FCS STUDENT REGISTRATION

SY: 2020-21

STUDENT INFORMATION

Student's Legal Name: First _____ Middle _____ Last _____

Home Resident Address(911 address) _____ City _____ State _____ Zip _____

Mailing Address IF different from residence _____ City _____ State _____ Zip _____

Home Phone ( ) _____ **Sex** M ☐ F ☐ **Grade**_____ **Birthdate**__/__/__

Birth City_____**Birth State**_____**Birth Country** (if other than US)_____ If born outside the US, has student received three or more years of education in the US? Yes ☐ No ☐ Date First Entered US School: _____

Race (mark all that apply) : ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Hispanic ☐ Latino

Do you have any concerns about your student's social, mental, or emotional health? Yes ☐ No ☐

ENROLLMENT HISTORY	YES	NO
Has student attended FCSD previously?	☐	☐
Has student been previously enrolled in FL Public Schools?	☐	☐
Has student been enrolled in special classes at previous school? (Such as atlernative, ESOL, gifted or special educational program)	☐	☐

SIBLINGS ATTENDING FRANKLIN COUNTY SCHOOLS		
Name	Relationship	Grade

HOME LANGUAGE SURVEY	YES	NO
1. Is a language other than English used in the home?	☐	☐
2. Did the student have a first language other than English?	☐	☐
3. Does the student most frequently speak a language other than English?	☐	☐
4. What language is most frequently spoken in the Home? _____		
Office use only: If any question 1-3 is answered "yes", a copy of this form goes to the ESOL Coordinator.		

PRIOR DISCIPLINE	YES	NO
My child has had a previous school expulsion.	☐	☐
My child is currently under expulsion from school.	☐	☐
My child has an arrest record resulting in a charge.	☐	☐
My child has been under Juvenile Justice Jurisdiction.	☐	☐
My child is currently placed in an Alternative school setting.	☐	☐

PARENT/GUARDIAN INFORMATION

Mother's/Female Guardian's Name _____ Workplace _____ City _____ Work Phone _____ Cell phone _____

Father's/Male Guardian's Name _____ Workplace _____ City _____ Work Phone _____ Cell phone _____

Mother's E-mail address _____ Father's Email address _____

Student lives with ☐ Both Parents ☐ Mother ☐ Father ☐ Guardian (Relationship) _____

CUSTODY: _____
(List any special custody arrangements. Appropriate legal documentation must be on file in student's cumulative folder)

Is this child of a military family? Yes ☐ No ☐ If yes, please complete the Military Family Student Form

Please note that transfer students may attend school 30 days while their school records are being obtained. Homeless students should be enrolled immediately, even if they do not have their records with them at the time of enrollment.

I understand FCSD reserves the right to release Directory Information including student names and photographs. FCSD will routinely publish this information in conjunction with press releases regarding school activities, honor roll announcements, athletic events, and other such activities. I further understand I may, by delivering a written statement to the principal within two (2) weeks of the first day of the school year or entry into the school system request that all or specific portions of directory information not be released.

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT, AND ANY FALSE OR MISLEADING INFORMATION MAY RESULT IN MY CHILD BEING EXCLUDED FROM SCHOOL. CHANGES TO THIS FORM MAY ONLY BE MADE BY THE INDIVIDUAL LISTED BELOW.

Signature of Parent/Guardian _____ **Printed Name** _____ **Date** _____

Original: Student's Cumulative Folder

STUDENT TRANSPORTATION AND PICK UP AUTHORIZATION FORM
SY: 2020-21

STUDENT'S LEGAL NAME: LAST:_____ **FIRST:**_____

GRADE:_____ **STUDENT ID#:**_____ **START DATE:**_____

It is ***EXTREMELY*** important that we know how your child is to get home each day. This form must be completed and returned on/before your child's first day of school. ***Your child will be dismissed according to the instructions on this form unless WRITTEN NOTICE (signed by a parent/guardian) is given to his/her teacher.***

A new form is required for permanent changes during the school year. Forms are available in the front office of the school or online at **www.franklincountyschools.org**.

☐ 1. Car Pick-Up: **My child will be a car-pick-up everyday** (**Continue at #4 (Alternate Pick-up)**)
(A Dash Pass will be issued for your use in the car-pick-up line)

☐ 2. Bus Rider: **My child will be a bus rider each day** (**Complete entire Form**)

PRIMARY PHYSICAL ADDRESS (No post office box number)	SECONDARY PHYSICAL ADDRESS
_____	_____
_____	_____
_____	_____
_____	_____

Other arrangements (for emergencies only) should be made before 10:00 a.m. A note from parent or guardian must be given to homeroom teacher. A Bus Pass will be completed by transportation staff and forwarded to the driver. Notes to the bus driver will not be accepted.

☐ 3. After-school program: **THE NEST**: ☐ Carrabelle ☐ Eastpoint ☐ **PROJECT IMPACT**:

If your child attends an after school program, your child will go there *every day*. **In the event of an emergency, you must make other arrangements.**

☐ 4. **Alternate Pick-up:** The following people may pick-up my student from school, after school program or the bus *with an approved Dash Pass* **(Must be at least 18 years of age)**

1. Name_____ Relationship_____ Contact #_____

2. Name_____ Relationship_____ Contact #_____

3 Name_____ Relationship_____ Contact #_____

4. Name_____ Relationship_____ Contact #_____

Parent/Guardian Printed Name: _____ **Date:**_____

Signature: _____ **Phone:** _____

My child(ren) may be released only to the individuals listed above.

******************************Transportation Department Use Only***************************

Bus# _____ for Primary address	Bus# _____ for Secondary address
_____ AM Pick-Up	_____ AM Pick-Up
_____ PM Delivery	_____ PM Delivery

Original: Transportation Department

EMERGENCY & MEDICAL FORM
SY: 2020-21

STUDENT INFORMATION

To be completed by Parent/Guardian only. **Use Pen**

School _____ Homeroom Teacher/First Period _____

Last Name _____ Student's Legal First Name _____ MI _____ Nickname _____ Student's Legal _____

Birth Date _____ Age _____ Grade _____ Sex/Race _____

Mailing Address _____

Resident Address (If different) _____

PARENT/GUARDIAN INFORMATION

Parent/Guardian Name _____ Place of Employment _____ Phone (H) _____ Phone (W) _____ Phone (C) _____

Parent/Guardian Name _____ Place of Employment _____ Phone (H) _____ Phone (W) _____ Phone (C) _____

STUDENT LIVES WITH: ☐ Both Parents (same address) ☐ Mother ☐ Father ☐ Other

CUSTODY: _____
(List any special custody arrangements. Appropriate legal documentation must be on file in a student's cumulative folder)

RELIGIOUS RESTRICTIONS/SPECIFY: _____

STUDENT HEALTH CONDITIONS/INSURANCE/DOCTOR INFORMATION

*****It is important that you provide information regarding your child's health conditions and health insurance. This information will assist us in the case of an emergency.**

Doctor's Name	**Address**	**Phone Number**

STUDENT HEALTH INSURANCE

☐ Healthy Kids Acct #_____	☐ Other Insurance_____
☐ Medicaid ID #	☐ None at this time

Children's Medical Services: ☐ Yes ☐ No If yes, name of case manager:

STUDENT HEALTH CONDITIONS

☐ Allergy to insects- **specify severity below**	☐ Heart Disease/Murmur- **specify below**	☐ Asthma-**requiring treatment at school**	☐ Transplant- **specify below**
☐ Allergy to medicine -**specify severity below**	☐ Psychological Problems- **specify below**	☐ Diabetes (Type_____)	☐ Ear Infection/Repeated
☐ Allergy to food – **specify severity below**	☐ Epilepsy/Seizures **(date of last seizure)**	☐ Hypoglycemia	☐ Visual Problems- **specify below**
☐ Cancer - **specify below**	☐ High blood pressure	☐ Drug Dependency	☐ Visual Correction Glasses
☐ Hernia – **specify below**	☐ Anemia	☐ Hyperactivity (ADD; ADHD)	☐ Visual Correction Contacts
☐ Cerebral Palsy	☐ Sickle Cell disease	☐ Urological Conditions	☐ Hearing Impairment
☐ Scoliosis	☐ Sickle Cell trait	☐ Gastrointestinal Condition	☐ Speech Impairment
☐ EpiPen	☐ Arthritis	☐ Kidney Disease	☐ Motor Impairment
☐ Headache	☐ Leukemia	☐ Muscular Dystrophy	☐ Hemophilia
☐ Nosebleeds	☐ Physical Impairment	☐ Pregnancy	☐ Other -**specify below**

Specify severity of health conditions/Specify restrictions on activity and any accommodations needed while at school: _____
_____

List all medications (prescription and non-prescription, including "as needed" and emergency meds) that student takes AT HOME OR SCHOOL: _____

NON-PRESCRIPTION MEDICATION

To assist the parents when their student is injured or ill, the Franklin County Health Department in partnership with the Franklin County School Board, have approved the use of acetaminophen (dose appropriate Tylenol for students (6 years and older) for treatment of minor pain, fever, cramps and muscular discomfort; Vaseline ointment for minor wound care and skin irritations; and ginger ale for minor indigestion.

☐ I request the above products be made available to my child as needed. My child has no known allergies to the above products

OR

☐ I **DO NOT** want my student to receive any of the above products

STUDENT HEALTH SCREENINGS

The Florida Department of Health in Franklin County and Franklin County Public Schools cooperate annually to provide state mandated health screenings for students in specific grades in Franklin County schools. Health screenings may help identify the need for medical care.

If a suspected health problem is identified, you will be notified in writing and advised to seek medical care. Florida law requires that parents be informed in writing at the beginning of each school year that children will receive such services.

The health screenings for specific grades are as follows:

SCREENING***	GRADES(S)
Vision/Hearing/Growth & Development	K, 1, 3 & 6
Scoliosis (Abnormal curvature of the spine)	6

*****New Students K-5 will be screened in vision, hearing, growth and development.**

☐ I want my student to participate in all health screenings offered for his/her grade level.

OR

☐ I **DO NOT** want my student to participate in the following health screenings:

- ☐ Hearing Screening ☐ Vision Screening
- ☐ Scoliosis Screening (Abnormal curvature of the spine)
- ☐ Growth and Development/Nutrition Screening (Body Mass Index Screening)

Screening Descriptions

Vision and Hearing: These screening procedures determine the ability of your child to see and/or hear as well as most children of the same age.

Scoliosis: This visual check is designed to check for abnormal curvature of the spine while wearing everyday clothing.

Growth & Development: This screening determines your child's height, weight and Body Mass Index (BMI) wearing normal clothing without shoes. The BMI calculation tells us if a child is in the normal range for height and weight, or is outside the norm and has increased potential to develop certain chronic diseases during childhood or adulthood.

EMERGENCY AND PRIVACY INFORMATION

Child Pickup/Emergencies: Should my child become ill or injured during the school day and the school is unable to contact me, I hereby give the school permission to contact one or more of the persons listed on the Transportation and Pick Up Authorization Form to pick up my child at school and care for my child during my absence. *(Must be at least 18 years of age.)* ***NO STUDENT WILL BE RELEASED TO ANYONE OTHER THAN THOSE PERSONS LISTED.***

In case of accident or serious illness during the school day, I request that the school contact me. In case of an emergency, I hereby understand and authorize that my child's medical records or other medical information, furnished to the school, will be shared with school officials and emergency personnel who have a legitimate purpose for accessing such information. I give my authorization and consent to this school to obtain emergency medical care and necessary emergency transportation to a healthcare facility. I understand that I will be responsible for any and all related charges. I understand that it is the parents'/guardians' responsibility to notify the school of any changes in this information throughout the school year.

I hereby grant permission for my child to participate in school related field trips.

I approve emergency treatment by the hospital physician and/or qualified medical technician for my child while participating in school related trips and any extracurricular activities in or out of Franklin County, Florida.

This form is carried to all extracurricular functions and is readily available in the event it is needed by emergency personnel.

My signature indicates I have read and understand the information contained on both sides of this Emergency & Medical Form and I have marked my decision for each of the selections above: Non-prescription medication, student health screenings and field trip emergency treatment.

_____ _____

Parent/Guardian Signature **Date**

Original: School Clinic **Copy: Classroom Teacher**

Franklin County District Schools
Student Residency Questionnaire

This survey is intended to address the requirements of the No Child Left Behind Act: Title IX/ Part C, and Title I/Part C. The answers to questions below will assist us in determining if your student may qualify for additional educational support services. **PLEASE PRINT, COMPLETE ONE PER FAMILY, and return the form. ¿Habla Ud. Español? Por favor doble este papel al otro lado para llenar este estudio.**

How many children/youth are in your household? _____

Names of Students Enrolled in School (PK – grade 12) or Adult School (*If needed, use an additional sheet of paper.)*

First Name	MI	Last Name	Birth date	Grade	School
_____	_____	_____	___/___/_____	_____	_____
_____	_____	_____	___/___/_____	_____	_____
_____	_____	_____	___/___/_____	_____	_____
_____	_____	_____	___/___/_____	_____	_____

Parent or Guardian Name (Print): _____
Street Address (Location of House):_____
Mailing Address:_____
Home phone:_____Cell phone:_____ Work phone:_____

Check the appropriate box to answer "Yes" or "No".	Yes	No	Code
1. We Rent/own our own home where student permanently resides with parent/guardian.	☐	☐	None
2. My family lives in an emergency or transitional shelter or FEMA trailer.	☐	☐	A
3. My family is sharing the housing of other persons due to loss of housing, economic hardship or a similar reason; doubled-up.	☐	☐	B
4. My family is living in a car, park, trailer park or campground due to lack of alternative adequate accommodation, abandoned building, substandard housing, public or private place not designed for or ordinarily used as a regular sleeping accommodation for people or similar settings.	☐	☐	D
4. My family lives in a hotel or motel.	☐	☐	E
5. A child/youth in my home is waiting for foster care placement.	☐	☐	F
6. A child/youth in my home is a foster child who has been placed in my care.	☐	☐	None
7. With an adult that is not a parent or legal guardian, or alone without an adult.	☐	☐	U/Y

Have you moved in the past 3 years to seek work as a paid laborer in any type of farming (sod, dairy, chicken, vegetable, citrus or other) or fishing? Check one: Yes ☐ No ☐

***If you marked "Yes" to questions 2-6 above, please indicate the cause by placing an "X" in the appropriate box below.**

☐ Mortgage Foreclosure (M) ☐ Natural Disaster-Flooding (F) ☐ Natural Disaster-Hurricane (H)
☐ Natural Disaster-Tropical Storm (S) ☐ Natural Disaster-Tornado (T) ☐ Natural Disaster-Wildfire or Fire (W)
☐ Man-made Disaster (Major) (D) ☐ Natural Disaster-Earthquake (E) ☐ Other – i.e., lack of affordable housing, long-term poverty, unemployment or underemployment, lack of affordable health care, mental illness, domestic violence, forced eviction, etc.

I certify that the information provided above is correct:
Parent or Guardian signature: _____

For School Use Only: Based on the above information and a brief interview with this family (where applicable), I attest that to the best of my knowledge they are eligible under the McKinney-Vento Act and/or Title 1 Part A/C:

School Contact	Title	Phone	Signature (required)	Date
_____	_____	_____	_____	_____

Original: Student's Cumulative Folder **Copy: Homeless Liaison**