

District School Board of Madison County

WITHDRAWAL FORM

_____ School
 _____ Street

 City State Zip

Date _____

Student # _____ Grade _____

Name _____ Date of Birth _____
 Last First Middle

Reason _____ Withdrawal Code _____

AUTHORIZATION TO LEAVE:

Parent Signature _____ Other _____

Counselor Signature _____

****Students are required to check in textbooks and clear all library accounts ****

Please indicate grade for work done since last reports were posted.

NINE WEEKS GRADING PERIOD:

1 2 3 4 (circle)

Class Period	Teacher	Course Number	Subject	Grade	Days	Books Returned	Amt Owed	Amt Paid	Initial
H.R.									
1									
2									
3									
4									
5									
6									
7									
8									

Attach a copy of report card from previous nine/six weeks grading period.

EXCEPTIONAL EDUCATION OR ADDITIONAL PROGRAMS: (Identify, e.g., Migrant, ESOL)

Library: Books Returned Yes C] NO _____ Media Specialist _____

Attendance _____ Treasurer _____

Other _____ Principal or Designee _____

Grading System: A - Excellent (100-90) B - Good (89-80) C - Average (79-70) D - Poor (69-60) F - Failure (Below 60) U - Unsatisfactory S - Satisfactory

District School Board of Madison County
Student Registration Form 2017-2018

School: _____ Date: _____ Birth Verification: _____ Assignment: _____

Code: To be completed by the parent/legal guardian: _____

Student's Full Legal Name: _____

Last: First: Middle: Suffix: Nickname: _____

Date of Birth ____/____/____ *Social Security Number _____ ☐ Yes ☐ No This student is a child of an active
Month Date Year Military Family.

Gender: (Check One) Ethnicity: (Check One) Race: (Check all that apply)
☐ Female ☐ No, not Hispanic or Latino ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Male ☐ Yes, Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander ☐ White

Grade: _____ Birth City: _____ Birth State: _____ Birth Country: _____

If Birth Country is not "US", has the student attended school in the US for more than three years? ☐ Yes ☐ No Date Entered US School: _____

Has this child ever been enrolled in a Madison County School? ☐ Yes ☐ No If Yes, Where: _____

Last School Attended: _____ School Address: _____ County: _____

Has this student ever had any previous retentions? ☐ Yes ☐ No If yes, which grade level(s)? _____

House #: _____ Street Name: _____ Apt. #: _____ City: _____ State: _____ Zip Code: _____

Mailing Address if different from Residence Address:

House #: _____ Street Name: _____ Apt. #: _____ City: _____ State: _____ Zip Code: _____

Home Telephone: () _____ Student lives with: ☐ Both ☐ Father ☐ Mother ☐ Guardian

Was this student in special education (with an IEP), served as gifted, or have a 504 Plan? ☐ Yes ☐ No If Yes, which program: _____

Has this student had any previous expulsion, felony arrests resulting in a charge, or juvenile justice actions? ☐ Yes ☐ No (If yes, complete follow up with AP)

Did the student have a first language other than English? ☐ Yes ☐ No If Yes, which language? _____ (Native Language)

Is a language other than English used in the home? ☐ Yes ☐ No If Yes, Which language? _____ (Parent/Guardian Language)

Does the student most frequently speak a language other than English? ☐ Yes ☐ No If Yes, which language? _____

*=Optional-(refer to Registration Requirements Handout) Florida Statue 119.071(5) requires that we notify you of the purpose for collecting and utilizing your social security number (SSN). The SSN is being requested on this form for student records and reporting (1002.221 F.S.), cumulative student records (1003.25(1) F.S.), records of children in the voluntary prekindergarten education program (1002.72(1) F.S.), and student records - dropout prevention and academic intervention programs (1003.53(6)F.S.) **COMPLETE BACK OF SHEET (OVER)**

Parent Guardian Information: (The adult Male and/or Female with whom the student lives.)

Last Name First Name Relationship Home Phone () Work Phone () Ext. Cell or Pager (circle one) ()

Legal Custody/Guardianship? ☐ Yes ☐ No/NA Permission to Pick up? ☐ Yes ☐ No Email Address: _____

Last Name First Name Relationship Home Phone () Work Phone () Ext. Cell or Pager (circle one) ()

Is there a shared-custody or parenting plan in effect? ☐ Yes ☐ No (If yes, plan must be on file with the school for enforcement.)

Is there a restraining order in effect? ☐ Yes ☐ No (If yes, legal papers must be on file with the school for enforcement.)

Restraining Order Against: ☐ Mother ☐ Father ☐ Other _____

Is this student in a homeless situation (e.g., living in an emergency or transitional shelter, car, trailer park, outdoors, hotel/motel, or with other family *due to economic hardship*)? ☐ Yes ☐ No (If yes, please complete Student Residency Form)

Is this student *awaiting* foster care placement? ☐ Yes ☐ No (If yes, please complete Student Residency Form)

Is the Child under DCF (Department of Children and Families) Supervision? ☐ Yes ☐ No

Local persons or parent to call in an emergency other than contacts listed above:

Last Name First Name Relationship Home Phone () Work Phone () Ext. Cell or Pager (circle one) ()

Legal Custody/Guardianship? ☐ Yes ☐ No/NA Permission to Pick up? ☐ Yes ☐ No Email Address: _____
Address: _____ (optional)

Last Name First Name Relationship Home Phone () Work Phone () Ext. Cell or Pager (circle one) ()

Legal Custody/Guardianship? ☐ Yes ☐ No/NA Permission to Pick up? ☐ Yes ☐ No Email Address: _____
Address: _____ (optional)

Siblings Information (School Age):

Last Name	First Name	Grade	Age	School Attending
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

I am the parent/guardian of the child named above. The information on this form is true and accurate as of this date. I understand that falsification of information to achieve enrollment or assignment may be cause for revocation of the student's enrollment or assignment to a school in the Madison County Public Schools. I understand that it is my responsibility as parent/guardian to keep this information current. I give permission for the information on this form to be reviewed and utilized by the staff of this school and by district personnel to assist in the provision of school health services, and be disclosed to relevant state agencies to facilitate the process of verifying current Medical eligibility (if applicable).

Parent/Guardian Signature _____

Date _____



REQUEST FOR STUDENT RECORDS

To: _____

Date: _____

For enrollment purposes, please email, fax, or mail the following information for:

Student Name: _____ DOB: _____

_____ Official Transcript of Grades

_____ Standardized Test Scores

_____ Immunization Record

_____ Health Physical Form

_____ IEP/504

_____ Psychological Reports

_____ Withdrawal Grades

_____ Birth Certificate

Forward Records to:

Madison Creative Arts Academy
2812 W. US 90
Madison, FL 32340
Fax: 850-973-8974
barrsj@mcaa.academy

(Signature of Parent or Guardian)

2812 W. US 90, Madison, Florida 32340
Phone: (850) 973-2529 Fax: (850) 973-8974
www.mcaa.academy

Madison Creative Arts Academy, Inc. is a tuition-free public charter school and will not discriminate illegally on the basis of sex, race, religion, national origin, disability, or age as to employment or educational programs and activities.

**DISTRICT SCHOOL BOARD OF MADISON COUNTY
EMERGENCY AND HEALTH INFORMATION**

Student's Name _____ Sex _____ Birthdate _____

Grade _____ Teacher _____ School _____

Student's Mailing Address _____ Phone _____

(If address or phone number changes, please contact school with the new information)

Directions to Home _____

	Relationship:	Employer Name, Address & Phone:
Male Head of Household (Last, First, Initial) _____	<input type="checkbox"/> Parent	_____
	<input type="checkbox"/> Guardian	_____
	<input type="checkbox"/> Other	_____
Female Head of Household (Last, First, Initial) _____	<input type="checkbox"/> Parent	_____
	<input type="checkbox"/> Guardian	_____
	<input type="checkbox"/> Other	_____

Person to Contact if Parent Listed Above Cannot Be Reached

Name _____	Relationship _____	Phone _____	Name _____	Relationship _____	Phone _____
Name _____	Relationship _____	Phone _____	Name _____	Relationship _____	Phone _____
Name _____	Relationship _____	Phone _____	Name _____	Relationship _____	Phone _____

Hospital Preference _____ School Insurance? ☐ Yes ☐ No Medicaid Number (Required) _____ Other Insurance? ☐ Yes ☐ No Kid Care? ☐ Yes ☐ No

Physician's Name _____ Phone _____ Dentist's Name _____ Phone _____

MEDICATIONS: Is the student taking any regular medication (including over-the-counter medications)? ☐ Yes ☐ No

_____	_____
_____	_____
_____	_____

Medication Allergies: ☐ Yes ☐ No (Life Threatening or Non-Severe)

Food Allergies: ☐ Yes ☐ No (Life Threatening or Non-Severe)

_____	_____
_____	_____

Other Allergies: ☐ Yes ☐ No

HEALTH PROBLEMS: ☐ History of Asthma ☐ Active Asthma ☐ Diabetes (Type 1 or Type 2) ☐ Seizures ☐ Cardiac Condition ☐ Nosebleeds ☐ Sickle Cell Disease ☐ Sickle Cell Trait ☐ ADD ☐ ADHD ☐ Psychiatric Condition ☐ Kidney Disorders ☐ Autism ☐ Asperger's ☐ Cancer ☐ Migraines

List any others: _____

Record any injury or major illness student has had: _____

Does the child wear glasses? ☐ Yes ☐ No

Does the child wear a hearing aid? ☐ Yes ☐ No

I hereby give consent for my child to receive an EpiPen injection if medically necessary. ☐ Yes ☐ No

I HEREBY GIVE CONSENT FOR MY CHILD TO PARTICIPATE IN THE FOLLOWING HEALTH SERVICES:

☐ **SCOLIOSIS SCREENING** (Curvature of the Spine)
(6th & 7th Grades)

☐ **PUBERTY CLASSES**
(5th & 6th Grade Girls & Boys)

☐ **TOBACCO PREVENTION EDUCATION**
Prevention Surveys

☐ **NUTRITION CLASSES**
(Age Appropriate)

☐ **PEDICULOSIS SCREENING** (Head Lice)
(All Grade Levels)

☐ **HIV/AIDS EDUCATION**
(K-12th Grade Appropriate)

☐ **DENTAL HEALTH CLASSES**
(Age Appropriate)

☐ **TEEN PREGNANCY PREVENTION EDUC.**
(Age Appropriate)

THE FOLLOWING SERVICES ARE DONE ROUTINELY:

Emergency Medical Care

First Aid

Head Lice Screenings (Targeted Grades)

Hearing & Vision Screening (Targeted Grades)

Weight & Height Screening (Targeted Grades)

Body Mass Index (Targeted Grades)

List any activity in which you do not want your child to participate.

I hereby give my consent for my child to participate in the School Health Services Program. In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to contact the physician indicated on this form and to follow his instructions. If it is impossible to contact this physician, the school may make whatever arrangements are necessary to provide care and treatment of my child. In the case of an accident or illness where immediate treatment of my child is not indicated but where (she)he is unable to remain at school, I request that the school contact me or my spouse to arrange transportation for my child. If the school is unable to contact either me or my spouse, I request that one of the persons listed on this form be contacted and requested to care for my child until I can be reached.

Parent or Guardian Signature

Date

If my child is Medicaid eligible, I authorize the School District of Madison County, Florida to release and exchange my child's confidential information to agencies of the State of Florida which would allow Madison County Schools to receive Medicaid funding for exceptional student services provided to my child while at school.

Parent or Guardian Signature Date

Date

The School Health Program of the Florida Department of Health in Madison County will be billing Medicaid for school clinic services for the school year 2017-2018 to help support the delivery of health care services throughout the district. By signing below, you are giving the School Health Program permission to access your child's public benefits to pay a share of the cost for services provided. At no time will you be required to incur out of pocket expenses for these services regardless of your child's Medicaid eligibility status. Any personally identifiable information about your child will not be disclosed to any other organization for any purpose except what has been noted above.

By signing below you are giving the School Health Program permission to utilize health information on the Emergency Health Form that is required by the Agency for Health Care Administration in order to verify Medicaid eligibility. You have the right to revoke this consent at any time. Failure to provide consent will not affect the health services your child is eligible to receive.

Parent or Guardian Signature Date

Date

Madison County District Schools Student Residency Questionnaire

Student's Name _____ Grade: _____ Homeroom: _____ Date: _____

Your child/children may be eligible for additional educational services through Title I Part A, Title IX, Part A (formerly known as Title X Part C) Federal McKinney-Vento Homeless Assistance Act. Please answer the following questions to determine eligibility: **If you and/or your family are presently living in one of the following situations:**

- ☐ My Family lives in an emergency or transitional shelter or FEMA trailer. (A)
- ☐ My family is living with **another family** due to loss of housing, economic hardship or a similar reason; doubled up (B)
- ☐ My family is living in a car, park, temporary trailer park or campground due to lack of alternative adequate accommodations, public space, abandoned building, substandard housing, bus or train station, public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings or similar settings. (D)
- ☐ My family lives in a hotel or motel. (E)
- ☐ A child/youth in my home is not in the physical custody of a parent or a guardian. (Unaccompanied Youth) (Y)



IF YOU ARE NOT LIVING IN ONE OF THE SITUATIONS ABOVE, STOP HERE!



Please provide the following information of ALL school-age children in your home.

Student Name	Grade	Date of Birth	School

Have you moved in the past 3 years to seek work in pine straw, farming, dairy, chickens, or other? ☐ Yes ☐ No

Are there any siblings 0-4 years old living in the home? ☐ Yes ☐ No

IF YOU MARKED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE INDICATE THE CAUSE BY PLACING AN "X" IN THE APPROPRIATE BOX.

- ☐ Mortgage Foreclosure (M)
- ☐ Natural Disaster—Flooding (F)
- ☐ Natural Disaster—Wildfire or Fire (F)
- ☐ Natural Disaster—Tropical Storm (S)
- ☐ Natural Disaster—Tornado (T)
- ☐ Other (i.e. lack of affordable housing, long-term poverty, unemployment or underemployment, lack of affordable health care, mental illness, domestic violence, forced eviction, etc.) (O)
- ☐ Man-made Disaster (major) D
- ☐ Natural Disaster—Hurricane (H)

Parent/Guardian Name: _____

Relationship to Student: _____

Address: _____

Name of Person Living With: _____

Signature of Parent/Guardian _____

Contact Number: _____

****Return form to Paula Ginn or Mimi Replogle ****

For more information, please contact Paula Ginn at 850-973-1534 (paula.ginn@madison.k12.fl.us) or Mimi Replogle at 850-973-5887 (mimi.replogle@madison.k12.fl.us)

SCHOOL USE ONLY

I certify the above named student qualifies for the Student in Transition Program under the provisions of the McKinney-Vento Act and as such is qualified for the Free Lunch Program under the provision of the McKinney-Vento Act.

Paula Ginn, Federal Programs Coordinator

Date _____

Students in Transition Liaison Use Only:

- ☐ Focus Data Entry
- ☐ School Liaison Contact
- ☐ Food Service Contact



Topical/DEET/Photo Permissions

When our students have scrapes, abrasions, stings, etc. we are not allowed to apply topical medications such as Bactine, alcohol, peroxide, hydrocortisone, Neosporin, Vaseline, etc. We would like your permission to do so when needed. Please indicate your willingness for us to use these topical medications on your child.

_____ Yes, you may apply topical medications on my child's scrapes, abrasions, stings, etc.

_____ No, you may not apply topical medications on my child's scrapes, abrasions, stings, etc.

As you know, Florida has had confirmed cases of humans infected with the West Nile Virus. The Center for Disease Control states that the chance of becoming ill from a mosquito bite is low. However, they do recommend the use of an insect repellent containing DEET (N, N-diethyl-meta-toluamide).

Madison Academy plans to spray the **clothing** of students before they go outside for recess or physical education as deemed necessary by the teachers or staff, especially those children who go outside in the early morning or the latter part of After School Care. The insect repellent used will contain a maximum concentration of 10% DEET as recommended for children by the National Biological Information Infrastructure.

_____ Yes, Madison Academy teachers or staff may spray the clothing of my child with an insect repellent containing a maximum concentration of 10% DEET.

_____ No, Madison Academy teachers or staff may NOT spray the clothing of my child with an insect repellent containing a maximum concentration of 10% DEET.

Also, we need permission to use your child's photo when we have school articles in the newspapers, on our advertising brochures, and on our web site. Photos used on our web site will not include names.

_____ Yes, you may use my child's photo as aforementioned.

_____ No, you may not use my child's photo as aforementioned.

Student Printed Name

Parent/Guardian Signature

Date

Parent/Guardian Printed Name: _____



MCAA Grandparent's Club

The Madison Creative Arts Academy Grandparent's Club will support the school and its mission through various projects throughout the year. Club members may donate hours of service at school functions, mentor students and staff members, or participate in fund raising events. We would like to invite your grandparent(s) to join in the fun! Help us invite them by providing their contact information below.

Name of Student: _____

Grandparent(s): _____

Address: _____

City, State, Zip: _____

Email: _____

Phone: _____

Grandparent(s): _____

Address: _____

City, State, Zip: _____

Email: _____

Phone: _____

Grandparent(s): _____

Address: _____

City, State, Zip: _____

Email: _____

Phone: _____

2812 W. US 90, Madison, Florida 32340
Phone: (850) 973-2529 Fax: (850) 973-8974

www.mcaa.academy

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District School Board of Madison County

Occupational Survey

Parent or Guardian Name

Child's Name

Child's Birthdate

Child's Grade

☐

Child's School

☐

MCCS

☐

MCHS

☐

LES

☐

GES

☐

PES

☐

EXCEL

☐

JMPHS

MCAA

This school system is interested in providing help to children whose family has had to move from one school district to another so a member of the family could work/seek work in certain kinds of jobs. Please assist us in finding out which children we will be able to serve in this special project by filling out one of these forms.

Present Occupation: _____

Have you or anyone in your family crossed state or county lines to work or seek work in one of the following occupations, either full-time or part-time during the last three years?

Yes **No**

Occupation or Type of Work

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Farming (plowing, planting, cultivating, harvesting, and process of farm crops) |
| <input type="checkbox"/> | <input type="checkbox"/> | Dairy Work |
| <input type="checkbox"/> | <input type="checkbox"/> | Livestock Work (hoofing, cutting, branding, feeding and rounding up) |
| <input type="checkbox"/> | <input type="checkbox"/> | Poultry or Egg Work |
| <input type="checkbox"/> | <input type="checkbox"/> | Planting, Growing or Harvesting of Trees |
| <input type="checkbox"/> | <input type="checkbox"/> | Commercial Fishing (fresh/saltwater, crabbing, and shrimping) |
| <input type="checkbox"/> | <input type="checkbox"/> | Working on a Fish Farm |
| <input type="checkbox"/> | <input type="checkbox"/> | Processing or Hauling of Farm/Fish Products |

If you marked yes in any category above, please continue on and answer the question below. If you checked No to all items, you may stop at this point.

Did your child(ren) move with you? ☐ Yes ☐ No

Parent/Guardian Signature

Date

Address

Home Phone Number

Cell Phone Number

Work Phone Number

Junta del Distrito Escolar del Condado de Madison

Encuesta Ocupacional

Parents: Please return to your child's school.

School Sites—Please return to: Mimi Replogle or Nicolas Gonzalez at MCCS or District Office

Updated 03/2015

Nombre del Padre o Tutor

El nombre del niño

Fecha de nacimiento del niño

Grado del niño

Escuela del Niño ☒ MCCS ☐ MCHS ☐ LES ☐ GES ☐ PES ☐ EXCEL ☒ JMPHS ☒ MCAA

Este sistema de la escuela está interesada en la prestación de ayuda a los niños y familia que ha tenido que pasar de un distrito escolar a otro por lo que un miembro de la familia puede trabajar / buscar trabajo en ciertos tipos de puestos de trabajo. Por favor ayúdenos en conocer cual son los niños que vamos a poder servir en este proyecto especial completando una de estas formas.

Ocupación Actual : _____

¿Usted o alguien en su familia cruzaron las fronteras estatales o del condado para trabajar o buscar trabajo en una de las siguientes ocupaciones, ya sea a tiempo completo oa tiempo parcial durante los últimos tres años?

Sí No

Profesión o Tipo de Trabajo

☐ ☐

Agricultura (arado, la siembra, el cultivo, la cosecha, y el proceso de los cultivos agrícolas)

☐ ☐

Trabajo lácteos

☐ ☐

Trabajo Ganadero (hoofing, el corte, la marca, la alimentación y el redondeo)

☐ ☐

Las aves de corral o huevos Trabajo

☐ ☐

Plantar, Crecer o recolección de árboles

☐ ☐

Pesca comercial (fresco / agua salada, pesca de cangrejos y camarón)

☐ ☐

Trabajo en una piscifactoría

☐ ☐

Procesamiento o Acarreo de Granja / Productos de Pescado

Si marcó sí en cualquiera de las categorías anteriores, por favor, seguir adelante y responder a la pregunta de abajo. Si marcó No a todos los elementos, puede detenerse en este punto.

¿Su hijo (a) se mueven con usted?

☒ Sí

☐ No

Firma del Padre / Tutor

Fecha

Dirección

Número De Teléfono De Casa

Número Celular

Número de teléfono del trabajo

Actualizado 06/2015