

Elizabethton City Schools ESP School Year Application

Phone Number for Automated School Messages: _____

Student's Name _____ Gender: M or F Date of Birth _____

Address where student lives: _____

City: _____ State: _____ Zip: _____

Grade: _____ School: _____ Homeroom Teacher: _____

Student's Ethnicity: (please circle all that apply) American Indian/Alaskan Native ● Asian ● African American
Native Hawaiian/Pacific Islander ● Caucasian ● Hispanic/Latino ● Other (please list) _____

☆ Is your child on an Individualized Education Plan (IEP) for special services from the school?
Yes, or No? _____ ***If no, please let us know if this answer changes during the year.***

Primary Contact: _____ **Gender:** M or F **Date of Birth** _____

Relationship to child: _____ **Primary Phone:** _____

Physical Address: _____ **Email:** _____

Place of employment: _____

Work phone _____ **Work Hours** _____

Secondary Contact: _____ **Gender:** M or F **Date of Birth** _____

Relationship to child: _____ **Primary Phone:** _____

Physical Address: _____ **Email:** _____

Place of employment: _____

Work phone _____ **Work Hours** _____

☆ List any siblings and their grade level enrolled in ESP: _____

***Please list the names address, phone number and relationship of any authorized adults who may pick up your child other than the listed Primary /Secondary contacts. ***
If a person IS NOT LISTED, he or she will NOT be allowed to pick up your child.
A photo ID may be required. You may add/remove names at any time.

	Name	Physical Address	Phone #	Relationship
1.				
2.				
3.				
4.				
5.				
6.				

DO NOT RELEASE:

In order to appropriately provide for, and (if necessary) deny parental access to a child, a copy of the divorce decree or court order (which denies parental access) **must be on file with the ESP site coordinator**. It is important that noncustodial parents who are, or are not, allowed access to a child be listed on the registration form.

***Do not release my child to:**

(DOCUMENTATION MUST BE ON FILE WITH ESP)

EMERGENCY RELEASE:

I _____ hereby give the ESP Staff authorization to act on my behalf in the case of an emergency involving my child. I understand that in the event of an emergency, I will be notified immediately.

Physician's Name _____ **Phone** _____

 Signature of Parent or Guardian

 Date

PARENTS/GUARDIAN, PLEASE INITIAL THE FOLLOWING:

1. My child may be photographed or videotaped for the school website:
_____yes _____no
2. My child may use the school internet system under adult supervision:
_____yes _____no
3. My child may be interviewed by the news media and be posted (name and/or photo) in the local newspaper: _____yes _____no
4. My child's photo may be posted on the school internet website:
_____yes _____no
5. My child may have sunscreen applied as needed: _____yes _____no
Special instructions for sunscreen: _____
6. My child may have bug spray applied as needed: _____yes _____no
Special instructions for bug spray: _____
7. I received, read, and understand the Summary of Child Care Approval Requirements:
(SEE ATTACHED) _____yes _____no
8. I received, read, and understand the Acceptable Network & Internet Use Procedures:
_____yes _____no (**DOCUMENTATION ON FILE IN SCHOOL OFFICE**)
9. I received, read, and understand the ESP Policy and Procedures Manual:
(SEE ATTACHED) _____yes _____no
10. My child's immunizations are current with the current Department of Health guidelines and/or exemptions are on file at _____ (school name) and _____ (school telephone number).
11. I understand that if I participate in automatic draft payments, fees are due on the first business day of each month and that my account will be automatically drafted for the full monthly amount in addition to any past due amounts owed. _____yes _____no

PARENT SIGNATURE: _____ Date: _____

STUDENTS WILL NOT BE CONSIDERED ENROLLED UNTIL APPLICATION IS FILLED COMPLETELY, AND REGISTRATION FEE IS PAID.

STUDENT HEALTH HISTORY

Student health information within the school is limited to the information necessary to serve the student's educational and health interests.

Student Name _____ Grade _____ Date _____

Please let us know your child's health needs by completing this form.

- My child has no health problems which would affect his/her school day.
- My child's health needs include the conditions checked (X).
- Allergies**, please list _____
What happens? _____
Is EpiPen Prescribed? Yes No (If yes, parent must provide EpiPen)
- Bee Sting Allergy**, What happens? _____
Is EpiPen Prescribed? Yes No (If yes, parent must provide EpiPen)
- Asthma** Is inhaler used? Yes No If yes, how often? _____
What medications are taken for asthma? _____
- Diabetes** What medications are taken? _____
Any special procedures during the school day? _____
- Hearing Problem**, Please describe _____
- Vision Problem** Wears glasses? Yes No Wears contacts? Yes No
- ADD or ADHD Diagnosed**, What medications are taken? _____
Will medication be needed in school? Yes No, When? _____
- Bone/Joint problem or fractures?** Which bone or joint? _____
Is a brace worn? Yes No
- Seizures** What type? _____ Date of last seizure _____
Medication taken _____
- Episode of loss of consciousness** When? _____
Any special treatment? _____
- Emotional concerns** List _____

List any other recurrent medical problem or illness you would like the school to be aware of _____

Name of Student's doctor _____ Phone _____

Does your child see a specialist? Yes No Name _____
Phone _____

Please contact school personnel for medication forms if your child needs medication at school, including inhalers for asthma or EpiPen for severe allergic reactions. Your child may carry an inhaler if medically authorized and developmentally appropriate, after informing school personnel.

Health History Informed Consent

Your signature gives permission for school staff to take precautions and procedures to protect your child in the classroom and to foster academic success. Your signature is an informed consent to share this health history information with school staff on a need-to-know basis for emergency plans.

Parent/guardian signature _____ Date _____

Phone number _____

YOU ONLY NEED TO FILL OUT THE FOLLOWING FORM IF YOU ARE SEEKING A LOWER MONTHLY FEE.

2 PERSON HOUSEHOLD

	FROM	TO	PER CHILD/MONTH
MONTHLY INCOME	\$0.00	\$380.00	\$17.00
MONTHLY INCOME	\$381.00	\$475.00	\$33.00
MONTHLY INCOME	\$476.00	\$570.00	\$42.00
MONTHLY INCOME	\$571.00	\$665.00	\$50.00
MONTHLY INCOME	\$666.00	\$760.00	\$54.00
MONTHLY INCOME	\$761.00	UP	\$60.00

4 PERSON HOUSEHOLD

	FROM	TO	PER CHILD/MONTH
MONTHLY INCOME	\$0.00	\$559.00	\$17.00
MONTHLY INCOME	\$560.00	\$698.00	\$33.00
MONTHLY INCOME	\$699.00	\$838.00	\$42.00
MONTHLY INCOME	\$839.00	\$977.00	\$50.00
MONTHLY INCOME	\$978.00	\$1,117.00	\$54.00
MONTHLY INCOME	\$1,118.00	UP	\$60.00

3 PERSON HOUSEHOLD

	FROM	TO	PER CHILD/MONTH
MONTHLY INCOME	\$0.00	\$469.00	\$17.00
MONTHLY INCOME	\$470.00	\$586.00	\$33.00
MONTHLY INCOME	\$587.00	\$704.00	\$42.00
MONTHLY INCOME	\$705.00	\$821.00	\$50.00
MONTHLY INCOME	\$822.00	\$938.00	\$54.00
MONTHLY INCOME	\$939.00	UP	\$60.00

5 PERSON HOUSEHOLD

	FROM	TO	PER CHILD/MONTH
MONTHLY INCOME	\$0.00	\$648.00	\$17.00
MONTHLY INCOME	\$649.00	\$810.00	\$33.00
MONTHLY INCOME	\$811.00	\$972.00	\$42.00
MONTHLY INCOME	\$973.00	\$1,134.00	\$50.00
MONTHLY INCOME	\$1,135.00	\$1,296.00	\$54.00
MONTHLY INCOME	\$1,297.00	UP	\$60.00


ECS Extended School Program
East Side / Harold McCormick / West Side

Carrie Taylor – Program Coordinator 423-895-0346

Attention: This form must be signed by your employer before submitting to ESP.

Employee's Name: _____

I authorize my employer to release the following information to Elizabethton City Schools Extended School Program (E.S.P). I understand this form is for eligibility purposes and that I will be asked to submit additional proof of my income with my next Redetermination. I understand that E.S.P. may need to verify this information or contact the employer by phone.

Employee's Signature: _____ Date: _____

TO BE FILLED OUT BY EMPLOYER:

Name of business (if applicable): _____

Type of business or work performed: _____

Name of business owner or employer: _____

Business address: _____

Business phone: () _____

Start date of current employment: _____

Actual—or average—number of hours worked by the employee **per week**:

The employee is paid by (check one): Cash Payroll check Other (please specify):

The employee is paid (check one): Weekly Biweekly Semi-monthly Monthly

The employee receives a gross amount of \$ _____ per pay period. (If amount varies, please give average amount.)

The employee's gross **hourly** wage: \$ _____ per hour

The employee receives **tips or commissions** in this estimated amount: \$ _____ per week

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:	AM	AM	AM	AM	AM	AM	AM
	PM	PM	PM	PM	PM	PM	PM
To:	AM	AM	AM	AM	AM	AM	AM
	PM	PM	PM	PM	PM	PM	PM

Please give the employee's typical work schedule. (Circle either "a.m." or "p.m." in each applicable box.)

I verify that the above information is true and correct to the best of my knowledge.

Employer's Name (Please Print): _____ Date: _____

Employer's Signature: _____ Phone: _____

**Please return this form with a copy of your most recent paycheck stub to
E.S.P. prior to the start date of your child.**