VPK Registration

Children must be four years of age on or before September 1, 2019.

Please complete ALL forms in this packet, provide ALL the information listed below before returning to the KMS Office.

1. Certified Birth Certificate (not hospital copy)
2. Florida Immunization Record (obtained at location shots were received)
3. Florida Physical (must be within one year of first day of school)
4. Early Learning Coalition Certificate
5. Social Security Card (this is optional)

Extended day?: Y or N

WASHINGTON COUNTY PUBLIC SCHOOLS

STUDENT REGISTRATION FORM
EMERGENCY AND MEDICAL INFORMATION

Student's Legal Name (Last, First, Middle) _____ Gender _____ Student Date of Birth _____

Student ID# (assigned by Data Entry) _____ Grade (2019-2020) _____

Home Street/911 Address, City, State, Zip Code _____

Mailing Address if different from above with City, State, Zip Code _____

Ethnicity: Hispanic or Latino (circle one): Y N

Race (check all that apply): White: _____ Black or African American: _____ Asian _____
American Indian or Alaskan Native _____ Native Hawaiian or Other Pacific Islander _____

Primary Phone _____ Bus Driver's Name _____ Bus Number _____

Child lives with: both parents__ mother__ father__ other__; please specify _____.

Custody: _____
(List any special custody problems and be sure to submit legal documents for the child's cumulative folder)

_____ Military Y N _____ _____ _____ _____
Father/guardian's name Home Phone Place of Employment Work Phone Cell Phone

_____ _____
Father/Guardian's Address Father/Guardian's E-Mail Address

_____ Military Y N _____ _____ _____ _____
Mother/guardian's name Home Phone Place of Employment Work Phone Cell Phone

_____ _____
Mother/Guardian's Address Mother/Guardian's E-Mail Address

Please list below anyone who has permission to pick up your child at any time including instances where he/she becomes sick or injured and you cannot be reached in the order they are to be contacted.

1. _____ _____ _____ _____
Name Relationship to child Daytime phone Cell phone

2. _____ _____ _____ _____
Name Relationship to child Daytime phone Cell phone

3. _____ _____ _____ _____
Name Relationship to child Daytime phone Cell phone

(Please complete the reverse side)

Revised 12/2018

Personal Physician _____ Phone # _____

Please list any allergies and reaction to the allergies that your child has:

Allergy_____ reaction_____

Allergy_____ reaction_____

Allergy_____ reaction_____

Chronic health problems: _____

Daily medications: _____

List any operations, serious injuries, or major illnesses this child had/has and give dates: _____

_____

Has your child had previous school expulsions? Y N

If yes, when/where? _____

Has your child had any arrests resulting in charges? Y N

Has your child had any juvenile justice actions? Y N

Has your child had any referrals for mental health services? Y N

List other children who live in the same household.

Name	Relationship to above	Grade
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has student ever attended a Washington County school? Where_____ When_____

Has student been identified as a Student with a Disability? Yes_____ No_____

School health services are provided by the Washington County Health Department Staff. IF you do not wish for your child to participate in the school health services program, you must submit a letter to the school nurse. Please list any services you do not desire for your child on the letter you submit.

In case of accident or serious illness during the school day, I request that the school contact me. **In case of emergency, I hereby give the school permission for my child to be transported by Emergency Medical Services to the hospital and give the necessary treatment.** I understand that I will be responsible for any and all related charges.

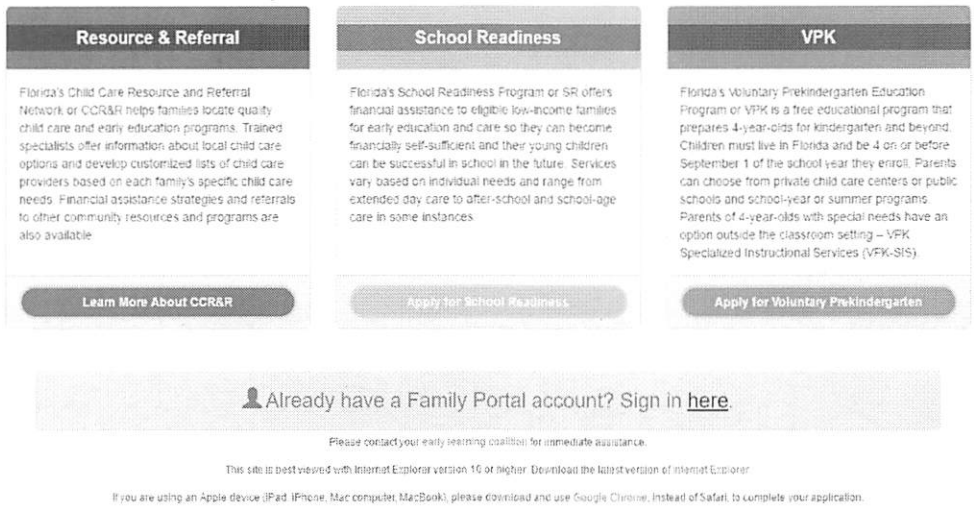
I understand that it is the parent's/guardian's responsibility to notify the school of any change in this information throughout the school year.

_____ _____

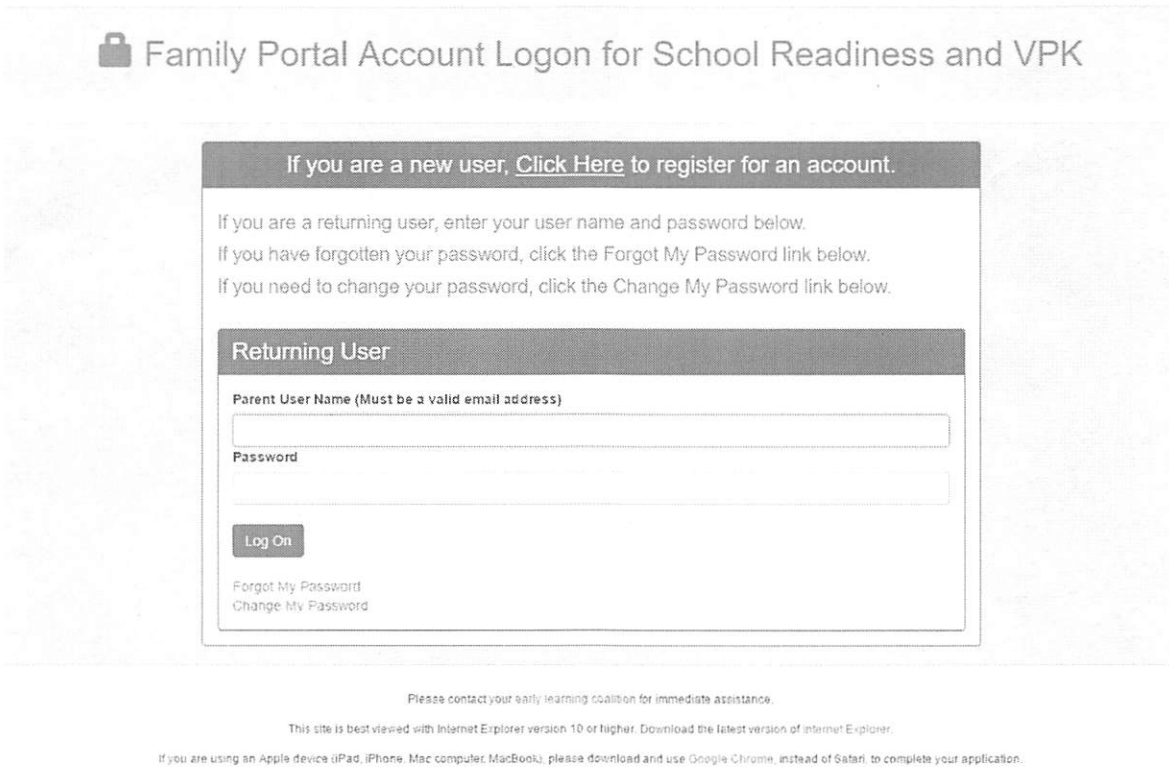
Parent/Guardian Signature Date

Revised 12/2018

To get your certificate for VPK, go to the following website: https://familyservices.floridaearlylearning.com/



Select "Apply for Voluntary PreKindergarten"



Register for a new account and follow the prompts. It also asks you to upload Birth Certificate and Proof of Residency. Once you have completed all the steps, you can then print your certificate from your conformation email from the Early Learning Coalition. If you have further questions, please contact ELC at 850-747-5400 ex 123 or ex 110.

WASHINGTON COUNTY HOME LANGUAGE SURVEY

SCHOOL NAME: _____ **DATE:** _____

STUDENT NAME: _____
Last Name (Family Name) First Name Middle Initial

TELEPHONE NUMBER: _____

ADDRESS: _____
Number Street City Zip

GRADE: _____ **AGE:** _____ **SEX:** _____ **DATE OF BIRTH:** _____

COUNTRY OF BIRTH: _____ **STATE/CITY OF BIRTH:** _____

NAME OF MOTHER: _____
Last Name (Family Name) First Name Middle Initial

NAME OF FATHER: _____
OR Last Name (Family Name) First Name Middle Initial

NAME OF GUARDIANS: _____
Last Name (Family Name) First Name Middle Initial

DATE OF ENTRY INTO UNITED STATES: _____

Please circle the correct response:

1. Is a language **other than English** spoken in the home? Yes No

   If "Yes", please state which language: _____

2. Did the student have a first language **other than English**? Yes No

   If "Yes", please state which language: _____

3. Does the student most frequently speak a language **other than English**? Yes No

   If "Yes", please state which language: _____

Washington County School District
Student Residency Information

SCHOOL Data Entry:
Date: _____
Code: R____ U____
Initials: _____

This survey is intended to address the requirements of the ESSA: Title X/ Part C, and Title I/Part C. The answers to questions below will assist us in determining if your student may qualify for additional educational support services. **PLEASE PRINT VERY CLEARLY, COMPLETE ONE PER SCHOOL, and return the survey to your student's teacher. ¿Habla Ud. Español? Por favor doble este papel al otro lado para llenar este estudio.**

How many other children/youth are in your household (even if not enrolled in school)? _____
Names of Students Enrolled in School (PK – grade 12) or Adult School (If needed, use an additional sheet of paper.)
School Name: _____

Student First Name	MI	Last Name	Birth date	Grade	
			__/__/____		
First Name	MI	Last Name	Birth date	Grade	
			__/__/____		
First Name	MI	Last Name	Birth date	Grade	
			__/__/____		

Parent or Guardian Name (Print): _____

Street Address (Location of House): _____

Mailing Address: _____
Street City State Zip

Telephone: _____ Cell phone: _____ Work phone: _____

Length of time at this address: _____ Former Address: _____

Parent or Guardian Signature: _____

Place an "X" in the appropriate box to answer "Yes" or "No."

QUESTION	YES	NO	*CODE*
1. My family lives in an emergency or transitional shelter or FEMA trailer.			*A*
2. My family is sharing the housing of other persons due to loss of housing, economic hardship or a similar reason; doubled-up.			*B*
3. My family is living in a car, park, temporary trailer park or campground due to lack of alternative adequate accommodations, public space, abandoned building, substandard housing, bus or train station, public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings or similar settings.			*D*
4. My family lives in a hotel or motel.			*E*
5. A child/youth in my home is waiting for foster care placement.			*F*
6. A child/youth in my home is an unaccompanied youth (youth not in the physical custody of a parent or guardian).			*Y or N*

If you answered "Yes" to some or all of the questions below, an education representative may contact you to find out whether your child is eligible for additional educational services.

	YES	NO
1. Have you moved to a new town to find work within the last 3 years?		
2. Did you find work in agriculture or fishing (e.g., field work, canneries, lumbering, dairy work)?		
3. *Is work in agriculture or fishing a major source of income for your family?*		

***If you marked "Yes" to any questions above, please indicate the cause by placing an "X" in the appropriate box.**

☐ Mortgage Foreclosure (M)
☐ Natural Disaster-Flooding (F)
☐ Natural Disaster-Hurricane (H)
☐ Natural Disaster-Tropical Storm (S)
☐ Natural Disaster-Tornado (T)
☐ Natural Disaster-Wildfire or Fire (W)
☐ Man-made Disaster (Major) (D)
☐ Do you need health services related to or the means used to control the spread of HIV and other sexually transmitted diseases?
☐ Other – i.e., lack of affordable housing, long-term poverty, unemployment or underemployment, lack of affordable health care, mental illness, domestic violence, forced eviction, etc. (O)

Directions for school staff: For students with positive responses to questions 1-6, complete data entry in student management program, complete school data entry box to indicate data entry has been completed, make a copy of the form for your records, and then return surveys with any positive responses to: Director of Federal Programs, 652 Third St., Chipley FL 32428.

Washington County School District
652 Third Street
Chipley, FL. 32428
850-638-6222

CUSTODY INFORMATION

By law, if parents are separated or divorced, each parent has equal rights to the custody of their children UNLESS one parent has a court order indicating that they have sole custody of their children. The school MUST HAVE A COPY OF THAT COURT ORDER ON FILE.

Otherwise, EITHER parent may, with proper identification:

- Check children in and OUT of school.
- Request copies of records.
- Have contact with children on campus.

If your family has circumstances that may require these papers, you must bring a copy to school. A copy of the court order will be kept on file at the school.

_____
Student's name

I have read the above statement and:

_____the above statement **DOES** apply to our family. **I will provide a copy of any court orders to the school.**

_____the above statement **DOES NOT** apply to our family.

_____
Father's signature Print name Date

OR

_____
Mother's signature Print name Date

This is for information only. This is not a legal document.

Rev. 7/18

Washington County School District
School Bus Transportation Request

******Do you require school bus transportation? Yes No******

What school zone will your child be attending? Chipley Vernon

If you answered yes, please complete below information.

You will be notified by your student's bus driver with stop information once bus assignment is made.

Child's Name	Grade	Date of Birth	Sex
			M F
			M F
			M F
			M F

Parent Contact Information

Parent's/Guardian's Name		Parent's/Guardian's Name	
( ) Home Phone	( ) Work Phone	( ) Home Phone	( ) Work Phone
( ) Cell Phone		( ) Cell Phone	

Alternative Emergency Contacts

Primary Emergency Contact		Secondary Emergency Contact	
( ) Home Phone	( ) Work Phone	( ) Home Phone	( ) Work Phone

BUS STOP INFORMATION

Address

Florida

City State

Date that you are requesting transport to start.

/ /

Parent/Guardian Signature Date

Rev. 7/18

PANHANDLE AREA EDUCATIONAL CONSORTIUM
FIELD TRIP
MEDICAL INFORMATION RELEASE AUTHORIZATION

The Federal Health Insurance Portability and Accountability Act , commonly referred to as HIPAA, requires an individual, or the individual's legal representative (parent of a minor, legal guardian, trustee, power of attorney) to provide permission for the release and exchange of that individual's health information in certain circumstances. If you sign this form, you are giving the health care providers designated below permission to share the information you indicate below. This form complies with the provisions of 45 C.F.R. § 164.508(c) regarding authorizations for release and exchange of protected health information. This form must be filled out entirely.

Purpose of Authorization: This form is designed to allow designated coaches, sponsors, athletic trainers, and school appointed chaperones to obtain health information necessary to determine a student's fitness and eligibility to participate in extracurricular/sports activities and/or field trips.

Please complete the following:

I/we the parents or legal guardian of _____, an extracurricular/sports participant of the school or person/student traveling on a field trip, give the authorization as indicated below for the communication between medical providers and activity/sponsors relative to the status of participation. Student Date of Birth_____

FROM MEDICAL PROVIDERS INDICATED BELOW:
Circle One Only:

A. All Providers

B. No Providers

C. Limited Providers

1 All providers except: _____

2 No providers but: _____

TO DESIGNATED COACHES, SPONSORS, ATHLETIC TRAINERS OR OTHER SCHOOL APPOINTED CHAPERONES:
Circle One Only:

A. Entire Health Record.

B. No protected health information.

C. Limited protected health information (describe information you do not wish for the provider to disclose, including any relevant time periods).

Enter the date that you want this authorization to expire. (If you do not enter a date, this authorization will expire one year from the date this form is signed.) _____

I understand that the information described above may be redisclosed by the person or group that I give the abovespecified health care providers permission to share my information with, and that my information would no longer be protected by the federal privacy regulations. Therefore, I release the providers identified above from all liability arising from the disclosure of my health information pursuant to this agreement.

I understand that I may inspect or request copies of any information disclosed by this authorization. I understand that I may revoke this authorization by notifying the Panhandle Area Education Consortium and the specified health care provider, in writing, knowing that previously disclosed information would not be subject to my revocation request.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or eligibility for benefits.

I have been provided with a copy of this authorization.

Signature of Parent or Legal Guardian Date

Printed Name of Parent or Legal Guardian Relationship to Student.

If there is a legal document verifying that you are acting in a representative capacity for the student identified above, please attach a copy to this authorization.

PAEC
Panhandle Area
Educational Consortium

STUDENT MEDICAL RELEASE FORM
PANHANDLE AREA EDUCATIONAL CONSORTIUM

Please fill this form out completely and sign
Student's Name _____ Circle one: Male Female
Date of Birth _____ Grade: _____ School Year: 20
Parent'(s) name(s)_____
Guardian(s) name(s)_____
Address:_____
City:_____ Zip: _____ Home Phone:_____
Work Phone: _____ Emergency Phone: _____ Cell Phone: _____
Email:_____@_____.___
..... I/We hereby give my/our permission for my/our child to attend the all school sponsored EXTRACURRICULAR/FIELD TRIPS and PARTICIPATE IN SPORTS events during the next 12 months, beginning in July 1, 20____ to June 30, 20____. I/We understand that there will be adult supervision at these events. I/We also understand that if there are any disciplinary problems with the above named Student, it will be our responsibility to pick up our child at the site of the event and they will not be eligible for future events without specific approval of the school staff in charge of those events or sports.

AUTHORIZATION FOR TREATMENT

I/We, the undersigned, parent(s)/Guardian(s) of the child named above on this consent form, do hereby authorize the school district, it's staff, our representatives, as agent(s) for the undersigned to consent to a X-ray examination, anesthetic, medical or surgical diagnosis, or treatment and hospital care that is deemed advisable by, and is to be rendered under the general supervision of any physician, physician extender, and surgeon licensed under the provisions of the Medicine Practice Act on the Medical Staff of any Hospital or medical clinic whether such diagnosis or treatment is rendered at the office of said physician or said hospitable.

It is understood that this authorization is given in advance of any specific diagnosis, assessment at time of injury treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his/her best judgment deem advisable; and to include emergency or urgent care as deemed necessary by supervising personnel.

The authorization is given pursuant to the provisions of Section 456.057, Florida Statutes, which allows Parent(s) or Guardian(s) to authorize any adult to consent to medical or dental treatment as stated in the above paragraphs).

This authorization shall remain effective from the date below, unless sooner revoked in writing delivered to said agent(s).
Signed _____ Dated _____

Print Name _____
(Parent or Guardian)

PANHANDLE AREA EDUCATIONAL CONSORTIUM

FIELD TRIP
MEDICAL INFORMATION RELEASE AUTHORIZATION

INTRODUCTION The privacy of medical records and information is protected and insured by new legislation entitled the Health Insurance Portability and Accountability Act ("HIPAA"). This law was developed to safeguard information about an individual's medical status from improperly being shared, discussed or released without their knowledge. The law is totally inclusive and does not allow for the beneficial communication about medical conditions or status absent valid authorization.

CONCERN – When an individual, especially a minor, participates in an extracurricular activity/field trip, there is always potential for injury or illness that may limit or prohibit participation. In order to make good decisions about the participation status of an individual, sponsors, coaches, directors, and chaperones need information concerning the individual participant's health status. Under the HIPAA regulations, that information may only be given by the parent or guardian of the minor participant (under 18) or the nonminor participant (18 or over). Medical providers including doctors, physical therapists, nurses, trainers, etc. may not directly discuss any medical condition of an extracurricular activity participant with the director of the activity without written consent from a parent or guardian or the adult participant.

REQUEST FOR CONSENT – Medical providers respect the right to privacy but also understand the need to communicate with activity directors about the participation status of individuals in their care. To accomplish this, a written consent form must be completed indicating the extent that this communication may occur. Three basic levels of consent are possible. These are A. TOTAL CONSENT, B. NO CONSENT, C. LIMITED CONSENT. This form is a request for a parent/guardian or adult participant to choose the level of consent desired. Included in the completion of this request form is the designation of what medical providers from whom medical information can be requested. There should be an understanding that total consent is still communication only BETWEEN those individuals who NEED to know the medical status of the participant. Since knowledge of certain medical information is necessary to determine the participation status and/ or the limitations of that participation (such as preseason medical screening), failure to release such information to the authorized sponsoring individual may disqualify the student from participating in extracurricular activities