Child Day Care Alternate Nutrition Agreement

Name of Facility----------

Name of Child---------- Age----------

Indicate Special Dietary Requirements:----------

I understand and approve the use of the Alternate Nutrition Plan. I agree to provide the following meals and/ or snacks to meet my child's nutritional and dietary needs:

(Mark P for Parent Provides, or C for Center Provides)

☐	☐	☐	☐	☐	☐
Breakfast	A.M.Snack	Noon Meal	P.M. Snack	Dinner	Formula

_____ _____

Date Signature of Parent

I agree to provide the parent with a suggested meal pattern and menus and to discuss any problems which might develop in the use of the Alternate Nutrition Plan.

_____ _____

Date Signature of Owner/Operator

DISTRICT SCHOOL BOARD OF PASCO COUNTY
STUDENT REGISTRATION FORM

MIS Form #148
Rev. 10/13

Student's Legal Name: Last Appendage (Jr., etc.) First Middle

Home Address: # and Street Name Apt/Bldg

City State Zip Zip+4

Mailing Address (only if different from the home address):

Mailing Address

City State Zip Zip+4

Resident of this school's attendance zone? ____Yes ____No

Resident of Pasco County? ____Yes ____No

Home Phone (____) ____ - ____ Unlisted? ____Yes ____No
Area Code Phone Number

FRONT OFFICE USE ONLY:
Entry Date/Code____
Teacher/Team____
Grade____
District Student # ____
Birth Verification Yes____Code____
Physical Yes____No____Date____
Immunization Yes____Code____No____
Temporary____Exp. Date____
Records Req. Yes____No____N/A____
Custody Concerns Yes____No____
Proof of Residency Yes____No____
ESE Yes____Program____
Special Attd. Req. Yes____N/A____
Registration C____IC____
Bus Letter/Pass Yes____No____
Bus Stop Number____
Bus Number____
Home Lang. Date____
Migrant C____IC____
Emergency Card C____IC____
Cum/Folder Made Yes____No____

Is the student Hispanic or Latino? ____Yes ____No

Race (mark all that apply): ____American Indian or Alaska Native ____Asian ____Black or African American
____Native Hawaiian or Other Pacific Islander ____White

Sex (M/F) ____ Birth Information - Day ____ City ____ State____
Month/Date/Year

Country of origin USA ____ Other specify ____

Student's Social Security # (optional) ____ Grade ____
The SSN will not be used to identify a student's immigration status. The Notice of Social Security Number Disclosure can be read on the District School Board of Pasco County's website.

Name and address of school last attended ____ (____) ____ - ____
School Name Area Code Phone Number

and Street Name City State Zip

If the student has ever attended school in Florida, please enter the school name, county, and school year:

School Name County School Year

Florida Student # (if known) ____

Has the student ever been retained? ____Yes ____No If yes, which grade(s)? ____

Has the student ever been enrolled in an alternative, ESOL, gifted, or special education program(s)? ____Yes ____No If yes, which program(s)? ____ Is the student presently in this program(s)? ____Yes ____No

Does the student have a health condition that substantially interferes with his/her learning? ____Yes ____No If yes, explain ____

Has the student dropped out of school and is now returning? ____Yes ____No

Are the driver's license requirements the reason or one of the reasons the student is returning to school? ____Yes ____No

Has the student ever been recommended for expulsion? ____Yes ____No If yes, which school year(s)? ____

Has the student been arrested resulting in a charge and juvenile justice action? ____Yes ____No

FOR KINDERGARTNER ONLY:

Did the student attend a PreK program (includes churches) or a family day care home in Pasco County last year? ____Yes ____No

If yes, did the student receive a government subsidy to pay the total or partial cost of this PreK child care last year? ____Yes ____No

MIS Form #148
Rev. 10/13
BACK

Please keep the school updated with current phone numbers and addresses in case we need to reach you.

PARENT OR GUARDIAN INFORMATION:

Father's Name _____ Workplace _____ City _____ Work Phone _____ Cell Phone _____

Father's Email Address _____

Mother's Name _____ Workplace _____ City _____ Work Phone _____ Cell Phone _____

Mother's Email Address _____

Other Person/Relationship _____ Workplace _____ City _____ Work Phone _____ Cell Phone _____

Student lives with _____
Name Relationship

Is there a custody concern regarding this student? ____Yes ____No

Is there a current court order concerning this student? ____Yes ____No

Is the order still valid for this school year? ____Yes ____No

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 - Names (also last names, if different) of any brothers and/or sisters in other Pasco County schools:

1. _____ First _____ Last _____ School _____ Grade
2. _____ First _____ Last _____ School _____ Grade
3. _____ First _____ Last _____ School _____ Grade
4. _____ First _____ Last _____ School _____ Grade

Is the student a child of a military family or will he or she be a child of a military family at any time during this school year?
____Yes ____No

Have you moved in the last three (3) years to seek work as a paid laborer in any type of farming (sod, dairy, chicken, vegetable, citrus, or other) or fishing? ____Yes ____No

Are you currently living in a motel, hotel, campground, vehicle, abandoned building, substandard housing, shelter, or temporarily living with another family? ____Yes ____No

Your signature below indicates that all information provided on this document is true and accurate. Incorrect or false information may result in an immediate change in your child's assigned school.

Parent or Guardian Signature _____ **Date** _____

State of Florida
Department of Children and Families

CHILD CARE APPLICATION FOR ENROLLMENT

Student Information: Date of Birth:_____ Sex: ___ Date of Enrollment:_____

Full Name:_____
Last First Middle Nickname

Child's Physical Address:_____

Primary Hours of Care: From _____ To _____

Days of the Week in Care: M T W Th F Sa Su

Family Information: Child Lives With: _____

Mother's Name: _____ Father's Name: _____

Address: _____ Address: _____

Home Phone: _____ Home Phone: _____

Employer: _____ Employer: _____

Address: _____ Address: _____

Work Phone: _____/Cell:_____ Work Phone:_____/Cell:_____

Custody: Mother _____ Father _____ Both _____ Other _____

Medical Information:

I hereby grant permission for the staff of this facility to contact the following medical personnel to obtain emergency medical care if warranted.

Doctor:_____Address:_____Phone:_____

Doctor:_____Address:_____Phone:_____

Dentist:_____Address:_____Phone:_____

Hospital Preference:_____

Please list allergies, special medical or dietary needs, or other areas of concern:_____

_____

_____

Emergency Care Plan instructions (if applicable):_____

_____

_____

Emergency Contacts:

Child will be released only to the custodial parent or legal guardian and the persons listed below. The following people will also be contacted and are authorized to remove the child from the facility in case of illness, accident or emergency, if for some reason, the custodial parent or legal guardian cannot be reached:

Name	Address	Work#	Home#
Name	Address	Work#	Home#
Name	Address	Work#	Home#

Name Address Work# Home#

Helpful Information About Child:

- Sections 7.1 and 7.2, of the Child Care Facility Handbook, require a current physical examination (Form 3040) and immunization record (Form 680 or 681) within 30 days of enrollment.
- Section 7.3, of the Child Care Facility Handbook, requires that parents receive a copy of the Child Care Facility Brochure, "Know Your Child Care Facility" (CF/PI 175-24), **or**
- Section 8.3, of the Family Day Care Home/ Large Family Child Care Home Handbook, requires that parent(s) receive a copy of the family day care home brochure, "Selecting A Family Day Care Home Provider" (CF/PI 175-28).
- Section 2.8, of the Child Care Facility Handbook, requires that parents are notified in writing of the disciplinary and expulsion policies used by the child care facility, **or**
- Section 2.3, of the Family Day Care Home/ Large Family Child Care Home Handbook, requires that parents are notified in writing of the disciplinary and expulsion policies used by the family day care provider.

Your signature below indicates that you have received the above items and that the information on this enrollment form is complete and accurate. I hereby grant permission for the staff of this facility to have access to my child's records.

Signature of Parent/Guardian Date

CYESIS NURSERY GUIDELINES
PASCO HIGH SCHOOL 2020 – 2021

BIRTH CERTIFICATE
&
SOCIAL SECURITY CARD

Only Vital Statistic Birth Certificates are acceptable for Cyesis Nursery. Visit Pasco County Health Department 13941 15th Street, Suite # 212 in Dade City, Florida 33525.
Need forms of identification when visiting Statistic Office.

Birth Certificate, Social Security card, Immunization records and Physical Form are due the first day you register to enter your child into the Cyesis Program at Pasco High School.

NO EXCEPTIONS !!!

CYESIS NURSERY GUIDELINES
PASCO HIGH SCHOOL 2020-2021

1. Documentation Required for Enrollment in the Nursery:

a. Completed Enrollment Package- available from Mrs. Simmons or Cyesis School Nurse.
a Child's Birth Certificate required before child can start attending.
b Child's Social Security Card is required before child can start attending.
c Child's Immunization Records required before child can start attending (HRS form 680)
d Child's Physical required before child can attend (HRS 3040)

2. Nursery Schedule:

A. Upon arrival parents must sign-in their child, change their diaper and complete the "Parents portion of the Daily Information Form on the clipboard.
B. Infants must have morning feeding before coming to school.
C. One year olds and up will be fed breakfast from the cafeteria.
D. Parents are responsible for getting to class on time! No late passes will be written unless you are specifically asked to remain in the nursery!
E. LUNCH BREAKS-All children are to be picked up at the beginning of lunch. **(unless arrangements have been made in advance)**
Children 1 year and up may be eligible for free/reduced lunch.
F. Parents are not allowed to take their children to class.
G. Parents must pick up their child immediately upon dismissal from 7th period class.

3. What to bring for your child
(Write child's name on everything with marker)

A. Diaper Bag
B. Diapers- Minimum of 6 per day for infants.
C. Change of clothes- at least 2 changes (Very important for potty training)
D. All sanitized bottles and nipples for each feeding
Sterilized prepared formula.
Only plastic bottles are allowed
Bottles must have caps (write name on both bottle and cap)
Fill bottles with only as much as your baby normally consumes in a single feeding. Feeding left-over formula will not be reused – it must be discarded. These precautions are taken to prevent thrush.
E. Baby food if age appropriate. (Child's name on the jar or container)

4. Feeding Guildlines- Based on HRS guidelines

A. Infants are fed on demand breastfeeding mothers will be called from class when needed.
B. Propped bottles are not allowed. They can cause choking and ear infections.
C. Mechanical Feeders are not allowed. They can cause choking and over-feeding.
D. Cereal is not given to any child under the age of 4 months unless a doctors note is provided.
E. Cereal is not to be given in the bottle at any age unless a doctors note is provided.
F. Fruits and vegetables are not given to any child under 5 months.
G. Meats and fruit juice are not given to any child under 6 months of age. Juice is only given in a cup.
H. Cow milk is not given to a child under the age of 1 year.
I. Parents must provide formula and food for children under 1 year of age.

5. Personal Property

A. No books, folders, purses or anything other than child care products are to be left in the nursery. **The Nursery in Not a Locker Room.**

B. Infant Jewelry- rings, bracelets, anklets and hoop earrings- are not allowed and will be removed. They can get on things causing serious injury and can be swallowed.

6. Visitors to The Nursery

A. The only people allowed in the nursery are parents with a child in that nursery that day.

B. Parents are not to loiter in the nurseries – **NO LATE PASSES ARE ISSUED.**

7. LEAVING CAMPUS

A. If you leave campus during the day, your child must leave with you unless you are participating in a school related activity during Cyesis childcare hours. Inform the Cyesis School Nurse or Mrs. Simmons to make arrangements.

B. If you remove your child from the nursery (except during lunch) you must sign the child out and state the reason for leaving early.

8. Illness

A. Do not bring your child to the nursery if any of the following conditions exist:

1. Fever of 101 degrees or higher.
2. Unexplained rash over most of their body.
3. Pink Eye
4. Diarrhea or Vomiting.
5. Exhibits signs of Communicable Disease (Chicken Pox, Mumps, Measles, etc.)

** **Children exhibiting any of these signs will be sent home.**

** **If transportation home is unavailable the parent will remain in the Clinic with their child.**

** **Parents must have proof of having seen a doctor before returning to the nursery.**

9. Medications

A. ALL medications (prescription, over-the-counter, oral tropical, inhalant) **must be authorized by Cyesis School Nurse.**

B. No medications are to be administered in the nursery by staff or by parent without this written authorization.

C. All pharmacy prescriptions should have original prescription label on medication bottle or container when being brought into Cyesis to give during nursery hours.

10. Discipline procedure for failure to follow these nursery guidelines.

A. 1st offense – Verbal warning

B. 2nd offense – Referral to Cyesis School Nurse.

C. 3rd offense- Referral to Ms. Fernandez, Assistant Principal

D. Repeated offenses will result in the loss of nursery privileges.

PLEASE SIGN BELOW

I have received a copy of the nursery guidelines for 2020-2021 school year.

I understand and agree to comply with the above guidelines

Signature

Date

CYESIS PARENT AGREEMENT

I----------parent of----------

wish to enroll my child in Cyesis Daycare Center and agree to abide by the policies and procedures set forth by this center. I agree that the center shall not be responsible in case of sickness or injury of this child while in attendance at this facility. I agree to work the assigned times and days and to not abandon the site except in an emergency or with written authorization.

AUTHORIZATION AND CONSENT FORM

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child----------. However, if i cannot be reached i hereby authorize the Cyesis Daycare Center to seek emergency medical care and transport my child, if necessary, to Dade City Hospital / East Pasco Medical Center and to secure for my child the necessary medical treatment.

I understand the teachers in the Cyesis Daycare Center are trained in the basics First Aid / CPR and i authorize them to give my child first aid when appropriate.

Parent 's Signature---------- Date----------

Site Manager---------- Date----------

CYESIS NURSERY DISCIPLINE PROCEDURE

No child shall be subject to corporal punishment, humiliation, or verbal abuse.
No child shall be denied food or drink as a form of punishment.
No child shall be punished for soiling or wetting their clothes.

Should a child demonstrate highly inappropriate or dangerous behavior, the staff will follow these procedures:

a) To use minimal force necessary to bring the child under control
b) To simultaneously explain to the child what the specific unacceptable behavior was
c) If necessary, to remove the child from the group until self-control has been restored (Time Out)

It is the goal of the daycare center to teach children self-discipline. Children are encouraged to verbalize feelings, take care of toys and equipment, take turns, and to make appropriate choices whenever possible. Guidelines are set forth to prevent a child from harming himself or other children.

PLEASE SIGN BELOW

I have recieved a copy of the discipline guidelines.
I understand and agree with the guidelines.

SIGNATURE

DATE

DISTRICT SCHOOL BOARD OF PASCO COUNTY

Dear Parents:

Please fill out the following information needed by the Pasco County School District by marking Yes or No.

1. Have you and your children moved from another county, state or country within the past 3 years? Yes _____ No _____

2. Please check if you have worked within the last 3 years in any of the following jobs.

_____ fruit farm	_____ dairy worker	_____ fish farm (tropical fish not included)
_____ grove worker	_____ fruit/vegetable grader	
_____ vegetable picker	_____ chicken farm worker	_____ Other agricultural worker
_____ farm worker	_____ nursery (plants)	_____ sod farm
_____ logging	_____ hauling (fruits & vegetables)	_____ commercial fishing/ shrimping

3. If you have checked yes to any of the questions above, please continue to fill out this form.

Child/Children's Name: _____ Date: _____

School: _____

Parent's Name: Present Job:

Father: _____ _____

Mother: _____ _____

Home Phone: _____ or number in case of emergency _____

Home Address: _____

Street directions to your home: _____

_____

Please send all completed forms to Migrant Recruiters

DISTRICTO ESCOLAR DEL CONDADO DE PASCO

Estimado Padres:

Por favor llene los blancos con la informacion necesaria marque sí o no por el districto de nuestro condado.

1. Ustede y su familia, sé hán mudado dentro los ultimos 3 años de otro Estado o condado? Sí _____ No _____

2. Por favor margue los blancos si ha trabajado en una de las siguientes areas dentrode los ultimos 3 años.

_____ Rancho/finca de frutas

_____ Calificador de frutas/vegetales

_____ Trabajador en la labor

_____ Trabajador en una polleria

_____ Pescador de vegetales

_____ Pescador de frutas

_____ Trabajador en un rancho o finca

_____ Transportando frutas o vegetales

_____ Trabajador en la leña

_____ Otros trabajos agriculturales

_____ Trabajador de lecheria

_____ Trabajador en un jardin de plantas (Nurseria)

_____ Rancho/finca de pecas (peces tropicales no incluidos)

3. Si usted contesto sí, por favor continue con lo siquiente.

Nombre de alumno/alumna: _____ Fecha: _____

Nombre de escuela: _____

Nombre de padres: empléo al presente:

Padre: _____ _____

Madre: _____ _____

Numero de teléfono en su casa: _____

Numero de teléfono en caso de emergencia: _____

Dirección de su casa/hogar: _____

Instrucción de como llegar a su casa: _____

FLORIDA DEPARTMENT OF HEALTH

FLORIDA CERTIFICATION OF IMMUNIZATION

Legal Authority: Sections 1003.22, 402.305, 402.313, Florida Statutes; rules 64D-3.046, 65C-20.011, Florida Administrative Code

LAST NAME	FIRST NAME	MI	DOB (MO/DA/YR)
PARENT OR GUARDIAN	CHILD'S SS# (optional)	STATE IMMUNIZATION ID# (optional)	

Directions:

- Enter all appropriate doses and dates below.
- Sign and date appropriate certificate (A, B, or C) on form.
- See "Immunization Guidelines Florida Schools, Child Care Facilities and Family Day Care Homes" for information and instructions on form completion. Guidelines are available at: http://us/disease_ctrl/immune/schoolguide.pdf.

VACCINE	DOE CODE	Dose 1 MO/DA/YR	Dose 2 MO/DA/YR	Dose 3 MO/DA/YR	Dose 4 MO/DA/YR	Dose 5 MO/DA/YR
DTaP/DTP	A					
DT	B					
Td/Tdap	C					
Polio	D					
Hib	E					
MMR (Combined)	F					
(Separate)	G, H,	*Measles (dose 1)*	*Measles (dose2)*	*Mumps (dose 1)*	*Mumps (dose 2)*	
	I	*Rubella (dose 1)*	*Rubella (dose 2)*			
Hepatitis B	J					
Varicella	K					
Varicella Disease	L	Year				
PneumoConju						

Select appropriate box(es)

Certificate of Immunization for K-12

☐ Part A-Complete

Part A (Immunizations are complete for school entry and attendance and meet requirements for kindergarten and/or 7th grade {and for grades kindergarten through 12.} I have reviewed the records available, and to the best of my knowledge, the above named child has adequately been immunized for school attendance as documented above.) DOE Code 1

Temporary Medical Exemption Expiration date: _____

☐ Part B-Temporary

Part B (For children in day care, family day care homes, preschool and kindergarten grades through 12 who are incomplete for immunization in Part A) Invalid without expiration date. DOE Code 2

Permanent Medical Exemption

☐ Part C-Permanent

Part C (For medically contraindicated immunizations, list each vaccine and state valid clinical reasoning or evidence for exemption.)
DOE Code 3 _____
I certify the physical condition of this child is such that immunization(s) as indicated in Part C above is medically contraindicated.

Physician or Clinic Name

_____

_____

_____

Physician or Authorized Signature: _____

Issued By: _____

Date: _____

FLORIDA CERTIFICATION OF IMMUNIZATION

Legal Authority: Sections 1003.22, 402.305, 402.313, Florida Statutes; rules 64D-3.046, 65C-22.011 Florida Administrative Code

PATIENT	TEST		01/01/2006
Last Name	First Name	MI	DOB
MOM PATIENT		9900001032	
Parent or Guardian	Child's SS# (optional)	State Immunization ID#	

Directions:

* *For additional information: See Immunization Guidelines for School and Child Care Facilities for information and instructions on form completion and immunization requirements. Guidelines are updated annually and are available from the local county health department.*

VACCINE	DOE CODE	Dose 1 MO/DA/YR	Dose 2 MO/DA/YR	Dose 3 MO/DA/YR	Dose 4 MO/DA/YR	Dose 5 MO/DA/YR
DTaP/DTP	A					
DT	B					
Td/Tdap	C				*Booster*	
Polio	D					
HIB	E					
MMR (Combined)	F					
(Separate)	G,H	*Measles (dose 1)*	*Measles (dose 2)*	*Mumps (dose 1)*	*Mumps (dose 2)*	
	I	*Rubella (dose 1)*	*Rubella (dose 2)*			
Hepatitis B	J					
Varicella	K					
Varicella Disease	L	*Year*				
PneuConju						

Certificate of Immunization for K-12

PART A (Immunizations are complete for school entry and attendance for grades kindergarten through 12:) DOE Code 1

I have reviewed the records available, and to the best of my knowledge, the above named child has been adequately immunized for school attendance as documented above.

Physician or Clinic Name:
BUREAU OF IMMUNIZATION
2585 MERCHANTS ROW BLVD
TALLAHASSEE, FL 32399

Physician or Authorized Signature: TEST DOCTOR

Electronic Certification: MD4N6GWBLG9

Date: 07/03/2007

Issued By: TEST USER

Form DH-680, 01-07 Stock Number: 7400006800

Sample

FLORIDA DEPARTMENT OF HEALTH

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.

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.

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 _____ Date of Birth _____ / _____ / _____
First Middle Last 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