(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 _____