

BLUE GRASS ELEMENTARY KINDERGARTEN ENROLLMENT 2024 – 2025

Packets WILL NOT be accepted until ALL information and forms are completed

PLEASE PRINT ALL INFORMATION ACCURATELY

\_\_\_\_\_ BIRTHDATE (5 years old) **ON OR BEFORE AUGUST 15, 2024**

\_\_\_\_\_ NEW STUDENT ENROLLMENT FORM

\_\_\_\_\_ STUDENT MEDICAL PROFILE

\_\_\_\_\_ KINDERGARTEN PERSONAL DATA QUESTIONNAIRE

\_\_\_\_\_ TENNESSEE DEPARTMENT OF HEALTH CERTIFICATE OF IMMUNIZATION

\_\_\_\_\_ COPY OF STATE CERTIFIED BIRTH CERTIFICATE WITH CERTIFIED STATE NUMBER

\_\_\_\_\_ VERIFIED PROOF OF RESIDENCE FOR IN ZONE (utility: gas, water, or electric - lease agreement/contract)

\_\_\_\_\_ STUDENT SUPPORT SERVICES (every student must have this form)

\_\_\_\_\_ TENNESSEE PARENT OCCUPATIONAL SURVEY (every student must have this form)

\_\_\_\_\_ HOME LANGUAGE SURVEY (every student must have this form)

\_\_\_\_\_ CAR RIDER TRANSPORTATION SIGN-UP

\_\_\_\_\_ PTO WELCOME WAGON

\_\_\_\_\_ [REDACTED]

\*\*Summer office hours will be posted on the front door and on the electronic sign in front of the school. If you have any questions, please call Blue Grass Elementary at 865-539-7864.

**KNOX COUNTY SCHOOLS  
NEW STUDENT ENROLLMENT**

FOR OFFICE USE ONLY	
Student ID	_____
Homeroom	_____
School	_____
Bus Number	_____

Enrollment Date: \_\_\_\_\_ Grade \_\_\_\_\_

Student Name: \_\_\_\_\_  

Last Name
First Name
Middle Name

Student PIN Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Birthplace / City: \_\_\_\_\_

Birth County: \_\_\_\_\_

Birth State: \_\_\_\_\_

Birth Country: \_\_\_\_\_

Mother's Maiden Name: \_\_\_\_\_

**Gender:**  Female  Male

**Ethnicity:**  Hispanic  Non-Hispanic

**Race:** (check all that apply)

- Asian
- Black
- American Indian
- Pacific Islander
- White

**Military Dependent:**  Reserve  National Guard  
*(if applicable)*  Active Military

**Related Students attending any Knox County Schools** (in same household) -- Please include Last Name, First Name, and Birthdate


**Please list all legal guardians individually. If the student has more than two guardians, please use the additional space provided at the end of the form for the other contacts.**

Main Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\*Primary Phone #: \_\_\_\_\_

Emergency #: \_\_\_\_\_

Employer: \_\_\_\_\_

Work #: \_\_\_\_\_

Other #: \_\_\_\_\_

\*Cell: \_\_\_\_\_

Primary E-mail: \_\_\_\_\_

Alternate E-mail: \_\_\_\_\_

Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\*Primary Phone #: \_\_\_\_\_

Emergency #: \_\_\_\_\_

Employer: \_\_\_\_\_

Work #: \_\_\_\_\_

Other #: \_\_\_\_\_

\*Cell: \_\_\_\_\_

Primary E-mail: \_\_\_\_\_

Alternate E-mail: \_\_\_\_\_

*\*This is the telephone number that receives automated telephone calls.*

**Notes** (Individuals other than parent/guardian who may pick up the child.)

Name \_\_\_\_\_ Phone Numbers \_\_\_\_\_

Name \_\_\_\_\_ Phone Numbers \_\_\_\_\_

Name \_\_\_\_\_ Phone Numbers \_\_\_\_\_

Name \_\_\_\_\_ Phone Numbers \_\_\_\_\_

Student Name: \_\_\_\_\_  
Last Name First Name Middle Name

**Alerts** (non-medical special instructions) \_\_\_\_\_  
\_\_\_\_\_

**School History**

Pre-schools attended (if kindergarten student): \_\_\_\_\_  
Last school attended: \_\_\_\_\_  
Address: \_\_\_\_\_  
Other schools attended: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Is this student currently under suspension / expulsion from another school?  Yes  No
- Has this student previously received Special Education services?  Yes  No
- Has this student previously received services under Section 504?  Yes  No
- Is this student currently receiving Special Education services?  Yes  No
- Is this student currently receiving services under Section 504?  Yes  No

If YES, list program(s): \_\_\_\_\_  
\_\_\_\_\_

**Does the student stay in any of the following places at night? Check any that apply:**

- home/apartment owned or rented by the parent(s)/guardian(s)
- in a shelter
- in a motel / hotel
- in a car
- at a campsite
- in another location that is not appropriate for people (e.g., an abandoned building, no electricity or running water)
- temporarily with more than one family in a house, mobile home or apartment (because the family does not have a place of its own)
- other (in an arrangement that is not fixed, regular and adequate and is not described by the other choices)

Form completed by \_\_\_\_\_ Date \_\_\_\_\_

Relationship to the student \_\_\_\_\_

**List additional contacts on the following page.**



## Student Guardians (Continued)

Student Name: \_\_\_\_\_  
Last Name First Name Middle Name

Contact: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\*Primary Phone #: \_\_\_\_\_  
Emergency #: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Work #: \_\_\_\_\_  
Other #: \_\_\_\_\_  
\*Cell: \_\_\_\_\_  
Primary E-mail: \_\_\_\_\_  
Alternate E-mail: \_\_\_\_\_

*\*This is the telephone number that receives automated telephone calls.*

Contact: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\*Primary Phone #: \_\_\_\_\_  
Emergency #: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Work #: \_\_\_\_\_  
Other #: \_\_\_\_\_  
\*Cell: \_\_\_\_\_  
Primary E-mail: \_\_\_\_\_  
Alternate E-mail: \_\_\_\_\_

Contact: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\*Primary Phone #: \_\_\_\_\_  
Emergency #: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Work #: \_\_\_\_\_  
Other #: \_\_\_\_\_  
\*Cell: \_\_\_\_\_  
Primary E-mail: \_\_\_\_\_  
Alternate E-mail: \_\_\_\_\_

*\*This is the telephone number that receives automated telephone calls.*

Contact: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\*Primary Phone #: \_\_\_\_\_  
Emergency #: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Work #: \_\_\_\_\_  
Other #: \_\_\_\_\_  
\*Cell: \_\_\_\_\_  
Primary E-mail: \_\_\_\_\_  
Alternate E-mail: \_\_\_\_\_

KNOX COUNTY SCHOOLS  
**Student Medical Profile**

*This information will be used by the school nurse to provide care for your child.*

Date: \_\_\_\_\_

Student's Name: \_\_\_\_\_  
(Last) (First) (Middle)

Grade: \_\_\_\_\_ Homeroom: \_\_\_\_\_

Did the Student require medical care/hospitalization at birth or at any other time? \_\_\_\_ Yes \_\_\_\_ No. If yes, please explain: \_\_\_\_\_

Does the student require a daily medical procedure performed by a school nurse? If so explain: \_\_\_\_\_

What medications, if any, does the student take? \_\_\_\_\_

Does the student seem to have vision, hearing or speech problems? \_\_\_\_ Yes \_\_\_\_ No. If yes, please explain: \_\_\_\_\_

The student has a history of (Check any that apply): C= Current P= Past

- | C   | P                        | C                        | P                        | C                        | P                        | C                        | P                        |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/>                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          | <input type="checkbox"/> | <input type="checkbox"/> |
| ADD/ADHD                                      |                          | ADD/ADHD                 |                          | Down's Syndrome          |                          | Shunts/hydrocephalus     |                          |
| <input type="checkbox"/>                      |                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Amputation(s)                                 |                          | Celiac disease           |                          | "G" / "J" feeding tubes  |                          | Skin problems            |                          |
| <input type="checkbox"/>                      | <input type="checkbox"/> | <input type="checkbox"/> |                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma/reactive                               |                          | Cerebral palsy           |                          | Heart defects            |                          | Stomach problems         |                          |
| airway disease                                |                          | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia               |                          | Swallowing problems      |                          |
| ____ Requires inhaler                         |                          | Crohn's Disease          |                          | <input type="checkbox"/> | <input type="checkbox"/> | Tracheotomy              |                          |
| (Please provide school)                       |                          | Cystic fibrosis          |                          | Migraine headache        |                          | Traumatic Brain Syndrome |                          |
| <input type="checkbox"/>                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Muscular dystrophy       |                          | Traumatic spinal injury  |                          |
| Allergies:                                    |                          | Diabetes                 |                          | Spina bifida             |                          | Urinary problems         |                          |
| ____ Bee stings                               |                          |                          |                          | <input type="checkbox"/> | <input type="checkbox"/> | Other: _____             |                          |
| ____ Food: _____                              |                          |                          |                          | Orthopedic problems      |                          |                          |                          |
| ____ Latex                                    |                          |                          |                          | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |
| ____ Requires Epi-pen (please provide school) |                          |                          |                          | Sensitivity to light     |                          |                          |                          |
|   |                          |                          |                          | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |
|   |                          |                          |                          | Seizure disorder         |                          |                          |                          |

If any are checked above, please explain: \_\_\_\_\_

It is important for teachers and principals to have your child's special medical information so that any emergency can be handled appropriately. Summarize any special medical conditions: \_\_\_\_\_

Does your child require any special dietary accommodations? \_\_\_\_ If you answered yes and you want your child to eat at school please obtain and have your child's doctor fill out the dietary accommodations form.

Form completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to the student \_\_\_\_\_



# CERTIFICATE OF IMMUNIZATION



Child's Name (Last name, first name, middle) \_\_\_\_\_ Birthdate (mm/dd/yy) \_\_\_\_\_

Parent/Guardian Name (Last name, first name, middle) \_\_\_\_\_

Phone (please include area code xxx-xxx-xxxx) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### Section 1a. Religious Exemption

Check here if religious exemption to immunization selected by parent/guardian

### 1b. Health Examination Documentation (if required)

This child has been examined: \_\_\_\_\_ MM/DD/YY

\_\_\_\_\_

Certified by (Signature/Stamp)

### 1c. Check if needed

Dental Screening

Vision Screening

Unless specifically exempted by law, Tennessee law requires a certificate on file for each child in attendance in any school or child care facility in Tennessee. Detailed instructions for this form and explanation of requirements are in "TDH Summary of Immunization Rules - Certificate Instructions" at the Tennessee Department of Health website (<https://www.tn.gov/health/cadep/immunization-program/ip/immunization-requirements.html>) and on the Tennessee Immunization Information System ([tennesseelis.gov](http://tennesseelis.gov)).

VACCINE	DATE MM/DD/YY	DATE MM/DD/YY	DATE MM/DD/YY	DATE MM/DD/YY	DATE MM/DD/YY	DATE MM/DD/YY	Diagnosis (X)	Serology (X)	History (X)	Medical Exemption (X)
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### Section 2a. Required Vaccines for School or Child Care Attendance (Dates Required)

Hib <small>Child Care Only (&lt;5 years)</small>										
Pneumococcal (PCV) <small>Child Care Only (&lt;5 years)</small>										
DTP, DTap, DT, Td										
Polio/myelitis										
<input type="checkbox"/> Hepatitis B <small>Check here if 11-15 years 2-dose schedule used</small>										
Hepatitis A <small>Child Care Effective 7/2010 Kindergarten Effective 7/2011</small>										
Measles										
Mumps										
Rubella										
Varicella										
Tdap Booster <small>7th Grade Entry Only</small>										

### Section 2b. Recommended Vaccines (Documentation Optional)

Rotavirus										
Influenza										
Meningococcal ACWY										
HPV										

### Section 3. Provider Assessment (select one\*, not valid if blank)

**A) Temporary Certificate - Expires** \_\_\_\_\_ MM/DD/YYYY  
Expiration date one month after date next catch-up immunization is due.

**B) Up to Date for Child Care Entry and <18 Months of Age**  
Only if requirements incomplete, but up to date for age. Expires at 19 months of age.

**C) Complete for Child Care / Pre-School\***  
Fulfills all requirements for child care / pre-school or pre-K under 5 years of age.

**D) Complete K-6th Grade\***  
Fulfills requirements, Kindergarten through 6th grade.

**E) Complete 7th Grade or Higher**  
Fulfills requirements, 7th grade or higher

\*If age 4 years and fulfills requirements for Pre-School and Kindergarten, check BOTH Boxes C and D.

### Section 4. (Required) Name, Address, Phone of Qualified Provider (MD, DO, PA, Advanced Practice Nurse or Health Department):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Certified by (Signature/Stamp) or TennIS \_\_\_\_\_ Date of Issue \_\_\_\_\_ MM | DD | YYYY

KNOX COUNTY SCHOOLS  
ANDREW JOHNSON BUILDING



To: Parents and/or Guardians of Students Who Are Entering or Withdrawing From Knox County Schools

From: Student Support Services

Re: Special Education Services Available Through Knox County Schools

Knox County Schools provides a full continuum of services for students who qualify for special education under the Individuals with Disabilities Education Improvement Act (IDEIA '04).

If you feel your child might require Special Education or other services and want Knox County Schools to provide those services, contact the school to which your child is zoned \_\_\_\_\_ or call Student Support Services at 594-1540.

If records are available for review or other information that the school might need in order to determine appropriate services for your child, please sign and return a release of information form available at your school so that we may review those records and plan services, if needed.

Thank you for your assistance in this matter.

\_\_\_\_\_  
Student Name

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date Signed

**(Please return a signed copy of this form to the school  
and retain a copy for your files.)**

White Copy – School  
Canary Copy – Parent

PP-155 (1/10)





## KNOX COUNTY SCHOOLS Home Language Survey

The Tennessee Department of Education requires *all* schools to identify the language of every student enrolled. This is accomplished by the Home Language Survey (HLS). This document is to be completed only **ONE TIME** at the student's initial enrollment into a school. If the student is a transfer student, schools must make every attempt to obtain the original HLS.

NOTE to registrar: If any language besides (or in addition to) English is given as an answer to questions 1-3, please give this document to the ELL teacher at your school (or who monitors your school) immediately.

### Student Information

First Name	Middle Name	Last Name	M <input type="checkbox"/> F <input type="checkbox"/> Gender
Country of Birth	Date of Birth (mm/dd/yyyy)	Date first enrolled in ANY U.S. school (grades K-12)	
Date first entered the United States	<b>THIS FORM IS NOT USED TO IDENTIFY STUDENT'S IMMIGRATION STATUS.</b> This information gives us insight into the knowledge and skills your child is bringing to our schools. This information may enable the district to receive additional federal funding to provide support for your child		

### School Information

Enrollment Date in New School	Name of Former School and Town	Last Grade attended
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### Questions for Parents/Guardians

1. What is the first language the student learned to speak?	Has this child ever received ELL (ESL) classes in another school? Y <input type="checkbox"/> N <input type="checkbox"/> I don't know. <input type="checkbox"/> If yes, what year did this student 1 <sup>st</sup> qualify for ELL?
2. What language does the student speak most often outside of school?	Will you require an interpreter/translator at Parent-Teacher meetings? Y <input type="checkbox"/> N <input type="checkbox"/> If yes, what language?
3. What language is most often spoken to the student at home?	What is your preferred language for receiving emails and communications from KCS?
Parent/Guardian Signature:  X	Today's Date: <u>          </u> / <u>          </u> / <u>          </u> (mm/dd/yyyy)

NOTE to ELL teacher: Please forward a copy of this form to the ELL Central Office. Place another copy in the student's green folder and the original in the purple file which is kept in the student's CR.



## Tennessee Parent Occupational Survey



Under Title I, Part C of the Elementary and Secondary Education Act (ESEA) our school district provides supplemental services to the children of agricultural workers who have recently moved. This survey is to help the school identify if your child might qualify for these free supplemental services such as tutoring, school supplies, summer camps in select counties, and other free services. Please answer the following questions and return this form to your child's school. **The information provided below will be kept confidential.**

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Parent/Guardian First & Last Name

\_\_\_\_\_  
Student First Name






\_\_\_\_\_  
Student Last Name

\_\_\_\_\_  
School Name

\_\_\_\_\_  
Student Grade

**1. Have you or an immediate family member performed any agriculture or fishing jobs temporarily or seasonally, in any part of the United States, in the past 3 years? Check all that apply.**

\_\_\_\_ NO  
\_\_\_\_ YES. Check all that apply:

<p><b>Agriculture/Field Work:</b> planting, picking, sorting crops, soil preparation, irrigation, fumigation</p>  <input style="float: right; margin-top: 10px;" type="checkbox"/>	<p><b>Processing &amp; Packaging:</b> fruit, vegetables, chicken, pork, beef, eggs, etc.</p>  <input style="float: right; margin-top: 10px;" type="checkbox"/>	<p><b>Dairy/Cattle Raising:</b> feeding, milking, rounding up.</p>  <input style="float: right; margin-top: 10px;" type="checkbox"/>
<p><b>Nursery/Greenhouse:</b> planting, potting, pruning, watering, harvesting</p>  <input style="float: right; margin-top: 10px;" type="checkbox"/>	<p><b>Forestry:</b> soil preparation, planting, cutting trees; does not include landscaping.</p>  <input style="float: right; margin-top: 10px;" type="checkbox"/>	<p><b>Other:</b> Any other agriculture or fishing work, please list here:</p> <p>_____</p> <p>_____</p>

**2. In the past 3 years, has your family moved to another state, city, school district, and/or county?**

\_\_\_\_ NO  
\_\_\_\_ YES. My family has moved within the past 3 years. Indicate how long ago below.

\_\_\_\_\_ Years                      \_\_\_\_\_ Months                      \_\_\_\_\_ Weeks

**If you answered "Yes" to question 1, please complete the information below. A staff from the Migrant Education Program will follow up with your family to verify if you qualify for free services.**

\_\_\_\_\_  
Home Street Address

\_\_\_\_\_  
Apt #

\_\_\_\_\_  
City

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Language

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
Best Day of Week and Time to Call

**For School Use Only:** Please forward all surveys with a "YES" response to Question 1 to your district migrant liaison for them to submit to the ID&R Team through [tn.msedd.com](http://tn.msedd.com). If you have any questions, email the TN MEP ID&R Team: [idr@tn-mep.net](mailto:idr@tn-mep.net)

Student State ID:	Enrollment Date:	District ID:
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## **BLUE GRASS PTO WELCOME WAGON** **CONTACT PERMISSION FORM**

Welcome to Blue Grass Elementary School! A member of our PTO Welcome Wagon would love the opportunity to welcome you to our close-knit community and answer any questions you may have about our school. To better serve you, please complete the form below. Thank you!

Our family is new to Blue Grass and would like a member of the PTO Welcome Wagon to contact us.

Our family is not new to Blue Grass, but we would still like a member of the PTO Welcome Wagon to contact us.

Please complete the following if you checked either line above:

Parent(s) / Guardian(s) Name(s): Please PRINT.

\_\_\_\_\_

Grades your child / children will be in at Blue Grass for the 2024-2025 school year (please check all that apply):

Kindergarten     1<sup>st</sup>     2<sup>nd</sup>     3<sup>rd</sup>     4<sup>th</sup>     5<sup>th</sup>

I prefer to be contacted by:

Phone (please list phone number) \_\_\_\_\_

Email (please list email address) \_\_\_\_\_

I do not wish to be contacted by a PTO Welcome Wagon member at this time.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



Jenn Hultz  
PTO President  
bluegrassptopresident@gmail.com



Child's Name: \_\_\_\_\_

Dear Parents,  
Please take a few minutes to answer the questions below.  
This will help us to get to know your child better. Thank you!

1. Please list the names and ages of your child's brothers and sisters.

2. Has your child had preschool or play-group experience?

3. Does your child have any health concerns or allergies?

4. Does your child have any special interests?

5. Is your child afraid of anything?



Turn over please.

6. What skills has your child acquired?

\_\_\_ can say full name

\_\_\_ knows address

\_\_\_ can tie shoes

\_\_\_ counts to...(how many)

\_\_\_ can print full name

\_\_\_ knows phone number

\_\_\_ knows the name of colors

\_\_\_ recognizes numbers to 10

7. What are your expectations for kindergarten?

8. Is there anything else that you would like to tell me about your child?

9. What is the best way to communicate with you? Please include phone numbers or e-mail addresses.

10. Would you be interested in helping in the classroom? Is there a particular day and time that is best for you?