

Crenshaw County Schools

Enrollment Packet

Mrs. Ashley Catrett, Superintendent

183 Votec Drive, Luverne, Alabama 36049

334-335-6519

www.crenshaw-schools.org

- | | |
|--|--|
| <input type="checkbox"/> Verification of Residency Checklist | <input type="checkbox"/> Employment Survey |
| <input type="checkbox"/> Complete Application for Student Enrollment | <input type="checkbox"/> Digital Access Survey |
| <input type="checkbox"/> Additional Information | <input type="checkbox"/> Student Residency Questionnaire |
| <input type="checkbox"/> Home Language Survey | <input type="checkbox"/> AL Dept Health Assessment |

☐ Brantley High School ☐ Luverne High School ☐ Highland Home School

Bus Rider ☐ No ☐ Yes Bus Number _____ Driver _____



Crenshaw County School System

Verification of Residency Checklist

Student Name: _____

Parent/Guardian: _____

E-911 Address: _____

Mailing Address: _____

Parents of new students seeking to enroll in Crenshaw County Public Schools must offer proof of residency by presenting at least one item documenting the physical address from each section listed below. Please check items of proof presented and keep this form in the student's permanent record.

Choose one of the following:

- ☐ 1. Property Tax Records indicating a homestead exemption
- ☐ 2. Mortgage Documents or Property Deeds
- ☐ 3. Apartment or Home Lease
- ☐ 4. Utility Bills

In the case of divorce, separation, or guardianship by anyone other than the parents, a legal document showing proof of custody must be included in the student's file.

Choose one of the following:

- ☐ 1. Driver's License
- ☐ 2. Voter Precinct Identification
- ☐ 3. Automobile Registration
- ☐ 4. Affidavit and/or Personal Visit by a designated school district official
- ☐ 5. Other: _____

Race and/or Ethnicity

What is the student's race and/or ethnicity? **SELECT ALL THAT APPLY**

AMERICAN INDIAN OR ALASKA NATIVE

For example, Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat
Traditional Government, Nome Eskimo Community, Aztec, Maya, etc.

ASIAN

For example, Chinese, Asian Indian, Filipino, Vietnamese, Korean, Japanese, etc.

BLACK OR AFRICAN AMERICAN

For example, African American, Jamaican, Haitian, Nigerian, Ethiopian, Somali, etc.

HISPANIC OR LATINO

For example, Mexican, Puerto Rican, Salvadoran, Cuban, Dominical, Guatemalan, etc.

MIDDLE EASTERN OR NORTH AFRICAN

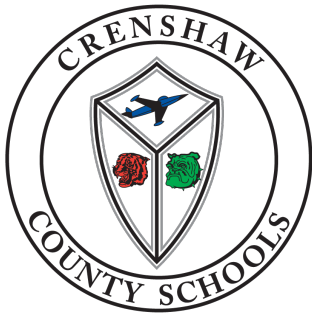
For example, Lebanese, Iranian, Egyptian, Syrian, Iraqi, Israeli, etc.

NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER

For example, Native Hawaiian, Samoan, Chamorro, Tongan, Fijian, Marsha/lese, etc.

WHITE

For example, English, German, Irish, Italian, Polish, Scottish, etc.



Crenshaw County School System

Application For Student Enrollment
Must be completed by Parent/Legal Guardian
Please Print

DATE: _____ SCHOOL: _____ GRADE: _____
LAST NAME: _____, FIRST NAME: _____ MIDDLE NAME: _____
DATE OF BIRTH: ____/____/____ GENDER: _____ PHONE: _____
STREET ADDRESS: _____ CITY: _____ ZIP CODE: _____

CHILD LIVES WITH: _____ Guardian: Relation: _____

SOCIAL SECURITY NUMBER (voluntary): _____

PARENT(S)/GUARDIAN NAME: *If guardian, provide school with a copy of guardianship papers/documentation.* _____

MOTHER/GUARDIAN: _____ ADDRESS: _____

EMAIL ADDRESS: _____ CELL PHONE: _____

EMPLOYER: _____ WORKPHONE: _____

FATHER/GUARDIAN: _____ ADDRESS: _____

EMAIL ADDRESS: _____ CELL PHONE: _____

EMPLOYER: _____ WORKPHONE: _____

SPECIAL INSTRUCTIONS ABOUT CUSTODY: _____

EMERGENCY CONTACTS: (Please list numbers other than your own. This information is very important.)

CONTACT PERSON 1: _____ RELATION: _____ PHONE: _____

CONTACT PERSON 2: _____ RELATION: _____ PHONE: _____

THESE PEOPLE HAVE PERMISSION TO CHECK MY CHILD OUT OF SCHOOL:

1. _____	RELATION: _____	PHONE: _____
2. _____	RELATION: _____	PHONE: _____
3. _____	RELATION: _____	PHONE: _____
4. _____	RELATION: _____	PHONE: _____

NAME AND ADDRESS OF FORMER SCHOOL: _____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

Disclosure of your child's social security number (SSN) is voluntary. If you elect not to provide a SSN, a temporary identification number will be generated and utilized instead. Your child's SSN is being requested for use in conjunction with enrollment in school as provided in Ala. Admin. Code 290-3-1-02(2)(b)(2). It will be used as a means of identification in the statewide student management system.



Crenshaw County School System

Student Information Form

Student Name: _____ **Date:** _____

The following information is being requested to enable the school to be more aware of additional student needs and services that are NOT addressed on the OFFICIAL Enrollment Application.

SPECIAL EDUCATION SERVICES: Is the student currently receiving special education services?

☐ Yes

☐ No

(Indicate if this student has been identified to receive services through special education.)

Briefly Explain: _____

PRESCHOOL: Did the student attend Pre-School? Please select all that apply.

HeadStart <input type="checkbox"/> Yes <input type="checkbox"/> No	FirstClassFundedPreschool <input type="checkbox"/> Yes <input type="checkbox"/> No	Home Visitation Program <input type="checkbox"/> Yes <input type="checkbox"/> No
Centered Based Child Care <input type="checkbox"/> Yes <input type="checkbox"/> No	Home Based Child Care <input type="checkbox"/> Yes <input type="checkbox"/> No	Special Education Funded <input type="checkbox"/> Yes <input type="checkbox"/> No
Other Preschool <input type="checkbox"/> Yes <input type="checkbox"/> No		No Preschool <input type="checkbox"/> Check if no Preschool

MILITARY: Is the student connected to an Active-Duty Military parent?

☐ Yes

☐ No

PREVIOUS ATTENDANCE: Please indicate if this student has attended school here before. If 'YES' indicate last year of attendance.

☐ Yes. Last year of attendance: _____

☐ No

List any household member attending school here:

Name: _____ **Grade:** _____

Name: _____ **Grade:** _____

Name: _____ **Grade:** _____

Special Information/Instructions: _____

Parent/Legal Guardian Signature: _____ **Date:** _____

Crenshaw County Public Schools

HOME LANGUAGE SURVEY

Student Name: _____ Birth Date: _____ Sex: ☐ Male ☐ Female

Parent/Guardian Name: _____

Address: _____

Home Telephone: _____ Work Telephone: _____

School: _____ Grade: _____ Date: _____

1. Was your child born in the United States? ☐ Yes ☐ No
If yes, in which state? _____
If no, in what other country? _____
2. Has your child attended any school in the United States for any three years during their lifetime? ☐ Yes ☐ No
If yes, please provide school name(s), state, and dates attended:
Name of School _____ State _____ Dates Attended _____
Name of School _____ State _____ Dates Attended _____
Name of School _____ State _____ Dates Attended _____
3. What language is spoken by you and your family most of the time at home? _____
4. If available, in what language would you prefer to receive communication from the school? _____
5. Please check if your child is:
A. ☐ Native American Indian C. ☐ Native Pacific Islander
B. ☐ Alaska Native D. ☐ Native U.S. Virgin Islander
6. Is your child's first-learned or home language anything other than English? ☐ Yes ☐ No

If you responded "Yes" to question number 6 above, please answer the following questions:

7. What language did your child learn when he/she first began to talk? _____
8. What language does your child most frequently speak at home? _____
9. What language do you most frequently speak to your child? (Father) _____
(Mother) _____
10. Please describe the language understood by your child. (Check only one)
A. ☐ Understands only the home language and no English.
B. ☐ Understands mostly the home language and some English.
C. ☐ Understands the home language and English equally.
D. ☐ Understands mostly English and some of the home language.
E. ☐ Understands only English.

Parent or Guardian's Signature

Date

OFFICE USE ONLY

Student ID #	Date Distributed	Date Received	



ALABAMA STATE DEPARTMENT OF EDUCATION

Parent Survey

for Newly Enrolled Students



SCHOOL SYSTEM

STUDENT

SCHOOL NAME

DIRECTIONS






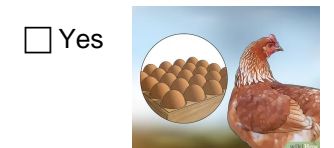


Please complete the following survey. Your child may be eligible for FREE additional educational services. If you answer yes to any of the questions below, an education representative may contact you to find out whether you, your child, or any member of your family is eligible for the migrant education program. All information will be kept confidential.

Please return the completed questionnaire to your child's school.

RELOCATION HISTORY

Have you ever traveled in or out of Alabama to work or find work in any of the pictures below in the past three (3) years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you or your spouse currently working in agriculture, farming, fishing or any of the pictures below?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mark all pictures of agriculture, farming, or fishing where you have worked in the past 3 years. See pictures below.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Other work you have done that is not shown in a picture below: _____

<p>Fruit or Tomato Farms</p> <p><input type="checkbox"/> Yes</p> 	<p>Fish or Shrimp Farms</p> <p><input type="checkbox"/> Yes</p> 	<p>Nursery, greenhouse, sod farm</p> <p><input type="checkbox"/> Yes</p> 	<p>Planting / Harvesting Crops</p> <p><input type="checkbox"/> Yes</p> 
<p>Cattle Farms; Milk Products</p> <p><input type="checkbox"/> Yes</p> 	<p>Hatchery; feeding, processing chickens, gathering eggs</p> <p><input type="checkbox"/> Yes</p> 	<p>Working on a worm farm</p> <p><input type="checkbox"/> Yes</p> 	<p>Growing, tending, felling trees</p> <p><input type="checkbox"/> Yes</p> 

PARENT INFORMATION

PARENT / GUARDIAN

ADDRESS	CITY	STATE	ZIP
PHONE NUMBER	PLACE OF EMPLOYMENT		
NUMBER OF CHILDREN IN HOME		DATE OF MOVE	

Digital Access Survey

The Alabama State Department of Education has requested that each school district in Alabama collect some demographic data regarding Internet accessibility in the home. Please fill out the following survey to assist us in collecting this data.

Student Name (First and Last Name as it appears in PowerSchool: _____

Grade Level: _____ School: _____

Internet in Residence - Do you have Internet Access in your home?

- ☐ Yes - Internet Access in Residence
- ☐ No - Internet is not available in the area of residence
- ☐ No - Internet service is not affordable in my area of residence
- ☐ No - Any other Reason

Internet Access - If you have Internet Access, which best describes the type of Internet Access you have?

- ☐ Residential Broadband (ex. DSL, Cable, Fiber)
- ☐ Cellular Network
- ☐ School Provided Hotspot
- ☐ Satellite
- ☐ Dialup
- ☐ Other
- ☐ None

Internet Performance - How well does the internet work in the residence?

- ☐ Yes - Adequate performance with minimal issues
- ☐ Yes - Internet works but it is not consistent
- ☐ No - Internet does not work well, or N/A

Device Access - For primary access to a device for the student to complete school work at home, which of the following is the most accurate?

- ☐ Personal - Dedicated (One person Per Machine Owned by the Child/Family)
- ☐ Personal - Shared (Shared among others in the household). The device is owned by the child/family and shared with others in the residence.
- ☐ School Provided - Dedicated (The device is owned by the school or district and is issued to the specified student for use.)
- ☐ School Provided - Shared (The device is owned by the school or district and is issued to a family. The device is shared with multiple students in the home.
- ☐ No Device in the home.

Device Type - Based on the answer to the previous question, what type of device is the one that the student uses most often to complete schoolwork?

- ☐ Desktop/Laptop
- ☐ Tablet
- ☐ Chromebook
- ☐ Smartphone
- ☐ Other
- ☐ No Device in the home.

Crenshaw County Public Schools

Student Residency Questionnaire

Name of Student: _____ Date of Birth: _____

Person completing form:

☐ Parent or guardian ☐ Unaccompanied youth (a youth that does not live with a parent or guardian)
☐ Youth ☐ Other;

Name: _____

Email: _____ Phone: _____

Please answer these questions about the student's residency. The information you provide is confidential and protected by the law called the Federal Education Rights and Privacy Act. We use this information to decide which school students should attend. We also use this information to make sure the rights of a child, youth, or an unaccompanied youth are met based on a law called the McKinney-Vento Homeless Assistance Act.

Is the student's address a temporary living arrangement? Yes ☐ No ☐
 Is the student's living arrangement due to loss of housing or financial hardship? Yes ☐ No ☐

If the answer to any of the above is YES, please complete the following:

Where is the student identified above currently living? (Please check one)

- ☐ In a motel or hotel due to loss of housing or financial hardship
☐ In an emergency shelter, transitional housing facility, or abandoned in a hospital
☐ Sharing another family's house or apartment
☐ In a car, park, trailer park (this does not refer to a mobile home [trailer] park, this refers to type of camping ground for fifth wheel camper trailers or other types of movable campers), camping ground, street, public space, substandard housing (housing that does not meet modern standards of living), or abandoned building
☐ In a bus or train station
☐ Moving from place to place (couch surfing)
☐ In a public or private place not meant to be used as a regular place for people to sleep
☐ Other: _____

Last school the student attended:

School: _____ District: _____
 City: _____ State: _____

Name of Parent, Guardian or education decision maker:

Name: _____ Signature: _____
 Name: _____ Signature: _____
 Address: _____
 City: _____ State/Zip: _____
 Home Phone: _____ Work Phone: _____
 Cell Phone: _____ Email: _____

OR

Student (if an unaccompanied youth that is homeless):

Name: _____ Signature: _____
 Address: _____
 Email: _____ Phone: _____

If a child, youth, or unaccompanied youth is NOT living in permanent housing, proof of residency and other documents (health, school records, etc.) normally needed for enrollment are NOT required. The child, youth, or unaccompanied youth must be enrolled immediately in his or her school of origin, the school where other children attend that are in the area where the student is currently living, or another school that the student may attend based on what is best for the student.

OFFICE USE ONLY			
Date Completed:	Eligible: <input type="checkbox"/> Yes <input type="checkbox"/> No	District Representative:	Comments:



ALABAMA STATE DEPARTMENT OF EDUCATION

HEALTH ASSESSMENT RECORD



School Year: **2025-2026**

To Parent or Guardian:

The purpose of this form is to provide the school nurse with additional information regarding your child's health needs. The school nurse may contact you for further information. The information requested is essential for the school nurse to meet the health needs of your child.

This information will be kept confidential.

PLEASE complete both pages of this form (Return to the School Nurse)

Name of Student (Last, First, Middle)	Birth Date	Sex	School
---------------------------------------	------------	-----	--------

Address (Street)

Home Telephone Number:	Cell Phone Number:	Additional Phone Number:	Grade	Teacher/Homeroom
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Name of Parent/Guardian (Last, First Middle)	Work Phone Number:
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Transportation

☐ Bus Rider Bus Number: ☐ Car Rider ☐ Special Needs Bus ☐ After School

Part I – Health Information

<p>Place your child receives health care:</p> <p>Physician's Name: _____</p> <p>Address: _____</p> <p>Phone: _____</p> <p><input type="checkbox"/> Community Health Center</p> <p><input type="checkbox"/> Health Department</p> <p><input type="checkbox"/> Hospital Clinic</p> <p><input type="checkbox"/> No Regular Place</p> <p><input type="checkbox"/> Private Doctor /HMO</p> <p>Preferred Hospital: _____</p>	<p>Your child's Insurance Information:</p> <p><input type="checkbox"/> ALL KIDS</p> <p><input type="checkbox"/> Medicaid</p> <p><input type="checkbox"/> No Insurance</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Private Insurance</p>	<p>Place your child receives dental care:</p> <p>Dentist's Name: _____</p> <p>Address: _____</p> <p>Phone: _____</p> <p><input type="checkbox"/> Community Health Center</p> <p><input type="checkbox"/> Health Department</p> <p><input type="checkbox"/> Hospital Clinic</p> <p><input type="checkbox"/> No Regular Place</p> <p><input type="checkbox"/> Private Dentist /HMO</p>
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Part II – Medical History Medical Equipment /Procedures Required at School

<input type="checkbox"/> Catheter	<input type="checkbox"/> Gastric Tube	<input type="checkbox"/> Nebulizer Treatments	<input type="checkbox"/> Oxygen Supplement	<input type="checkbox"/> Tracheostomy
<input type="checkbox"/> Vagal Nerve Stimulator (VNS)	<input type="checkbox"/> Ventilator	<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Walker	
<input type="checkbox"/> Other Please explain:				

Medications and Procedures at School require a Prescriber/Parent Authorization Form (one for each medication or procedure). Please see your school nurse.

Please Complete Both Pages of Form (Signature Required) ➡



ALABAMA STATE DEPARTMENT OF EDUCATION HEALTH ASSESSMENT RECORD



School Year: **2025-2026**

Name of Student _____

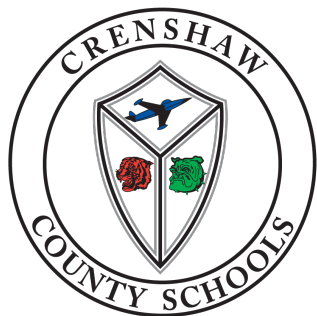
Part III – Medical History

<input type="checkbox"/> YES <input type="checkbox"/> NO	KNOWN HEALTH PROBLEMS If NO, go directly to the bottom of the page and provide parent/guardian signature If YES and diagnosed by a physician, answer each question below.		
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO	Attention Deficit Disorder (ADD) Attention Deficit Hyperactivity Disorder (ADHD) Requires medication <input type="checkbox"/> At school <input type="checkbox"/> At Home		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Allergies: <input type="checkbox"/> Food _____ <input type="checkbox"/> Insects _____ <input type="checkbox"/> Environmental _____ <input type="checkbox"/> Medications _____	<input type="checkbox"/> Hives/rash <input type="checkbox"/> Breathing difficulty <input type="checkbox"/> Other: _____	<input type="checkbox"/> Medications <input type="checkbox"/> Epi-pen
<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	Asthma <input type="checkbox"/> Uses an inhaler at school <input type="checkbox"/> Uses an inhaler at home		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Blood/Bleeding Problems: <input type="checkbox"/> Hemophilia, <input type="checkbox"/> Von Willebrand's, <input type="checkbox"/> Other <input type="checkbox"/> Requires medication <i>Please explain:</i> _____		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Frequent Nose Bleeds: <i>Please explain</i> _____		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Cancer/Leukemia: <i>Please explain</i> _____		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Cerebral Palsy: <i>Please explain</i> _____		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Cystic Fibrosis: <i>Please explain</i> _____		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Dental Problems: <i>Please explain:</i> _____		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Diabetes <input type="checkbox"/> Type 1 Diabetes <input type="checkbox"/> Monitors Blood Sugars at school <input type="checkbox"/> Requires Insulin at school <input type="checkbox"/> Type 2 Diabetes <input type="checkbox"/> Managed with diet <input type="checkbox"/> Insulin pump <input type="checkbox"/> Oral medication		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Emotional/Behavioral/Psychological: <i>Please explain:</i> _____		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Gastrointestinal/Stomach Problems: <i>Please explain:</i> _____		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Genetic / Rare Disorders: <i>Please explain:</i> _____		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Headaches: <i>Please explain:</i> _____		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Hearing Problems: <input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> Both ears <input type="checkbox"/> Hearing loss <input type="checkbox"/> Hearing aid <input type="checkbox"/> Tubes <input type="checkbox"/> Cochlear Implant		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Heart Condition: <input type="checkbox"/> Activity restrictions: <input type="checkbox"/> Medications taken at home: <i>Please explain:</i> _____		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Hypertension (High Blood Pressure): <i>Please explain:</i> _____		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Juvenile Arthritis/Bone-Joint Problems: <i>Please explain:</i> _____		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Kidney/ Bladder/ Urinary Problems: <i>Please explain:</i> _____		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Scoliosis: <input type="checkbox"/> No Treatment <input type="checkbox"/> Wears Brace <input type="checkbox"/> Surgery <input type="checkbox"/> Family History		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Seizures/Convulsions: Type of seizure: _____ Medications: <input type="checkbox"/> Diastat <input type="checkbox"/> Klonopin <input type="checkbox"/> Versed <input type="checkbox"/> Medication taken at home <input type="checkbox"/> Other _____ <i>Please explain:</i> _____		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Sickle Cell: <input type="checkbox"/> Anemia <input type="checkbox"/> Trait		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Shunt: <input type="checkbox"/> VP shunt <i>Please explain:</i> _____		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Spina Bifida: _____		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Special Diet: <i>Please explain:</i> _____		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Vision Problems: <input type="checkbox"/> Wears glasses <input type="checkbox"/> Wears contacts <input type="checkbox"/> Other		
<input type="checkbox"/> YES <input type="checkbox"/> NO	Other Medical Conditions: Please include any medications taken at home only: _____		

Required Signatures

(Electronic or Written) Parent(s) or Guardian Signature: _____ Date: _____

(Electronic or Written) School Nurse Signature: _____ Date: _____



Crenshaw County School System

Administration of Medicine

Please keep this page at home for reference



ADMINISTRATION OF MEDICINE

1. Parents or legal guardians must fill out an official registration form stating any medical problems which can affect the child in a classroom situation or at physical education.
2. Medication shall be administered at school only when absolutely necessary. The school nurse should be notified of all medicines to be brought on campus by students or parents for students.
3. Students shall not bring medicine from home to be administered for minor illness. For example: A student with an illness such as a cold, severe enough to require medication, should remain at home. This protects all on campus.
4. There will be cases where a student will need to receive medication for either a short or possibly extended period of time. In many of these situations, the medication can be given at home before school hours and when the child arrives at home in the afternoon. When no alternative is possible and the student needs medication during school hours, the school may cooperate with parents for the administration of medicine. Contact the school nurse.

REQUIREMENTS TO RECEIVE MEDICATION AT SCHOOL

- A written statement from the licensed physician, prescribing the medication, requesting that the student be medicated during school hours.
- A letter from the parent or legal guardian requesting that the medication be given at school and giving permission for the school nurse or other officials/person(s) to administer the medicine. Call the principal or the school nurse.
- The medication must be in a pharmacy container and be properly labeled with the name of the medicine, the dosage, the pharmacist, the prescribing doctor, and the child to whom the medicine belongs.

PARENTS ARE NOT TO SEND MEDICINE TO SCHOOL WITH A CHILD. PARENTS ARE TO BRING THE MEDICINE TO THE SCHOOL NURSE OR THE OFFICE.