Port St. Lucie High School

Parents/Guardians,

It is imperative that we have your student's transcripts & last report card from their previous school.

If we do not receive grades in a timely period, it could affect your child's GPA and the credits they receive.

Please make sure you bring them with you when registering or have the school e-mail or fax them to us.

E-mail is always best, but we do accept faxes as well.

Here is where the previous school can send the transcripts & last report card to:

E-mail:

Laurie.green@stlucieschools.org

Fax:

1772-337-6784

Port St. Lucie High School

Name:_____
562_____
Grade:_____ Enrollment Date: _________

PSLHS Registration Checklist
Students Coming from
Outside St. Lucie County or Private School

Please include copies of the following documents along with the enclosed forms to complete your student's registration.

- ❑ Parent or Guardian Picture I.D.
- ❑ 2-Proof of Address
- ❑ Birth Certificate
- ❑ Social Security Card
- ❑ Immunizations (Florida 680 Form)
- ❑ School Physical Exam
- ❑ Lunch Application-Online: foodservices.stlucie.k12.fl.us (Click on Meal Application)
- ❑ Academic Records from Prior Schools
- ❑ If Applicable- Current IEP or 504 information
- ❑ Legal Paperwork (Custody, Guardianship, etc.)
- ❑ Emergency Information Form STS00282
- ❑ St Lucie Pupil ID Data Form SP100113
- ❑ Record of Prior School Program Form STS0139
- ❑ Agreement of Ensuring Prior Records
- ❑ FL Migrant Survey Form CAP0065A
- ❑ Home Language Survey Form FED0023A
- ❑ St. Lucie County School Family Access Form SA00036
- ❑ Official Request for Records Form
- ❑ Course Selection Sheet
- ❑ McKinney Vento Form

(*PLEASE PRINT*)

Saint Lucie Public Schools Pupil Identification Data

Student ID#	School Year	School Name	Grade	Enrollment Date ____/____/____
Student Last Name	Student First Name	Student Middle Name		☐ Male ☐ Female
Race	**Social Security # ______-_____-________	Birth Date ____/____/______	Birth City	Birth State	Birth Country	Date entered US ____/____/____

** SS# is collected in order to identify students within the District's computer system, Medicaid billing if eligible, and program follow-up.

What is the student's Race (choose all that apply)? ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

What is the student's ethnicity? ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Street Address	Street #, Name, Apt/Lot#	City, State, Zip	Home Phone (_____)________- _________
Mailing Address	☐ Check if same as above	City, State, Zip	

Name of school student last attended:	What Grade?	School Phone ( ) -

Address of School (if not in St. Lucie County)	City, State, Zip	County	Country

Parent/Guardian Contact Information – *Please number your contacts in the order they should be called in case of emergency (circle 1-5)*

1 2 3 4 5	Mr. Mrs. Ms. Dr.	Last Name, First Name	Relation	Lives With: ☐ **Yes** ☐ **No** Custody/Shared Custody: ☐ **Yes** ☐ **No** If custody is "NO," legal documentation is required
Street Address (if different)		Home Phone ( ) -	Work Phone ( ) -	Cell Phone ( ) -
1 2 3 4 5	Mr. Mrs. Ms. Dr.	Last Name, First Name	Relation	Lives With: ☐ **Yes** ☐ **No** Custody/Shared Custody: ☐ **Yes** ☐ **No** If custody is "NO," legal documentation is required
Street Address (if different)		Home Phone ( ) -	Work Phone ( ) -	Cell Phone ( ) -

Other Emergency Contact Information - Any persons listed below will be identified as being able to pick up your child from school

1 2 3 4 5	Mr. Mrs. Ms. Dr.	Last Name	First Name		Relation
Street Address			Home Phone ( ) -	Work Phone ( ) -	Cell Phone ( ) -
1 2 3 4 5	Mr. Mrs. Ms. Dr.	Last Name	First Name		Relation
Street Address			Home Phone ( ) -	Work Phone ( ) -	Cell Phone ( ) -
1 2 3 4 5	Mr. Mrs. Ms. Dr.	Last Name	First Name		Relation
Street Address			Home Phone ( ) -	Work Phone ( ) -	Cell Phone ( ) -

Military Activity

☐ Yes ☐ No A parent* of this child is an Active Member of our Armed Forces. (* For this question, parent is defined as natural parent or appointed legal guardian).

Release of Information I agree that the following information may be released for my child (Failure to check "NO" may result in the release of information):

☐ Yes ☐ No My child's name and contact information to Military Recruiters. (High School Student's Only)
☐ Yes ☐ No My child's name and contact information to Higher Education Institutions. (High School Student's Only)
☐ Yes ☐ No My child's name, photo, voice & video to the press for recognition or news purposes. (Applicable to All Students)
☐ Yes ☐ No My child's name, photo, voice & video for publicly assessable school or district websites or broadcast. (Applicable to All Students)
☐ Yes ☐ No My child's name, photo, and contact information to the yearbook photographers'. (Applicable to All Students)
☐ Yes ☐ No My child's directory information (student's name and grade) (Applicable to All Students)

Note: A limited release of information is required for participation in student athletics as described on the Parent/Player Agreement, Permission, and Release form.

State legislation requires at the time of initial registration in the school district to indicate if any apply to your child:

☐Expulsions: Date_______ ☐ Arrests resulting in a charge: Date________ ☐Juvenile Justice Actions: Date______ ☐Referrals to mental health services: Date________

I understand that in case of emergency, my child will be taken to a hospital and given the necessary treatment. I understand that I am to pay the bill, including 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 that my child's medical treatment records created by health care personnel at school may be shared with school officials who have Legitimate Educational Purpose for accessing such treatment records. **I certify that I have read all of the information on this form, and it is true and correct.**

☐ Yes ☐ No I give my consent to allow the school district and their health care partners the ability to determine Medicaid eligibility, using my child's DOB and SS#, and if eligible, to bill Medicaid for any services for which my child is eligible.

Name (Please Print)____Signature____Date_____/____/_______

If you wish to receive communication by email, provide email address:

OFFICE USE ONLY

Entry Code______ AM BUS____________PM BUS_____________ ☐ Proof of Address ☐ Immunizations or 30-day letter ☐ Physical

☐ Home Language Survey ☐ Internet Survey ☐ Emergency Card ☐ Birth Certificate ☐ FASTER Request:_____/____/____☐ Legal Papers

Homeroom # and Teacher____________________________________DATE entered by School Data Specialist_____/____/____Initials ___________

St. Lucie Public Schools

Home Language Survey

In accordance with Rule 6A-1.0955, FAC: Each student, upon initial enrollment in a school district, shall be surveyed at the time of enrollment by being asked the questions identified below.

Student Name_____Date_____Grade_____

School Name _____Parent/Guardian Name_____

Date of Birth_____Birthplace_____

Date Student 1st enrolled in a school in ANY of the USA 50 states in grades K-12_____(month/day/year)

Has the student previously attended any school in Florida? ☐ No ☐ Yes
If "Yes" please complete: Last date attended _____City_____ School Name_____

You must answer ALL of the following questions by checking Yes or No and answering the questions

A. **Does** the **student** most frequently speak a language **other than** English? ☐ YES What language_____	☐ NO
B. **Did** the **student** have a first language **other than** English? ☐ YES What language_____	☐ NO
C. **Is** a language **other than** English used in the **home**? ☐ YES What language_____	☐ NO
D. What **language** would you prefer for **home/school communication**? ☐ Spanish ☐ Haitian-Creole ☐ English	

Read the following statements for Notification of Testing Procedure and Initial on the line provided

_____If you answer "yes" to **any** of the above questions your child will be tested for English proficiency so that the teacher(s) can better serve him/her. The St. Lucie County School District administers an oral language test in all grades to determine listening and speaking proficiency, as well as, an English reading/writing proficiency test for grades 3-12.

____ If you answer "yes" to questions A & B, your child will receive services from the ESOL program until completion of the eligibility assessment.

____ A letter of explanation will be sent if the testing cannot be administered within 20 school days of the date above. You will be notified regarding your son's/daughter's eligibility for ESOL services once testing is complete.
The ESOL program provides services to Limited English Proficient students by placing students with classroom teachers who have had training in strategies to make English and subject area content understandable to them.

If you have questions concerning the ESOL services of assessment of English proficiency, please call the school and ask to speak to the ESOL contact.

Relationship to student
☐ Mother ☐ Father ☐ Guardian ☐ Self ☐ Other (specify): _____

_____ _____
Signature of person completing survey Date

St. Lucie County Public Schools

Family Application

PARENT/GUARDIAN INFORMATION

P1

☐ Father ☐ Mother ☐ Other:_____	**PARENT/GUARDIAN** NAME: *Last*	*First and Middle Names*	Birth Date: *month/day/year* / /
This parent's address:		City and Zip Code	
Phone:	***Email Address:***		

P2

☐ Father ☐ Mother ☐ Other:_____	**PARENT/GUARDIAN** NAME: *Last*	*First and Middle Names*	Birth Date: *month/day/year* / /
This parent's address:		City and Zip Code	
Phone:	***Email Address:***		

SIBLING INFORMATION

S1

CHILD NAME: *Last*	*Appendage* __Jr__II__III	*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:** Please mark one. ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Birth Date: *month/day/year* / /	Place of Birth: *City, State, and Country*		Primary Language Spoken at Home:
Name of parent/guardian student lives with:			

S2

CHILD NAME: *Last*	*Appendage* __Jr__II__III	*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:** Please mark one. ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Birth Date: *month/day/year* / /	Place of Birth: *City, State, and Country*		Primary Language Spoken at Home:
Name of parent/guardian student lives with:			

S3

CHILD NAME: *Last*	*Appendage* __Jr__II__III	*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:** Please mark one. ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Birth Date: *month/day/year* / /	Place of Birth: *City, State, and Country*		Primary Language Spoken at Home:
Name of parent/guardian student lives with:			

Parent/Guardian Signature_____ Date_____

St. Lucie PUBLIC SCHOOLS

FLORIDA MIGRANT EDUCATION PROGRAM
OCCUPATIONAL SURVEY

DISTRICT_____

SCHOOL_____CHILD NAME_____

PARENT NAME_____PRESENT OCCUPATION_____

We are interested in providing help to children and families that have had to move from one school district to another so a member of the family could work/seek work in certain kinds of jobs. Please assist us in finding whom we may be able to serve in this special project by filling out one of these forms.

1. In the last three years have you or anyone in your family crossed state or county lines for the purpose of working in one of the following occupations, either full-time or part time?

YES	NO	
☐	☐	FARMING (plowing, planting, cultivating, harvesting, processing of farm crops)
☐	☐	DAIRY WORK (feeding, milking, rounding up)
☐	☐	POULTRY OR EGG WORK
☐	☐	TREES (planting, growing, harvesting)
☐	☐	NURSERY WORK (planting, potting, pruning)
☐	☐	COMMERCIAL FISHING (fresh/saltwater, crabbing, shrimping, clamming)
☐	☐	WORKING ON A FISH FARM
☐	☐	PROCESSING FISH PRODUCTS

If you checked YES in any category above, please answer questions 2 & 3.
If you check NO to all categories, you may stop at this point.

2. Do you have children under the age of 22?_____Yes _____No

3. Are you or your spouse under the age of 22?_____Yes _____No

Parent's Signature_____Date_____

Address_____Phone Number_____

CAP0065A

St. Lucie Public Schools

Record of Prior School Programs

Student's Name _____ Date of Birth _____ Current Grade ____

To enable us to place your child appropriately, please answer the following questions:

Has your child ever been enrolled in St. Lucie County Schools in the past?

____ Yes _____ No

Has your child ever been enrolled in a FLORIDA school other than St. Lucie County?

____ Yes _____ No If yes, what school district? _____

Is your child expelled or pending expulsion in this or any other county/state?

____ Yes _____ No If yes, what school district? _____

Does your child receive any of the following services?

____ Exceptional Student Education If yes, Check program (s)

____ Learning Disability (SLD/LD)
____ Autism Spectrum Disorder (ASD)
____ Emotional Behavioral Disorder (EBD)
____ Intellectually Disabled (IND)
____ Traumatic Brain Injury (TBI)
____ Speech
____ Language
____ Orthopedically Impaired
____ Other Health Impaired
____ Visually Impaired
____ Hearing Impaired
____ Occupational Therapy
____ Physical Therapy

____ Gifted/Talented

____ Section 504

____ English Speakers of Other Languages (ELL/ESOL)

____ Other _____

What school did your child last attend? (public, homeschooled, private, virtual, alternative)

Name of School _____

City and State _____

Phone (if known) _____

Parent/Guardian Signature _____ **Date** _____

Printed Name _____

FOR OFFICE USE ONLY:

Provided to School ESE Specialist and School Counselor by (please print) _____

Position _____ Date _____

Port St. Lucie High School
Ms. Nicole Telese, Principal

From the Office of the Registrar
1201 Jaguar Lane
Port St. Lucie, FL 34952
772.337.6714

Parents/Guardians:

Please be aware that you are responsible for ensuring that Port St. Lucie High School receives all required student records from the student's prior school(s).

If we do not receive grades in a timely period, it could affect your child's GPA and the credits they receive.

Your signature below acknowledges this and grants permission to request the records on your behalf. If we have not received official school records after three requests, it is the responsibility of the Parent/Guardian to obtain the records from the previous school(s) and bring them to the Registrar's Office.

_____	_____
Print Name	Relationship to Student
_____	_____
Signature	Date
_____	_____
Student's Name	Student's St. Lucie Schools ID#

Respectfully,
Laurie Green
Registrar

You must complete both sides of this card and return to the school as soon as possible.

Primary phone _____

The School Board of St. Lucie County

Emergency Information

ID # _____
AM Bus _____
PM Bus _____

Date _____ Student's Name _____ Grade _____ Homeroom _____

* Social Security # _____ Student's Date of Birth _____

* SS# is collected in order to identify students within the district computer system, Medicaid billing, if eligible, and program follow-up.

Street Address:

Street _____ City _____ Zip Code _____

Mailing Address if Different:

Street or P.O. Box _____ City _____ Zip Code _____

Parent/Guardian Information

Father/Male Guardian's Name _____ Home Phone _____ Cell Phone _____

Work Phone _____ E-mail Address _____

Mother/Female Guardian's Name _____ Home Phone _____ Cell Phone _____

Work Phone _____ E-mail Address _____

Other adults who can be contacted if your child becomes ill and we are unable to reach you at your home or work:

Name _____ Home Phone _____ Work Phone _____

Name _____ Home Phone _____ Work Phone _____

Name _____ Home Phone _____ Work Phone _____

I understand that in case of emergency, 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 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 certify that I have read all of the information on this form, front and back, and that it is all true and correct.

❒ yes ❒ no : I give my consent to allow the school district and their health care partners the ability to determine Medicaid eligibility, using my child's DOB and SS#, and , if eligible, to bill Medicaid for any services for which my child is eligibile.

Parent/Guardian's Signature _____ **Date** _____

You must complete both sides of this card and return to the school as soon as possible.

Primary phone _____

The School Board of St. Lucie County

Emergency Information

ID # _____
AM Bus _____
PM Bus _____

Date _____ Student's Name _____ Grade _____ Homeroom _____

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Street Address:

Street _____ City _____ Zip Code _____

Mailing Address if Different:

Street or P.O. Box _____ City _____ Zip Code _____

Parent/Guardian Information

Father/Male Guardian's Name _____ Home Phone _____ Cell Phone _____

Work Phone _____ E-mail Address _____

Mother/Female Guardian's Name _____ Home Phone _____ Cell Phone _____

Work Phone _____ E-mail Address _____

Other adults who can be contacted if your child becomes ill and we are unable to reach you at your home or work:

Name _____ Home Phone _____ Work Phone _____

Name _____ Home Phone _____ Work Phone _____

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❒ yes ❒ no : I give my consent to allow the school district and their health care partners the ability to determine Medicaid eligibility, using my child's DOB and SS#, and , if eligible, to bill Medicaid for any services for which my child is eligibile.

Parent/Guardian's Signature _____ **Date** _____

My Child's Doctor is _____ Number _____

Medical Information:

Condition	Currently Being Treated Y or N	Medication for Condition	Condition	Currently Being Treated Y or N	Medication for 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 Specify Medication Name(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: _____

Name(s) of Brothers and Sisters:	DOB	School

STS0028.2 Rev. 5/19

My Child's Doctor is _____ Number _____

Medical Information:

Condition	Currently Being Treated Y or N	Medication for Condition	Condition	Currently Being Treated Y or N	Medication for 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 Specify Medication Name(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: _____

Name(s) of Brothers and Sisters:	DOB	School

STS0028.2 Rev. 5/19