (Other family members may also read to the child)
 - Parents are required to sign Family Support Program contract and agree to participate as a condition of enrollment at Southern Avenue Charter School.
 - **Parent Participation is MANDATORY**

FAMILY SUPPORT CONTRACT

- ✓ I agree to support my child's academic performance by communicating regularly with my child's teacher and or academic support team members, and by attending parent – teacher conferences.
- ✓ I agree to attend Parent orientation, parent meetings and other school – sponsored events as scheduled and or required.
- ✓ I agree to volunteer a minimum of ten (10) hours per semester.

By signing this contract, I understand that I am agreeing to the aforementioned guidelines and responsibilities. I also understand that if I do not adhere to these guidelines, future enrollment of my child at Southern Avenue Charter School of Academic Excellence and Creative Arts may be affected.

Parent / Guardian Signature

Date



Southern Avenue Charter Elementary School
of Academic Excellence and Creative Arts

TEACHER'S AGREEMENT

It is important that students achieve. Therefore, I shall strive to do the following:

- ✓ Provide meaningful homework assignments for students.
- ✓ Provide necessary assistance to parents so that they can help with assignments.
- ✓ Encourage students and parents by providing frequent reports about student progress.
- ✓ Use special activities in the classroom to make learning enjoyable.
- ✓ Inform parents of homework and classroom policies and procedures.
- ✓ Encourage parents to visit and/or observe their child's classroom regularly.
- ✓ Ask parents to help in school.
- ✓ Provide instruction that fosters high academic expectation and provide challenging and exciting class assignments.
- ✓ Maintain ongoing communication with parents by providing information about student progress.
- ✓ Be a model life-learner for my students.
- ✓ Determine the student's educational needs and adjust the instruction to accommodate those needs.
- ✓ Demand higher cooperation and participation from students and parents.

Teacher's Signature _____

PRINCIPAL AGREEMENT

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

- ✓ Provide a supportive, safe, and effective learning environment that allows for positive communication between the teacher, parent, and student.
- ✓ Encourage teachers to regularly provide homework assignments that will reinforce classroom instruction.
- ✓ Enforce district and school uniform policies.
- ✓ Provide high-quality curriculum and instruction in a supportive and effective learning environment that enable children to meet the state's academic achievement standards.
- ✓ Provide multiple/flexible opportunities for parent-teacher conferences to discuss the compact as it relates to an individual child's achievement.
- ✓ Provide time to listen to student concerns.
- ✓ Provide time to listen to parent concerns.
- ✓ Encourage teachers to regularly provide homework assignments that are an extension of classroom instruction.
- ✓ Encourage teachers and students to have high expectations academically, socially, emotionally, and physically.
- ✓ Encourage teachers and students to always respect self, others, and property.
- ✓ Make expectations widely known when students and parents enter the school doors.
- ✓ Maintain open communication with parents (phone calls, conferences, parent meetings, parent visitations).
- ✓ Involve parents as assistants in the school day-to-day business.
- ✓ Help foster a school environment where educators work collaboratively daily so that student achievement is attained at a higher level.

Principal's Signature _____