TREASURE COAST HIGH SCHOOL

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

REGISTRATION

Any parent of 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)

AN APPOINTMENT WITH YOUR COUNSELOR WILL BE SCHEDULED ONCE THE REGISTRATION PROCESS IS COMPLETE.

PARENT/ LEGAL GUARDIAN MUST BE PRESENT.

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	☐ 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 ___________

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** _____

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

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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, 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 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

PARENT/GUARDIAN NAME: *Last*	*Appendage* __Jr__II__III	*First*	*Middle*
Residential Guardian: Y/N	Email Address:		Primary Phone Number

PARENT/GUARDIAN NAME: *Last*	*Appendage* __Jr__II__III	*First*	*Middle*
Residential Guardian: Y/N	Email Address:		Primary Phone Number

CHILD NAME: *Last*		*Appendage* __Jr__II__III	*First*	*Middle*
Current Grade:	Birth Date: *month/day/year* / /	Current School Placement:		

CHILD NAME: *Last*		*Appendage* __Jr__II__III	*First*	*Middle*
Current Grade:	Birth Date: *month/day/year* / /	Current School Placement:		

CHILD NAME: *Last*		*Appendage* __Jr__II__III	*First*	*Middle*
Current Grade:	Birth Date: *month/day/year* / /	Current School Placement:		

CHILD NAME: *Last*		*Appendage* __Jr__II__III	*First*	*Middle*
Current Grade:	Birth Date: *month/day/year* / /	Current School Placement:		

CHILD NAME: *Last*		*Appendage* __Jr__II__III	*First*	*Middle*
Current Grade:	Birth Date: *month/day/year* / /	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)

____ 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 _____

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 AI 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.