PUTNAM COUNTY SCHOOLS
PUPIL INFORMATION SHEET

____
Florida Student Number

LAST NAME ______________________ FIRST______________________ MIDDLE ________________________

TEACHER'S NAME __________________________________ LUNCH NUMBER ___________________________

AGE________ GRADE__________ SEX__________ SOCIAL SECURITY NUMBER (optional)_______________

In compliance with Florida Statute 119.071(5)(a), the school district issues this notification regarding the purpose of the collection and use of social security numbers. The school district collects social security numbers for use in performance of district duties and responsibilities. To protect identity, the school district will secure social security numbers from unauthorized access. The school district will never release social security numbers to unauthorized parties.

DATE OF BIRTH________________________ PLACE OF BIRTH ______________________________________
CITY COUNTY STATE

RACE: WHITE ______ BLACK ______ HISPANIC ______ INDIAN ______ ASIAN ______ MULTI RACIAL ______

SCHOOL LAST ATTENDED ____________________________CITY________________________STATE_______
ADDRESS____PHONE NUMBER _________________

(INCLUDE NAME OF ANY PUBLIC OR PRIVATE SCHOOL)

HAS STUDENT EVER ATTENDED A FLORIDA PUBLIC SCHOOL PRE-K OR K-12 GRADE? YES ________ NO ___________
IS STUDENT IN AN EXCEPTIONAL EDUCATION PROGRAM? YES ____ NO ____ SPEECH THERAPY YES ____ NO ________
STATE ANY PREVIOUS EXPULSIONS, ARRESTS RESULTING IN A CHARGE AND JUVENILE JUSTICE ACTIONS:
____
____

NAME OF FATHER OR GUARDIAN _________________________________ OCCUPATION ____________________
DRIVER'S LICENSE NUMBER ____________________________________ DATE OF BIRTH __________________
HOME PHONE NUMBER ___________________________ CELL NUMBER ___________________________________
MAILING ADDRESS ____ CITY ____________________ ZIP ______
911 ADDRESS ____CITY ____________________ ZIP ______
WORK NAME ___________________________ADDRESS _______________ PHONE NUMBER __________________
E-MAIL ADDRESS ____

NAME OF MOTHER OR GUARDIAN _________________________________ OCCUPATION ____________________
DRIVER'S LICENSE NUMBER ____________________________________ DATE OF BIRTH __________________
HOME PHONE NUMBER ___________________________ CELL NUMBER ___________________________________
MAILING ADDRESS ____ CITY ____________________ ZIP ______
911 ADDRESS ____ CITY ____________________ZIP ______
WORK NAME ___________________________ADDRESS _______________ PHONE NUMBER __________________
E-MAIL ADDRESS ____

PUPIL LIVES WITH: BOTH PARENTS _____; FATHER _____; MOTHER _____; OTHER ______________________

GIVE DIRECTIONS TO THE STUDENT'S 911 ADDRESS: ____
____
____

*** PLEASE FILL OUT FRONT AND BACK OF THIS FORM ***

SIGNATURE ____ DATE _______________________

SWORN TO AND SUBSCRIBED BEFORE ME THIS ______ DAY of _____________ 20 ___

____
(Signature of Notary Public State of Florida)

Personally Known _____ OR Produced Identification _____
Type of Identification Produced ______________________

____
(Print, Type, or Stamp Commissioned Name of Notary Public)

EMERGENCY INFORMATION:

NAME OF PERSON TO CONTACT IN AN EMERGENCY OTHER THAN PARENT ________________________________
DATE OF BIRTH ______________________________ RELATIONSHIP TO CHILD _____________________________
HOME PHONE #____________________CELL # __________________WORK PHONE #_________________________
911 ADDRESS____CITY _______________________ ZIP __________

SECOND PERSON TO CONTACT IN AN EMERGENCY OTHER THAN PARENT ________________________________
DATE OF BIRTH ______________________________ RELATIONSHIP TO CHILD _____________________________
HOME PHONE #____________________CELL # __________________WORK PHONE #_________________________
911 ADDRESS____CITY _______________________ ZIP __________

NAMES OF BROTHERS AND SISTERS LIVING AT HOME:	AGE:	GRADE:	SCHOOL:

IF CHILD RIDES BUS: BUS NUMBER _____________________ DRIVER _________________________________
IF CHILD DOES NOT RIDE BUS, HOW DOES HE OR SHE GET TO SCHOOL? ___________________________________

PARENT'S MEDICAL AUTHORIZATION

I do/do not (circle one) authorize the school to obtain necessary medical services for my son/daughter, _____________________________ in the event I cannot be located. My child's doctor is: _______________________________ Phone number: ( ) ____________________.

SIGNATURE _______________________________________ DATE ____________________________________

PARENT CONSENT FOR HEALTH SCREENINGS

I hereby give consent for my child, ____ to participate in School Health Services Screenings conducted during the school year. Such screenings may include measurement of height, weight, vision, hearing, blood pressure, observation for scoliosis (spinal curvature), and nursing assessment for real or suspected health problems.

It is understood no treatment will be administered without additional parental permission. Parents will be notified of any problems detected.

Please list any problems, conditions or medications which might affect this child's progress in school or participation in physical education, or other classes.

____
____

SIGNATURE ____ DATE _____________________________

HISTORY: ADOPTED 09-12-77, AMENDED 05-12-80, AMENDED 02-08-82, AMENDED 08-22-94, AMENDED 10-28-96, AMENDED 10-12-98, AMENDED 05-02-06, AMENDED 01-19-10, AMENDED 09-21-10, AMENDED 08-07-12 AMENDED 04-10-14

PCSB FORM #8330-F1

District School Board Of Putnam County
LEP and Occupational Survey

To Be Completed By The Parent, Guardian or Adult With The Student Upon Initial Enrollment

Student Name:________________________________**School:**_____________________________________

Date entered United States School:_______________________

Part I **HOME LANGUAGE SURVEY**

1. Is a language other than English used in the home? ___Yes___No
2. Did the student above have a first language other than English? ___Yes___No
3. Does the student most frequently speak a language other than English? ___Yes___No
4. What language is used in the home? ____
5. What is the national origin of the student? ____

If you checked **Yes** to any of the questions on **The Home Language Survey** Part I, your child will be temporarily placed in the ELL program pending further assessment to determine if he or she meets criteria for entry into the program.

The ELL program services include:

- Teachers have state ELL endorsement training.
- Children will be taught using ELL strategies for effective instruction.
- Parents are invited to special LEP (Limited English Proficient) meetings concerning their child to discuss plans for the child's academic education.
- All ELL students participate in the same programs as regular students.
- Students are tested each year and will remain in the ELL program with a LAS score of 1, 2 or 3 and will exit with a score of 4 or 5.
- Students' progress is monitored for two years after exiting the ELL program.
- Children that qualify for ESOL and Exceptional Education will receive both services.

_______________________________ ____________________________________ ____/____/____

Parent's Signature Interpreter Date

Federal Definition of an Immigrant Student

The term "immigrant children and youth," which is defined in section 3301(6) of Title III refers to individuals who: (A) are aged 3 through 21; (B) were not born in any State; and(C) have not been attending one or more schools in any one or more States for more than 3full academic years. **Part II**

Present occupation (s) of parent(s):____

1. Have you or anyone in your family crossed state or county lines to work or seek work in one of the following occupations, either full-time or part-time during the last six (6) years?

Yes No

___ ___ FARMING (plowing, planting, cultivating, harvesting, or processing of farm crops)

___ ___ DAIRY WORK

___ ___ LIVESTOCK WORK (hoofing, cutting, branding, feeding, or rounding up)

___ ___ PLANTING, GROWING OR HARVESTING OF TREES

___ ___ POULTRY OR EGG WORK

___ ___ COMMERCIAL FISHING (fresh/salt water, crabbing and shrimping)

___ ___ WORKING ON A FISH FARM

___ ___ PROCESSING OR HAULING OF FARM/FISH PRODUCTS

2. If you checked **Yes** to any of the questions in part II, did your child move with you? ___Yes___No

PCSD
Putnam County School District

DEPARTMENT OF EDUCATION
RACE AND ETHNICITY FORM

Student Name: ____________________ Grade: ________

Please answer **BOTH** questions 1 and 2.

1. Is your child Hispanic or Latino? **(Please mark only one)**

☐ No, my child is not Hispanic or Latino

☐ Yes, my child is Hispanic or Latino – A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

2. What is your child's race? **(Please mark all that apply)**

☐ American Indian or Alaska Native – A person having origins in any of the Original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.

☐ Asian – A person having origins in any of the original peoples of the far East, Southeast Asia, of the Indian subcontinent, e.g., Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ Black or African American – A person having origins in any of the Black Racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American".

☐ Native Hawaiian or Other Pacific Islander – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ White – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

______________________________ ______________________________
Parent/Guardian Signature Date

Chronic Disease Information Form

Health Information

Student's Name________________________Date of Birth___________ School Year_________

Teacher/ Homeroom___________________________School____________________________

This form must be completed annually. The parent or guardian is responsible for keeping the school informed of any changes in your child's medical condition. Information will be shared with appropriate school staff for your child's best care.

____ My Child does not have a medical condition

List medical conditions your child has NOW	***List all medicines your child takes NOW (home and school)***	***List any medication(s) to be given at school. A medication authorization form is required.***
ADD____ ADHD_____		
A2___ ALLERGY –INSECTS		*___Epipen*
A4____ALLERGY -MEDICATIONS *Name the medication*		*___ Epipen*
A5 ____ALLERGY –LATEX		*___Epipen*
A7____ALLERGY –FOOD *List the food.* *Physician order is needed for special diet.*		*___Epipen*
A9 ____ALLERGY –OTHER *Specify the allergy*		*___Epipen*
AS____ ASTHMA *How frequent are the episodes?*		*___ Inhaler at school* *___Inhaler at home* *___Nebulizer at home* *___Nebulizer at school*
CA____CANCER		
CP____CEREBRAL PALSY		
CYF____CYSTIC FIBROSIS		
DB____DIABETES *Hypoglycemia or Hyperglycemia*		*____ diet____oral medication* *____insulin____pump* *____carb counting*
EA____Ear problems(describe)		*____Hearing aide (Left/Right/Both)* *____FM System* *____Deaf (Left/Right/Both)*
EP ____EPILEPSY/SEIZURES *List known triggers*		*Last seizure__________*
GA____Gastrointestinal *____Reflux____IBS____Crohn's* *____Other*		
HD____HEART DISEASE *HM____HEART MURMUR*		
HE____HEMOPHILIA		

HP____HYPERTENSION		
KD ____KIDNEY DISEASE		
MD____MUSCULAR DYSTROPHY		
MG____MIGRAINES		
NO____NOSEBLEEDS *Occasional____Frequent____* *Medical condition____*		
PC____PSYCHIATRIC CONDITIONS *(Please list)*		
SC____SICKLE CELL ANEMIA *____Trait only*		*Last Crisis? __________*
VP____VISION PROBLEMS *Describe____________* *__________________________*		*____Glasses____Contacts* *____Visually Impaired* *____Blind (Left/Right/Both)*
Any medical condition not covered above, please list.		

Will any medication be taken at school for any of the illnesses listed above? ____Yes_____No
If yes, Dr.______________________________________Dr.'s Phone #________________________
*******Medication cannot be given at the school until an authorization form is completed.***

Does your child use any adaptive equipment? Wheelchair ____ Walker_____ Braces_____
Other____(Specify)________________

********The Health Room Staff will be contacting you to set up a Care Conference for certain conditions listed above.***

Please print clearly persons to call in case of emergency

1st______________________________________Phone(H)_______________Cell_____________

2nd_____________________________________Phone(H)_______________Cell______________

____Date__________________________
Parent or Guardian Signature

PCDSB FORM: #8330-F3
Revised April 2014