

Saint Lucie Public Schools Pupil Identification Data

(Please Print)

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.

What is the student's Race (choose all that apply)? <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian				What is the student's ethnicity?			
<input type="checkbox"/> Black or African American		<input type="checkbox"/> Native Hawaiian or Other Pacific Islander		<input type="checkbox"/> White		<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 () - -	
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Address of School (if not in St. Lucie County)		City, State, Zip		County	Country
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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 <small>If custody is "NO," legal documentation is required</small>		
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 <small>If custody is "NO," legal documentation is required</small>		
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.

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	<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: ___/___/___	<input type="checkbox"/> Legal Papers

Homeroom # and Teacher _____ DATE entered by School Data Specialist ___/___/___ Initials _____

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) | ____ Speech | ____ Visually Impaired |
| ____ Autism Spectrum Disorder (ASD) | ____ Language | ____ Hearing Impaired |
| ____ Emotional Behavioral Disorder (EBD) | ____ Orthopedically Impaired | ____ Occupational Therapy |
| ____ Intellectually Disabled (IND) | ____ Other Health Impaired | ____ Physical Therapy |
| ____ 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

<p>A. Does the student most frequently speak a language <u>other than</u> English? <input type="checkbox"/> YES What language _____</p>	<input type="checkbox"/> NO
<p>B. Did the student have a first language <u>other than</u> English? <input type="checkbox"/> YES What language _____</p>	<input type="checkbox"/> NO
<p>C. Is a language <u>other than</u> English used in the home? <input type="checkbox"/> YES What language _____</p>	<input type="checkbox"/> NO
<p>D. What language would you prefer for home/school communication? <input type="checkbox"/> Spanish <input type="checkbox"/> Haitian-Creole <input type="checkbox"/> English</p>	

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