Classical Preparatory School
K-12 Enrollment Checklist

Please print and complete the following forms:

_____ Student Enrollment Application (2 pages)
_____ Home Language Survey
_____ Student Services Health Information Form (2 pages)
_____ Student/Family Domicile Questionnaire (SIT) with parent signature
_____ Thirty-day Immunization Waiver (only for students previously enrolled in a Florida Public School; Does NOT apply for students entering Kindergarten or 7th grade)
_____ Signed Release of Records
_____ Shadow Day Form (Grades 1-12 only)

Please provide the following information:

_____ Proof of Annual Fee payment
_____ Proof of Residency (utility bill, mortgage statement, lease agreement, etc.)
_____ **Original** Parent ID (school will make a copy)
_____ Current Physical (dated within one year of school start date; doctor part and parent part must be completed and dated). This is not needed if the student is transferring from another Florida Public School
_____ Florida Certificate of Immunizations (Must have doctor's signature) Thirty-day waiver can be used if student is transferring from another Florida Public School
_____ **Original** Birth Certificate issued by state of birth (not necessary if a student is transferring from a **Pasco County** K-12 Public School; School will make a copy)
_____ **Original** Social Security Card (school will NOT make a copy, we will only verify that the social security number is accurate on the Enrollment application.
_____ **Original** custody/legal papers (if applicable;school will make a copy)
_____ Copy of IEP for ESE students (if applicable)
_____ Student Progression Plan-Release of Records for Homeschool students ONLY
_____ Medical Management Plan (if applicable)

In order to register your child, you must complete all forms and provide all required documents. Incomplete applications will not be accepted.

CLASSICAL PREPARATORY SCHOOL

2019-2020 Enrollment Application

CLASSICAL PREP
Date Rec'd:
Received By:

Legal Name Last First Middle

Grade Entering 2019/2020

Sex ☐ Male ☐ Female **Birthdate** ____/____/____
Month Day Year

Student ID # *(if applicable)*

\- -

Place of Birth **Social Security Number**

Home Address: Street Number and Name Apt./Bldg.

City State Zip **County**

Mailing Address *(only if different from the home address):*

City State Zip County

Primary Phone: ( ) - ☐ Landline ☐ Cell Phone

Primary E-mail: _____

CLASSICAL PREP OFFICE:
- ☐ Proof of Residency
- ☐ Parent Identification
- ☐ Home Language Survey
- ☐ Student Health Info Form
- ☐ Current Immunizations *OR* 30 Day Waiver Exp._____
- ☐ Emergency Card
- ☐ S.I.T. Form
- ☐ Annual Fee *(non-refundable)*

If Applicable:
- ☐ Birth Certificate
- ☐ Current Physical
- ☐ Original Custody Papers
- ☐ Copy of IEP
- ☐ Most recent schedule
- ☐ Most recent report card

( ) - ( ) -

Name of Last School Attended **Phone** **Fax**

Name of Zoned School *(if different from last school attended)* City County

Has the student ever been retained? ☐ Yes ☐ No If yes, which grade?_____

Please indicate if the student ever enrolled or qualified for any of the following?
☐ Alternative School ☐ ESOL Program ☐ Gifted Program ☐ Special Education Program

Please elaborate: _____

Does the student currently receive any services? ☐ Yes ☐ No
If yes, please describe in detail: _____

Does the student have a health condition that substantially interferes with his/her learning?
☐ Yes ☐ No
If yes, please explain: _____

Has the student ever been recommended for expulsion? ☐ Yes ☐ No If yes, which grade?_____

Has the student been arrested resulting in a charge and juvenile justice action? ☐ Yes ☐ No

Is the student a child of a military family or will he/she be a child of a military family during the school year? ☐ Yes ☐ No

FOR KINDERGARTEN ONLY:

Did the student attend a PreK program or a family day care home in Pasco County last year? ☐ Yes ☐ No

Is student Hispanic or Latino? ☐ Yes ☐ No

Ethnicity (Mark all the apply): ☐ White ☐ Black or African American ☐ Asian

☐ Native American Indian or Alaska Native ☐ Hawaiian or Other Pacific Islander

CLASSICAL PREPARATORY SCHOOL

2019 -2020 *Enrollment Application*

PARENT/GUARDIAN INFORMATION

Parent/Guardian #1: Last First Middle Relationship to student

Primary Phone: ( ) - ☐Landline ☐Cell Phone ☐Subscribe to text communication

Secondary Phone: ( ) - ☐Landline ☐Cell Phone ☐Subscribe to text communication

Work Phone: ( ) - **Employer:** _____

E-mail: _____ ☐Subscribe to Alerts

Parent/Guardian #2: Last First Middle Relationship to student

Primary Phone: ( ) - ☐Landline ☐Cell Phone ☐Subscribe to text communication

Secondary Phone: ( ) - ☐Landline ☐Cell Phone ☐Subscribe to text communication

Work Phone: ( ) -

E-mail: _____ ☐Subscribe to Alerts

Parent/Guardian #3: Last First Middle Relationship to student

Primary Phone: ( ) - ☐Landline ☐Cell Phone ☐Subscribe to text communication

Secondary Phone: ( ) - ☐Landline ☐Cell Phone ☐Subscribe to text communication

Work Phone: ( ) -

E-mail: _____ ☐Subscribe to E-mail Alerts

Student lives with _____
Name(s) Relationship to student

Is there a custody concern regarding this student? ☐No ☐Yes
Is there a current court order concerning this student? ☐No ☐Yes
Is the order valid for the 2019-2020 school year? ☐No ☐Yes

NOTE: FLORIDA STATUTE PROVIDES THAT BOTH PARENTS HAVE EQUAL RIGHTS AND ACCESS TO THEIR CHILD AND HIS/HER SCHOOL RECORDS, UNLESS A COURT ORDER STATES DIFFERENTLY. COURT ORDER(S) SHOULD BE COPIED AND KEPT IN THE CHILD'S CUMULATIVE RECORD AT SCHOOL.

SIBLING INFORMATION

	First Name	Last Name	School	Grade
1.				
2.				
3.				
4.				

Your signature below indicates that all information provided on this document is true and accurate. Incorrect or false information may make an impact on your child's placement.

Signature of Parent/Guardian Date

DISTRICT SCHOOL BOARD OF PASCO COUNTY
HOME LANGUAGE SURVEY
ENGLISH FOR SPEAKERS OF OTHER LANGUAGES (ESOL)

MIS Form #580
Rev. 2/16

Date of Survey _____ Student # _____ Grade_____

Student Name _____ Date of Birth _____ / _____ / _____
First Middle Last Month Day Year

Parent or Guardian Name _____ Primary Phone _____

Parent or Guardian Email Address _____ Alternate Phone _____

ESOL Program Eligibility Questions

1. If the answer to one or more of the following questions (2-4) is yes, your child's English proficiency will be evaluated in accordance with Florida statutes to determine eligibility for ESOL language services. Please initial that you understand the above statement **before** proceeding. _____

2. Is a language **other** than English spoken in your home? Yes _____ No _____
   If yes, what language? _____
   Who speaks this language? _____

3. Does the student have a first language **other** than English? Yes _____ No _____
   If yes, what language? _____

4. Does the student most frequently speak a language **other** than English? Yes _____ No _____
   If yes, what language? _____

5. When did the student first enter a U.S. school (kindergarten-12th grade)? _____/_____/_____
   Month Day Year

6. In what language do you prefer to receive school information when possible? _____

Immigrant Children and Youth Program Eligibility Questions

Immigrant children and youth: are individuals ages 3-21; were not born in any U.S. state; and have attended one or more US schools for less than 3 full academic years. The program provides educational and cultural support.

1. Was the student born outside of the United States? Yes ___ No ___ If yes, where?_____
   Country

2. If born outside of the U.S., how many years of school has the student completed in the United States?
   ___0 years ___1 year ___ 2 years ___3 or more years

Signature _____ Relation to student _____

For more information regarding these programs, contact The Office for Teaching and Learning
(813) 794-2251 (352) 524-2251 (727) 774-2251 http://www.pasco.k12.fl.us/esol/

DISTRIBUTION: White-Cumulative Folder; Canary-Compliance Teacher; Pink-ESOL Instructional Assistant

Immunization Waiver

TRANSFER STUDENT 30 DAY IMMUNIZATION WAIVER FORM

Students who are enrolling, and who have previously attended school in Florida, are granted a 30 day period of time for their previous records to arrive. A Florida Certification of Immunization (Form DH680) must be used to document the immunizations required for entry and attendance in a Florida school. The immunization record must show that the student has met the minimum state requirements.

A 30 day waiver is not applicable for first time Kindergarten enrollees or students entering the 7th Grade. Homeless students are the only exception to this rule. Florida Statute gives homeless students a 30 day grace period to comply.

Student's Name:_____

Previous School:_____

Date of Birth: _____ /_____ /_____ Date of Enrollment: _____ /_____ /_____

30th Calendar Date: _____ /_____ /_____

As the parent/guardian of the above named student, I understand that I am responsible for obtaining the required certificate of immunization on or before the 30th calendar date from the date of enrollment. I further understand that if I fail to obtain the required documents, my child will be withdrawn from school on the 31st calendar day.

Print Parent/Guardian's Name: _____

Parent/Guardian's Signature: _____

DISTRICT SCHOOL BOARD OF PASCO COUNTY
STUDENT HEALTH INFORMATION FORM

(To be completed for initial registration and for change in health status)

MIS Form #442
Rev. 5/13

Student_____ School_____ Date_____
Last Name First Middle

Student #_____ Grade_____ DOB_____ Sex: Male_____ Female_____

Does your child have any of the following health conditions or concerns?

1. Allergy to any foods, medications, or insects? ___Yes ___No If yes, list _____
   Reaction: ___Mild ___Severe Needs: ___Epipen ___Benadryl

2. Asthma or wheezing? ___Yes ___No
   If yes, please indicate if uses nebulizer: ___Yes ___No If yes, how often? _____
   If yes, please indicate if uses inhaler: ___Yes ___No If yes, how often? _____

3. Diabetes or high/low blood sugar? ___Yes ___No If yes, list medication/treatment _____

4. Epilepsy or convulsion/seizure? ___Yes ___No If yes, list medication/treatment _____
   Date of last episode_____

5. Recent hospitalization? ___Yes ___No If yes, reason_____ Date_____
   If yes, reason_____ Date_____

6. Heart murmur or history of heart condition? ___Yes ___No If yes, explain_____

7. Serious burn or broken bone? ___Yes ___No If yes, explain_____

8. Ear infection or draining ear? ___Yes ___No If yes, explain_____

9. Trouble hearing? ___Yes ___No Wears hearing aid: ___Yes ___No
   Should be wearing hearing aid: ___Yes ___No

10. Trouble seeing? ___Yes ___No Wears glasses or contacts: ___Yes ___No
    Should be wearing glasses or contacts: ___Yes ___No

11. Major head injury or concussion? ___Yes ___No If yes, explain_____

    _____

12. Kidney or bladder problems? ___Yes ___No If yes, explain_____

DISTRICT SCHOOL BOARD OF PASCO COUNTY
STUDENT HEALTH INFORMATION FORM

MIS Form #442
Rev. 5/13 - Back

(To be completed for initial registration and for change in health status)

13. Frequent bed-wetting? ___Yes ___No If yes, explain_____

14. Stomach or bowel problems? ___Yes ___No If yes, explain_____

15. Trouble sleeping? ___Yes ___No If yes, explain_____

16. Hernia or rupture of groin or navel? ___Yes ___No If yes, explain_____

17. Trouble with teeth? ___Yes ___No If yes, explain_____

18. Anemia or low iron? ___Yes ___No If yes, explain_____

19. Attention Deficit Disorder (ADD/ADHD) or hyperactivity? ___Yes ___No If yes, explain_____

_____

20. Mental health concerns? ___Yes ___No If yes, explain_____

21. Difficulty understanding dangerous situations, wanders or runs away from adults? ___Yes ___No If yes, explain_____

Please list any other medicine taken regularly and dosage: _____

_____

Are there any special health procedures that should be followed at school? _____

_____

Are there any limits on your child's participation in physical education or recess activities due to a health condition?

_____

If your child is Medicaid eligible, please provide Medicaid number _____ and name of the Medicaid Insurance Plan _____.

_____	_____	_____
Print - Parent/Guardian Name	Parent/Guardian Signature	Date

DISTRIBUTION: This form will be placed in your child's cumulative record.

DISTRICT SCHOOL BOARD OF PASCO COUNTY
Students In Transition (SIT) Program
Student Eligibility Questionnaire

MIS 140
Rev. 04/19

Dear Students/Families/Caregivers,

The Pasco County School District wants to make sure that your child receives the best possible education. The information from this form will help to find out if your student is able to **receive benefits under the federal McKinney Vento Act**, a law that helps students who are temporarily displaced from their home for certain reasons. PLEASE PRINT VERY CLEARLY, COMPLETE ONE PER FAMILY, and return the survey to your student's school. **Students/Families/Caregivers MUST CONTACT SIT PROGRAM OFFICE FOR NEEDED SERVICES**..

SECTION 1: Your Housing is fixed, regular and adequate

___ Rent/Own your home
___ Live with someone (not due to financial hardship)
___ Live in foster care placement

IF YOU CHECKED ONE OF THESE BOXES, PLEASE **DO NOT** COMPLETE THIS FORM.

SECTION 2: Your Housing is NOT fixed, regular and adequate (complete all sections below)

Are you living in any of these situations?

YES	NO	
___	___	An emergency or transitional shelter. (A)
___	___	Temporarily with another family due to loss of housing, economic hardship or similar reason (B)
___	___	A vehicle of any kind, trailer park or campground, abandoned building or other substandard housing (D)
___	___	A hotel/motel due to loss of housing, economic hardship or similar reason (E)

Reason for temporary residence:

__ Foreclosure (M)
__ Eviction
__ Unemployment (O)
__ Fire (W)
__ Tornado (T)
__ Earthquake (E)
__ Flooding (F)
__ Wildfire (W)
__ Tropical Storm (S) : storm name _____
__ Hurricane (H) : storm name _____
__ Man Made Disaster (D)
__ Other (N) _____

SECTION 3: Print Current Address and Contact Information

Parent/Legal Guardian Name: _____

Street Address or location of housing: _____

Telephone Number: _____ Email: _____

SECTION 4: Student Information

Print the names of ALL school-aged AND preschool-aged (3 & 4 year old) children in your family

Name	Student ID	D.O.B.	F/M	Grade	School	Bus **

** Be sure to mark if the student will need transportation to/from SCHOOL OF ORIGIN

SECTION 5: Unaccompanied Youth Must Complete This Section

__ Student is living alone without an adult - sign Section 6 below
__ Student is living with an adult that is NOT a parent/legal guardian – fill out following:

Caregiver Name: _____

Phone: _____ Email: _____

SECTION 6: Signatures

The undersigned certifies that the information provided is accurate.
Florida Statute 837.06 provides that whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his/her official duty shall be guilty of a misdemeanor of the second degree.

Name of the Person Completing This Form (Print) | Signature of the Person Completing This Form | Date

DISTRIBUTION:
1 - All schools MUST keep original forms separately from the Student Cumulative Folder for audit purposes during the year.
2 - SIT PROGRAM FAX: (813) 794-2560

Must be faxed or emailed immediately to sitprogram@pasco.k12.fl.us

AUTHORIZATION FOR RELEASE OF RECORDS

AND/OR INFORMATION FROM RECORDS

RECORDS TO BE RELEASED TO: Megan Hersh - Data Entry Operator .

School/Agency: Classical Preparatory School Phone: (813) 803-7903 .

Address 16500 Lyceum Way, Spring Hill, FL, 34610

RECORDS TO BE RELEASED FROM _____ Fax: _____ ___

(Name of Prior School/Agency)

Address _____

I ,_____, do hereby authorize the release of the following information on

_____ _____ _____

Student Name Date of Birth Student #

From the above named school/agency/person:

X Entire Cumulative Record Folder (Applicable for student transfer to another school or system)

X Exceptional Student Education Records

X Grades at Time of Withdrawal

__ Grading System

__ Graduation Requirements

__ Home Language Survey

__ Record of Achievements, Special Awards/Activities

__ Medical/Health Records (including speech, language, hearing/vision reports)

__Official School Transcript

__ Psychiatric Evaluation

__ Psychological/Social Work Reports

X Standardized Test Scores

__ Treatment/Services Plan

__ Other confidential records (please specify): _____

AUTHORIZATION FOR EXCHANGE OF INFORMATION/RELEASE FOR CLIENT RECORDS

These records will be for the professional use of authorized District School Board of Pasco County personnel only. Records will be used for educational planning, placement, and/or evaluations. Parent permission is not required when records are requested from authorized personnel or from officials of schools/school systems in which the student seeks to enroll (Family Educational Rights and Privacy Act of 197 4, FERPA). Records information shall not be released except on the condition that they will not subsequently be transferred to a THIRD PARTY without first obtaining the proper consent of the parent or eligible student.

Conditions of this exchange of information shall be in compliance with federal regulations, the Family Educational Rights and Privacy Act of 1974 (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and all other applicable federal laws, state statutes, State Board of Education Rules, and local School Board policy.

This authorization shall be terminated one year from the date of signature unless otherwise specified. This consent may be revoked by the client/representative at any time. Revocation has no effect on action previously taken.

_____ _____

Signature of Parent/Guardian or Eligible Student Date

2019-2020 Classical Preparatory School PHOTO HERE

K-12 Access and Emergency Information Card

Student_____ **Student #**_____**DOB** _____**Grade** _____ **Gender** _____
Last Name **First** **Middle Initial**

Primary Phone_____ **Date Card Completed** _____

Home Address _____ City_____ Zip_____

Parent/Guardian _____ Parent Guardian_____

Home Phone _____ Home Phone _____
Cell Phone _____ Cell Phone _____
Email Address _____ Email Address _____
Employed By _____ Employed By _____
Work Phone _____ Work Phone _____

Person(s) who will care for child in case parent/guardian cannot be reached; these individuals may sign child out (photo I.D. required)
Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____
First and Last name of brothers/sisters attending Classical Preparatory School _____
Person(s) who **MAY NOT** legally contact or remove my child (provide legal documentation) _____
_____
List any medication(s) your child is currently taking at home _____
List any medication(s) your child is currently taking at school _____
List all health problems and or allergies (food, medication, sting, etc.) even if previously reported _____
_____
_____
Severity of Allergy symptoms _____
Hospital Preference _____ Hospital Address _____
Physician's Name _____ Physician's Number _____
Dentist Name _____ Dentist Number _____
Parent/guardian must notify the school cafeteria of food allergies or special nutritional needs for student.
It is the parent/guardian's responsibility to keep the school updated with new information and contact numbers

PARENTAL CONSENT- SIGNATURE REQUIRED

I hereby give my consent for my child to participate in the School Health Services Program. This means my child will receive vision, hearing, dental, skin, blood pressure, and height and weight screening at certain grade levels. *(Grade 6-12 in addition, the school nurse conducts classroom, individual, and small group presentations on health issues such as abstinence, substance abuse prevention, dating and relationship issues, birth control, and sexually transmitted diseases at certain grade levels*). If I object to any of these health screening or programs, I will notify the school in writing.

In Case of accident or serious illness. I want to be contacted by the school. Id the school is unable to reach me, I hereby authorize the school to contact the physician or dentist indicated above and to follow his/her instructions. If it is impossible to contact physician or dentist, the school will take whatever actions necessary to provide care and treatment for my child, and exchange medical information with the provider as necessary to support continuity of care for my child. I agree to pay all expenses incurred by the handling of this emergency care. In case of an accident or illness where immediate treatment of my child is not indicated, but where he/she is unable to remain in school, I request that one of the persons listed on this form be contacted and requested to care for my child until I can be reached.

I authorize the District School Board of Pasco County to release and exchange my child's confidential information (e.g., student name, records, and information related to services provided) to agencies of the state of Florida which would be allowed the District to verify Medicaid eligibility, bill Medicaid for reimbursable Certified School Match services reference on my child's individualized educational plan (IEP), and receive Medicaid reimbursement for Exceptional Student Education (ESE) services it provides to my child while at school. I understand that my child will continue to receive service referenced in his/her IEP whether or not I give consent.
My Signature indicates my parental consent, understanding, and agreement.

_____ _____ _____
PRINT- PARENT/GUARDIAN NAME **PARENT/GUARDIAN SIGNATURE** **DATE**

REF: Pasco County School District
Rev. 7.25.2019