UCPS
UNION COUNTY PUBLIC SCHOOLS
www.ucps.k12.nc.us

Weddington Middle School
Marcus Leake, Principal
5903 Deal Road
Matthews, NC 28104
Phone 704-814-9772
Fax 704-814-9775
marcus.leake@ucps.k12.nc.us

Dear Parent(s) and Student:

Welcome to Weddington Middle School! Attached is a student informational packet that will need to be completed and returned to the school in order to start the enrollment process.

Along with the completed forms, please include a copy of the following documents:

- Birth Certificate
- Immunization Record
- Proof of residence (2): At this time we DO NOT ACCEPT CONTRACTS or PURCHASE AGREEMENTS. You must have closed on your home to enroll in the school. Rental Agreements are accepted but need to be notarized.
- Previous report cards, test scores, and recommendations for placement
- Withdrawal Slip from previous school if enrolling during the school year

The above information must be obtained before we can enroll your child.

We look forward to working with you and your child at Weddington Middle School. Please feel free to call with any questions.

Regards,

Christie Haas

Data Manager

704-814-9772 ext. 1804

Christie.haas@ucps.k12.nc.us

STUDENT ENROLLMENT FORM

UNION COUNTY PUBLIC SCHOOLS

For Office Use Only:

Student ID _____ Enrollment Date_____ Grade____

Registration completed _____ School _____

Need ☐ Immunization Record ☐ Birth Certificate ☐ POR Transportation _____

School Receiving Packet _____ Teacher's Name _____

Date Received _____ Packet received by_____

Please indicate the student's academic placement:

☐ New Kindergartener for the _____ school year

☐ New Pre-Kindergartener for the _____ school year

☐ New student entering grade _____ for the _____ school year

Student Information

Birth certificate or other satisfactory evidence of age and official record of immunizations must be presented at time of enrollment. Copies of these documents are to be placed in folder and originals returned to parent/guardian.

Legal Name _____ / _____
Last First Middle Nickname

Physical address _____
House/Apt. Number Street City State Zip

Mailing Address(if different)_____
House/Apt. Number Street City State Zip

Home Phone _____

☐ Male ☐ Female Date of Birth _____ Place of Birth_____
Month/Day/Year City/State/Country

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Race: (select all that apply) ☐ American Indian ☐ Black ☐ Asian ☐ Hawaiian/Pacific Islander ☐ White

Child resides with _____ _____
Relationship to Student

Legal Custodian_____ Legal paperwork provided to school ☐ Yes ☐ No

Family Information

Father's Full Name _____

Place of Birth (City/State/Country) _____ Deceased ☐ Yes ☐ No

Address _____

Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

Highest Education level completed _____ E-mail address _____

Mother's Full Name (include maiden name)_____

Place of Birth (City/State/Country) _____ Deceased ☐ Yes ☐ No

Address _____

Home Phone _____ Cell Phone _____

Employer _____ Work Phone _____

Highest Education level completed _____ E-mail address _____

Stepparent's, Legal Guardian's, or Sponsor's information (if applicable) Relationship to student_____

Name _____Address_____

Home/Cell Phone _____Employer _____ Business Phone_____

E-mail address _____

STUDENT ENROLLMENT FORM

UNION COUNTY PUBLIC SCHOOLS

Other Information

Pick up Child

Emergency Contact (Other than parent) Name Relationship Phone ☐ Yes ☐ No

Emergency Contact (Other than parent) Name Relationship Phone ☐ Yes ☐ No

Emergency Contact (Other than parent) Name Relationship Phone ☐ Yes ☐ No

If someone does not have your permission to pick up your child, please list name and relationship.

Other children in the family (please note if the sibling is a stepsibling)

Name_____ School_____ Grade ____

Name_____ School_____ Grade ____

Name_____ School_____ Grade ____

Give pertinent health or medical information and instructions (including any medicines prescribed and any physical restrictions)

Permission to obtain medical attention ☐ Yes ☐ No

Medical Provider _____
Name Address Phone

Dentist _____
Name Address Phone

Please indicate the student's previous academic placement (if applicable)

☐ Private School _____ _____
Name Street Address, City, State, Zip

☐ Charter School _____ _____
Name Street Address, City, State, Zip

☐ Public School _____ _____
Name Street Address, City, State, Zip

☐ Group Home/Institution _____ _____
Name Street Address, City, State, Zip

☐ Home School

Date last attended previous placement _____ Grade___ Homeroom teacher _____
Month/Year

Has the student ever been enrolled in Union County Public Schools? ☐ Yes ☐ No
If yes, School Name _____ School Year _____

Is the student identified as a student with special needs and being served with a(n):

Individualized Education Program (IEP) ☐ Yes ☐ No If yes, has a copy of the plan been provided? ☐ Yes ☐ No
Section 504 Plan ☐ Yes ☐ No If yes, has a copy of the plan been provided? ☐ Yes ☐ No
Academically Gifted (AIG or TD) ☐ Yes ☐ No If yes, has a copy of the plan been provided? ☐ Yes ☐ No

Has the child ever been retained? ☐ Yes ☐ No If yes, what grade? _____
Has the student ever left any school due to a Suspension or Expulsion? ☐ Yes ☐ No If yes, explain:

Transportation

Morning-student will arrive by ☐ Bus ☐ Car ☐ Walk Afternoon-student will leave by ☐ Bus ☐ Car ☐ Walk

Military Information

Does your child have any member of their immediate family serving in the US Armed Forces? ☐ Yes ☐ No
If yes, _____
Name Relationship Branch of military service

_____
Name Relationship Branch of military service

Parent/Legal Guardian_____ _____
Signature Date

Weddington Middle School

5903 Deal Road

Matthews, NC 28104

Phone: 704-814-9772

Fax: 704-814-9775

Request for Transcripts

Previous School Name and Address:

_____

_____

_____

Student Name: _____ **Date of Birth:** _____

The above named student has enrolled in our school in the _____ grade and has informed us that your school is the last attended.

Please send the following:

- **Transcript of the student's school record including K-5 grades**
- **Grades at the date of withdrawal from your school**
- **Attendance records**
- **Standardized test results**
- **Immunization records**
- **Gifted/Advanced Records**
- **Exceptional Records including IEP or 504**

Please send to the attention of:

Christie Haas

Data Manager/Registrar

christie.haas@ucps.k12.nc.us

UCPS
UNION COUNTY PUBLIC SCHOOLS

Weddington Middle School
Steve Wray
5903 Deal Road
Matthews, NC 28104
Phone 704.814.9772
Fax 704.814.9775

Proof of Residence

Student's Name: _____

Parent's Name : _____

Address: _____

City: _____ State: _____ Zip: _____

Student's Grade: _____

Please attach a tangible proof of residence for the above address.

The following list of items will constitute proof of residence in Union County by individuals who are relocating to Union County as a homebuyer, a renter, or are living with a relative or a friend. Where items are linked by and, both items must be verified before proof or residence is granted.

1. A notarized rental agreement or purchase agreement for a house with a person's name and address on it.
2. An electric bill and a telephone bill with the person's name and address on it.
3. An automatic registration card and a driver's license with the person's name and address on it.
4. Car insurance and property insurance policy with the person's name on it.
5. Income tax W-2 form and property tax bill with the person's name and address on it.
6. A notarized statement from the owner of the house where the person is living, listing the names of the person and their child(ren) and a visit by the attendance counselor.

understand that if I must take temporary housing outside of Union County before I locate permanently inside the oundary of Union County , I MUST pay a tuition charge of $35.00 per week per child and provide transportation until I btain residence inside Union County . Contact Jonathon Moultrie at 704-292-2504 with any questions.

Parent Signature: _____ Date: _____

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UCPS
UNION COUNTY PUBLIC SCHOOLS
Transportation Department
201 Venus Street
Monroe, NC 28112
Phone 704.296.3015 Fax 704.226.1895
www.ucps.k12.nc.us

Transportation Department
NEW BUS RIDER INFORMATION FORM

School Year: _____ Date: _____
School: _____ Grade: _____
Student Name: _____ Power School #: _____
Telephone Number: _____
Parent Name: _____

Please check all that apply:

_____ Student has special transportation as a related service on an IEP.
_____ Student is on a modified schedule FROM _____ TO _____
_____ Student in transitioning FROM _____ TO _____
(school) (school)

Modified Transportation Schedules: *This form must be faxed to then EC Office for the EC Director's signature only when a student is not following the regular school transportation schedule.*

EC Director Signature: _____ **Date:** _____

Please check all that apply (attach documentation where appropriate):

___Medical condition, if so what condition _____
___Hearing Limitation ___ Vision Limitation ___ Communication Concerns
___Medication, if so what _____
___BIP ___IHP ___ Allergies, if so, to what? _____
Action needed, if any _____

- Is the child on medication? ____ Yes ____ No;
  If yes, will administration be required during transport? _____ (Attach doctor's order);
- Does child have self-administration/carry approval? _____ (Attach copy);
- Will medication be transferred between adults? _____
  If yes, identify what medications will either be carried by student or transferred by adults:
  _____

Please check the appropriate special or supportive services needed:

___Bus stop relocation ___Device to access steps ___Monitor
___Preferential seating ___Assigned seat ___Mom Seat

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___Add-on restraint ___Peer Buddy ___BIP
___Air conditioning ___Student Weight ___Medication
___IHP ___Wheelchair/ stroller tie downs ___Harness measurements: Waist ____
___Head phones ___Medical equipment transport ____Chest _____ Shoulder to hip

***All modifications in seating or restraint must be determined in consultation with a physical therapist and must be addressed on the DEC 4 (IEP) under the section which documents transportation as a related service. Measurements are only needed for students requesting a harness.**

Student Name: _____ Power School #: _____

Residence Street Address: _____
(NO PO BOX #'S) _____

Transportation Needs: AM only _____ PM only _____ Both _____

Daily Bus Rider _____ Occasional Bus Rider _____

Please record the address in which the student will be picked up and dropped off if different from the residence street address. Three to five (3-5) business days are needed for processing unless an existing stop is available. Each school should review Everyinfo software for transportation start date.

Address for Morning Stop: _____
_____

Address for Afternoon Stop: _____
_____

Fax to Mandy Benton (TIMS Office) during the school year as students receive transportation as a related service or as the school learns of medical issues which would impact transportation AND at the end of the school year for transition.

Please respond in English

UCPS
UNION COUNTY PUBLIC SCHOOLS

English Home Language Survey

HOME LANGUAGE SURVEY

Date _____ School _____ Grade _____

Has the student ever attended a U.S. school before? ____yes ____no _____
If yes Date of Entry

Student's Name _____ DOB _____
First Name Middle Initial Last Name M/D/Y

Address _____
Street City State Zip

Phone Number _____
Home Work

Parent or Guardian's Name _____
First Name Middle Initial Last Name

What is the student's country of origin and ethnicity? _____ / _____
Origin Ethnicity

1. Is the student's first-learned or home language anything other than English? _____ Yes (Please continue survey) _____ No (Stop here and sign below)
2. Which language did your son/daughter learn when he/she first began to talk? _____
3. What language does your son/daughter speak most often? _____
4. What language is most often spoken in your home? _____
5. Other than languages studied in school, what Language(s) does your son/daughter speak? _____

** If the answer to questions 2-5 is a language other than English, the student will be assessed with the State-designated English language proficiency test to ensure appropriate placement and English language assistance if needed.*

_____ _____
Parent or Guardian Signature Date

Phone 704-289-5460 Fax 704-296-3107

Request for Health Information

Must be completed annually

School _____ Date _____

Student's Name _____ Date of Birth _____

Teacher _____ Grade _____

Parent/Guardian (names) _____

Home Phone _____ Mom's work _____ Mom's cell _____

Dad's work _____ Dad's cell _____

Emergency Contact Person _____ Daytime Phone _____

Drug Allergy(s) ☐None Known ☐ Yes (list) _____

Treating Physician _____ Office Phone _____

☐ **MY CHILD DOES NOT HAVE ANY KNOWN MEDICAL CONDITIONS. (You may stop here if there are no known medical conditions. Please sign at the bottom and return.)**

Asthma Triggers: ☐environmental ☐seasonal ☐exercise induced
Inhaler at school- ☐upper respiratory infection ☐others _____
MD order required. Inhaler location: ☐Carried by student **(requires self carry form)**
☐Classroom ☐Health Room

Diabetes ☐ Type I ☐Type II Diagnosis Date: _____ Insulin by: ☐Pump ☐Injections
Desire Diabetes Care Plan: ☐yes ☐no, independent with all care **Please call for Nurse Conference - Notify your school nurse and principal immediately if newly diagnosed**

Food Allergy** ☐Peanuts ☐Tree Nuts ☐Milk ☐other/s _____
Date/Type of Last Reaction _____
Student Needs for Class/School _____
Diet Order signed by MD required (diet form may be obtained in the front office)

Severe Sting Allergy**
Date and Type/Description of Last Reaction: _____

****Notify your school nurse and principal immediately if anaphylaxis may occur****

Epilepsy Type(s) of Seizure(s): _____
☐controlled with medication ☐on medication, continues to have seizures
☐Diastat needed at school ☐no medication needed at school
Date and Type/description of last seizure _____

Head Injury/Concussion within the past year Date: _____

Other conditions/or specify pertinent data to help us better serve your child: _____

Does your child take routine medication(s) ☐yes ☐no List Meds: _____

Does your child need medication(s) at school? ☐ yes ☐no List Meds: _____

If your child needs medication at school, a medication consent form is required to be signed by the health care provider and the parent/guardian. *Medication cannot be given at the school until appropriate consents have been received. ***UCPS does not provide medications for students.**

I give permission to the School Staff/School Nurse to share information regarding my child's medical condition(s) with my physician or emergency personnel:

Date: _____ Parent/Guardian Signature _____

A health care provider's written diagnosis is required in order for an Individualized Healthcare Plan to be developed by the school nurse. Also, please let your school nurse know if your child participates in extracurricular school activities.

Revised 5-2016 cs

Union County Public Schools
North Carolina Immunization/Health Assessment Law Information

Every parent, guardian and person or agency, whether governmental or private, with legal custody of a child shall have the responsibility to ensure that the child has received the required immunizations at the age required by law. It shall be the responsibility of the parent to provide a complete immunization record of each school age child to the school not later than 30 calendar days after the child enters school *or the child will be suspended* from school until such time as a valid complete immunization record can be provided to the school. Please review your child's record to assure that it meets N.C. Immunization Law requirements.

General Statute 130A-152 through 130A-157 states in part that each child's immunization record must have the dates of each immunization and the specific immunizations. The following is a description of the requirements:

If a child enrolled in kindergarten or 1st grade for the first time after 7/1/94, but before7/1/99:

- 5 DTaP/DPT/Td — last dose on or after 4th birthday
- 4 Polio — 3 doses if last dose on or after 4th birthday
- 3 Hib — at least 1 Hib on or after 1st birthday (not given after age 5)
- 2 MMR — 1st dose on or after 1st birthday

If child enrolled in kindergarten for the 1st time after 7/1/99, but before 7/1/2015:

- 5 DTaP/DPT/Td — last dose on or after 4th birthday
- 4 Polio — 3 doses if last dose on or after 4th birthday
- 3 HIB — at least 1 HIB on or after 1st birthday (not given after age 5)
- 2 MMR — 1st dose on or after 1st birthday
- 3 Hepatitis B — last dose not before 24 weeks of age
- 1 Varicella — before school entry

If child enrolled in kindergarten for the first time after 7/1/15:

- 5 DTaP/DPT/Td — last dose on or after 4th birthday
- 4 Polio — 3 doses if last dose on or after 4th birthday
- 3 Hib — at least 1 Hib on or after 1st birthday and before 5 years of age
- 2 MMR — 1st dose on or after 1st birthday
- 3 Hepatitis B — last dose not before 24 weeks of age
- 2 Varicella — before school entry (history of chickenpox disease must be documented by a provider)

Additional requirements beginning 7/1/2015:

- 1 Tdap — before entry into 7th grade (this booster dose is required if no Tdap given since age 10)
- 1 Meningococcal — before entry into 7th grade (this booster dose is required if no MCV given since age 10)

Any medical exemption must be in writing from a physician and must state the basis for the exemption pursuant to G.S. 130A-156.

North Carolina Health Assessment Law
G.S. 130A-440 states that every child in the State entering N.C. public schools for the first time shall receive a health assessment. The health assessment shall be made no more than 12 months prior to the day of school entry. The parent, guardian, or responsible person shall have 30 calendar days from the first day of school to present the required health assessment form for the child.

Please feel free to call the School Health Office @ 704-296-0845 to speak with a school nurse if you have questions about the North Carolina Immunization Law or Health Assessment Law.

I am aware that my child's complete immunization record/Health Assessment is due within 30 days of my child's first day of school or he/she will not be allowed to continue in school until such time as a valid immunization record and Health Assessment can be provided to the school. I realize that this responsibility is that of the parent/guardian, not that of the former school. A health assessment form is required for my child if he/she is entering NC public school for the first time.

Student's Name	Date of Birth	Enrollment Date

Parent/Guardian Signature	Date

Original in File: copy to parent — revised 2/17 cs

This will be the only notification of health requirements.

January 2016

PUBLIC SCHOOLS OF NORTH CAROLINA
State Board of Education | Department of Public Instruction

NORTH CAROLINA HEALTH ASSESSMENT TRANSMITTAL FORM

This form and the information on this form will be maintained on file in the school attended by the student named herein and is confidential and not a public record.
(Approved by North Carolina Department of Public Instruction and Department of Health and Human Services)

PARENT to COMPLETE THIS SECTION

Student Name: ☐ M ☐ F

(Last) (First) (Middle)

Birthdate (M/D/YYYY): **School Name:**

Hispanic of Latino Origin: ☐ 1 Yes ☐ 2 No

Race: ☐ 1 Other Non-White ☐ 2 White ☐ 3 Black ☐ 4 American Indian ☐ 5 Chinese ☐ 6 Japanese ☐ 7 Hawaiian ☐ 8 Filipino ☐ 9 Other Asian ☐ 10 Unknown

Home Address: **City:** **State:** **County:**

Parent Information: Name of Parent, Guardian, or person standing in loco parentis:

Telephone(s)

Home:

Work:

Cell Phone:

Health Concerns to be shared with authorized persons (school administrators, teachers, and other school personnel who require such information to perform their assigned duties):

HEALTH CARE PROVIDER TO COMPLETE THIS SECTION

Medications prescribed for student:

Student's allergies, type, and response required:

Special diet instructions:

Health-related recommendations to enhance the student's school performance:

Vision screening information:
Passed vision screening: ☐ Yes ☐ No
Concerns related to student's vision:

NC Public Health
HEALTH AND HUMAN SERVICES

PUBLIC SCHOOLS OF NORTH CAROLINA
State Board of Education | Department of Public Instruction

Hearing screening information:
Passed hearing screening: ☐ Yes ☐ No
Concerns related to student's hearing:

Recommendations, concerns, or needs related to student's health and required school follow-up:

School follow-up needed: ☐ Yes ☐ No

Medical Provider Comments:

Please attach other applicable school health forms:

Immunization record attached: ☐
School medication authorization form attached: ☐
Diabetes care plan attached: ☐
Asthma action plan attached: ☐
Health care plans for other conditions attached: ☐

Health Care Professional's Certification
I certify that I performed, on the student named above, a health assessment in accordance with G.S. 130A-440(b) that included a medical history and physical examination with screening for vision and hearing, and if appropriate, testing for anemia and tuberculosis. I certify that the information on this form is accurate and complete to the best of my knowledge.

Name: Title:

Signature: _____ Date (m/d/yyyy):

Practice/Clinic Name:			Practice/Clinic Address:	
Practice/Clinic City:	State:	Zip:	Phone:	Fax:

Provider Stamp Here:

NC Public Health
HEALTH AND HUMAN SERVICES