Marion County Public Schools
Developing Successful Citizens -- Every Student, Every Day

SCHOOL ENROLLMENT/REGISTRATION CHECKLIST

512 SE 3RD Street, Ocala FL 34471 • PO Box 670
(352) 671-7700 • (352) 671-7788 • www.marionschools.net
FRS (800) 955-8770 • (800) 955-8771 (TTY)

Florida statutes 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 or her official duty shall be guilty of a misdemeanor of the second degree.

- ⇨ **To enter kindergarten, children MUST be at least 5 years old on or before September 1.**
- ⇨ **To enter first grade, children MUST be at least 6 years old on or before September 1 AND show proof of having successfully completed Kindergarten.**

To register your child in school, the following documentation is needed along with the Initial Registration Application:

☐ 1. Verification of Age (**ONE** of the following):
   a. Certified Birth Certificate (required for Pre-K & Kindergarten) - no photocopies (school will make photocopy)
   b. Insurance policy
   c. Passport
   d. School record
   e. Certificate of baptism, accompanied by parent's affidavit
   f. Authentic Bible record, accompanied by parent's affidavit

☐ 2. Proof of Residence (**ONE** of the following sets of documents):
   a. Copy of mortgage or lease/rental contract **AND** a copy of a recent (two months or less) electric bill in parent's/guardian's name
   b. Copy of a recent (two months or less) electric bill in parent's/guardian's name **AND** affidavit from landlord verifying residency
   c. Affidavit completed on Form eMIS15b from head of household **AND** mortgage or lease/rental contract in the name of head of household **AND** a copy of a recent (two months or less) electric bill in name of head of household

☐ 3. Proof of Immunizations:
   a. **MUST** be on Florida Immunization Form 680
   b. All out-of-state immunizations **MUST** be transferred to Form 680

☐ 4. Proof of Physical Examination:
   a. **MUST** be within 12 months of 1st day of school enrollment in a Florida public school
   b. **MUST** be signed **AND** dated by a physician

☐ 5. Academic History (provide any or all of the following):
   a. Last (most recent) report card
   b. Transcript
   c. Withdrawal form
   d. Special education information

☐ 6. Legal Documentation: If you are not the legal guardian or residential custodial parent of a student OR there is a court decision regarding release of information related to custody/restraining orders, etc., state law REQUIRES that **one** of the following documents be provided for enrollment:
   a. Court Custody Documentation stating specifications
   b. Department of Children and Families Placement Letter
   c. Educational Guardianship - notarized documents verifying parent/legal guardian of student is incarcerated

☐ 7. Completed Emergency & Medical Information Form (eCHN06)

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RETURNING STUDENT REGISTRATION APPLICATION

Student Name _____

Student Number _____

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STUDENT INFORMATION: *PLEASE PRINT LEGIBLY*

Last Name:	First Name:	Middle Name:	Jr., Etc.:
Birth Date: / /	Grade:	Age:	Gender: ☐ Female ☐ Male
Birth City:	Birth County:	Birth State:	Birth Country:

MIGRANT/HOMELESS/MILITARY STATUS:

❋Has a parent of this student traveled to do agricultural or fishing work (such as picking crops, milking cows, packing fruits, etc.)? ☐ Yes ☐ No If yes, please complete the "Migrant Parent Survey" Form# FED44

❋Does this student fit homeless profile? ☐ Yes ☐ No If yes, provide explanation. _____

❋Did student move to Marion County School District this school year due to a hurricane? ☐ Yes ☐ No

❋Did student move to Marion County School District this school year due to an earthquake? ☐ Yes ☐ No

❋Did student move to this district this school year from outside of Florida due to the Gulf of Mexico Deepwater Horizon oil spill incident? ☐ Yes ☐ No

❋Does the legal parent/guardian meet one of the following:

☐ Yes ☐ No **Active duty member of uniformed services, including *National Guard* and *Reserves.***
☐ Yes ☐ No **Active member or veteran of uniformed services severely injured or medically discharged or retired for a period of 1 year.**
☐ Yes ☐ No **Active members of the uniformed services killed in the line of duty.**
☐ Yes ☐ No **Active members of the uniformed services who died, within 1 year, as a result of injuries sustained on active duty.**

RESIDENCE ADDRESS:

Address:	Apt#:	City:	State:	Zip:

MAILING ADDRESS: (If Different)

Address:	Apt#:	City:	State:	Zip:

SCHOOL HISTORY: Please list last school attended				
School:	City:	County:	State:	Country:

OTHER CHILDREN:

Name:	Grade:	Name:	Grade:	Name:	Grade:

MEDICAL INFORMATION:

Emergency and medical information will be collected with the Emergency & Medical Information form (eCHN06). This form must be updated yearly by a parent or guardian. I understand that certain educational records of my child will be shared with the district's health care partners as needed to provide and evaluate health care services to students. I also understand and agree that my child's medical treatment records created by health care personnel at school may be shared with school officials and agents who have a legitimate educational purpose. I understand and agree that if my child is or becomes Medicaid eligible, reimbursable service may be billed to Medicaid.

In case of accident or serious illness during the school day, I request that the school contact me. In case of emergency, I hereby give the school permission for my child to be transported by Emergency Medical Services to the hospital and given the necessary treatment. ***I understand that I will be responsible for any and all related charges. I understand that it is the parent's-guardian's responsibility to notify the school of any changes in this information throughout the year.***

_____
Parent Initials

CUSTODY ALERTS: List any special custody problems. (***Appropriate legal documentation must be provided for student's cumulative folder.)***

RETURNING STUDENT REGISTRATION APPLICATION

Student Name _____

Student Number _____

CONTACTS: *(When providing this information please be aware that the school will notify in the order that contacts are listed below.)*

PARENT CONTACT:

LEGAL CUSTODY? ☐YES ☐NO	LIVES WITH STUDENT? ☐Yes ☐No	PICK-UP? ☐Yes ☐No	
Relation to Student:	Last Name:	First Name:	
Home Phone:	Work Phone:	Cell Phone:	Other:
Address:	City:	State:	Zip:
Email:	Place of Employment:		

PARENT CONTACT:

LEGAL CUSTODY? ☐YES ☐NO	LIVES WITH STUDENT? ☐Yes ☐No	PICK-UP? ☐Yes ☐No	
Relation to Student:	Last Name:	First Name:	
Home Phone:	Work Phone:	Cell Phone:	Other:
Address:	City:	State:	Zip:
Email:	Place of Employment:		

ADDITIONAL CONTACT (optional):

PICK-UP? ☐Yes ☐No			
Relation to Student:	Last Name:	First Name:	
Home Phone:	Work Phone:	Cell Phone:	Other:
Address:	City:	State:	Zip:
Email:	Place of Employment:		

ADDITIONAL CONTACT (optional):

PICK-UP? ☐Yes ☐No			
Relation to Student:	Last Name:	First Name:	
Home Phone:	Work Phone:	Cell Phone:	Other:
Address:	City:	State:	Zip:
Email:	Place of Employment:		

RETURNING STUDENT REGISTRATION APPLICATION

Student Name _____

Student Number _____

ADDITIONAL STUDENT INFORMATION:

1. Have you ever attended a Marion Co. Public School? (Including Pre-K and Kindergarten)	☐ **Yes**	☐ **No**	**6. Has the student ever been expelled from another school district?** If yes, please explain.	☐ **Yes**	☐ **No**
2. Have you ever attended a VPK (Voluntary Pre-K program) (Not ESE PK)? If yes, complete the following: **2a**. Select one: ☐ **Private VPK Provider** ☐ **Marion County Public School** **2b.** Select one: ☐ **Summer program** ☐ **School year program**	☐ **Yes**	☐ **No**	**7. Has the student ever been withdrawn to avoid being expelled?** If yes, please explain.	☐ **Yes**	☐ **No**
3. Have you ever participated in the H.I.P.P.Y. program?	☐ **Yes**	☐ **No**			
4. Is the student currently enrolled or ever been enrolled in a Special Education Program? If yes, please list all prior/current programs and /or services.	☐ **Yes**	☐ **No**	**8. Has the student ever had an arrest which has resulted in charges?** If yes, please explain.	☐ **Yes**	☐ **No**
5. Is this a Section 504 student?	☐ **Yes**	☐ **No**	**9. Has the student ever been retained?** If yes, list grade level(s) here.	☐ **Yes**	☐ **No**

NETWORK ACCESS AND INTERNET USAGE POLICY

As a parent or legal guardian of the above student, I have read the Acceptable Use Policy and Guidelines, and I understand that network access is designed for education purposes. I will not hold the School Board responsible for any claims or damages that may arise from my child's use of network access provided by the School Board, and I release the School Board and its personnel from any and all claims and damages of any nature arising from my child's use of or inability to use the School Board's system of network access. I give permission for my son or daughter to use the network for educational purposes consistent with the policies and guidelines of the Marion County School Board. This agreement will remain in effect until the school receives written notice revoking permission.

☐ I ***do give*** ☐ I ***do not give*** permission for him/her to have access to the Internet, World Wide Web, and e-mail (networks).

I hereby state and declare under penalty of perjury pursuant to 28 U.S.C. § 1746(2), that the above information is true and correct.

Parent/Guardian Name (Print): _____

Parent/Guardian Signature: _____ **Date:** _____

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AFFIDAVIT OF RESIDENCE

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State of Florida
County of _____

Before me this day personally appeared _____
Owner or Lease Holder (Print)

_____
Signature

_____
Address

_____
City

who, being duly sworn, deposes and says

The permanent residence of _____ is
Name of Parent/Guardian

_____
Address

_____
City

Also residing at the same address are:
(Names of School Age Children)

_____

_____

_____

_____

Sworn to (or affirmed) and subscribed before me**, by means of** ☐ **physical presence or** ☐ **online notarization**, this _____ day of _____ , _____(year), by _____.

Produced identification in the form of: _____
Type of Identification Produced

_____

My commission expires: _____

. . . any person making a false oath before a notary public shall be guilty of perjury and be subject to the penalties, forfeitures, and disabilities that are prescribed by law in cases of willful and corrupt perjury.
History-September 13, 1822; RS 219; GS 304; RGS 415; CGL 481; s. 20, ch. 73.334

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STUDENT MEDICAL INFORMATION FORM

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This form is to be completed annually by parent/guardian ONLY. Please notify school of any changes in this information throughout the school year.

STUDENT INFORMATION: *PLEASE PRINT LEGIBLY*

Student #: _____

Last Name: _____ First Name: _____ Middle Name: _____ Jr., II, etc.: _____

Birth Date: ____/____/____ Age: _____ Grade: _____ School: _____

PARENT/GUARDIAN INFORMATION:

Mother/Guardian: _____ Home Phone: _____
Last Name, First Name

Work Phone: _____ Cell Phone: _____

Father/Guardian: _____ Home Phone: _____
Last Name, First Name

Work Phone: _____ Cell Phone: _____

All parent/guardian contact information MUST be verified and updated by the parent/guardian using Skyward Family Access, if you do not have an account please contact the school office.

HEALTH CONDITIONS AND/OR NEEDS REQUIRING MEDICAL ASSISTANCE AT SCHOOL: (Check all that apply)

☐ NONE – Student has no known health condition(s) or medical need(s)

☐ ADHD/ADD
☐ Life Threatening Allergies
(Specify) _____
☐ Non-Life Threatening Allergies
(Specify) _____
☐ Asthma – History of Asthma ONLY ☐
☐ Autism (ASD)
☐ Bleeding Disorder
☐ Cerebral Palsy
☐ Cancer
(Specify) _____
☐ Cardiac Condition(s)
(Specify) _____
☐ Crohn's Disease
☐ Cystic Fibrosis
☐ Type 1 Diabetes
☐ Type 2 Diabetes
☐ Feeding Tube
(Specify Type) _____
☐ Hypoglycemia
☐ Kidney Disorder
(Specify) _____
☐ Lupus (SLE)
☐ Mental/Behavioral Health Disorder
(Specify) _____
☐ Seizure Disorder/Epilepsy
☐ Sickle Cell Disease
☐ Spina Bifida
☐ Tracheostomy
☐ Other: _____

Medical Services needed at SCHOOL: ***(Parent/Guardian authorization & physician order required)***

_____

_____

_____

SCHOOL USE ONLY: Received by _____ Date _____ Reviewed by nurse _____ Date _____ ☐ Comments on back

I understand and agree to the following:

- My child's records and information may be shared with the School Board's health care partners as needed to provide and evaluate health care services.
- If my child is or becomes Medicaid eligible, reimbursable services may be billed to Medicaid and my child's information and records may be provided to Medicaid and/or the School Board's Medicaid processing agents or the School Board's health care partners. Consent for Medicaid billing may be revoked at any time and if consent is revoked, these services will be provided at no cost.
- In case of emergency, my child may be transported by Emergency Medical Services to a hospital and provided treatment, and I am responsible for charges related to the transportation and medical treatment.
- My child will participate in the School Health Services Program. If I wish for my child to opt out of any School Health Service, I will provide a written letter to the school principal. For more information about our School Health Services Program visit www.marionschools.net/HealthServices.

Student's Physician (Print): _____ **Phone:** _____

Parent/Guardian Name (Print): _____

Parent/Guardian Signature: _____ **Date:** _____

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