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)
_____ Thirty-day Immunization Waiver (only for students previously enrolled in a Florida Public School; Does NOT apply for students entering Kindergarten or 7th grade)
_____ Emergency Card (please note, as per Pasco County guidelines you will need to complete a new emergency card after July 1st for the upcoming school year)
_____ Signed Release of Records
_____ Family Acknowledgements with initials and signature
_____ *IF APPLICABLE:* Student/Family Domicile Questionnaire (SIT)

Please provide the following information:

_____ Proof of Annual Fee payment
_____ Proof of Residency (utility bill, mortgage statement, lease agreement, etc.)
_____ Parent ID
_____ 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). A thirty-day waiver can be used if the student is transferring from another Florida Public School.
_____ Birth Certificate issued by state of birth (not necessary if a student is transferring from a **Pasco County** K-12 Public School)
_____ Signed custody/legal papers (if applicable)
_____ Copy of IEP for ESE students (if applicable)
_____ Homeschool students ONLY: Student Progression Plan-Release of Records
_____ Medical Management Plan (if applicable)

Return completed enrollment packets to the lower school (building #1), or upper school (building #2).

If you have any questions, please email enrollment@classicalprep.org

Incomplete applications will not be accepted.

CLASSICAL PREPARATORY SCHOOL

2023-24 *Enrollment Application*

Internal Use Only:
Date Received:
Received By:

Legal Name Last First Middle

Grade Entering 2023-24

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 Email: _____

CLASSICAL PREP OFFICE USE:

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

If Applicable:

- ☐ Birth Certificate
- ☐ Current Physical
- ☐ Original Custody Papers
- ☐ Copy of IEP
- ☐ Student Driver Application

For Grades 6-12 ONLY

- ☐ Most recent schedule
- ☐ Most recent report card
- ☐ Locker contract (w/combo)

_____ ( ) - ( ) -
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 your 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

Will he/she be a child of an active military parent/guardian during the applicable school year? ☐ Yes ☐ No

Is student Hispanic or Latino? ☐ Yes ☐ No
Ethnicity (Mark all that apply):
☐ White ☐ Black or African American ☐ Asian
☐ Native American Indian or Alaska Native ☐ Hawaiian or Other Pacific

FOR KINDERGARTEN USE ONLY:
Did the student attend a VPK program or a family day care home in Pasco County last year? ☐ Yes ☐ No

CLASSICAL PREPARATORY SCHOOL

2023-24 *Enrollment Application*

PARENT/GUARDIAN INFORMATION

_____

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

Primary Phone:_____ ☐ Landline ☐ Cell Phone ☐ Subscribe to text communications

Secondary Phone:_____ ☐ Landline ☐ Cell Phone ☐ Subscribe to text communications

Work Phone: _____ **Employer:** _____

Email: _____ ☐ Subscribe to Alerts

_____

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

Primary Phone:_____ ☐ Landline ☐ Cell Phone ☐ Subscribe to text communications

Secondary Phone:_____ ☐ Landline ☐ Cell Phone ☐ Subscribe to text communications

Work Phone: _____ **Employer:** _____

Email: _____ ☐ Subscribe to Alerts

_____

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

Primary Phone:_____ ☐ Landline ☐ Cell Phone ☐ Subscribe to text communications

Secondary Phone:_____ ☐ Landline ☐ Cell Phone ☐ Subscribe to text communications

Work Phone: _____ **Employer:** _____

Email: _____ ☐ Subscribe to 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 your student? ☐ No ☐ Yes
Is the order valid for the 2023-24 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 _____ (First Middle Last) Date of Birth _____ / _____ / _____ (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

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

MIS Form #442
Rev. 5/13 - Back

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.

2023-24 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 the child in case parent/guardian cannot be reached; these individuals may sign the 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 an accident or serious illness. I want to be contacted by the school. If the school is unable to reach me, I hereby authorize the school to 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. 8.5.2019

FLORIDA DEPARTMENT OF HEALTH

STATE OF FLORIDA
School Entry Health Exam

To Parent/Guardian: Please complete and sign Part I — Child's Medical History.
State law for school entry requires a health examination by a legally qualified professional. Additional requirements may be determined by local school districts.

(Please Print)

Name of Child (Last, First, Middle)		Birth Date	Sex
Address (Street)		School	Grade
City and ZIP Code	Home Telephone Number	Parent/Guardian (Last, First, Middle)	

PART I — CHILD'S MEDICAL HISTORY

To Parent/Guardian: Please check answers to questions 1 through 8 below in the column on the left.
(Please explain any "Yes" answers in the space provided below.)

1. Yes ☐ No ☐ Any concerns about general health (eating and sleeping habits, weight, etc.)?
2. Yes ☐ No ☐ Any other specific illness or social/emotional or behavioral problems?
3. Yes ☐ No ☐ Any allergies (food, insects, medication, etc.)?
4. Yes ☐ No ☐ Any prescription medication (daily or occasionally)?
5. Yes ☐ No ☐ Any problems with vision, hearing, or speech (glasses, contacts, ear tubes, hearing aids)?
6. Yes ☐ No ☐ Any hospitalization, operation, or major illness (specify problem)?
7. Yes ☐ No ☐ Any significant injury or accident (specify problem)?
8. Yes ☐ No ☐ Would you like to discuss anything about your child's health with a school nurse?

To Parent/Guardian: Please explain any "Yes" answers from above.

_____

_____

_____

_____

_____

I am the parent/guardian of the child named above. I give permission for the information on PARTS I and II of this form provided about my child to be reviewed and utilized only by the staff of this school and any school health personnel providing school health services in the district for the limited purpose of meeting my child's health and educational needs.

☒ _____ _____
Signature of Parent/ Guardian — Date

Partnership for School Readiness Recommendations for Prekindergarten and Kindergarten

To Parent/Guardian: Please obtain the services listed below in order to find any problems. Please work with your health care provider to correct or treat any problems that may reduce your child's ability to learn in school. **(These services are recommended but not required.)**

1. Comprehensive Vision Examination (3-5 years of age) Date of Exam: _____ Results of Exam: _____ _____ Health Care Provider: _____ *(check one)* Optometrist ☐ Ophthalmologist ☐	Please describe any corrective action for any problems detected and any accommodations required.
2. Comprehensive Dental Examination Date of Exam: _____ Results of Exam: _____ _____ Dentist: _____	Please describe any corrective action for any problems detected and any accommodations required.
3. Hearing Screening Date of Exam: _____ Results of Exam: _____ _____ Health Care Provider: _____	Please describe any corrective action for any problems detected and any accommodations required.

Name of Child (Last, First, Middle)	Birth Date

PART II — MEDICAL EVALUATION

To be completed and signed by the Health Care Provider ONLY:

The child named above has had a complete history and physical exam on the following date: _____ Month _____ Day _____ Year
(Exam must be within one year of enrollment)

Screening Results:

Height: _____ Weight: _____ BMI%: _____ B/P: _____ Hct/Hgb: _____ Lead: _____ Urinalysis: _____

Vision - Without Glasses	Right 20/____	Left 20/____	Passed ☐ Failed ☐ Referred ☐	Hearing – Right	Passed ☐	Failed ☐	Referred ☐
Vision - With Glasses	Right 20/____	Left 20/____		Hearing – Left	Passed ☐	Failed ☐	Referred ☐

Gross dental (teeth and gums)	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____
Head/scalp/skin	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____
Eyes/Ears/Nose/Throat	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____
Chest/Lungs/Heart	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____
Abdomen	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____
Postural assessment	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____

TB risk assessment done ☐ ***(Please review Targeted Testing Guidelines listed below.)***

This child has the following problems that may impact the educational experience:

☐ Vision ☐ Hearing ☐ Speech/Language ☐ Physical ☐ Social/Behavioral ☐ Cognitive

Specify: _____

☐ This child has a health condition that may require emergency action at school, e.g. seizures, allergies. Specify below.

(This form will be stored in the child's Cumulative Health Folder and may be accessed by both school and health personnel.)

Recommendations (Attach additional sheet if necessary): _____

(Please Check One)

☐ This child may participate fully in school activities including physical education.

☐ This child may participate in school activities including physical education with the following restriction/adaptation.

(Specify reason and restriction) _____

Signature/Title of Health Care Provider	Date	Address (Please print or stamp)
☒	__/__/__	
Name (Please print or stamp)		

Tuberculosis Targeted Testing Guidelines for Health Care Providers

Tuberculosis Infection Risk:

Review the following risks and administer a Mantoux TB skin test if child is in one or more categories. The TB test is administered confidentially as part of the health examination. ***Do not record administration of any TB test or related information on this form.***

- Recent immigrant (< 5 years), frequent visitor to TB endemic areas
- Close contact to active TB case
- Frequent contact with adults at high-risk for disease, HIV+, homeless, incarcerated, illicit drug user
- HIV+ or have other medical conditions that increase the risk to progress from infection to disease, e.g., chronic renal failure, diabetes, hematologic or any other malignancy, weight loss > 10% of ideal body weight, on immunosuppressive medications

Active TB Disease Risk:

- Does the child exhibit signs/symptoms of tuberculosis (e.g. cough for three weeks or longer, weight loss, loss of appetite)?
- If symptoms are present, work-up or refer for TB disease evaluation.

Guide for Completing the School Entry Health Exam (DH 3040 Form)

DH 3040, 6/02, Stock Number: 5744-000-3040-2

General Information

Purpose: The School Entry Health Exam has been designed to meet the requirements for the school entry health examination, as mandated by s.1003.22, F.S. (formerly s. 232.0315, F.S.) for student entry into Florida public and private schools, grades Pre-Kindergarten to 12. It provides basic health and screening information that will assist the school and school health personnel in meeting the needs of the child.

Health Care Provider: A health professional who is licensed in Florida or in the state where the student resided at the time of the health examination, and who is authorized to perform a general health examination under such licensure shall certify that the health examination has been completed.

Time Limits: The child's health examination must be completed within one year prior to enrollment in school. A homeless child shall be given a temporary exemption for 30 school days.

Exemptions: A child shall be exempt from this requirement upon written request from parent or guardian on religious grounds.

Copies: A copy of the front and back of the completed form may be retained in the child's medical file kept by the health care provider. The original completed DH 3040 Form should be given to the parent to take to the school to provide information and to document that this requirement is met.

Directions for completing the School Entry Health Exam Form

Page 1: The health history is to be filled in by the parent or interviewer in the provider's office. If the parent seeks the exams recommended by the Partnership for School Readiness, the appropriate provider will fill in the information regarding the exam results.

1. Child Identifying Information: Fill in all of the information requested, including child's middle name and parent's complete names. This information is critical for distinguishing between children with the same or similar name.
2. PART I—CHILD'S MEDICAL HISTORY: The parent or interviewer in the provider's office should answer these questions before the exam. All questions answered "yes" should be explained in the space provided below.
3. Partnership for School Readiness Recommendations for Pre-kindergarten and Kindergarten: After the school entry health exam form has been completed, parents should be encouraged to seek the recommended vision examination from an optometrist or ophthalmologist and the dental examination from a dentist. The practitioner providing the school entry health exam may provide the hearing screening.

Page 2: This page is to be completed by the health care provider only.

1. Fill in the complete name and birth date of the child, as it appears on page 1.
2. PART II—MEDICAL EVALUATION: Provide the month, day and year of the entry exam.
3. Screening Results: Perform the indicated screenings and fill in the results of each of the indicated screenings, including vision and hearing information.
4. Exam Components: Indicate whether the results of the exam are normal or abnormal and any actions taken by the provider.
5. TB Risk Assessment: See guidelines on the bottom of the page for TB risk assessment. The screening and results should not be recorded on the school health form. If a test is given, arrangements should be made with the parent/guardian for follow up.
6. If the child has any physical or behavioral problem that may adversely affect the educational experience, check the appropriate box and explain the impairment or restrictions. Because the record will not be subject to the strict protection of medical records, providers are asked to refrain from including information of a confidential nature such as child abuse and HIV/AIDS.
7. Participation in Activities: Indicate whether the child has health or physical conditions that would prevent participation in normal school activities such as physical activities in recess, physical education or other physical activities during the school day.
8. Provider information: Fill out or stamp the form to provide information that identifies the provider and their address.

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: _____

Classical Preparatory School

Traditional Education. Transformational Learning.

2023-24 Family Acknowledgements

Classical Preparatory School's Family Handbook contains the rules and policies that have been put in place after much consideration and adopted by our school board for the governing of the school. The full Family Handbook can be found on our website. The points that are listed below are just some of the sections that may be of interest to you. Each family is required to be familiar with the policies set forth in the Family Handbook as they will greatly affect our ability to fulfill our mission and vision.

Please take the time to visit the 'Parents' tab on our website to view the Family Handbook in its entirety. Also, please initial next to each section below to confirm your acceptance of each policy.

_____ **Aftercare** - Aftercare is provided by the YMCA for registered families **only.** A child that is a car-rider and is not picked up by 3:55 p.m. will wait in the office and the parent will be responsible for any fee that is incurred as a result.

_____ **Attendance Policy** - Regular attendance and prompt arrival at school are vital to a student's attitude and subsequent success as a serious scholar. It is the responsibility of the parent to report an absence by submitting the online absence form on the school's website within three days of the student's Absence. Students will be recorded as having an unexcused absence if no form is submitted within three days. Absences cannot be recorded and/or excused verbally; they must be submitted in writing. Pre-arranged absences must be approved at least seven days prior to the anticipated absence.

_____ **Cell Phones/Smart Devices** - The use of cell phones during the school day is prohibited. Phones brought to campus will be powered off and voluntarily surrendered at the front door each morning and picked up from the front office at dismissal time.

_____ **Drop-off and Pick-up** - Car-riders must be picked up through the carline. Families cannot park their vehicle and come into the building to pick up their child(ren) after 1:00 p.m.

_____ **Emergency Contact Information** - It is important that all contact information is kept current with Classical Prep. This includes but is not limited to, change of address, phone, number, email Address, custody, medical conditions, etc. The form to update this information is located on our website. Only a parent/guardian may submit an Emergency Information Card.

_____ **Family Handbook Amendments** - The Board reserves the right to amend the Family Handbook throughout the school year. If this is the case, changes will be posted on the school website and parents will be notified electronically.

_____ **Homework Policy** - Homework is necessary for learning. Students should expect to do meaningful homework each night. Parents should provide a quiet time and place for homework completion.

_____ **Illness Policy** - If your child has a fever with a temperature greater than 100 degrees (orally), has been vomiting or has diarrhea he or she must stay home for 24 hours AFTER the symptoms are gone.

_____ **Lost/Damaged Instructional Materials Policy** - Instructional materials are the Property of the school.These items must be returned at the end of the semester or year in the same condition in which they were issued. Any damaged or lost books must be paid for before another book is issued for home use.

_____ **Medication Procedures** - Parents must fill out a Medical Information Form with the upper or Lower school clinic coordinator that will remain on file in the school office each school year. If a scholar must take prescription or any over-the-counter (OTC) drugs (cold remedies, pain relievers, etc.) while at school, the parent must bring the prescription/OTC medication to the office and indicate this on the Emergency Contact and Medical Information Form. Medication cannot be administered by any staff member to a child without a specific amount and times each medication must be administered. Parents may choose to come to school and administer the medication themselves if they are unable to obtain doctor's orders. No prescription analgesic narcotics will be administered at school.

_____ **Medical Procedures** - Classical Prep does not have a school nurse on site. It is at the discretion of Classical Prep staff to determine whether or not to call an ambulance in an emergency situation. Students must be up-to-date on all immunizations records in order to attend school.

_____ **Parent Grievance** - Throughout the school year, conflict between teachers, students, and parents may arise from time to time. The positive resolution of conflict promotes growth for all parties involved. How both sides handle conflict plays a major role in defining the culture of our school. Resolving conflicts with civility allows the Classical Preparatory School administration and parents to model behaviors that we seek to instill in our students. It is hoped that issues that cause conflict between students, teachers, and parents can be resolved at the earliest time and at the lowest level.

_____ **Transportation** - Classical Prep utilizes buses for field trips and athletic events only. For safety and security purposes, all students must ride school-provided transportation for school-related field trips and events and hereby release Classical Preparatory School, its Board of Directors, administration, teachers, or other employees of the school, and volunteer leaders from any financial responsibility because of injury or sickness of the student while being transported on the bus.

_____ **Uniform Policy** - The uniform policy will be strictly enforced and uniform violations will be issued if your child is out of uniform at any time during the school day.

_____ **Volunteer Hours** - Classical Prep recognizes that for a classical education to be effective, teachers, administrators, students and parents must volunteer time and talent. Classical Prep requires all enrolled families to complete a minimum of 10 service hours per year. These hours may be satisfied during school hours, after school hours or during weekend Events.

I acknowledge that I have read and will abide by the policies listed above.

_____ _____

Print Name **Sign Name**

Date _____

DISTRICT SCHOOL BOARD OF PASCO COUNTY
STUDENTS IN TRANSITION (SIT) PROGRAM
MCKINNEY-VENTO ACT REFERRAL FORM
(One form per family) Submit online at: sitprogram@pasco.k12.fl.us

MIS 140
Rev. 06/20

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 determine 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. Specific rights are listed on the next page.

A student qualifies for the McKinney-Vento Act if they are between the ages of 0-22 *and* lack a fixed, regular and adequate nighttime residence. Specifically, if a student lives under any of these conditions:

- a house or apartment with more than one family because of economic hardship or loss
- a shelter (family, youth or domestic violence shelter or transitional living program)
- a motel, hotel or weekly rate housing
- an abandoned building, in a car, at a campground, on the street, etc.
- substandard housing (without electricity, heat or water)
- with friends or family because the youth is a runaway or unaccompanied youth

PLEASE DO NOT complete this form if your housing **DOES NOT** meet one of the conditions listed above. If you rent, share housing for convenience, or if you are buying a house and do not need support services, your students **DO NOT** qualify for the McKinney-Vento Act.

STUDENT INFORMATION

School-Aged AND Non School-Aged Children - ***List ALL children in your family, please PRINT or TYPE***

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

HOUSING INFORMATION

Where is the student(s) living at this time? *(Please check all that may apply)*

___ 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 living: *(If due to COVID-19, please check additional reasons)*

___ Foreclosure (M) ___ Tornado (T) ___ Tropical Storm (S) : Storm Name: _____
___ Eviction ___ Earthquake (E) ___ Hurricane (H) : Storm Name: _____
Unemployment (O) ___ Flooding (F) ___ Man Made Disaster (D)
___ Fire (W) ___ Wildfire (W) ___ Other (N) : _____
___ COVID-19 (P)

The student(s) is/are *(Check 1 only)*:

1.___ in the physical custody of a parent or legal guardian
2.___ NOT in the physical custody of a parent or legal guardian (ex: living alone, with a relative who is not their legal guardian, living with other people, etc.) . If you checked #2, please provide the following information:

Student Contact Information for Unaccompanied Youth:

Email: _____ Phone Number: _____

PARENT/GUARDIAN/CAREGIVER CONTACT INFORMATION

Parent/Guardian/Caregiver Name: _____ Relationship to student: _____
Temporary address or location of housing: _____ City: _____
Zip: _____
Cell Phone: _____ Alt. Phone: _____ Email: _____
Primary Language Spoken: _____
How long has/have the student(s) been in the TEMPORARY place? _____

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.

STUDENT IS IN SCHOOL ZONE: _____ YES ____ NO SIT BUS REQUIRED: _____ YES ____ NO PARENT/STUDENT RIGHTS PAGE PROVIDED: _____ YES

_____ _____
Name of the Person Completing This Form (print) Signature of the Person Completing This Form Date

DISTRICT SCHOOL BOARD OF PASCO COUNTY
STUDENTS IN TRANSITION (SIT) PROGRAM
MCKINNEY-VENTO ACT REFERRAL FORM
(One form per family) Submit online at: sitprogram@pasco.k12.fl.us

MCKINNEY-VENTO ACT RIGHTS

- **Child must be immediately enrolled in school even if you lack a permanent address.**
- **Child's enrollment may NOT be delayed due to lack of proof of residency or other documents.**
- **Continued enrollment in the school that he/she attended before becoming homeless, or the school for which they are currently enrolled.**
- **Child can attend classes while the new school secures previous school records**
- **If enrollment dispute is made, child can continue to attend classes while dispute is being heard and resolved.**
- **Parent can request assistance with transportation to school of origin.**
- **Child can participate in school programs with children who are not homeless.**
- **Child is eligible to receive free school meals.**

SIT PROGRAM & BAND APPLICATION FOR SMART PHONES/ONLINE:

BAND is a communication app that helps the SIT Program stay connected with you, and it can be downloaded to any Apple or Android device. Being able to communicate with you about your housing, educational (electronics and WIFI), and basic needs can be a challenge.
We have created a group for SIT families/students on this application and will use this to post information, resources, reminders, forms, etc. We can communicate with the entire group, or just with you. You can get started by scanning this QR code:

Students In Transition
Hey you, welcome! Join us!
Scan this QR code and join!

PROGRAM CONTACT

If you need supportive services, such as those found in the rights listed above, please contact our office. **Students In Transition (SIT) Program**

7227 Land O'Lakes Blvd. Land O'Lakes, FL 34638 (813) 794-2262 sitprogram@pasco.k12.fl.us