



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	Discipline/Behavioral Records	Withdraw Grades
Attendance Data	Individual Educational Plan	Safety Plan
Section 504 Documentation	Intellectual Evaluations	Medical & Physical Records
Psychological/Mental Health Records	Special Services Assessments	All Academic Testing Results
RtI/MTSS Documentation	Threat Assessment Documentation	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. 18 th 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: 352-329-0624 |
| ____ 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. 19 th 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 ACCOMIDATIONS 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: _____

RECIVING MENTAL HEALTH SERVICES: _____

A SAFETY PLAN: _____

ASSIGNED TEACHER: _____

(OFFICE USE ONLY)



Putnam County School District

Parent/Guardian Information

Parent/Guardian contact information is required to be kept up to date. In the case of any emergency (e.g. Student Safety, Injury, Reunification) PCSD will use the information given to contact parents/guardians. Driver license number is used for identification.

FAMILY INFORMATION:

NAME OF FATHER OR GUARDIAN _____ OCCUPATION _____
DRIVER'S LICENSE NUMBER _____ DATE OF BIRTH _____
HOME PHONE NUMBER _____ CELL NUMBER _____
EMERGENCY PHONE NUMBERS _____ E-MAIL ADDRESS _____
MAILING ADDRESS _____ CITY _____ ZIP _____
911 ADDRESS _____ CITY _____ ZIP _____
WORK NAME _____ ADDRESS _____ PHONE NUMBER _____

NAME OF MOTHER OR GUARDIAN _____ OCCUPATION _____
DRIVER'S LICENSE NUMBER _____ DATE OF BIRTH _____
HOME PHONE NUMBER _____ CELL NUMBER _____
EMERGENCY PHONE NUMBERS _____ E-MAIL ADDRESS _____
MAILING ADDRESS _____ CITY _____ ZIP _____
911 ADDRESS _____ CITY _____ ZIP _____
WORK NAME _____ ADDRESS _____ PHONE NUMBER _____

PUPIL LIVES WITH: BOTH PARENTS ____; FATHER ____; MOTHER ____; OTHER ____

GIVE DIRECTIONS TO THE STUDENT'S 911 ADDRESS: _____

EMERGENCY INFORMATION:

PRIMARY PERSON TO CONTACT IN AN EMERGENCY OTHER THAN PARENT _____
DRIVER'S LICENSE NUMBER _____ DATE OF BIRTH _____
911 ADDRESS _____ CITY _____ ZIP _____
RELATIONSHIP TO CHILD _____ HOME PHONE # _____ CELL # _____

SECONDARY PERSON TO CONTACT IN AN EMERGENCY OTHER THAN PARENT _____
DRIVER'S LICENSE NUMBER _____ DATE OF BIRTH _____
911 ADDRESS _____ CITY _____ ZIP _____
RELATIONSHIP TO CHILD _____ HOME PHONE # _____ CELL # _____

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

IF CHILD RIDES BUS: (Office Use) BUS NUMBER _____ DRIVER _____
IF CHILD DOES NOT RIDE BUS, HOW DOES HE OR SHE GET TO SCHOOL? _____



Putnam County School District Home Language Survey

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.

Parent Signature

____/____/____
Date

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? Si No
2. ¿El estudiante de arriba tiene un primer idioma que no sea inglés? Si No
3. ¿Habla el estudiante con más frecuencia un idioma que no sea inglés? Si 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



Putnam County School District Occupational Survey











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 <input type="checkbox"/>	 Vegetables <input type="checkbox"/>	 Tobacco <input type="checkbox"/>	 Pine Straw <input type="checkbox"/>	 Eggs <input type="checkbox"/>	 Chickens <input type="checkbox"/>
 Soil Preparation (planting, weeding, etc) <input type="checkbox"/>	 Processing (vegetables, meat, fruit, trees, etc) <input type="checkbox"/>	 Cut Fern, Nursery, Sod, Greenhouse, Flowers <input type="checkbox"/>	 Livestock (cattle, pigs, sheep, dairy, etc) <input type="checkbox"/>	Other agriculture work: _____ <input type="checkbox"/>	

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.



Distrito Escolar del Condado de Putnam
Encuesta ocupacional

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 empackadora? **(sin incluir su propiedad)**

Favor de circular todos los que aplican.

 Frutas <input type="checkbox"/>	 Vegetales <input type="checkbox"/>	 Tabaco <input type="checkbox"/>	 Paja de Pino <input type="checkbox"/>	 Huevos <input type="checkbox"/>	 Pollos <input type="checkbox"/>
 Preparacion del terrero (sembrar, deshierbe, etc) <input type="checkbox"/>	 Procesadora (carnes, frutas, vegetales, arboles, etc) <input type="checkbox"/>	 cortar el ollaje, Vivero, Cesped, Invernadero, Flores <input type="checkbox"/>	 Ganado (vaca cerdos, ovejas, lecheria, etc) <input type="checkbox"/>	 Otro trabajo de campo: _____ <input type="checkbox"/>	

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

2. ¿En los últimos 3 años, usted u 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.



Putnam County School District

Exceptional Student Education
INTAKE INFORMATION FOR TRANSFER

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: _____



Putnam County School District

**IMMUNIZATION RECORDS/THIRTY-DAY
PHYSICAL EXAMINATION EXEMPTION**

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**

List medical conditions your child has NOW	List all medicines your child takes NOW (home and school)	List any medication(s) to be given at school. A medication authorization form is required.
ADD ___ ADHD ___		
A2 ___ ALLERGY –INSECTS		___ Epipen
A4 ___ ALLERGY –MEDICATIONS Name the medication		___ Epipen
A5 ___ ALLERGY –LATEX		___ Epipen
A7 ___ ALLERGY –FOOD List the food. Physician order is needed for special diet.		___ Epipen
A9 ___ ALLERGY –OTHER Specify the allergy		___ Epipen
AS ___ ASTHMA How frequent are the episodes?		___ Inhaler at school ___ Inhaler at home ___ Nebulizer at home ___ Nebulizer at school
CA ___ CANCER		
CP ___ CEREBRAL PALSY		
CYF ___ CYSTIC FIBROSIS		
DB ___ DIABETES Hypoglycemia or Hyperglycemia		___ diet ___ oral medication ___ insulin ___ pump ___ carb counting
EA ___ Ear problems(describe)		___ Hearing aide (Left/Right/Both) ___ FM System ___ Deaf (Left/Right/Both)
EP ___ EPILEPSY/SEIZURES List known triggers		Last seizure _____
GA ___ Gastrointestinal ___ Reflux ___ IBS ___ Crohn's ___ Other		
HD ___ HEART DISEASE HM ___ HEART MURMUR		
HE ___ HEMOPHILIA		

Chronic Disease Information Form Continued

HP ___ HYPERTENSION		
KD ___ KIDNEY DISEASE		
MD ___ MUSCULAR DYSTROPHY		
MG ___ MIGRAINES		
NO ___ NOSEBLEEDS Occasional ___ Frequent ___ Medical condition ___		
PC ___ PSYCHIATRIC CONDITIONS (Please list)		
SC ___ SICKLE CELL ANEMIA ___ Trait only		Last Crisis? _____
VP ___ VISION PROBLEMS Describe _____		___ Glasses ___ Contacts ___ Visually Impaired ___ Blind (Left/Right/Both)
Any medical condition not covered above, please list.		

Will any medication be taken at school for any of the illnesses listed above? ___ Yes, ___ No.

If yes, 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: _____



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 RELESE 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 ____

(Signature of Notary Public State of Florida)

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

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