BRIGHT from the START
Georgia Department of Early Care and Learning

Please write the school year in the box →

# Pre-K Registration Form

2019-2020 **School Year**

| | |
|---|---|
| PROVIDER LEGAL NAME: NEWTON COUNTY SCHOOL SYSTEM | (this section to be entered by the provider) |
| SCHOOL/SITE NAME: | |

| **CHILD INFORMATION** | **(Please print name exactly as it appears on the birth certificate.)** | | |
|---|---|---|---|
| CHILD'S LAST NAME: \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| | | |
| CHILD'S FIRST NAME: \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| | | |
| CHILD'S MIDDLE NAME: \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| \| NAME SUFFIX: \| \| \| (i.e. Jr, Sr, II,III) | | |
| CHILD'S SOCIAL SECURITY#: | D.O.B. (MM/DD/BY): | SEX: [ ]M [ ]F |
| HOME ADDRESS(Do not enter PO Box Info): | | COUNTY: |
| CITY: | STATE: GA ZIP: | HOME PHONE: ( ) |

**If the Student is transferring from another Pre-K, please provide the following**:
Previous School Name: _____ Last Date in Attendance: _____

| **PARENT/GUARDIAN INFORMATION** | | | |
|---|---|---|---|
| MOTHER'S LAST NAME: | FIRST: | | MIDDLE INITIAL: |
| HOME ADDRESS (If different from child): | | | |
| CITY: | STATE: | ZIP: | |
| HOME PHONE: ( ) | DAY TIME PHONE: ( ) | EMAIL: | |
| PLACE OF EMPLOYMENT: | | | |
| ADDRESS: | | | |
| CITY: | STATE: | ZIP: | |
| FATHER'S LAST NAME: | FIRST: | | MIDDLE INITIAL: |
| HOME ADDRESS (If different from child): | | | |
| CITY: | STATE: | ZIP: | |
| HOME PHONE: ( ) | DAY TIME PHONE: ( ) | EMAIL: | |
| PLACE OF EMPLOYMENT: | | | |
| ADDRESS: | | | |
| CITY: | STATE: | ZIP: | |

| **EMERGENCY CONTACT INFORMATION** | **(Person to contact in the event that either parent/guardian cannot be contacted)** | |
|---|---|---|
| NAME: | | DAY TIME PHONE: ( ) |
| DAY TIME ADDRESS: | | |
| CITY: | STATE: | ZIP: |

**I verify the above information to be correct, and I understand that completion of this form does not guarantee placement in a Pre-K class. If my child is placed in Georgia's Pre-K Program, I agree that my child will attend the program for the required number of hours and days as prescribed by the Georgia Department of Early Care and Learning and outlined by the center where my child is enrolled. I understand that failure to comply with these attendance requirements could result in disenrollment. I understand that I cannot register my child without appropriate age documentation. I have attached a copy of appropriate age documentation to this registration form.**

**SIGNATURE (Parent/Guardian):** _____ **DATE:** _____

| **CHILD MAINTENANCE** | |
|---|---|
| CHILD'S LIVING ARRANGEMENTS: | [ ]BOTH PARENTS [ ]MOTHER [ ]FATHER [ ]OTHER |
| CHILD'S LEGAL GUARDIAN: | [ ]BOTH PARENTS [ ]MOTHER [ ]FATHER [ ]OTHER |

**THE CHILD MAY BE RELEASED TO THE PERSON(S) SIGNING THIS AGREEMENT OR TO THE FOLLOWING**:

| NAME | ADDRESS | RELATIONSHIP |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**CHILD'S PHYSICIAN OR CLINIC'S NAME (CHILD'S PRIMARY HEALTH SOURCE): .**

DATE OF LAST FULL HEALTH SCREENING:_____ PHONE: ( )

**MY CHILD HAS THE FOLLOWING SPECIAL NEED(S):**

**THE FOLLOWING SPECIAL ACCOMMODATION(S) MAY BE REQUIRED TO MOST EFFECTIVELY MEET MY CHILD'S NEEDS WHILE AT THIS CENTER**:

**MY CHILD IS CURRENTLY ON MEDICATION(S) PRESCRIBED FOR LONG-TERM CONTINUOUS USE AND/OR HAS THE FOLLOWING PRE-EXISTING ALLERGIES, ILLNESS, OR HEALTH CONCERNS**:

## GENERAL RELEASE

I verify the above information to be correct and true. I hereby grant permission for the information provided in the preceding Registration Form to be distributed to Pre-K providers, the Department of Early Care and Learning (DECAL), and certain agencies or those entities contracted by Pre-K providers or DECAL which shall include, but not be limited to, the Georgia Department of Education, and colleges/universities.

**SIGNATURE (Parent/Guardian):** _____

**DATE:** _____

## PHOTOGRAPH/VIDEOTAPE RELEASE

I hereby grant permission for the Pre-K provider specified below, the Georgia Department of Early Care and Learning (DECAL) and certain agencies or entities contracted by the Pre-K provider or DECAL which shall include, but not be limited to, the Georgia Department of Education, and colleges/universities, to record the participation and appearance of my child,

The undersigned hereby jointly and severally releases, acquits, forgives, and discharges the Pre-K provider, DECAL, and other entities contracted by the Pre-K provider or DECAL, from any actions, agreements, claims, controversies, demands, judgments, liabilities, proceedings, and suits, whether arising in equity or in law regarding such participation and appearance by said child.

This release shall remain binding upon all successors in interest and personal representatives of the parties, to the extent permitted by law.

PRE-K PROVIDER NAME/ADDRESS: _____

SIGNATURE (Parent/Guardian): _____

DATE: _____


# Waiting List Information Form

Please clearly print the name as it appears on the birth certificate

| Child's Last Name | | | |
|---|---|---|---|
| | | | |
| Child's First Name | | | |
| | | | |
| Child's Middle Name | | | Name Suffix (Jr, Sr, II, III) |
| | | | |
| Last 4 Digits of SSN (if provided) | Date of Birth (M/D/Y) | | Gender |
| | | | ☐ M ☐ F |
| Home Address | City | State | Zip |
| | | GA | |
| County of Residence | Date Started on Waiting List (M/D/Y) | | |
| | ____/____/_____ | | |
| Parent/Guardian Name | Phone Number | | |
| | | | |

** Directory information on this form may be shared with
Bright from the Start: Georgia Department of Early Care and Learning

Parent/Guardian Signature Date

# Registration Checklist

☑ **The following documents are required in order for Pre-k registration packet to be considered complete.**

Two Proofs of Residency:
(Electric, gas, garbage or water bill in the name of the person enrolling the child; **AND** a mortgage statement or lease agreement.) *Please note: If the child does not live with one or both parents, guardianship or custody documents must be presented.

- ☐ Utility Bill, AND
- ☐ Lease Agreement OR Mortgage Statement

☐ Certified Birth Certificate-- **The child must be 4 years old on or before September 1, 2019.**

☐ Child's Immunization Record – GA Form 3231 (obtain from your child's Physician or Health Department)

☐ Eye, Ear, Dental (EED) and Nutrition Screening– GA Form 3300 (obtain from your child's physician or Health Department). Only needed for students entering a Georgia public school for the first time or re-entering a Georgia school after being gone for one entire school year

☐ Child's Social Security Card, or signed waiver request

☐ *Bright from the Start* Pre-K Registration Form

☐ *Newton County* Pre-K Registration Form

☐ Proof of Custody/Guardianship (if applicable)

# Newton County School System

*PRE-K STUDENT REGISTRATION PACKET*

Student's Legal Name: _____
Last Name First Name Middle Name Suffix (Jr, Sr, II, III, etc)

Gender: ___Male ___Female Date of Birth: _____|_____|_____
mm dd yyyy

Student's Social Security Number: _____|____|_____

Last school attended:_____ Grade:_____

Services received (check if applicable): ___EL ___Gifted ___SPED ___EBIS ___RTI ___504

***Previous Newton County School***

___Yes ___No Has this student ever been enrolled in a Newton County School?

If Yes:_____|_____|_____
School Name Grade Year

***Ethnicity / Race Information*** - New Federally Mandated Questions. Please answer both parts.

***Part A - Ethnicity***: Is the student Hispanic or Latino? (choose only one)

___No, not Hispanic/Latino

___Yes, Hispanic/Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race).

*The above part of the question is about ethnicity, not race. No matter what you selected above, please continue to answer the following by marking one or more boxes to indicate what you consider this student's race to be.*

***Part B - Race***: What is the student's race? (choose all that apply)

___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.)

___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.)

___Black or African American (A person having origins in any of the black racial groups of Africa.)

___Native Hawaiian or Other Pacific Islander (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)

___White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

# Newton County School System

*PRE-K STUDENT REGISTRATION PACKET*

Student's Name: _____

Student's **Residence** Address: _____ | _____ | _____
Number Street Name Apt #

_____ | _____ | _____
City State Zip code

Household **Mailing** Address: _____ | _____ | _____
(if different from above) Number Street Name Apt #

_____ | _____ | _____
City State Zip code

**Preferred phone number** the school should normally use to contact you: _____

***PRIMARY HOUSEHOLD INFORMATION*** - *Where student normally sleeps on a nightly basis.*

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

Parent/Guardian Date of Birth: ____ | ____ | ____
mm dd yyyy

Relationship to Student: (Mother, Father, Grandparent, Guardian, etc) _____

Email Address: _____

Residence Phone: _____ Work Phone: _____

Cell Phone: _____ Place of Work: _____

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

Parent/Guardian Date of Birth: ____ | ____ | ____
mm dd yyyy

Relationship to Student: (Mother, Father, Grandparent, Guardian, etc) _____

Email Address: _____

Residence Phone: _____ Work Phone: _____

Cell Phone: _____ Place of Work: _____

***Does the child have a parent or guardian who is currently on active duty in the U.S. Armed Forces, including the National Guard or Reserve Forces? Yes or No***

# Newton County School System

*PRE-K STUDENT REGISTRATION PACKET*

Student's Name:_____

***SECONDARY HOUSEHOLD INFORMATION*** - Where student sleeps on a part time basis. Leave blank if this does not apply to your family situation.

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

Parent/Guardian Date of Birth: ____ | ____ | _____
mm dd yyyy

Relationship to Student: (Mother, Father, Grandparent, Guardian, etc) _____

Email Address: _____

**Residence** Address: _____ | _____ | _____
Number Street Name Apt #

_____ | _____ | _____
City State Zip code

Residence Phone: _____ Work Phone: _____

Cell Phone: _____ Place of Work:_____

***Additional Household Members & Siblings*** - **Please list the names of all additional household members and siblings (under 21 years of age).**

| Last Name | First Name | Date of Birth | Relation to Student | School |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Student's Name:_____

***Emergency Contact Information*** - Please list at least two family members or friends who could assume temporary care of your child in the event that you cannot be reached.

Emergency Contact #1: _____ | _____
Name Phone Relation to Student

Emergency Contact #2: _____ | _____
Name Phone Relation to Student

***Student Residency Statement*** - Do you live in any of the following situations? Please mark as appropriate.

___Sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason (example: evicted from home, cannot afford housing, etc).
___In a motel, hotel, campground or similar setting due to lack of alternative adequate accommodations.
___In emergency or transitional shelters such as domestic violence or homeless shelters or transitional housing through MUST, Center for Family Resources, or other shelter or agency.
___Have a primary nighttime residence that is a place not designed for or ordinarily used as a regular sleeping accommodation for humans.
___In cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings.
___None of the above.

How long do you anticipate living at this location? _____

Student's Name:_____

# *Home Language Survey*

***Home Language Survey*** - In order to comply with state guidelines, we are required to have a Home Language Survey on file **for ALL students**.

**Student's Legal Name:** _____
Last Name First Name Middle Name Suffix (Jr, Sr, II, III, etc)

**Student's Address:** _____ | _____ | _____
Number Street Name Apt #

_____ | _____ | _____
City State Zipcode

**Telephone:** _____

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

Where was this student born (in what country)? _____

Date this student entered the USA (if applicable): ____ | ____ | ____
mm dd yyyy

Date this student first started school in the USA: ____ | ____ | ____
mm dd yyyy

1. Which language does your child most frequently speak at home?_____
2. Which language do adults in your home most frequently use when speaking with your child? _____
3. Which language(s) does your child currently understand or speak? _____
4. If possible, would you prefer notice of school activities in a language **other** than English?
   Yes No

   If yes, which Language?_____

   Parent signature _____Date_____

PLACE IN PERMANENT RECORD FOLDER

If the answer to any of the above questions is a language other than English, send a copy of this form to the designated ESOL contact at the school for student screening.

Student's Name:_____

# *Kindergarten and Pre-Kindergarten Parent Questionnaire*

**(Complete this section ONLY if registering a student for Pre-Kindergarten or Kindergarten for THE 2019-2020 SCHOOL year.) Form SHOULD ONLY BE COMPLETED ONCE—AT THE BEGINNING OF PRE-KINDERGARTEN OR AT THE BEGINNING OF KINDERGARTEN (if child did not attend Pre-K in the Newton County School System)**

Which of the following services are you presently receiving, if any? Check all that apply.

**____ Medicaid ____TANF _____Food Stamps _____SSI ____PeachCare ____CAPS**

Have you applied for pre-kindergarten anywhere else?_____ If so, where?_____

Do you have guardianship or custody of the child who you are registering for pre-kindergarten?_____

If so, how is this child related to you?_____

Do you get your child's immunizations at the Newton County Health Department?_____

If not, where do you get your child's immunizations?_____

Any problems during pregnancy or delivery?_____

At birth was the child ____ Full Term ____ Premature Birth weight _____ pounds _____ounces

Do you have special concerns about this child?_____

## BEHAVIOR AND FAMILY INTERACTION

How is the child disciplined?_____ For what is he/she disciplined?_____

Are there any family problems which might affect your child's school success?_____

Has your child ever attended pre-school? _____ Head Start? _____ Nursery? _____

Where? _____

Student's Name:_____

# *Kindergarten and Pre-Kindergarten Parent Questionnaire* (continued)

## DEVEPLOMENTAL HISTORY
***(If guess, label as such)***

Give Age:

When did this child: Sit?_____ Crawl?_____ Walk?_____ Use Words?_____

Talk in sentences?_____ Feed self?_____ Dress self?_____ When was the child weaned?_____

Is the child toilet trained?_____ When was child toilet trained?_____

Does the child perform the following? Mark one by placing an "X" under the best answer:

| | Often | Sometimes | Rarely |
|---|---|---|---|
| Talk a lot? | ☐ | ☐ | ☐ |
| 1. Seems to speak as well as other children the same age? | ☐ | ☐ | ☐ |
| 2. Speak so you can understand him or her? | ☐ | ☐ | ☐ |
| 3. Speak so other adults understand him or her? | ☐ | ☐ | ☐ |
| 4. Speak so other children understand him or her? | ☐ | ☐ | ☐ |

If the child does not talk, does he or she (mark one):

| | | | |
|---|---|---|---|
| 1. Make any sounds? | ☐ | ☐ | ☐ |
| 2. Use gestures to communicate? | ☐ | ☐ | ☐ |

What language(s) is spoken most frequently in the home?_____

Student's Name:_____

# *Kindergarten and Pre-Kindergarten Parent Questionnaire* (continued)

## Medical Information

_____Asthma _____Sinus trouble _____Thumb sucking _____Heart trouble
_____Indigestion _____Allergies _____Nail biting _____Frequent fevers
_____Diarrhea _____Vomiting _____Headaches _____Nightmares
_____Constipation _____Bed wetting _____Nose bleeding _____Difficulty seeing
_____Epilepsy/seizures _____Difficulty hearing
_____Overtired or lacking pep
_____Other physical problems (Explain):_____
Hearing problems:_____
Vision problems:_____
Childhood diseases:_____
Hospitalization:_____
Serious injuries:_____
Allergies:_____
Family Doctor:_____
(Name) (Telephone Number)

_____
(Address)

Is this child currently on medication? _____ No _____Yes (If yes, describe)_____

_____

**I UNDERSTAND THAT WITHIN 30 DAYS OF ENROLLMENT, I MUST SUBMIT MY CHILD'S HEALTH SCREENING.**
**DATE:**_____ **SIGNATURE:**_____

**I UNDERSTAND THAT THIS APPLICATION DOES NOT GUARANTEE MY CHILD'S PLACEMENT IN THE PRE-KINDERGARTEN PROGRAM.**
**DATE:**_____ **SIGNATURE:**_____

Student's Name:_____

# *EMERGENCY CLOSING INSTRUCTIONS*

Should school be dismissed early, we need to know if your child is to ride the bus, go to day care, or be picked up by you. Weather, plumbing, electrical problems or other emergencies could cause us to dismiss early. It is important that arrangements are made in case of these unforeseen events. Sometimes our phone lines are busy so we cannot rely on a last minute phone call for directions. If the need to close early occurs, we would call all day care centers that pick up at our school.

Child's Name: _____

Address: _____

Phone: _____

**CHECK ONE:**

_____ Ride regular bus home

_____ Ride bus to neighbor/friend/relative:

Name:_____ Bus Number:_____

_____ Day Care:
Name:_____ Phone _____

_____ Parent Pickup

_____ Other (please explain): _____

_____

Parent/Guardian signature_____ Date: _____

Thank you. We hope we do not need this information. Please discuss this plan with your child.

Student's Name:_____

# *SCHOOLWIDE E-MAIL OPTION*

Dear Parents,

In an atmosphere of true economic concern and faced with impending financial cutbacks, we wish to be as fiscally responsible as possible. One thing we can do is reduce the number of "hard copy" information sheets sent home. Throughout the county, schools are attempting to save toner and paper costs by using email when possible.

We realize that everyone does not have access to email but a large number of families do. One school reported a 75% savings by updating its email directory and using email instead of "hard copy" handouts.

Please complete the appropriate portion of the form below and return to the school as soon as possible. If you have a current email address that school information could be sent to, please give that address. If you must continue to receive "hard copy" handouts, please indicate which of your children (for families with more than one child) you would like us to send information home with.

Thank you for your help and understanding in these challenging times.

Student Name: _____

Homeroom Teacher: _____

***Please write clearly and case sensitive.***

Preferred E-mail: _____

(the above is for Parent/guardian name_____)

Secondary E-mail: _____

(the above is for Parent/guardian name_____)

____ I wish to continue to receive "hard copy" handouts. Please send them home with (**choose 1 child only**)

Student name _____

Homeroom Teacher _____

Home Telephone # _____

# *Newton County School System*

*PRE-K STUDENT REGISTRATION PACKET*

## CLINIC INFORMATION CARD

Gender: ___Male ___Female Student's Name: _____
Last First

Date of Birth: _____|_____|_____ Grade ____ HmRm Teacher _____
mm dd yyyy

Name of siblings enrolled in this school: _____

## HEALTH HISTORY (If yes, please explain)

| | | | |
|---|---|---|---|
| ___Yes ___No | Allergies (LIST ALL) | ___Yes ___No | Kidney Problem |
| ___Yes ___No | Asthma | ___Yes ___No | Migraine Headache |
| ___Yes ___No | Cancer | ___Yes ___No | Physical Handicaps |
| ___Yes ___No | Diabetes | ___Yes ___No | Skin Condition |
| ___Yes ___No | Seizure | ___Yes ___No | Heart Problems |
| ___Yes ___No | Menstrual | | |
| ___Yes ___No | Drug Allergies/Reaction | | |
| ___Yes ___No | Other | | |
| ___Yes ___No | My child needs an inhaler/nebulizer available at school (if YES, provide medication to keep at school) | | |
| ___Yes ___No | My child requires an Epi-Pen for severe allergic reaction (if YES, provide Epi-Pen to keep at school) | | |
| ___Yes ___No | My child received immunizations this past year<br>If YES list type and date: | | |
| ___Yes ___No | My child takes prescribed medications routinely/occasionally<br>If YES please list: | | |

## EMERGENCY INFORMATION

Parent/Guardian #1: _____ Relationship to Student: _____
Residence Ph: _____ Work Ph: _____ Cell Ph: _____

Parent/Guardian #2: _____ Relationship to Student: _____
Residence Ph: _____ Work Ph: _____ Cell Ph: _____

If parents cannot be reached, list two (2) Emergency Contacts who will assume care of your child:
Emerg.Contact #1: _____ Relationship _____ Ph: _____
Emerg.Contact #2: _____ Relationship _____ Ph: _____

| | |
|---|---|
| **Please Note** | In the event that Emergency Medical care is deemed necessary, the school will immediately attempt to make contact using phone numbers provided on the clinic card and will contact Emergency Medical Services (911) to respond to the school for evaluation and possible transport. |
| ___Yes ___No | Medical information, as indicated above, may be shared with appropriate staff as needed. |
| ___Yes ___No | In an **emergency**, I give the principal, or designee, permission to administer Tylenol or Benadryl in the event the parent or contact person cannot be reached. |
| ___Yes ___No | In non-emergency health concerns I authorize the school nurse/school personnel to utilize the following medications: anti-itch medication (caladryl, cortisone cream/lotion), antiseptic sprays, cough drops or the generic of these. I understand that it is the **parents'** responsibility to provide non-prescription medications to have available at school such as Motrin, Tylenol, Benadryl, etc. All medication must be labeled and **must be** in the original container. School Nurses are prohibited by their license restrictions to dispense prescription medication without the prescribing doctor's signature. |

Should there be a need for school personnel to dispense prescription/nonprescription medication to my child, I will contact the school for the appropriate medication form that must accompany medication. I understand that **all medication must be provided by the parent/guardian** and that no personnel can dispense without parent/guardian signature.

**Parent/Legal Guardian Signature**

## Georgia Department of Education
## ESOL & Title III Unit

# 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**

***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 |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

1. Has anyone in your household moved in order to work in another city, county, or state, in the last three (3) years? ☐ **Yes** ☐ **No**

2. 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.0. 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: ☐