



TREASURE COAST HIGH SCHOOL

1000 SW Darwin Blvd.
Port St. Lucie, FL 34953
(772) 807-4300
Fax: (772) 807-4320

REGISTRATION

Any parent or guardian registering students in St. Lucie Public Schools must have the following documents when registering for Treasure Coast High School.

Treasure Coast High School CANNOT process a registration without these documents:

- Original birth certificate (MANDATORY)
- Physical Health Exam (within the last 12 months – MANDATORY)
- Florida State Immunization Form 680 (MANDATORY)
- Social Security Card (if available)
- Proof of custody (if the child/ren are not living with both natural parents)
- Picture ID (MANDATORY)
- Transcripts and withdrawal grades (MANDATORY)
- Copy of IEP (Individual Education Plan) if your child is in an Exceptional Education Programs (MANDATORY)
- TWO Proofs of Address –
 - **Note: If the Proofs of Address are not in the Custodial Parent/Guardians name, a notarized affidavit of residence must be completed and submitted with the required proofs of address.
 - One of the following documents is required as primary proof of address:
 - Current electric, water, or land line bill – within last 30 days
 - Official Rent Receipt – within last 30 days
 - Signed Lease Agreement – within last 60 days
 - Current Mortgage deed – within last 60 days
 - Mortgage Payment Coupon – within last 30 days
 - Sales/builder's contract- (with completion within 6 months)

YOU WILL BE CONTACTED BY YOUR COUNSELOR ONCE ALL INFORMATION/
DOCUMENTS HAVE BEEN COMPLETED

veronica.reyes3@stlucieschools.org

Phone: 772-807-4307
Fax: 772-807-4302



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Records Release Form

The following student was enrolled at our school on _____

1st Request _____ 2nd Request _____ 3rd Request _____

Student Name: _____ DOB: _____

Parent/Guardian/Student Signature: _____

Previous School Information

Name of School: _____

Circle one: Public School Private School Alternative School Home School

City: _____ State: _____ County: _____

Phone #: _____ Fax #: _____

Records may be sent via email to:
veronica.reyes3@stlucieschools.org

or faxed to:

772.807.4302

PLEASE, do not send a cumulative file... send separate files.

Please send the following records:

- **Official Transcript**
- **Withdrawal Grades** – current incoming grades
- **Test Scores** – EOC grades/Waivers
- **Copy of Health/Immunization Records** – Shots and Physical 504 Plan
- **ESE** – (Psychological Data, current IEP, current Re-Eval, Behavior Plan).
- **ESOL**
- **Disciplinary Record**
- **Birth Certificate**
- **Social Security Card**
- **Applicable Legal/Court Documents**

Thank you,

Veronica Reyes, Registrar
772.807.4307

(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		<input type="checkbox"/> Male <input type="checkbox"/> 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.							
<input type="checkbox"/> What is the student's Race (choose all that apply)? <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White				<input type="checkbox"/> What is the student's ethnicity? <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino			
Street Address	Street #, Name, Apt/Lot#			City, State, Zip		Home Phone (____) - _____	
Mailing Address	<input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No Custody/Shared Custody: <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No Custody/Shared Custody: <input type="checkbox"/> Yes <input type="checkbox"/> 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							
<input type="checkbox"/> Yes <input type="checkbox"/> 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):							
<input type="checkbox"/> Yes <input type="checkbox"/> No My child's name and contact information to Military Recruiters. (High School Student's Only)							
<input type="checkbox"/> Yes <input type="checkbox"/> No My child's name and contact information to Higher Education Institutions. (High School Student's Only)							
<input type="checkbox"/> Yes <input type="checkbox"/> No My child's name, photo, voice & video to the press for recognition or news purposes. (Applicable to All Students)							
<input type="checkbox"/> Yes <input type="checkbox"/> No My child's name, photo, voice & video for publicly assessable school or district websites or broadcast. (Applicable to All Students)							
<input type="checkbox"/> Yes <input type="checkbox"/> No My child's name, photo, and contact information to the yearbook photographers'. (Applicable to All Students)							
<input type="checkbox"/> Yes <input type="checkbox"/> 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:							
<input type="checkbox"/> Expulsions: Date _____ <input type="checkbox"/> Arrests resulting in a charge: Date _____ <input type="checkbox"/> Juvenile Justice Actions: Date _____ <input type="checkbox"/> 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.							
<input type="checkbox"/> Yes <input type="checkbox"/> 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 _____				<input type="checkbox"/> Proof of Address		<input type="checkbox"/> Immunizations or 30-day letter <input type="checkbox"/> Physical	
<input type="checkbox"/> Home Language Survey <input type="checkbox"/> Internet Survey <input type="checkbox"/> Emergency Card <input type="checkbox"/> Birth Certificate <input type="checkbox"/> FASTER Request: _____/_____/_____ Homeroom # and Teacher _____				<input type="checkbox"/> DATE entered by School Data Specialist _____/_____/_____ Initials _____		<input type="checkbox"/> Legal Papers	

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

The School Board of St. Lucie County

Emergency Information

Primary phone _____

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 eligible.

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
<input type="checkbox"/> ADHD			<input type="checkbox"/> Tourette's		
<input type="checkbox"/> Epilepsy/seizures			<input type="checkbox"/> Cerebral Palsy		
<input type="checkbox"/> Asthma			<input type="checkbox"/> Muscular Dystrophy		
<input type="checkbox"/> Diabetes			<input type="checkbox"/> Cancer		
<input type="checkbox"/> Heart Condition			<input type="checkbox"/> Sickle Cell		
<input type="checkbox"/> Kidney/bladder			<input type="checkbox"/> Bleeding Disorder		
<input type="checkbox"/> Headaches			<input type="checkbox"/> Psychiatric Condition		
<input type="checkbox"/> 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



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Parents,

Please be aware that you are responsible for ensuring that Treasure Coast High School receives ALL required student records from your child's previous school.

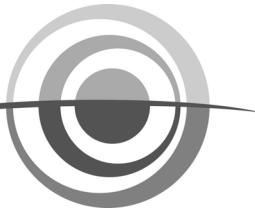
If we do not receive grades in a timely period, it could affect your student's GPA and credits.

Student Name: _____

Parent 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, clamping)
- 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



Accredited System-wide by the Southern Association of Colleges and Schools
The School Board of St. Lucie County is an Equal Opportunity Agency

**St. Lucie County School District
School Family Access Form**

After filling out this form, you must go to your child's school to have your account activated by showing a picture id for verification. We assure you that your child's privacy is very important to us. Access to information is restricted by a secure parent log-on and password, and state-of-the-art technology for encryption that scrambles the information as it is transferred to your computer via the internet. If you have any questions, concerns, or suggestions to make this portal better, please contact your child's school between the hours of 8:00am and 3:00pm.

Home Address:	City and Zip Code
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PARENT/GUARDIAN NAME: <i>Last</i> <i>Appendage</i> <i>_Jr_II_III</i>		<i>First</i>	<i>Middle</i>
Residential Guardian: Y/N	Email Address:	Primary Phone Number	

PARENT/GUARDIAN NAME: <i>Last</i> <i>Appendage</i> <i>_Jr_II_III</i>		<i>First</i>	<i>Middle</i>
Residential Guardian: Y/N	Email Address:	Primary Phone Number	

CHILD NAME: <i>Last</i> <i>Appendage</i> <i>_Jr_II_III</i>		<i>First</i>	<i>Middle</i>
Current Grade:	Birth Date: <i>month/day/year</i> / /	Current School Placement:	

CHILD NAME: <i>Last</i> <i>Appendage</i> <i>_Jr_II_III</i>		<i>First</i>	<i>Middle</i>
Current Grade:	Birth Date: <i>month/day/year</i> / /	Current School Placement:	

CHILD NAME: <i>Last</i> <i>Appendage</i> <i>_Jr_II_III</i>		<i>First</i>	<i>Middle</i>
Current Grade:	Birth Date: <i>month/day/year</i> / /	Current School Placement:	

CHILD NAME: <i>Last</i> <i>Appendage</i> <i>_Jr_II_III</i>		<i>First</i>	<i>Middle</i>
Current Grade:	Birth Date: <i>month/day/year</i> / /	Current School Placement:	

CHILD NAME: <i>Last</i> <i>Appendage</i> <i>_Jr_II_III</i>		<i>First</i>	<i>Middle</i>
Current Grade:	Birth Date: <i>month/day/year</i> / /	Current School Placement:	

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)

- | | | |
|--|--|---|
| <input type="checkbox"/> Learning Disability (SLD/LD) | <input type="checkbox"/> Speech | <input type="checkbox"/> Visually Impaired |
| <input type="checkbox"/> Autism Spectrum Disorder (ASD) | <input type="checkbox"/> Language | <input type="checkbox"/> Hearing Impaired |
| <input type="checkbox"/> Emotional Behavioral Disorder (EBD) | <input type="checkbox"/> Orthopedically Impaired | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Intellectually Disabled (IND) | <input type="checkbox"/> Other Health Impaired | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Traumatic Brain Injury (TBI) | | |

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 _____

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

The College Board

Consent Form for Request for English Learner (EL) Supports

Student's Name: _____

School Name: _____ School A1 Code: _____

Student's Date of Birth: ____ / ____ / ____

I wish to use certain testing EL support(s) provided by my school as part of the ____ / ____ / ____ administration.

<Test Date>

<Test Name, choose from PSAT 8/9, PSAT 10 or SAT School Day>

Student and Parent/Guardian Signature

I wish to use EL Supports on _____ <Test Name> due to my status as an English Learner. I authorize my school: to release to the College Board copies of my records that document my need for EL Supports; to release any other information in the school's custody that the College Board requests for the purpose of determining my eligibility for EL Supports on College Board tests; and to discuss my English Learner status and support needs with the College Board. I also grant the College Board permission to receive and review my records, and to discuss my status and needs with school personnel and other professionals. I understand that EL Supports are only available for PSAT 8/9, PSAT 10 and SAT School Day at this time.

Student's Signature

Date

Parent /Guardian's Signature

Date

(Required if Student is under 18)

Instructions to the School:

Unless you have been specifically advised by your state that this consent form is not needed, this form must be completed and kept on file at the school when a request for EL Supports on

the _____ is submitted to the College Board for the purposes of the ____ / ____ / ____

<Test Name>

<Test Date>

_____ administration. For each student for whom EL Supports have been

<Test Name>

requested, a copy of this form bearing the signatures of the student and parent/guardian must be obtained by the school. The school should maintain the completed, signed form with the student's records. The signed form does not need to be sent to the College Board, but the school should indicate in Student Information Confirmation page of the EL Supports request application that a signed form is on file.