NORTH FLORIDA SCHOOL OF SPECIAL EDUCATION
New Student Information Check List

To the Parent/Guardian of:

Name: _____ Date: _____

The following items are required for a student to attend North Florida School of Special Education.

_____ IEP (Most recent)

_____ Psychological/Educational Evaluation

_____ Copy of Social Security Card

_____ Copy of Birth Certificate

_____ Student Information Record

_____ Release of Information Form

_____ Authorization for Student Pickup/ Dismissal

_____ Consent to Photograph/Fieldtrip Permission/Internet Usage

_____ Acknowledgement of Review of Parent Handbook
Handbook is located on our website at www.northfloridaschool.org

MCKAY SCHOLARSHIP FORMS
These forms must be signed by the parent/guardian whose name appears on the McKay check

_____ Affidavit Section 1002.39, Florida Statues, for all students on McKay Scholarship
(*This form **must** be **NOTARIZRED***)

_____ Florida Department of Education Student Data Collection Form

_____ McKay District Verification Form

MEDICAL FORMS

_____ Application for Participation (Medical Form). **This must be completed by student's doctor even if they do not plan to participate in Special Olympics.**

_____ Medical Release **must be completed and signed by student's doctor**

_____ Authorization for Medical Treatment (This form **must** be **NOTARIZED**.)

_____ Florida Immunization Certificate (Form: DH 680 from student's doctor)
(Immunizations must be up to date)

NORTH FLORIDA SCHOOL OF SPECIAL EDUCATION

223 Mill Creek Road* Jacksonville, Florida 32211
Telephone: 724-8323 Fax: 724-8325

AUTHORIZATION T0 RELEASE /OBTAIN/EXCHANGE INFORMATION

1. **Name** _____ **2. DOB** ____/____/____/
Last First Middle

3. ____ **Male** ____ **Female**

4. **Indicate the name/agency AND the address of where North Florida School of Special Education is to obtain or release records.**

Name/Agency _____

Address _____

City/State/Zip _____

5. **I, the undersigned, authorize North Florida School to:**

(check one) ____Obtain ____Release ____Exchange

6. **The following information:** ____**Written** ____**Verbal** ____**Other (specify)** _____
(check all that apply)

____ Medical Records
____ Psychological Evaluation Testing
____ Educational Evaluation Testing
____ Record of Disciplinary Actions
____ Other (Specify) _____
____ Speech & Language Records
____ I.E.P.
____ Progress Reports
____ Report Card

6. I understand that this authorization is revocable by me in writing at any time and that North Florida School of Special Education shall not be held liable for any information released prior to its receipt. This authorization is valid only for the facility to which it has been addressed and will ***expire one year*** after the date of signature. A photocopy of this signed form is acceptable and may be honored as an original.

I acknowledge that I have read this authorization and fully understand its content.

_____ _____
Signature of parent/guardian Date

_____ _____
Relationship Social Security # (if applicable)

_____ _____
Witness Date

PROHIBITION OF DISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further disclosure is strictly prohibited unless the client provides specific written consent for the subsequent disclosure of this information.

DO NOT SIGN THIS FORM UNTIL ALL ITEMS HAVE BEEN COMPLETED

FLORIDA DEPARTMENT OF EDUCATION
OFFICE OF INDEPENDENT EDUCATION AND PARENTAL CHOICE

IEPC – AFF1
Pursuant to Rule 6A-6.0970
Effective November 2009

AFFIDAVIT

STATE OF FLORIDA
COUNTY OF _____

Before me this day personally appeared _____ (Name of Parent), who being duly sworn, attests that he or she is the parent or legal guardian of _____ (Name of Student), and that the signature below is his or her true and correct signature and is the signature that will be used to endorse warrants issued on behalf of the above-named student under the McKay Scholarship Program.

_____
(SIGNATURE OF PARENT)

Sworn to (or affirmed) and subscribed before me this _____ day of _____, 20__, by _____ (Name of Parent).

Personally Known ☐ Or Produced Identification ☐

Type of Identification Produced _____

NOTARY SEAL

_____
(SIGNATURE OF NOTARY)

_____
(PRINTED NAME OF NOTARY)

Parent's Address _____

Parent's Home Telephone _____-_____-_____ Parent's Work Telephone _____-_____-_____

Please review the statutory parent and student responsibilities pursuant to Section 1002.39, Florida Statutes, which include, but are not limited to:

Any student participating in the program must remain in attendance at a McKay approved school a minimum of 170 actual school days at the school's physical location, unless excused by the school for illness or other good cause.

Each parent and each student has an obligation to comply with the private school's published policies.

The parent to whom the scholarship warrant is made must endorse the warrant to the private school for deposit into the account of the private school. The parent may not designate any entity or individual associated with the participating private school as the parent's attorney in fact to endorse a scholarship warrant.

MICHAEL D. KOOI, ESQ.
Executive Director
Office of Independent Education and Parental Choice

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FLORIDA DEPARTMENT OF EDUCATION

Office of Independent Education and Parental Choice

SCHOOL CHOICE

Student Data Collection Form

Dear Parent or Guardian:

Every school district in Florida is required to report to the Florida Department of Education each year student data by race and ethnicity categories that are set by the federal government. The Department of Education does not report individual student data to the federal government but does report the total number of students in various categories in each school. These reports help us keep track of changes in student enrollments and ensure that all students receive the education programs and services to which they are entitled.

The federal government has adopted new standards for collecting and maintaining ethnicity and race data that will allow individuals to more accurately report their origins. As a result of this, you have the opportunity to update the student data for your child. With the new reporting categories, you may now identify your child by ethnic group and by **one or more** racial groups.

Please answer **all** questions below by checking "Yes" or "No" for each of your children.

Question	YES	NO
ETHNICITY		
1. Is the student of Hispanic/Latino origin?		
RACE		
2. Is the student American Indian or Alaska Native?		
3. Is the student Asian?		
4. Is the student Black or African American?		
5. Is the student Native Hawaiian or Other Pacific Islander?		
6. Is the student White?		

Student Name _____ Grade _____

School District Where Private School is Located _____

Name of Private School _____

Parent/Guardian Signature _____ Date _____

FLORIDA DEPARTMENT OF EDUCATION

Office of Independent Education and Parental Choice

SCHOOL CHOICE Florida Department of Education

McKAY DISTRICT VERIFICATION FORM

THIS SECTION TO BE COMPLETED BY THE PARENT/LEGAL GUARDIAN:

I, _____ (NAME OF PARENT), verify that my child, _____ (NAME OF STUDENT)

has been withdrawn from _____ (NAME OF DISTRICT) County Public Schools on _____ (DATE OF WITHDRAWAL),

and is currently enrolled and attending _____ (NAME OF PRIVATE SCHOOL) as of _____ (FIRST DATE OF ATTENDANCE),

_____ (STUDENT ID#), _____ (DATE OF BIRTH).

I certify that the above statement is true:

PARENT/LEGAL GUARDIAN NAME: _____ *PLEASE PRINT YOUR NAME* PHONE: _____

PARENT/LEGAL GUARDIAN SIGNATURE: _____ DATE: _____

THIS SECTION TO BE COMPLETED BY THE PUBLIC SCHOOL DISTRICT ADMINISTRATOR:

_____ (NAME OF PUBLIC SCHOOL) verifies that the above named student was withdrawn from

_____ (NAME OF DISTRICT) County Public Schools on _____ (DATE OF WITHDRAWAL).

PUBLIC SCHOOL DISTRICT ADMINISTRATOR NAME: _____ *PLEASE PRINT YOUR NAME* PHONE: _____

PUBLIC SCHOOL DISTRICT ADMINISTRATOR SIGNATURE: _____ DATE: _____

Public School District Administrator check here if applicable: _____ ***Student is currently enrolled in public school or is registered with district home-school office***

THIS SECTION TO BE COMPLETED BY A PRIVATE SCHOOL ADMINISTRATOR:

_____ (NAME OF PRIVATE SCHOOL) verifies that the above named student has been enrolled in and

attending our school as of _____ (FIRST DATE OF ATTENDANCE).

PRIVATE SCHOOL ADMINISTRATOR NAME: _____ *PLEASE PRINT YOUR NAME* PHONE: _____

PRIVATE SCHOOL ADMINISTRATOR SIGNATURE: _____ DATE: _____

APPLICATION FOR PARTICIPATION (Medical Form)

(must be completed and signed by licensed examiner every 3 years)

Special Olympics Florida

COUNTY:_____ School/Agency:_____

SSN:____/____/____ T-shirt Size: Children:_____ OR Adult:_____

LAST NAME_____ **FIRST**_____ **SEX** M or F _____ **DATE OF BIRTH** month/day/year ____/____/____

Street Number/Address_____

City_____ State_____ Zip Code_____ Home Phone (____) _____

Parent/Guardian_____

Address (if different)_____ Work Phone (____) _____

City_____ State_____ Zip Code_____

Emergency Contact (other than parent/guardian)_____ Emerg. Phone (____) _____

Health Insurance Company_____ Ins. Policy #_____

Signature of parent/guardian/adult athlete completing form_____

FOR ATHLETES WITH DOWN SYNDROME -- Persons with Down syndrome should have a lateral x-ray of the cervical spine in hyperflexion and hyperextension. The interpretation of the radiographs should include measurements of the atlanto-dens interval.

☐ Yes ☐ No Has an x-ray evaluation for atlantoaxial instability been done?

☐ Yes ☐ No If yes, was it positive for atlantoaxial instability? (positive indicates that the atlanto-dens interval is 5mm or more)

IS THERE PRESENT OR A HISTORY OF (to be completed by parent/caregiver):

Heart problems/high blood pressure	☐ Yes	Tobacco use	☐ Yes	Emotional/psychiatric/behavioral problems	☐ Yes
Chest pain	☐ Yes	Major surgery or serious illness	☐ Yes	Asthma/breathing problems with exertion	☐ Yes
Seizures/epilepsy/fainting spells	☐ Yes	Heat stroke/exhaustion	☐ Yes	Contact lenses/glasses/dentures/false teeth	☐ Yes
Diabetes	☐ Yes	Easy bleeding	☐ Yes	Head injury/history of concussion	☐ Yes
Hearing aid/hearing problems	☐ Yes	Bone/joint problems	☐ Yes	Immunizations (shots) are up-to-date	☐ Yes
Blindness/vision problem	☐ Yes	Sickle cell disease or trait	☐ Yes	Special Diet Needs (list below)	☐ Yes
Absence of one kidney or testicle	☐ Yes	Uses a wheelchair	☐ Yes	Year of last tetanus shot_____	

Other problems that would interfere with participation _____

Allergy to the following (list specific):

Food_____ Insect sting/bites_____

Medication_____

MEDICATIONS

Medication Name	Dosage	Date Presc.	Times per day	Medication Name	Dosage	Date Presc.	Times per day

PHYSICAL EXAMINATION

		Normal	Abnormal		Normal	Abnormal		Normal	Abnormal
Blood Pressure _____	Vision	☐	☐	Oral Cavity	☐	☐	Cardiovascular system	☐	☐
Pulse _____	Hearing	☐	☐	Extremities	☐	☐	Respiratory system	☐	☐
Weight _____	Neck	☐	☐	Coordination	☐	☐	Gastrointestinal system	☐	☐
Height _____	Skin	☐	☐	Reflexes	☐	☐	Genitourinary system	☐	☐
							Cranial nerves	☐	☐

Other:_____

Primary MR Etiology/Category_____

I have reviewed the above health information and examined the athlete named in the application and certify that there is no medical evidence available to me which would preclude the athlete's participation in Special Olympics.

Restrictions_____

Examiner's Name:_____ Certification: ☐ MD ☐ DO ☐ DC ☐ PA ☐ ARNP

EXAMINER'S SIGNATURE_____ **DATE**:_____

OPTIONAL INFORMATION

Ethnic background: ○ Asian ○ African American ○ Caucasian ○ Hispanic ○ Native American ○ Other_____

Created by The Joseph P. Kennedy, Jr. Foundation for the Benefit of Persons with Intellectual Disabilities

North Florida School of Special Education

Medical Release Form

(MUST BE COMPLETED AND SIGNED BY ***STUDENT'S DOCTOR***)

Student's Name: _____

Date of Birth: _____ Age: _____ Diagnosis: _____

Please list all medical conditions. Conditions may include vision, hearing, cardiac, orthopedic or neurological issues.

_____

_____

_____

_____

_____

Scoliosis Screening for all students turning age 11/Grade 6 by Aug. 15

Screened for scoliosis? **YES____** **NO____**

If YES, please indicate results:

_____

_____

Immunization for all students turning age 12/Grade 7 by Aug. 15

Current on all immunizations? **YES____** **NO____**

If NO, list immunizations needed:

_____

_____

Please list current daily medications:

NAME & DOSAGE	**DIAGNOSIS/REASON FOR MEDICATION**

Physical Precaution/Restrictions/Allergies:

_____

_____

_____

_____

I certify that the above named person has medical approval to participate in P.E. programs while in school, except for the above named precautions/restrictions.

Physician: _____ **Date:** _____

(Signature)

_____

(Print Physician's Name)