PTV 2019-2020 ST. LUCIE COUNTY VIRTUAL SCHOOL APPLICATION

SCHOOL BOARD OF ST LUCIE COUNTY, FLORIDA

4204 OKEECHOBEE ROAD, FORT PIERCE, FL 34947 Tel. (772) 429-5504

Please complete ONE application per child. If kindergartner or new to the county, you MUST provide all of the following documents to complete the registration process. Return application to any school or Student Assignment. **Proof of address is required for all applicants**.

Original Birth Certificate ****Social Security Card** *(If available)* ***Proof of Address**
*Proof of address is required for all applicants.

*Only **ONE** of the following documents is required as Proof of address:

1. Current utility bill – **within the last 30 days**
2. Official rent receipt
3. Current mortgage deed
4. Signed lease agreement
5. Mortgage payment coupon
6. Builder's Contract (6 month completion)

Parent/Guardian's name and address must be showing on the proof of address. Not acceptable: driver's license, voter's registration card, or cable bill.

I. STUDENT PROFILE: ID#			
Grade:	STUDENT NAME: *Last* *Appendage*	*First*	*Middle*
Gender: ☐**F** ☐**M**	**Race: Please mark one or more races to indicate what this person considers himself/herself to be. ☐ American Indian/Alaskan Native ☐ Asian ☐ Black ☐ Hawaiian/Pacific Islander ☐ White	Ethnicity: ☐ Hispanic/Latino	
Birth Date: *month/day/year* / /	Place of Birth: *City, State, and Country*	Primary Language Spoken at Home:	
***Social Security Number: / /	(***Student social security numbers are collected in order to identify students within the District's computer system and will be used only for that purpose.)	Previous School Name, City and State:	
Home Address:		City and Zip Code	
Mailing Address:		City and Zip Code	
Home Phone:	Work Phone:	Emergency Phone:	

****Note: RACE/ETHNICITY** Definitions:

Race:

- **American Indian or Alaska Native**. A person having origins in any of the originals peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.
- **Asian**. A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, e.g., Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- **Black or African American**. A person having origins in any of the black racial groups of Africa.
- **Native Hawaiian or Other Pacific Islander**. A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- **White**. A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Ethnicity:

- **Hispanic or Latino**. A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.
- **Not Hispanic or Latino**.

II. GUARDIAN INFORMATION: Residential/Custodial Parent

☐ Father ☐ Mother ☐ Other:_____	**PARENT/GUARDIAN** NAME: *Last*	*First and Middle Names*	Birth Date: *month/day/year* / /
☐ Father ☐ Mother ☐ Other:_____	**PARENT/GUARDIAN** NAME: *Last*	*First and Middle Names*	Birth Date: *month/day/year* / /

III. PREVIOUS PROGRAM INFORMATION:

A. Has your child been participating in an exceptional education program(s)? ☐Yes ☐No

☐ Other Health Impaired	☐ Autism Spectrum Disorder	☐ Emotionally/Behaviorally Disabled
☐ Orthopedically Impaired	☐ Hospital/Homebound	☐ Speech Impaired
☐ Traumatic Brain Injury	☐ Intellectually Disabled	☐ Gifted
☐ Visually Impaired	☐ Specific Learning Disability	☐ Dual Sensory Impaired
☐ Deaf or Hard of Hearing	☐ Developmentally Delayed	☐ Language Impaired

B. Indicate if any apply to your child:

☐ Expulsions: Date_____ ☐ Arrests: Date_____ ☐ Juvenile Justice Actions: Date_____

IV. DIVERSITY INFORMATION

Yes	No	
☐	☐	Has the student (or sibling in the same household) received free or reduced-price meals at school in St. Lucie County in the last year?
☐	☐	Do you receive Food Stamps or TANF for the student (or sibling in the same household)?
☐	☐	Is the student (or sibling in the same household) eligible for Medicaid?
☐	☐	Does the student (or sibling in the same household) receive benefits from the Women, Infants and Children (WIC) program?

***V.* SIBLINGS:** *(Siblings are defined as brother, sister, half-brother, half-sister, stepbrother or stepsister living in the same household.)*

Please list all siblings. Of the siblings listed, please check which are currently attending or applying for your first choice school.

S1 ☐

SIBLING NAME: *Last*	*First and Middle*	Gender: ☐**F** ☐**M**
Birth Date: *month/day/year* / /	***Race: Please mark one or more races to indicate what this person considers himself/herself to be. ☐ American Indian/Alaskan Native ☐ Asian ☐ Black ☐ Hawaiian/Pacific Islander ☐ White	***Ethnicity: Please mark one. ☐ Hispanic/Latino ☐ Not Hispanic/Latino

S2 ☐

SIBLING NAME: *Last*	*First and Middle*	Gender: ☐**F** ☐**M**
Birth Date: *month/day/year* / /	***Race: Please mark one or more races to indicate what this person considers himself/herself to be. ☐ American Indian/Alaskan Native ☐ Asian ☐ Black ☐ Hawaiian/Pacific Islander ☐ White	***Ethnicity: Please mark one. ☐ Hispanic/Latino ☐ Not Hispanic/Latino

S3 ☐

SIBLING NAME: *Last*	*First and Middle*	Gender: ☐**F** ☐**M**
Birth Date: *month/day/year* / /	***Race: Please mark one or more races to indicate what this person considers himself/herself to be. ☐ American Indian/Alaskan Native ☐ Asian ☐ Black ☐ Hawaiian/Pacific Islander ☐ White	***Ethnicity: Please mark one. ☐ Hispanic/Latino ☐ Not Hispanic/Latino

VI. EQUIPMENT INFORMATION

Yes No

☐ ☐ Do you have a computer at home? Make_____ Operating System_____

☐ ☐ Do you have internet access at home? Service Provider_____

VII. MEDICAL INFORMATION

My Child's Doctor is_____Medicaid ☐Yes ☐No Number_____

Insurance Provider_____ Number_____

Medical Information:

	Currently Being Treated Y or N	Medical Condition		Currently Being Treated Y or N	Medical Condition
☐ADHD	_____	_____	☐Tourette's	_____	_____
☐Epilepsy/Seizures	_____	_____	☐Cerebral Palsy	_____	_____
☐Asthma	_____	_____	☐Muscular Dystrophy	_____	_____
☐Diabetes	_____	_____	☐Cancer	_____	_____
☐Heart Condition	_____	_____	☐Sickle Cell	_____	_____
☐Kidney/bladder	_____	_____	☐Bleeding Disorder	_____	_____
☐Headaches	_____	_____	☐Psychiatric Condition	_____	_____

☐Other, please specify _____

Allergies to Medications: ☐Yes☐No SpecifyMedicationName(s):_____

Allergic Reaction to bee stings, ant bites, food: ☐Yes ☐No Specify:_____

Can you provide medical documentation of the above? ☐Yes ☐No

Pollen and Other Allergies: ☐Yes ☐No Specify allergy and medications:_____

I understand that in case of emergency if my child is at a school site my child will be taken to a hospital and given the necessary treatment. I understand that I am to pay the bill, including emergency transport. I understand that certain educational records of my child will be shared with the district Health Care Partners as needed to provide and evaluate health services to students. I also understand and agree that my child's medical treatment records created by health care personnel at school may be shared with school officials who have a Legitimate Educational Purpose for accessing such treatment records. I also consent that the school district and their health partners are able to bill Medicaid for any services for which my child is eligible.

Parent/Guardian Signature_____ **Date**_____

If an application is completed for a currently enrolled student, the current seat will no longer be available.

I have read and understand the directions for applying for my child's assignment. I agree to abide by the policies of St. Lucie County Public Schools. I testify that all of the information on this form and the documentation submitted with my request are true and accurate. I understand that failure to comply with these conditions, or falsification of any portion of this application may result in the revocation of my assignment.

Parent/Guardian Signature_____ **Date**_____

FOR OFFICE USE ONLY

DATE_____INTAKE LOCATION_____VERIFIED BY_____SCHOOL ASSIGNMENT_____