

207 N. San Marco Avenue
Saint Augustine, Florida 32084

904.827.2200
www.fsdb.k12.fl.us

APPLICATION FOR STUDENT EVALUATION

Name of Child:			
Last	First	Middle	
DOB: / /	Sex:		
Month/Day/Full Year			
Place of birth:			
City	State	Country	
Mark one or more racial/ethnic groups for your child:			
Asian <input type="checkbox"/>	White <input type="checkbox"/>	Hispanic or Latino <input type="checkbox"/>	Black or African American <input type="checkbox"/>
American Indian or Alaska Native <input type="checkbox"/>	Native Hawaiian or Other Pacific Islander <input type="checkbox"/>		

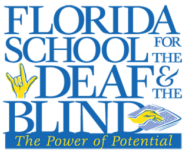
Parent/Guardian Personal Information:

	Father	Mother	Guardian
Title:	Mr. <input type="checkbox"/> Other:	Mrs. <input type="checkbox"/> Other:	Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Other:
Last Name:			
First Name:			
Address:			
City, State, Zip: , , , , ,			
County:			
Home Phone:	<input type="checkbox"/> TDD	<input type="checkbox"/> TDD	<input type="checkbox"/> TDD
Work Phone:	Ext:	Ext:	Ext:
Unlisted Phone:			
Cell Phone:			
Fax:			
Email:			

Parent's Marital Status: Married
 Divorced (Name of Parent where child lives):
(Please include a copy of the custody papers)
 Other (please explain):

Who has legal custody of the child?

Is your child:	Deaf/Hard of Hearing	<input type="checkbox"/>	
	Visually Impaired	<input type="checkbox"/>	
	Dual Sensory Impaired (Deaf/Blind)	<input type="checkbox"/>	
Is your child being served in a Special Education Class in his/her local school?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is your child in a Program for the Deaf/Hard of Hearing?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is your child in a Program for the Visually Impaired?		Yes <input type="checkbox"/>	No <input type="checkbox"/>
Please list other Exceptional Student Education (ESE) programs or services your child receives:			
<p>Please include a copy of the most recent Individual Educational Plan (IEP).</p> <p>Please be sure to sign the Permission for Release of Information on next page.</p>			



207 N. San Marco Avenue
Saint Augustine, Florida 32084

904.827.2200
www.fsdb.k12.fl.us

PERMISSION FOR RELEASE OF INFORMATION

Name of Child: _____

DOB: _____

Please list all schools or other programs your child has attended: (Use additional paper if needed)

Name of School or Program	Complete Address City, State, ZIP	Dates of Attendance
	,	
	,	
	,	

Please list the name, address and phone number of any service provider who has treated your child: (Use additional paper if needed)

Name	Complete Address City, State, ZIP	Telephone Number
Family Doctor	,	
Pediatrician	,	
Neurologist	,	
Cardiologist	,	
Geneticist	,	
Ophthalmologist	,	
Psychiatrist	,	
Psychologist	,	
Counselor	,	
Educational Evaluator	,	
Audiologist	,	
Low Vision Specialist	,	
Other	,	

****By my signature below, I certify that I have listed above ALL persons, facilities, and other providers that have delivered educational, medical, psychological or other services to my child. In addition to the above, I agree to provide updated information regarding such future services that may be provided to my child. I hereby give my consent for any educational, medical, psychological or other service provider to forward all documentary information, including all medical, psychological and psychiatric information, to the Florida School for the Deaf and the Blind upon request of the School. Failure to provide all information or falsification of information will prevent applications from being processed and/or result in dis-enrollment if the student is found eligible based on incomplete/inaccurate information.

SIGNATURE OF PARENT/GUARDIAN: _____

DATE: _____

This permission for release of information will expire one year from the date of signature above.



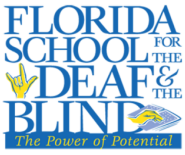
207 N. San Marco Avenue
Saint Augustine, Florida 32084

904.827.2200
www.fsdb.k12.fl.us

HEALTH SUMMARY

Name of Child:	DOB:	Sex:
Cause of Deafness or Blindness:		

Allergies to medications:	Special Diet:
Allergies to foods:	Activity Restrictions:
Allergies to other things:	Medications your child is receiving:
Present health of your child:	Special medical treatments your child needs:
Present health problems or concerns:	<p>Please make sure you listed your child's doctor(s) on the Application for Student Evaluation (Release of Information). It is very important for us to have all past medical records.</p>
Behavioral or psychological problems and treatment (excessive fears, hyperactivity, etc.)	
Past illness or injuries:	
Past surgeries:	



207 N. San Marco Avenue
Saint Augustine, Florida 32084

904.827.2200
www.fldb.k12.fl.us

TB QUESTIONNAIRE

Name of Child:	DOB:
Organization administering questionnaire:	Date:

Tuberculosis (TB) is a disease caused by TB germs and is usually transmitted by an adult person with active TB lung disease. It is spread to another person by coughing or sneezing TB germs into the air. These germs may be breathed in by the child.

Adults who have active TB disease usually have many of the following symptoms: cough for more than two weeks duration, loss of appetite, weight loss of ten or more pounds over a short period of time, fever, chills and night sweats.

A person can have TB germs in his or her body but not have active TB disease (this is called latent TB infection or LTBI).

Tuberculosis is preventable and treatable. TB skin testing (often called the PPD or Mantoux test) is used to see if your child has been infected with TB germs. No vaccine is recommended for use in the United States to prevent tuberculosis. The skin test is not a vaccination against TB.

We need your help to find out if your child has been exposed to tuberculosis.

Place a mark in the appropriate box

	Yes	No	Don't Know
TB can cause fever of long duration, unexplained weight loss, a bad cough (lasting over two weeks), or coughing up blood. As far as you know: has your child been around anyone with any of these symptoms or problems? or	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
has your child had any of these symptoms or problems? or	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
has your child been around anyone sick with TB?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was your child born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has your child traveled in the past year to Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia for longer than 3 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If so, specify which country/countries:			
To your knowledge, has your child spent time (longer than 3 weeks) with anyone who is/has been an intravenous (IV) drug user, HIV-infected, in jail or prison or recently came to the United States from another country?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Has your child been tested for TB? Yes (if yes, specify date) No

Has your child ever had a positive TB skin test? Yes (if yes, specify date) No

For school/healthcare provider use only

PPD administered Yes ___ No ___

If yes, date administered ___/___/___ Date read ___/___/___ Result of PPD test _____ mm response

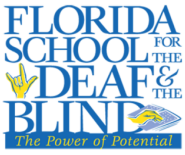
Type of service provider (i.e. school, Health Steps, other clinics) _____

PPD provider _____ _____
signature printed name

Provider phone number _____ City _____ County _____

If positive, referral to healthcare provider Yes ___ No ___

If yes, name of provider _____



207 N. San Marco Avenue
Saint Augustine, Florida 32084

904.827.2200
www.fsdb.k12.fl.us

PROOF OF FLORIDA RESIDENCY

NOTARIZED RESIDENCY FORM MUST BE RETURNED WITH APPLICATION FOR STUDENT EVALUATION Persons claiming "Residency" under Florida law must provide proof

Student applicants are classified as Florida or Non-Florida residents in order to determine fees. Residents of Florida who meet FSDB's enrollment criteria may attend the School at no charge. Non-Florida residents are charged tuition.

"Residency" is defined to mean that the person is physically present in a place which is his home. It must be his intention to remain there permanently or for an indefinite period of time.

A. Parent's Residency Affidavit

I, _____, am the (parent or guardian) of _____ who is less than 18 years of age. I claim residency in the State of Florida as of the 1st day of school for my child.

B. STUDENT'S RESIDENCY AFFIDAVIT

I, _____, am the applicant to the Florida School for the Deaf and the Blind. I am, or will be, 18 years of age or older and I will have been a resident of the State of Florida immediately preceding my first day of class

PERSONS CLAIMING RESIDENCY IN "A" OR "B" ABOVE, MUST COMPLETE THE FOLLOWING AND SIGN IN THE PRESENCE OF A NOTARY PUBLIC.

My permanent legal address is:

Address: _____ City: _____ State: FL Zip: _____

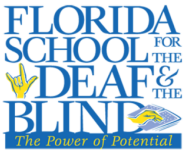
Signature of Florida Resident: _____ Date: _____

This portion to be filled out by a Notary Public only

I, first being duly sworn on my oath, say that information was provided to verify the above statements, and that by virtue of this information the student for whom this application is submitted is entitled to classification as a Florida Student for tuition purposes under 247.331(4)F.S. and Rule 6D-3.01(1)(e)F.A.C.

State of Florida, County of _____ Sworn and subscribed before me this _____ day of _____, 20____.

Signature of Notary Public My commission expires: _____



207 N. San Marco Avenue
Saint Augustine, Florida 32084

904.827.2200
www.fsdb.k12.fl.us

ESOL QUESTIONNAIRE

The laws of the State of Florida require schools to identify and provide services to students whose native language is other than English. As parents, you can help us identify such students by answering the following questions about your child.

Name of child:

Name of school your child is currently attending:

What is your child's current grade in school?

Is your child:	Deaf/Hard of Hearing	<input type="checkbox"/>
	Visually Impaired	<input type="checkbox"/>
	Dual Sensory Impaired (Deaf/Blind)	<input type="checkbox"/>

Mark one or more racial/ethnic groups for your child:

Asian	<input type="checkbox"/>
Black or African American	<input type="checkbox"/>
American Indian or Alaska Native	<input type="checkbox"/>
Native Hawaiian or Other Pacific Islander	<input type="checkbox"/>
White	<input type="checkbox"/>
Hispanic/Latino	<input type="checkbox"/>

What is the ethnic or national origin of parents?

Mother:

Father:

HOME LANGUAGE SURVEY (Consists of 4 Questions)

1. Is a language other than English spoken in the home? Yes No

If yes, what is the other language?

2. Did the student have a first language other than English? Yes No

3. Does the student most frequently speak a language other than English? Yes No

4. When did the student arrive in the US? Month Day Year

Date completed: Month Day Year