Release of Confidential Information
Putnam County School District

PCSD ONLY uses FASTER & SCRIBBLES to receive and transfer student records. For SCRIBBLES go to Putnamschools.org, under “Quick Links” click “Student Records Request” and then “Records Request.”

Student’s Full Name: _____________________________

Last                        First                        Middle

DOB: ______________________  Student’s Grade: ___________  Today’s Date: ______________________

Name of Last School Attended Phone

Address of Last School Attended

I, the undersigned, hereby request and authorize the school named to release the following information including confidential records indicated to the School named below:

- Educational Transcript
- Attendance Data
- Section 504 Documentation
- Psychological/Mental Health Records
- RtI/MTSS Documentation

- Discipline/Behavioral Records
- Individual Educational Plan
- Intellectual Evaluations
- Special Services Assessments
- Threat Assessment Documentation

- Withdraw Grades
- Safety Plan
- Medical & Physical Records
- All Academic Testing Results
- Other:

Is the student allowed continued enrollment: Yes____ No____

Parental permission is no longer required when records are requested by authorized school personnel. (FER&P Act FS41, No 118)

Signature of Parent/Guardian __________________________ Signature of Authorized School Personnel __________________________

_____ Browning Pearce Elementary School @ 100 Bear Blvd. San Mateo, FL 32187 Phone: 386-329-0557 Fax: 386-329-0623
_____ C. H. Price Middle School @ 140 N. State Road 315 Interlachen, FL 32148 Phone: 386-684-2113 Fax: 386-684-3908
_____ C. L. Overturf Sixth Grade Center @ 1100 S. 18th St. Palatka, FL 32177 Phone: 386-329-0569 Fax: 386-329-0670
_____ Crescent City High School @ 2201 S. Hwy. 17 Crescent City, FL 32112 Phone: 386-698-1629 Fax: 386-698-3073
_____ E. H. Miller @ 156 Horseman Club Rd. Palatka, FL 32177 Phone: 386-329-0595 Fax: 386-329-0601
_____ Interlachen Elementary School @ 251 S. State Rd. 315 Interlachen, FL 32148 Phone: 386-684-2130 Fax: 386-684-3909
_____ Interlachen High School @ 126 N County Rd. 315 Interlachen, FL 32148 Phone: 386-684-2116 Fax: 386-684-3915
_____ James A. Long Elementary @ 1400 Old Jacksonville Hwy. Palatka, FL 32177 Phone: 386-329-0575 Fax: 386-329-0675
_____ Kelley Smith Elementary School @ 141 Kelley Smith Rd. Palatka, FL 32177 Phone: 386-329-0568 Fax: 386-329-0629
_____ Mellon Elementary School @ 301 Mellon Rd. Palatka, FL 32177 Phone: 386-329-0593 Fax: 386-329-0594
_____ Melrose Elementary School @ 401 SR 26 Melrose, FL 32666 Phone: 352-475-2060 Fax: 352-475-1049
_____ Middleton-Burney Elementary @ 1020 Huntington Rd. Crescent City, FL 32112 Phone: 386-698-1238 Fax: 386-698-4364
_____ Miller Middle School @ 101 S. Prospect St. Crescent City, FL 32112 Phone: 386-698-1360 Fax: 386-698-1973
_____ Ochwilla Elementary School @ 299 N. SR. 21 Hawthorne, FL 32640 Phone: 352-481-0204 Fax: 352-481-5541
_____ Palatka High School @ 302 Mellon Rd. Palatka, FL 32177 Phone: 386-329-0577 Fax: 386-329-0624
_____ Q.I. Roberts Jr. – Sr. High School @ 901 SR 100 Florahome, FL 32140 Phone: 386-659-1737 Fax: 386-659-1986
_____ R. H. Jenkins Middle School @ 1100 N. 19th St. Palatka, FL 32177 Phone: 386-329-0588 Fax: 386-329-0636
_____ W. D. Moseley Elementary School @ 1100 Husson Ave. Palatka, FL 32177 Phone: 386-329-0562 Fax: 386-329-0563

Per FL Senate Bill 7030 the transfer of records shall occur within 3 school days. The records shall include: Verified reports of serious or recurrent behavior patterns, including Threat Assessment Evaluations and Intervention Services. Psychological Evaluations, including Therapeutic Treatment Plans and therapy or progress notes created or maintained by school district or charter school staff, as appropriate.
Putnam County School District
Pupil Information

LAST NAME: ___________________ FIRST ___________________ MIDDLE ___________________

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.

AGE_______ DATE OF BIRTH_______________________ CURRENT GRADE_______
GENDER _______ CITY AND STATE OR COUNTRY OF BIRTH ______________________________________
RACE: CAUCASIAN______ AFRICAN AMERICAN______ HISPANIC____
INDIAN_______ ASIAN_______ MULTI RACIAL ______

PUBLIC OR PRIVATE SCHOOL LAST ATTENDED ______________________________________
ADDRESS___________________________________________________________
CITY____________________________ STATE__________
PHONE NUMBER: ______________________ FAX NUMBER: ______________________

TO INSURE ALL ACADEMIC SUPPORTS, CREDITS AND EDUCATIONAL SERVICES ARE PROVIDED
HAS STUDENT EVER ATTENDED A FLORIDA PUBLIC SCHOOL PRE-K-12 GRADE? YES _____ NO _____

NAMES OF ANY PAST PUBLIC OR PRIVATE SCHOOL (LIST HIGHEST GRADE FIRST):
SCHOOL __________________________ GRADE____________________
SCHOOL __________________________ GRADE____________________
SCHOOL __________________________ GRADE____________________
CHILD OF A MILITARY FAMILY YES ___ NO ___ CITY__________ COUNTY________ STATE________

IS THE STUDENT IN AN EXCEPTIONAL EDUCATION PROGRAM? YES _____ NO _____
HAS STUDENT EVER HAD AN INDIVIDUAL EDUCATION PLAN (IEP) YES_____ NO_____
IF YES, WHAT WAS THE PLAN FOR? ____________________________________________
HAS THE STUDENT EVER HAD SPEECH THERAPY? YES _____ NO _____
HAS THE STUDENT EVER BEEN AFFORDED ACCOMMODATIONS THROUGH A 504 PLAN? YES ___ NO ___
IF YES, WHAT WAS THE PLAN FOR? ____________________________________________
HAS THE STUDENT RECEIVED TIER 2 or 3 SUPPORTS THROUGH RTI/MTSS: YES _____ NO _____
IF YES, WHAT SUBJECT(S): ______________________________________________________
HAS THE STUDENT RECEIVED SERVICES AS AN ENGLISH LANGUAGE LEARNER (ELL)? YES ___ NO _____

TO BEST PROVIDE NECESSARY STUDENT SUPPORTS, INTERVENTIONS AND SERVICES
(REQUIRED THROUGH SENATE BILL 7026) HAS THE STUDENT HAD?

ANY PREVIOUS EXPULSIONS: ____________________________________________________
ARRESTS RESULTING IN A CHARGE: _______________________________________________
JUVENILE JUSTICE ACTIONS: ____________________________________________________
REFERRALS FOR MENTAL HEALTH SERVICES: ______________________________________
RECEIVING MENTAL HEALTH SERVICES: __________________________________________
A SAFETY PLAN: _______________________________________________________________

ASSIGNED TEACHER: __________________________________________________________ (OFFICE USE ONLY)
FAMILY INFORMATION:

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME OF FATHER OR GUARDIAN</td>
<td></td>
</tr>
<tr>
<td>OCCUPATION</td>
<td></td>
</tr>
<tr>
<td>DRIVER’S LICENSE NUMBER</td>
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<tr>
<td>DATE OF BIRTH</td>
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<tr>
<td>HOME PHONE NUMBER</td>
<td></td>
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<tr>
<td>CELL NUMBER</td>
<td></td>
</tr>
<tr>
<td>EMERGENCY PHONE NUMBERS</td>
<td></td>
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<tr>
<td>E-MAIL ADDRESS</td>
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<tr>
<td>MAILING ADDRESS</td>
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<tr>
<td>CITY</td>
<td>ZIP</td>
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<tr>
<td>911 ADDRESS</td>
<td></td>
</tr>
<tr>
<td>CITY</td>
<td>ZIP</td>
</tr>
<tr>
<td>WORK NAME</td>
<td>ADDRESS</td>
</tr>
<tr>
<td>PHONE NUMBER</td>
<td></td>
</tr>
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<table>
<thead>
<tr>
<th>Field</th>
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<tr>
<td>NAME OF MOTHER OR GUARDIAN</td>
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<td>CELL NUMBER</td>
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<td>EMERGENCY PHONE NUMBERS</td>
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<tr>
<td>WORK NAME</td>
<td>ADDRESS</td>
</tr>
<tr>
<td>PHONE NUMBER</td>
<td></td>
</tr>
</tbody>
</table>

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

GIVE DIRECTIONS TO THE STUDENT’S 911 ADDRESS:

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME OF BROTHERS AND SISTERS</td>
<td>AGE:</td>
</tr>
<tr>
<td></td>
<td>GRADE:</td>
</tr>
<tr>
<td></td>
<td>SCHOOL:</td>
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EMERGENCY INFORMATION:

<table>
<thead>
<tr>
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<th>Details</th>
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<tr>
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<tr>
<td>DRIVER’S LICENSE NUMBER</td>
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<td>DATE OF BIRTH</td>
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<td>911 ADDRESS</td>
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</tr>
<tr>
<td>CITY</td>
<td>ZIP</td>
</tr>
<tr>
<td>RELATIONSHIP TO CHILD</td>
<td>HOME PHONE #</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>SECONDARY PERSON TO CONTACT IN AN EMERGENCY OTHER THAN PARENT</td>
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</tr>
<tr>
<td>DRIVER’S LICENSE NUMBER</td>
<td></td>
</tr>
<tr>
<td>DATE OF BIRTH</td>
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<tr>
<td>911 ADDRESS</td>
<td></td>
</tr>
<tr>
<td>CITY</td>
<td>ZIP</td>
</tr>
<tr>
<td>RELATIONSHIP TO CHILD</td>
<td>HOME PHONE #</td>
</tr>
</tbody>
</table>

NAMES OF BROTHERS AND SISTERS LIVING AT HOME:

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Grade</th>
<th>School</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

IF CHILD RIDES BUS: (Office Use) BUS NUMBER DRIVER

IF CHILD DOES NOT RIDE BUS, HOW DOES HE OR SHE GET TO SCHOOL?
To Be Completed By Parent, Guardian or Adult with the Student upon Initial Enrollment

Student Name: _________________________________  School: _________________________________

Date entered United States School: ________________________________________

1. Is a language other than English used in the home?   ___Yes ___No
2. Does the student most frequently speak a language other than English?   ___Yes ___No
3. Does the student above have a first 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 above, your child will be temporarily placed in the ELL Program pending further assessment to determine if he/she meets the criteria for entry into the program.

____________________________________  ____/_____/_____
Firma del padre  Fecha

Putnam County School District
Home Language Survey

Para ser completado por el padre, tutor o adulto con el estudiante en la inscripción inicial

Nombre del estudiante: _________________________________  Escuela: _________________________________

Fecha de ingreso a United States School: ________________________________________

ENCUESTA DE IDIOMA DEL HOGAR

1. ¿Se usa un idioma que no sea inglés en el hogar?   ___Sí ___No
2. ¿El estudiante de arriba tiene un primer idioma que no sea inglés?   ___Sí ___No
3. ¿Habla el estudiante con más frecuencia un idioma que no sea inglés?   ___Sí ___No
4. ¿Qué idioma se usa en el hogar? _________________________________
5. ¿Cuál es el origen nacional del estudiante? _________________________________

Si marcó Sí en cualquiera de las preguntas anteriores, su hijo será colocado temporalmente en el Programa ELL en espera de una evaluación adicional para determinar si cumple con los criterios para ingresar al programa.

____________________________________  ____/_____/_____
Firma del padre  Fecha
Child’s Name: ________________________________________________________________

Birthdate: _______________ Grade: __________ School: ____________________________

Parent/Guardian current job/occupation: ________________________________________

1. In the past 3 years, has anyone in your household had a job working on a farm, in a field, in a greenhouse, in a nursery or in a packing house? (Not including your own property)

   Please circle all that apply.

   - Fruits
   - Vegetables
   - Tobacco
   - Pine Straw
   - Eggs
   - Chickens
   - Soil Preparation (planting, weeding, etc)
   - Processing (vegetables, meat, fruit, trees, etc)
   - Cut Fern, Nursery, Sod, Greenhouse, Flowers
   - Livestock (cattle, pigs, sheep, dairy, etc)
   - Other agriculture work: ________________________________

   If you selected one or more, continue to #2 □ None of these (stop here)

2. In the past 3 years, have you or another member in your household traveled to another country or another state to do this work? (Including during the summer, winter or spring break) □ Yes □ No

PLEASE HAND COMPLETED FORM TO YOUR SCHOOL.
Nombre del Niño: ________________________________________________________________

Fecha Nacimiento: __________ Grado: _____ Escuela: ________________________________

Padre / Guardián, trabajo / ocupación actual: ________________________________________________

1. ¿En los últimos 3 años, usted o algún miembro de su hogar ha trabajado en una granja, en el campo, en invernadero, en un vivero o en una empacadora? (sin incluir su propiedad)

Favor de circular todos los que aplican.

- Frutas
- Vegetales
- Tabaco
- Paja de Pino
- Huevos
- Pollos

- Preparación del terrero (sembrar, deshierbe, etc)
- Procesadora (carnes, frutas, vegetales, arboles, etc)
- Cortar el ollaje, Vivero, Cesped, Invernadero, Flores
- Ganado (vaca cerdos, ovejas, lechería, etc)
- Otro trabajo de campo: ________________________________

Si usted circula uno o más, continúe con el #2. Ninguno de estos (pare aquí).

2. ¿En los últimos 3 años, usted o otro miembro de su hogar ha viajado a otro condado o a otro estado para hacer este tipo de trabajo? (incluyendo las vacaciones de verano, invierno y primavera)

- Si
- No

Favor de enviar la forma complete a su escuela.
Enrollment Date: _____________  ___ Florida Transfer  ___ Out-of-State Transfer

Student Name: ___________________________  Race: ___________  Gender: M__ F___
DOB: ___________  School: _______________  Grade: ___  Contact Person: _________________________

Parent Name: ___________________________________  Home Phone: (_____) ___________  Work (_____) __________
Mailing Address: ___________________________________  City: ______________________  State: ______  Zip: ________
Last School Attended: ___________________________  Phone: (_____) ___________  Fax: (_____) __________
Mailing Address: ___________________________________  City: ______________________  State: ______  Zip: ________
Sending School Contact Person: _________________________  Job Title: ______________________  Date of Call: ________________
Exceptionality (ies): ___________________________________  Time Per Week: ________________
Subject Areas in ESE: ______________________________________________________________

(Check if received)  ___ Signed Release  ___ Signed Permission for Placement  ___ IEP _____________
  ___ Staffing Information  ___ Psychological  ___ Matrix
  ___ Medical Information  ___ Signed Permission for Testing

______________________________

FOR ESE OFFICE USE – RECORDS CHECKLIST

Intellectual: _______________________________  Speech/Language Eval: ________________________________
Achievement: _______________________________  PT Evaluation: ________________________________
Process: ________________________________  OT Evaluation: ________________________________
Adaptive: ________________________________  Medical Evaluation: ________________________________
Personality: _______________________________  Physician’s Referral: ________________________________
Social History: _______________________________  Functional Vision: ________________________________
Audiological Eval: _______________________________  Eye Exam: ________________________________

Must be within one year

Received: _______________  A23: _______________  IEP Date: _______________  Complete: _______________
Retest: ___ Yes  ___ No  Re-eval Review Date: _______________  Logged: _______________  Re-eval Date: _______________
IMMUNIZATION RECORDS

Florida Law authorizes school officials to grant up to a thirty (30) day exemption for any student who transfers from another school.

I understand that (Student’s Name) ________________________________ is granted this temporary exemption in order to be admitted to class until his/her immunization record can be obtained from the previous school. I also understand that my child will be temporarily excluded from school after the thirty (30) days until the student physical examination form is presented to the school. This exemption will expire in thirty (30) days.

Today’s Date: ___________________ Expiration Date: ___________________

(30 days after Today’s date)

Parent/Guardian Signature: ____________________________________________

THIRTY-DAY PHYSICAL EXAMINATION EXEMPTION NOTICE

Florida Law authorizes school officials to grant up to a thirty (30) day exemption for any student who transfers from another school.

I understand that (Student’s Name) ________________________________ is granted this temporary exemption in order to be admitted to class until his/her physical examination form can be presented to the current school. I also understand that my child will be temporarily excluded from school after the thirty (30) days until the immunization record is provided to the school. This exemption will expire in thirty (30) days.

Today’s Date: ___________________ Expiration Date: ___________________

(30 days after Today’s date)

Parent/Guardian Signature: ____________________________________________
Putnam County School District
Chronic Disease Information Form

Student's Name ________________________________ DOB: ____________ 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

<table>
<thead>
<tr>
<th>List medical conditions your child has NOW</th>
<th>List all medicines your child takes NOW (home and school)</th>
<th>List any medication(s) to be given at school. A medication authorization form is required.</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADD__ ADHD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A2__ ALLERGY - INSECTS</td>
<td>__ Epipen</td>
<td></td>
</tr>
<tr>
<td>A4__ ALLERGY - MEDICATIONS</td>
<td>__ Epipen</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Name the medication</td>
<td></td>
</tr>
<tr>
<td>A5__ ALLERGY - LATEX</td>
<td>__ Epipen</td>
<td></td>
</tr>
<tr>
<td>A7__ ALLERGY - FOOD</td>
<td>__ Epipen</td>
<td></td>
</tr>
<tr>
<td>List the food.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician order is needed for special diet.</td>
<td></td>
</tr>
<tr>
<td>A9__ ALLERGY - OTHER</td>
<td>__ Epipen</td>
<td></td>
</tr>
<tr>
<td>Specify the allergy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A5__ ASTHMA</td>
<td>__ Inhaler at school</td>
<td></td>
</tr>
<tr>
<td>How frequent are the episodes?</td>
<td>__ Inhaler at home</td>
<td></td>
</tr>
<tr>
<td></td>
<td>__ Nebulizer at home</td>
<td></td>
</tr>
<tr>
<td></td>
<td>__ Nebulizer at school</td>
<td></td>
</tr>
<tr>
<td>CA__ CANCER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CP__ CEREBRAL PALSY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CYF__ CYSTIC FIBROSIS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DB__ DIABETES</td>
<td>__ diet _ oral medication</td>
<td></td>
</tr>
<tr>
<td>Hypoglycemia or Hyperglycemia</td>
<td>__ insulin _ pump</td>
<td></td>
</tr>
<tr>
<td></td>
<td>__ carb counting</td>
<td></td>
</tr>
<tr>
<td>EA__ Ear problems (describe)</td>
<td>__ Hearing aide (Left/Right/Both)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>__ FM System</td>
<td></td>
</tr>
<tr>
<td></td>
<td>__ Deaf (Left/Right/Both)</td>
<td></td>
</tr>
<tr>
<td>EP__ EPILEPSY/SEIZURES</td>
<td>List known triggers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Last seizure</td>
<td></td>
</tr>
<tr>
<td>GA__ Gastrointestinal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>___ Reflux ___ IBS ___ Crohn’s</td>
<td></td>
<td></td>
</tr>
<tr>
<td>___ Other</td>
<td></td>
<td></td>
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<tr>
<td>HD__ HEART DISEASE HM</td>
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<td></td>
</tr>
<tr>
<td>_____ HEART MURMUR</td>
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</tr>
<tr>
<td>HE__ HEMOPHILIA</td>
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Chronic Disease Information Form Continued

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<tr>
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<td>KD</td>
<td>KIDNEY DISEASE</td>
</tr>
<tr>
<td>MD</td>
<td>MUSCULAR DYSTROPHY</td>
</tr>
<tr>
<td>MG</td>
<td>MIGRAINES</td>
</tr>
<tr>
<td>NO</td>
<td>NOSEBLEEDS</td>
</tr>
<tr>
<td>Occasional</td>
<td>Frequent</td>
</tr>
<tr>
<td>Medical condition</td>
<td></td>
</tr>
<tr>
<td>PC</td>
<td>PSYCHIATRIC CONDITIONS</td>
</tr>
</tbody>
</table>
(Include list)
| SC  | SICKLE CELL ANEMIA |
| Trait only |
| VP  | VISION PROBLEMS |
| Describe |

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, Please provide the following:

Prescribing Doctor: ________________________________ Dr.’d Phone: _________________________

*Medication cannot be given at the school until an authorization form is completed.*

Does your child use any adaptive equipment?

Wheelchair___

Braces ___

Other ___ Please Specify: ________________________________________________________________

The Health 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 an emergency*

1st contact’s name: _____________________________________________________________________ Phone: H (     )                 C (     )                 .

2nd contact’s name: _____________________________________________________________________ Phone: H (     )                 C (     )                 .

Parent/Guardian Signature: _____________________________________________________________________ Date: ______________

PCSD Form: #8330-F3

Revised June 2019
PARENT’S MEDICAL AUTHORIZATION IN THE CASE OF AN EMERGENCY

_____ I DO authorize the school to obtain necessary medical services for my son/daughter in the event I cannot be located.

_____ I DO NOT authorize the school to obtain necessary medical services for my son/daughter in the event I cannot be located.

Student’s Name: ___________________________ DOB: ___________________________

(Doctors Name) (Facility Name)

(Address) (Doctor’s Phone number)

As the parent/guardian, I acknowledge responsibility to notify the school in writing, of any change in the name of my child’s physician and any change in medical condition.

Signature: ___________________________ Print Name: ___________________________ Date: ___________

PARENT/GUARDIAN CONSENT TO RELEASE STUDENT INFORMATION FOR SCHOOL-BASED OUTSIDE COUNSELING SERVICES

Students enrolled in the School District of Putnam County have the opportunity to receive counseling and support services from district based mental health counselors or from community partnering agencies during the school day. Information is confidential. Permission for sharing this information between PCSD and counseling agencies is effective upon parent consent.

By completing the information below you consent to allow PCSD to use the information in the referral process for mental health services only if needed. A mental health counselor will confer with you should your child need mental health services and discuss the means in which those services will be provided prior to delivery of such services. The information below is solely to assist in expediting the process.

Student’s Name: ___________________________ DOB: ___________________________

MEDICAID TYPE: ___________________________ MEDICAID NUMBER: ___________________________

PRIVATE INSURANCE? YES ____ NO ____ CARRIER ___________________ NUMBER: ___________________

Parent’s/Guardian’s Main Phone: (____) ___________________ Alternate Phone: (____) ___________________

Signature: ___________________________ Print Name: ___________________________ Date: ___________

PARENT CONSENT FOR MEDICAID BILLING UNDER ESE SERVICES

I authorize the School District of Putnam County to release and exchange my child’s confidential information to agencies of the State of Florida which would allow Putnam District Schools to verify Medicaid eligibility, bill Medicaid for reimbursable Certified School Match services referenced on the child’s Individual Education 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 services referenced on his/her IEP whether or not I give consent.

Student’s Name: ___________________________ DOB: ___________________________

Signature: ___________________________ Print Name: ___________________________ 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.

________________________________________________________________________________________

As the parent/guardian, I acknowledge responsibility to notify the school in writing, of any change in medical condition.

Signature: ____________________________ Print Name: ____________________________ Date: __________

ASBESTOS ACKNOWLEDGEMENT

I (We) am (are) aware that there are asbestos containing building materials located throughout the school district, that the type and location of these materials are identified in each facility’s Project Manual located in the main office, and additional information can be obtained from the Facilities Director 386-329-0550.

Signature: ____________________________ Print Name: ____________________________ Date: __________

PARENT AND STUDENT ACKNOWLEDGEMENT OF PCSD STUDENT CODE OF CONDUCT

The Student Code of Conduct has been written so students and parents/guardians know what behavior is expected and prohibited at school or at school sponsored functions. It is helpful for parents to be aware of school rules so they can help support them from home.

In an effort to conserve resources, PCSD are providing printed copies of the Student Code of Conduct by request only. The full document is readily available online at PutnamSchools.org under Student Services.

Student Signature: ____________________________ Date: __________

Parent/Guardian Signature: ____________________________ Date: __________

Student Name: _____________________________________________________ DOB: __________

________________________________________________________________________________________

By signing this document, you are verifying that all the information is true and you are the legal guardian of the child above. In the case of an unaccompanied youth, you will proceed in acquiring In-Loco Parentis responsibility of the child within 30 days.

Signature: ____________________________ Print Name: ____________________________ Date: __________

SWORN TO AND SUBSCRIBED BEFORE ME THIS _______ DAY of _______ _______ 20 ___

________________________________________________________________________________________

(Personally Known _____ OR Produced Identification _____
Type of Identification Produced __________________________
(Signature of Notary Public State of Florida)

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

PCSB FORM E-5 July 2016, June 2019