

HEALTH CARD

Student ID# _____

Birthdate: _____

Student _____

Month/day/year

Last

First

Middle

Grade: _____ Teacher: _____ Best daytime Phone: _____

Street Address: _____

Mailing Address: _____

Doctor's Name: _____ Dentist's Name: _____

Allergies: _____ Glasses/Lenses: _____ Yes _____ No

Chronic/Serious Health Problems: _____

Medications _____

WE MUST HAVE A PHONE NUMBER OF SOMEONE TO CONTACT DURING THE SCHOOL DAY

Father's Name: _____ Phone: _____ Employer _____

Mother's Name: _____ Phone: _____ Employer _____

NAME OF PERSON (S) WHO WILL CARE FOR THE CHILD IN CASE PARENT CANNOT BE REACHED

Name: _____ Phone: _____ Address: _____

Name: _____ Phone: _____ Address: _____

Name: _____ Phone: _____ Address: _____

In case of accident or serious illness I request the school contact me. If the school is unable to reach me or a person named above, I hereby authorize the school to contact the physician indicated on this form and follow his/her instructions. If it is impossible to contact this physician or dentist, the school may make whatever arrangements necessary to provide care and treatment for my child.

Signature of Parent or Guardian

Date

Notice of Screening

Non-invasive screening (vision, hearing, growth & development, BMI, scoliosis) will be done in selective grades. If you DO NOT wish for your child to participate you must notify the office in writing.

CSD0042

GLADES COUNTY SCHOOL BOARD

Glades County School District is an Equal Opportunity Institution for Education and Employment
NEW /RETURNING STUDENT REGISTRATION MHES WGS MHS PECS

Record Request _____ Entry Date _____
Data Base _____ Teacher _____
Schedule _____ Glades Student ID _____ Bus _____
1. Student's Legal Name _____ 2. Current Grade _____

Last _____ First _____ Middle _____ 3. Sex: Male Female

4. Home Phone # _____ 5. Social Security (Optional) _____

6. Parent Email Address _____ 7. Cell Phone # _____

8. Date of Birth _____ 9. Place of Birth _____

10. Resident Status: In-County Out-Of-County

11. Race: Hispanic/Latino(White) Hispanic/Latino(Black) Am. Ind/Alaska Native Asian
 Black/African Am. Pacific Islander White

12. Is your child in an Exceptional Student Program Yes No Name of Program: Speech SLD
 Other(explain) _____

13. Has Student Ever Been Retained? Yes No If Yes, What Grade(s) _____

14. Pupil lives with: Both Parents Father Mother Other(explain) _____

15. Is there a court order restricting either parent contact with the student? Yes No If Yes, Please bring a copy to school.

16. Physical Address: _____
Street City State Zip

17. Mailing Address: _____
Street City State Zip

18. Father/Guardian: _____ Work Phone # _____

19. Mother/Guardian: _____ Work Phone # _____

20. EMERGENCY: In case of emergency 911 will be called and your child will be taken to the nearest hospital if deemed necessary.
Student has current: Immunization records: Yes No Health physical: Yes No

21. Children will only be released to Parents/Guardians and those persons listed below. In order to release children to ANYONE ELSE, the school must have written or verbal permission from the legal parent or guardian.

Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____

22. Has this child been enrolled in any preschool? Yes No Pre-K Disabilities(D) Head Start(H)
 Pre-K Early Intervention(L) Migrant Pre-K(M) Non-Subsidized Child Care(F) Subsidized Child Care(S)

HOME LANGUAGE SURVEY

23. Is a language other than English used in the home? Yes No If Yes, Language used _____

24. Did the student have a first language other than English? Yes No If Yes, Language used _____

25. Does the student most frequently speak a language other than English? Yes No If Yes, Language spoken _____

26. FEDERAL IMPACT SURVEY:
 Yes No Student resides on Federal Property(C) Yes No Student Resides in low rent housing
 Yes No Student resides on Indian Lands (B) Yes No Parent is employed on federal property
 Yes No Parent is employed on low rent housing Yes No Parent is uniformed Services(A)

27. Name of Last School Attended _____ Grade _____
Address _____

28. Has this student been expelled from a previous school? Yes No Date: _____ Name of District: _____

29. Has this student ever been arrested resulting in a charge or juvenile justice action? Yes No
If Yes, please explain: _____

30. Does this student have any medical or physical condition that the school ought to know about that might require special attention or restriction? Yes No If yes, please explain _____

31. Has this student ever had any mental health needs or concerns? Yes No
If Yes, please explain: _____

I verify that the information given is true and accurate to the best of my knowledge:

Signature of Parent or Legal Guardian Date Revised: 10/18

SCHOOL Data Entry:
Date: _____
Code: R _____ U _____
Initials: _____

Student Residency Information

This survey is intended to address the requirements of the No Child Left Behind Act: 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 FAMILY, 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.)

Name of Student to be Enrolled: Other Children/Youth in Your Household (even if not enrolled in school)

First Name	MI	Last Name	/ /	Birth date	Grade	School
First Name	MI	Last Name	/ /	Birth date	Grade	School
First Name	MI	Last Name	/ /	Birth date	Grade	School
First Name	MI	Last Name	/ /	Birth date	Grade	School

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: _____ Date _____

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

- | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> Mortgage Foreclosure (M) | <input type="checkbox"/> Natural Disaster-Flooding (F) | <input type="checkbox"/> Natural Disaster-Hurricane (H) |
| <input type="checkbox"/> Natural Disaster-Tropical Storm (S) | <input type="checkbox"/> Natural Disaster-Tornado (T) | <input type="checkbox"/> Natural Disaster-Wildfire or Fire (W) |
| <input type="checkbox"/> Man-made Disaster (Major) (D) | <input type="checkbox"/> Natural Disaster-Earthquake (E) | |
| <input type="checkbox"/> 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) | | |

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?		

Revised: 8/10/2018

Glades County School Board – Health Information

Glades County School District is an Equal Opportunity Institution for Education and Employment

Students Full Name: _____ Date: _____
 Address: _____ Phone: _____
 Date of Birth: _____ Sex: M ___ F ___ School: _____ Grade: _____
 Parent/Guardian Name: _____ Relationship: _____

Please indicate Yes or No next to each entry as appropriate. Use the "Comments" section at the bottom of the page for explanations, or the back if necessary.		Yes	No None
1.H	Blood Sugar Problems: Low ___ High ___		
2.H	Allergies to: Food _____ Medicine _____ Ants ___ Wasps ___ Bee Stings _____ Environment _____ Other _____ Specify reaction to allergy or allergen. _____ Does child take medication for allergies? Yes ___ No ___ List medications: _____ Special Diet Restrictions: _____		
3.H	Asthma, Wheezing, or other frequent respiratory conditions List Medications: _____		
4.H	Heart Murmur, Heart Condition, Rheumatic fever? Explain: _____ List Medications: _____		
5.H	Convulsion, "fit" or seizure, febrile seizures? _____ List Medications: _____		
6.C	Psychiatric Disorder? Explain: _____ List Medications: _____ ADD or ADHD? ___ List Medications: _____ Are Medications taken during school hours? _____		
7.C	Trouble Hearing? If yes, does the child wear a hearing aid? _____		
8.C	Vision Problems? Wear or has been prescribed glasses, contacts? _____ Other eye disease, Vision problems? Explain _____		
9.C	Low Blood count/Anemia? History of lead poisoning? _____		
10.C	Sickle Cell Anemia? Cancer? Leukemia?		
11.C	High blood pressure (also called Hypertension)?		
12.C	Cystic Fibrosis, Cerebral Palsy, Muscular Dystrophy, or Rheumatoid arthritis?		
13.C	Frequent Headaches or Migraines? List Medications: _____		
14.	Head injury, concussion, or been "knocked out"? _____		
15.	Kidney or bladder disease, infection, or injury? _____ Bowel or Bladder control problems? _____ Under a doctor's care? ___ List Medications: _____		
16.	Chicken pox? Date: _____		
17.	Ever been hospitalized? Explain: _____		
18.	Ever had surgery? _____ Explain: _____		
19.	Is child enrolled in Medicaid? Children's Medical Services? _____		
20.	Other health problems? _____		
21.	Other children in the family- name & age _____		

Comments:

I agree to keep the School Health Team updated in a timely manner of any health changes in this child and keep up to date phone numbers available to them throughout his/her school year.

Signature: _____ Date of Signature: _____ Revised 8/09

Moore Haven Elementary School
401 Terrier Pride Drive
P.O. Box 160
Moore Haven, FL 33471
Phone: 863-946-0737 Fax: 863-946-1670

REQUEST FOR CUMULATIVE RECORDS

To: STUDENT RECORDS

Last School Attended

Mailing Address

City, State, Zip Code

Please send cumulative records for the following student who is enrolling in our school.

Name _____ Grade _____ DOB _____

Please be assured that we will assist in attempting to obtain any fees owed by this student, but we must receive records as promptly as possible.

If your local school board has adopted policies which do not permit the transfer of cumulative folders, the following information is requested.

- _____ Transcript of all academic records K- _____
- _____ Transcript of test results: achievement, intelligence, sociological, aptitude, and interest surveys.
- _____ Results of Florida Statewide Assessment (FCAT)
- _____ Current grade card and partial transcript of grades for the current term.
- _____ Dibels/FAIR scores for the current year.
- _____ Health record - Immunization/Physical/Birth Certificate
- _____ Record of disciplinary action taken, if any.
- _____ Any and/all psychological records/Exceptional Student Records (IEP)/504 Plan

Your school has my permission to release the records for the above named student to Moore Haven Elementary School.

Signature of parent of guardian

Thank you for your assistance.

Signature Title _____ Date _____

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