Apalachicola Bay Charter School Registration 2017/2018

Student Information:

Last Name: _____ First/Middle Name: _____ Nickname: _____

Grade Student is Entering _____ Date of Birth: _____ Gender: ☐ *Male* ☐ *Female*

Student lives with: ☐ Mother ☐ Father ☐ Both Parents ☐ other _____

Is there a restraining order in effect? ☐ (yes) ☐ no) (If yes, legal papers must be on file with the school for enforcement.)
Restraining order is against: ☐ Mother ☐ Father ☐ other, _____
Note: Florida Statute provides that both parents have equal rights and access to their child's school records, unless a court order states differently. Court Order(s) should be copied and kept in the child's cumulative file at school. If no court order is received, the school will reference the birth certificate for custody.

Parent and Guardian Information

Parent/Guardian's Name: _____ Relationship: _____ Legal Custody: ☐ *(yes)* ☐ *(no)*

Home phone# _____ Cell phone# _____

Place of Employment/Work # _____ Email: _____

Mailing Address: _____

Parent/Guardian's Name: _____ Relationship: _____ Legal Custody: ☐ (yes) ☐ (no)

Home phone# _____ Cell phone# _____

Place of Employment/Work # _____ Email: _____

Mailing Address: _____

Emergency Contact/Pick Up Information

(Please list Adults, other than yourself that may be contacted and pick up your child in case of emergency or unscheduled early dismissal)

1. Name: _____ Relation: _____ Home #_____ Cell # _____
2. Name: _____ Relation: _____ Home #_____ Cell # _____
3. Name: _____ Relation: _____ Home #_____ Cell # _____
4. Name: _____ Relation: _____ Home #_____ Cell # _____
5. Name: _____ Relation: _____ Home #_____ Cell # _____

Student Cell Phone Number: _____

Permissions

Do you consent to receive "paperless" communication? (This means school announcements and newsletters will be emailed to you.)
☐ (yes) ☐ no)

Do you give permission for your student to appear in possible school publicity images or videos, including postings on our school website and facebook page: ☐ (yes) ☐ (no)

Do you give permission for your student to attend any and all local field trips within Franklin County. ☐ (yes) ☐ (no)

Student Health Information

(It is very important that you provide information regarding your child's health conditions. This information will assist us in the case of an emergency. The ABC School administers first aid and emergency responses for all illnesses and emergency accidents. Information provided on the registration form is used by our school staff and health officials for your child and/or this student's safety.)

Please check if your child has the following:

- ☐ Allergy to insects, specify _____
- ☐ Allergy to food, specify _____
- ☐ Asthma/ Inhaler
- ☐ Physical Impairment, specify _____
- ☐ Epi Pen Date of expiration: _____
- ☐ Visual Problems, specify _____
- ☐ Seizures/Epilepsy
- ☐ Allergy to medicine, specify _____
- ☐ ADD / ADHD, _____
- ☐ Hearing Impairment/ Hearing Aid
- ☐ Insulin Injections
- ☐ Glucose monitoring
- ☐ Visual Correction (Glasses or Contacts)
- ☐ Repeated Ear Infections or Headaches, _____

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

_____

Does this student use any assistive devices? _____Does this student have religious restrictions? _____

Does this student require any regular medication? _____ Specify: _____

Does this student require medication during school hours? _____

(ALL MEDICATION must be administered by the school nurse and requires an administration permission form – please contact our school nurse at 653-1222 x. 41 or 45)

Please list names and grades of student's brothers and/or sisters attending the ABC School August 2015:

1. _____ Grade: _____ 2. _____ Grade: _____

3. _____ Grade: _____ 4. _____ Grade: _____

Birth City: _____ Birth State: _____

Birth Country: _____ Social Security #: _____/_____/_____

Student Survey

Is student a child of an active military family: ☐ (yes) ☐ (no)

Ethnicity:

- ☐ No, not Hispanic or Latino
- ☐ Yes, Hispanic or Latino

Race: (Check all that apply)

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ White
- ☐ Native Hawaiian or Other Pacific Islander

Is a language other than English used within the home? ☐ (yes) ☐ (no) If yes, which language _____

Primary Language spoken at home: _____ Is this student bi-lingual? _____

Is or was this student in a special education program (with an IEP), served as Gifted, or have a 504 plan? (Please inform us of the program your child was or currently is in):

_____

Has this student ever participated in a speech program? ☐ (yes) ☐ (no) If yes, where and what services were provided:

_____

Has this student ever been enrolled in a VPK or Private PreSchool? ☐ (yes) ☐ (no) If yes, where

_____

Which School has this student previously attended? _____

Grades attended at previous school: _____ City of State of School: _____

Telephone of School: _____ Fax of School: _____

Parent/Guardian Consent and Signature

I am the parent/guardian of this child named above. The information on this form is true and accurate as of this date. I understand and take responsibility for notifying the ABC School with changes in my address and phone numbers, so that accurate data can be maintained on my child. I understand and consent to EMS (911) being called in a situation where my child needs immediate emergency attention. If my child is unable to remain at school due to illness, I request the school nurse to contact a parent or guardian. If I am unable to be reached, I request that one of the adults on my emergency contact list be notified to care for my child until I can be reached.

Print Name: _____ Signature: _____ Date: _____

APALACHICOLA BAY CHARTER SCHOOL
INTERNET TECHNOLOGY CONSENT AND WAIVER OF LIABILITY

(SIGNATURES REQUIRED)

Please complete all of the information below and return the form to the school principal or designee. Internet access will not be granted to your child unless this form is completed and returned.

STUDENT SIGNATURE:I understand and will abide by the provisions and conditions of the contract provided by the Franklin County School Board regarding Internet usage. In understand that any violations of these provisions may result in disciplinary action, the revocation of my access privileges, and/or appropriate legal action. I also agree to report any misuse of the information system to an administrator or a teacher. All the rules of conduct described in the Franklin County School Board Internet policy and code of conduct, apply when I am on the Internet. I have read and fully understand the rules of which I am to abide by.

Student Name:(please print) _____

Student Signature:_____ Date: _____

PARENT OR LEGAL GUARDIAN SIGNATURE: As the parent or guardian of this student, I have read and understand this contract and understand that Internet access is being provided solely for educational purposes. I understand that it is impossible for the Franklin County School Board to restrict access to every un-educational and inappropriate site acquired via the Internet. I agree to hold harmless the District and its employees for any complaints related to my child's use of the Internet. I also agree to report any misuse of the Internet to school administration. I accept full responsibility for the supervision of my child, should he/she misuse the Internet according to school policy. I also understand that Internet access is a privilege and not a right and any abuse of the privilege will result in revocation of my child's Internet privilege.

Parent or Guardian Name: _____

Home Phone:_____ Work Phone: _____

Signature:_____ Date: _____

PRINCIPAL OR DESIGNEE SIGNATURE: I have read this contract and agree to promote this agreement with the student. As the principal or designee, I agree to provide instruction to the student on the acceptable use of the network and proper network etiquette. I also agree to report any misuse of the information to the school technology representative.

Principal or Designee Name:_____

Signature:_____ Date: _____

TRANSPORTATION SIGN UP SHEET

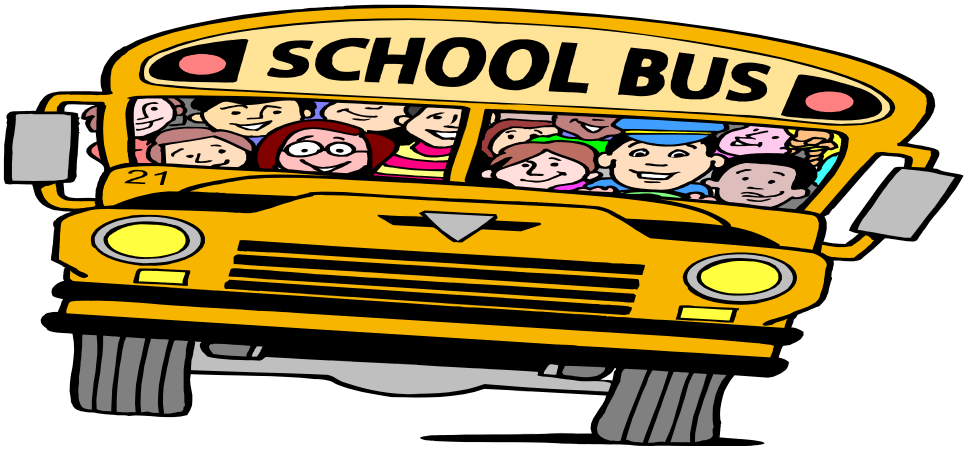
Apalachicola Bay Charter School

Transportation will begin on the first day of school for all students residing in Eastpoint, Carrabelle, St. George Island and Apalachicola.

For those Students residing in Apalachicola, you must live more than 2 miles from the ABC School property.

This form must be completed and returned to the ABC School before transportation can begin.

Those Students starting bus transportation after the School year has started, please fill in the date the student will start bus transportation.
If there are any transportation changes, make sure you send a note with your child and/or call the front office before lunch.



Student Name:_____

Grade:_____ **Phone #:**_____

Cell Phone #:_____**Work #:**_____

Physical Street Address:_____

_____

☐ **Apalachicola** ☐ **St. George Island** ☐ **Eastpoint** ☐ **Carrabelle**

Bus Transportation Start Date:_____

☐ **My child will walk home from bus stop**

☐ **A responsible guardian will be there to meet my child at bus stop**

Parent Signature:_____ **Date:**_____

SCHOOL HEALTH 2017/2018 EMERGENCY MEDICAL FORM

STUDENT INFORMATION

To be completed by Parent/Guardian only. Use Pen

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

Birth Date _____ Age _____ Grade _____ Sex/Race _____ Student SSN (optional) _____

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

☐ 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:

_____

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**	GRADE(S)
Vision	Grades K, 1, 3 & 6
Hearing	Grades K, 1, 3 & 6
Scoliosis (Abnormal curvature of the spine)	Grades 6
Growth and Development/Nutrition	Grades 1, 3, & 6
Blood Pressure	Grades 9
Oral Screening (Dental)	Grades K, 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
Blood Pressure 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.

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
			___/___/_____		
			___/___/_____		
			___/___/_____		
			___/___/_____		

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**
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. 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.**
☐ 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
_____	_____	_____	_____	_____

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