



Student's Legal Name: First Middle Last

Home Address(911 address) #and Street Name City State Zip

Mailing Address (only if different from home address):

Mailing Address City State Zip

Home Phone ( ) Sex M F Grade

Birthdate Birth City Birth State Birth County ( 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 Hispanic Latino Native Hawaiian or Other Pacific Islander White

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

Has student attended FCSD previously Yes No

Has student been previously enrolled in FL Public Schools?

Yes No

Has student been enrolled in special classes at previous school

Yes No

(Such as an alternative, ESOL, gifted or special education program)

List siblings attending Franklin County Schools

Table with 3 columns: Name, Relationship, Grade

HOME LANGUAGE SURVEY

PRIOR DISCIPLINE

- 1. Is a language other than English used in the home? Yes No
2. Did the student have a first language other than English? Yes No
3. Does the student most frequently speak a language Other than English? Yes No
4. What language is most frequently spoken in the home?

- My child has had a previous school expulsion Yes No
My child is currently under expulsion from school Yes No
My child has an arrest record resulting in a charge. Yes No
My child has been under Juvenile Justice Jurisdiction. Yes No
My child is currently placed in an Alternative school setting. Yes No

If any question 1 – 3 is answered "yes", copy of this form goes to the ESOL Coordinator.

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)

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.

Exemption: Homeless students should be enrolled immediately, even if they do not have their records with them at the time of enrollment. School records should be obtained after enrollment.

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

Signature of Parent or Guardian:

Printed Name:

Date:

**STUDENT NETWORK AND INTERNET ACCEPTABLE USE AND SAFETY AGREEMENT**

Policy - 7540.03 F1

To access e-mail and/or the Internet at school, students under the age of eighteen (18) must obtain parent permission and must sign and return this form. Students eighteen (18) and over may sign their own forms.

**Use of the Internet is a privilege, not a right. The Board of Education's Internet connection is provided for educational purposes only. Unauthorized and inappropriate use will result in a cancellation of this privilege.**

The Board has implemented technology protection measures, which protect against (e.g. block/filter) Internet access to visual displays/depictions/materials that are obscene, constitute child pornography, or are harmful to minors. The Board also monitors online activity of students in an effort to restrict access to child pornography and other material that is obscene, objectionable, inappropriate and/or harmful to minors. Nevertheless, parents/guardians are advised that determined users may be able to gain access to information, communication and/or services on the Internet that the Board has not authorized for educational purposes and/or that they and/or their parents/guardians may find inappropriate, offensive, objectionable or controversial. Parents/Guardians assume this risk by consenting to allow their students to participate in the use of the Internet. Students accessing the Internet through the school's computers assume personal responsibility and liability, both civil and criminal, for unauthorized or inappropriate use of the Internet.

The Board has the right, at any time, to access, monitor, review and inspect any directories, files and/or messages residing on or sent using the Board's computers/networks. Messages relating to or in support of illegal activities will be reported to the appropriate authorities. **Please complete the following information:**

Student User's Full Name (please print): \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_

**Parent/Guardian -** As the parent/guardian of this student, I have read the Student Network and Internet Acceptable Use and Safety Policy and Guidelines, and have discussed them with my child. I understand that student access to the Internet is designed for educational purposes and that the Board has taken available precautions to restrict and/or control student access to material on the Internet that is obscene, objectionable, inappropriate and/or harmful to minors. However, I recognize that it is impossible for the Board to restrict access to all objectionable and/or controversial materials that may be found on the Internet. I will not hold the Board (or any of its employees, administrators or officers) responsible for materials my child may acquire or come in contact with while on the Internet. Additionally, I accept responsibility for communicating to my child guidance concerning his/her acceptable use of the Internet - i.e., setting and conveying standards for my daughter/son to follow when selecting, sharing and exploring information and resources on the Internet. I further understand that individuals and families may be liable for violations.

To the extent that proprietary rights in the design of a website hosted on the Board's servers would vest in my child upon creation, I agree to assign those rights to the Board. Please answer yes or no to questions 1 - 4 below:

- 1) I give permission for my child to use and access the Internet at school and for the Board to issue an Internet/e-mail account to my child.  Yes  No
- 2) I give permission for my child's image (photograph) to be published, provided only his/her first name is used.  Yes  No
- 3) I give permission for the Board to transmit "live" images of my child (as part of a group) over the Internet via a web cam.  Yes  No
- 4) I authorize and license the Board to publish my child's class work without infringing upon any copyright my child may own with respect to such class work. I understand only my child's first name will accompany such class work.  Yes  No

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Student -** I have read and agree to abide by the Student Network and Internet Acceptable Use and Safety Policy and Guidelines. I understand that any violation of the terms and conditions set forth in the Policy and Guidelines is inappropriate and may constitute a criminal offense. As a user of the Board's computers/network and the Internet, I agree to communicate over the Internet and the Network in an appropriate manner, honoring all relevant laws, restrictions and guidelines.

Student's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Teachers and building principals are responsible for determining what unauthorized or inappropriate use is. The principal may deny, revoke or suspend access to the Network/Internet to individuals who violate the Board's [Student Network and Internet Acceptable Use and Safety Policy](#) and related [Guidelines](#), and take such other disciplinary action as is appropriate pursuant to the Student Code of Conduct.

**EMERGENCY AND MEDICAL FORM****STUDENT INFORMATION****SCHOOL YEAR:** \_\_\_\_\_**To be completed by Parent/Guardian only.** Use Pen

School \_\_\_\_\_

Homeroom Teacher/First Period \_\_\_\_\_

Student's Legal Last Name \_\_\_\_\_

Student's Legal First Name \_\_\_\_\_

MI \_\_\_\_\_

Nickname \_\_\_\_\_

Birth Date \_\_\_\_\_

Age \_\_\_\_\_

Grade \_\_\_\_\_

Sex/Race \_\_\_\_\_

**Mailing Address** \_\_\_\_\_**Resident Address** (If different) \_\_\_\_\_**PARENT/GUARDIAN INFORMATION**

Mother's Name \_\_\_\_\_

Place of Employment \_\_\_\_\_

Phone (H) \_\_\_\_\_

Phone (W) \_\_\_\_\_

Phone (C) \_\_\_\_\_

Father's Name \_\_\_\_\_

Place of Employment \_\_\_\_\_

Phone (H) \_\_\_\_\_

Phone (W) \_\_\_\_\_

Phone (C) \_\_\_\_\_

Guardian's 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:** \_\_\_\_\_**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. If an application is not included with this form and you would like one sent to you, you can contact your clinic for more information.****Doctor's Name** \_\_\_\_\_**Address** \_\_\_\_\_**Phone Number** \_\_\_\_\_**HEALTH INSURANCE** **Healthy Kids Acct #** \_\_\_\_\_  **Medicaid ID #** \_\_\_\_\_ **Other Insurance** \_\_\_\_\_  **None at this time**Children's Medical Services:  Yes  No If yes, name of case manager: \_\_\_\_\_**HEALTH CONDITIONS**

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

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**:

**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 following persons 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 BELOW**

(1) Name	Relationship	Telephone
(2) Name	Relationship	Telephone
(3) Name	Relationship	Telephone
(4) Name	Relationship	Telephone

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.

**Parent/Guardian Signature**

**Date**

**HEALTH SCREENING**

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/Oral (Dental)	K, 1, 3 & 6
Scoliosis (Abnormal curvature of the spine)	6
Growth and Development/Nutrition	1, 3 & 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)

**Student Name**

**Parent Signature**

**Date**

**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.

**STUDENT TRANSPORTATION / BUS RIDERSHIP REQUEST FORM**

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. Please complete this form and return it on/before your child's first day of school. **Your child will be dismissed according to the instructions on this form unless WRITTEN NOTICE is given to his/her teacher.**

FOR PERMANENT CHANGES, COMPLETE A NEW FORM IN THE FRONT OFFICE.

1. Car Pick-Up: **My child will be a car-pick-up everyday (Continue at #4 (Alternate Pick-up))**

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 office 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:**

**OTHER:** \_\_\_\_\_ 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 (**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  
\_\_\_\_\_ AM Pick-Up  
\_\_\_\_\_ PM Delivery

Bus# \_\_\_\_\_ for Secondary address  
\_\_\_\_\_ AM Pick-Up  
\_\_\_\_\_ PM Delivery

**Franklin County School District  
Supervised School Sponsored Trips Emergency Medical Treatment Form**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Grade: \_\_\_\_\_

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.

My insurance company is: \_\_\_\_\_

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

Policy Number: \_\_\_\_\_

Name of person insurance is carried under: \_\_\_\_\_

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

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

Please make sure that you list all of the information concerning your insurance company and **notify us if this information should change**. Adequate insurance is required. Make sure that you are very explicit with your information about medication or previous and/or prevailing illnesses.

Hospitals WILL NOT provide treatment for any person who does not have permission from parents, legal next of kin, or legal guardian. The Emergency Treatment Authorization Forms are carried to all extracurricular functions and are readily available in the event they are needed.

Parents should read the Emergency Treatment Authorization Form very carefully. If there are any questions, feel free to call the school.

**Below please list any medications that your child takes on a regular basis or any medical conditions your child might have:**

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

\_\_\_\_\_  
**SIGNATURE OF PARENT OR GUARDIAN**

\_\_\_\_\_  
HOME ADDRESS

\_\_\_\_\_  
GUARDIAN HOME PHONE

\_\_\_\_\_  
WORK PHONE

\_\_\_\_\_  
CELL PHONE

LIST ANOTHER PERSON TO CONTACT IN CASE YOU CANNOT BE REACHED:

\_\_\_\_\_  
NAME

\_\_\_\_\_  
RELATIONSHIP

\_\_\_\_\_  
HOME PHONE

\_\_\_\_\_  
WORK PHONE

\_\_\_\_\_  
CELL PHONE

## Franklin County District Schools Student Residency Questionnaire

This survey is intended to address the requirements of the No Child Left Behind Act: Title X/ 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
_____		_____	_____	___/___/___		_____		_____
First Name		MI	Last Name	Birth date		Grade		School
_____		_____	_____	___/___/___		_____		_____
First Name		MI	Last Name	Birth date		Grade		School
_____		_____	_____	___/___/___		_____		_____
First Name		MI	Last Name	Birth date		Grade		School

Parent or Guardian Name (Print): \_\_\_\_\_  
 Street Address (Location of House): \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_  
 Telephone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

**I certify that the information provided above correct:**

**Parent or Guardian signature:** \_\_\_\_\_

QUESTION – Check the appropriate box to answer “Yes” or “No”.	Yes	No	Code
<b>1. We Rent/own our own home where student permanently resides with parent/guardian.</b>	<input type="checkbox"/>	<input type="checkbox"/>	None
2. My family lives in an emergency or transitional shelter or FEMA trailer.	<input type="checkbox"/>	<input type="checkbox"/>	A
<b>3. My family is sharing the housing of other persons due to loss of housing, economic hardship or a similar reason; doubled-up.</b>	<input type="checkbox"/>	<input type="checkbox"/>	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.	<input type="checkbox"/>	<input type="checkbox"/>	D
4. My family lives in a hotel or motel.	<input type="checkbox"/>	<input type="checkbox"/>	E
5. A child/youth in my home is waiting for foster care placement.	<input type="checkbox"/>	<input type="checkbox"/>	F
<b>6. With an adult that is not a parent or legal guardian, or alone without an adult.</b>	<input type="checkbox"/>	<input type="checkbox"/>	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.**  
 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.  
 \*\*\*\*\*

**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