MICANOPY ACADEMY

Growing Minds, Hearts & Futures

New Student Enrollment

Print Version

Student Information

*Last Name: _____ *First Name: _____ Middle Name: _____
Name Suffix: _____ Nickname:_____ *Gender: M / F
*Date of Birth: _____ Age: _____ *Birth City: _____ Birth State: _____
*Birth Country: _____ Birth County: _____

(Circle **Y** for Yes and **N** for No)
Y N *Was the student born outside the United States?
*Date Entered the US School (if never attended US school prior to enrollment, please use first date of current enrollment): _____

Y N *Is the student part of a military family?
Mom's Maiden Name: _____
Student Social Security Number (see **Federal State Indicators** below for information): _____

Y N *Is Student Hispanic/Latino?
*Federal Race - Select all that apply:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

*Language Spoken Most: _____ *Native Language: _____
*Language Spoken at Home: _____ *Contact Language: _____

Y N *Is a language other than English used in the home as a primary method of communication?
Y N *Does the student most frequently speak a language other than English?
Y N *Did the student have a first language other than English?
Y N *Has the student attended a school in this district previously?
Previous School District: _____
School in the District Student Previously Attended: _____

What school year is this enrollment for?: _____ *Expected Enrollment Date: _____

*Expected Grade Level: _____ * Expected School to Enroll into: _____

How did you hear about Micanopy Academy?
_____

☐ I authorize this student's directory information to be distributed for the purposes of Military

By checking this box, you allow the sharing of student directory information for military recruitment or other purposes. By not checking, you are opting out of student directory information being shared for such purposes.

☐ I authorize this student's directory information to be distributed for the purposes of Higher Education

By checking this box, you allow the sharing of student directory information with higher education institutions (colleges/universities). By not checking, you are opting out of student directory information being shared with these institutions.

☐ I authorize this student's directory information to be distributed for the purposes of Public usage

By checking this box, you allow the student directory information to be used in such a way as may be seen by the public, such as photographs, video or articles (i.e. television, newspapers, social media, websites, etc.) in which student's directory information is identified. By not checking the box, you are opting out of student directory information being shared for such purposes.

☐ I authorize this student's directory information to be distributed for the purposes of District usage

By checking this box,you allow the student directory information to be used for school and district based purposes, such as yearbooks, sports programs, award announcements, photographs, etc. in which student directory information is identified. By not checking the box, you are opting out of student directory information being shared for such purposes.

Parent Signature _____ Date (MM/DD/YYYY): _____

Family/Guardian Information

Enter Information for the Primary Guardian and the Family this student lives with

*Primary Phone (_____) _____ - _____

***Home Address**

House #: _____ Direction: _____ Street Name: _____ Apartment: _____
PO Box: _____ Address 2: _____ City:_____ State: _____ Zip Code: _____
County: _____

Mailing Address (e.g. P.O. Box) if different than home address

House #: _____ Direction: _____ Street Name: _____ Apartment: _____
PO Box: _____ Address 2: _____ City:_____ State: _____ Zip Code: _____

Enter Information for the Primary Guardian of the Family this Student lives with

*Last Name: _____ *First Name: _____ Middle Name: _____
Name Suffix: _____ Name Prefix: _____ *Date of Birth: (MM/DD/YYYY) _____ *Gender: M F
*Relationship to Child: _____ Marital Status: _____
*Does this guardian have custody of the child? Yes No
*Is this guardian allowed to pick up the student from school? Yes No
Sexual Offender/Predator? Yes No
Cell Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____
Contact Email Address (Required for Family Access and Alerts):_____
Employer: _____

Enter Information for other Legal Guardians who live at this address

*Last Name: _____ *First Name: _____ Middle Name: _____
Name Suffix: _____ Name Prefix: _____ *Date of Birth: (MM/DD/YYYY) _____ *Gender: M F
*Relationship to Child: _____ Marital Status: _____
*Does this guardian have custody of the child? Yes No
*Is this guardian allowed to pick up the student from school? Yes No
Sexual Offender/Predator? Yes No
Cell Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____
Contact Email Address (Required for Family Access and Alerts): _____
Employer: _____

Emergency Contact Information

Enter the Information for Emergency Contact #1

*Last Name: _____ *First Name: _____ Middle Name: _____
Name Suffix: _____ Name Prefix: _____
Gender: M F Date of Birth: (MM/DD/YYYY) _____ *Pick-up student? Y / N
*Primary Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____
Work Phone: (_____) _____ - _____
Relationship to Child: _____ Relationship Comment: _____

Enter the Information for Emergency Contact #2

*Last Name: _____ *First Name: _____ Middle Name: _____
Name Suffix: _____ Name Prefix: _____
Gender: M F Date of Birth: (MM/DD/YYYY) _____ *Pick-up student? Y / N
*Primary Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____
Work Phone: (_____) _____ - _____
Relationship to Child: _____ Relationship Comment: _____

Enter the Information for Emergency Contact #3

*Last Name: _____ *First Name: _____ Middle Name: _____
Name Suffix: _____ Name Prefix: _____
Gender: M F Date of Birth: (MM/DD/YYYY) _____ *Pick-up student? Y / N
*Primary Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____
Work Phone: (_____) _____ - _____
Relationship to Child: _____ Relationship Comment: _____

Enter the Information for Emergency Contact #4

*Last Name: _____ *First Name: _____ Middle Name: _____
Name Suffix: _____ Name Prefix: _____
Gender: M F Date of Birth: (MM/DD/YYYY) _____ *Pick-up student? Y / N
*Primary Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____
Work Phone: (_____) _____ - _____
Relationship to Child: _____ Relationship Comment: _____

Enter the Information for Emergency Contact #5

*Last Name: _____ *First Name: _____ Middle Name: _____
Name Suffix: _____ Name Prefix: _____
Gender: M F Date of Birth: (MM/DD/YYYY) _____ *Pick-up student? Y / N
*Primary Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____
Work Phone: (_____) _____ - _____
Relationship to Child: _____ Relationship Comment: _____
Additional Emergency Contacts can be provided on a separate page or updated at the school following enrollment.

Zoned School

*Are you planning to attend your zoned school? **Y** **N** (for Pre-K ESE and VPK, select No and indicate below)

If **No**, continue

Y **N** Have you applied for **school choice/controlled open enrollment**?
Y **N** Have you applied for a **zoning exception**?
Y **N** Has your student been accepted to a **magnet program**?
If yes, which one? _____
Y **N** Will your student be attending a **charter school**?
If yes, which one? **Micanopy Academy**

Other Schools Check if your student will be attending one of these schools:

- ☐ Sidney Lanier
- ☐ A.Quinn Jones
- ☐ Alachua eSchool (full-time)
- ☐ VPK program - must have VPK voucher (age 4)
- ☐ Pre-K ESE program (age 3-4)

Federal State Indicators

Prior School Information (Circle **Y** for Yes and **N** for No)
Y **N** *As a 3-year-old, did the student attend preschool/daycare? If yes, where: _____
Y **N** *As a 4-year-old, did the student attend preschool/daycare? If yes, where: _____

List all schools and grade levels at each school previously attended if outside of Alachua County.

Required History (Circle **Y** for Yes and **N** for No)
Y **N** *Has the student ever been retained? If so, what grade? _____
Y **N** *Has the student ever participated in a special education (ESE) program?
If so, which program? (Check all that apply)

- ☐ Autism Spectrum Disorder
- ☐ Developmentally Delayed
- ☐ Emotional/Behavior Disability
- ☐ Gifted
- ☐ Hearing Impaired
- ☐ Orthopedically Impaired
- ☐ Specific Learning Disability (SLD)
- ☐ Speech Therapy
- ☐ Language Therapy
- ☐ Visually Impaired
- ☐ Other Health Impaired
- ☐ Other:

Y **N** *Has the student ever attended an alternative school? If so, in what grade level(s)? _____
Y **N** *Has the student been expelled from another school?
Y **N** *Has the student been arrested or charged with an offense?
Y **N** *Has the student been involved with the juvenile justice system?
Y **N** * Has the student been issued a juvenile civil citation?

Social Security Number Acknowledgement
☐ *I acknowledge that the school district is required to request my student's social security number pursuant to section 1008.386, Florida Statutes, but I am not required to provide it as a condition of enrollment. (For more information on the uses of SS# by the district, please refer to the Office of Student Assignment website at www.sbac.edu.)

Parent Signature _____ Date (MM/DD/YYYY): _____

Health Information

Medical Information

Physician's Name: _____ Physician's Phone: _____
Date of Health Examination: _____
Hospital Preference (See Medical Emergency Release Below): _____

Insurance (Circle **Y** for Yes and **N** for No)
Y N *Medicaid
Y N *School Insurance
Y N *Other Insurance

Foster Care Agency Worker (if applicable): _____ Phone: _____

Conditions

(Circle **Y** for Yes, **Y-WT** for Yes with Treatment, and **N** for No)
Y Y-WT N *Allergies If **Y** or **Y-WT**, list allergies (ex, food, bee sting, etc.): _____
Y Y-WT N *Endocrine/Metabolic (Diabetes, etc)
Y Y-WT N *Renal (Urinary, Kidneys, Bladder, etc.)
Y Y-WT N *Gastrointestinal (Stomach, G-Tube)
Y Y-WT N *Heart/Blood/Circulatory(Heart Defect, Sickle Cell, etc.)
Y Y-WT N *Vision If **Y** or **Y-WT**, Corrective Lenses (glasses or contacts) ☐
Y Y-WT N *Respiratory (Asthma, Tracheostomy, Cystic Fibrosis, etc.)
Y Y-WT N *Neurological (Seizures, Epilepsy)
Y Y-WT N *Skin (Eczema, etc.)
Y Y-WT N *Muscular/Skeletal (Scoliosis, Spina Bifida, CP, MD etc.)
Y Y-WT N *Hearing If **Y** or **Y-WT**, Hearing Aids or Coclear Implants ☐

☐ Referred for Mental Health Services
Y Y-WT N *Mental Health (ADD, ODD, Depression, Bipolar, Anxiety, etc.) If **Y** or **Y-WT**, describe:
Restrictions:

Other Health Issues:

Current Medications:

MEDICAID BILLING STATEMENT (Required, even if not currently on MEDICAID)

(Circle **Y** for Yes and **N** for No)
Y N
By choosing YES above, I understand and give my consent to the school district to share information about my child with the State Medicaid Agency (State of Florida Agency for Health Care Administration), its fiscal agent, and the school district's Medicaid billing agent or billing facilitator for the school district to verify Medicaid eligibility, seek Medicaid reimbursement, and satisfy audit and review requests related to services provided to my child. I understand that I may withdraw this consent to release information for Medicaid reimbursement at any time. I understand that if I refuse to give my consent or withdraw this consent, the school district will continue to provide all required services necessary to receive an appropriate education at no charge to my child in accordance with 34 CFR § 300.154(d)(2)(v)(D) or other services provided outside of the IEP/Service Plan. If consent is withdrawn, it will become effective on the date of withdrawal and no information will be released after that date. The information shared may include my child's name, date of birth, address, primary special education disability (if applicable), Social Security number, Florida Medicaid identification number, and the type and amount of health services provided, including the times and dates services were provided. Services may include assistive communication services, counseling services, physical therapy services, occupational therapy services, speech therapy services, hearing and language therapy services, behavioral services, transportation services, and nursing services. The records to be released or exchanged may include IEPs/Service Plans, assessment and eligibility records, related service therapy records and logs, transportation logs, progress notes, and nursing reports or records.

By choosing NO above, I do NOT give my consent to the school district to share information about my child in order for the school district to verify Medicaid eligibility, seek Medicaid reimbursement, and satisfy audit and review requests related to services provided to my child.

MEDICAL STATEMENTS

My child will receive emergency care at the school, if needed. Screening and evaluation for problems in areas of vision, hearing, growth and development, nutrition, dental, scoliosis, communicable diseases, blood pressure, speech and language, or other non-invasive health screenings will be done as part of the School Health Service program by written consent. I may choose to opt-out of any of the School Health Service screenings in writing pursuant to Florida Statutes, 381.0056.
**COVID-19 testing is considered an "invasive screening" and requires additional specific parental consent.
In the event of a serious accident or illness, the school will attempt to contact me. If I cannot be reached, designated school personnel will take or send my child to the hospital specified above. In some circumstances, Emergency Services personnel may determine that another hospital should receive my child. I consent to be responsible for all expenses incurred. In case of an accident or illness where immediate medical treatment is not indicated, but where my child is unable to remain in school, the school will contact me. If I cannot be reached, the school will contact persons listed as emergency contacts with pick-up rights to remove my child from school and to be responsible for his/her care. These persons listed have transportation and are immediately available to come to school.

In the case of a mental health emergency including risk to my child or others, a Mobile Response Team will provide outpatient crisis intervention services including individual therapy, group therapy, counseling, or other forms of verbal therapy provided by a trained mental health professional. I understand that this service will be used in an effort to reduce the risk of an involuntary Baker Act. I give consent for the Mobile Response Team to provide this service in case of emergency. To refuse consent for this mental health crisis intervention I understand that I must provide a letter to the school principal to opt-out.

Parent Signature _____ Date (MM/DD/YYYY): _____

Consent for Annual Health Services

In accordance with Florida Statute 381.0056, our district's Health Services Program will offer several different services in order to promote student's health and wellness, to enhance learning and support success.

All students will be provided with emergency care, first aid treatment, and acute care (defined as providing medical care for sudden or severe symptoms that appear, change or worsen rapidly) as deemed necessary by a nurse's initial assessment and clinical expertise.

Each year, state and program required health screenings are performed in the following grades:

- Height and Weight (BMI) – 1st, 3rd, 6th
- Vision – Kg, 1st, 3rd, 6th
- Hearing – Kg, 1st, 6th
- Scoliosis – 6th
- Dental – 3rd

Additionally, students entering Florida schools for the first time in grades Kg-5 will be screened for vision and hearing. Individual students may be referred for screenings as needed, such as a teacher who notes that a student is having difficulty with vision. Parents will always be notified of screenings performed, and are encouraged to seek medical evaluation if problems are identified through the screening process. Results of screenings performed will be sent home, and may also be provided at parent/guardian request.

The following are health services offered and provided to all students in the Alachua County School District. Please indicate by selecting yes or no for your child to participate in each service. This consent will remain valid throughout the school year unless indicated in writing:

(Circle **Y** for Yes and **N** for No)
Y N * Care management for chronic health conditions (medications/treatments)
Y N * Individualized health care plan development
Y N * Vision screening
Y N * Hearing screening
Y N * Height and weight (BMI) screening
Y N * Scoliosis screening
Y N * Dental screening
Vaccines: Certain optional vaccines will also be offered at the school, such as the Flu Mist. A separate consent form will be sent home for those, and a student must have that specific consent signed for vaccine administration.

*Parent Signature _____ Date (MM/DD/YYYY): _____

McKinney-Vento/Homeless *This form is optional. Only use if applicable.

The purpose of this form is intended to address the McKinney-Vento Act 42 U.S.C 11435. The answers received will help to determine the services the student(s) may be eligible to receive.

Section A: Residency Verification (Please answer all that apply)

Is the student:
☐ living in a shelter/transitional housing
☐ living with family or friends temporarily due to loss of housing, economic hardship or similar reason; doubled-up
☐ living in cars, parks, campgrounds, temporary trailer parks, public or abandoned buildings, substantial housing
☐ living in a hotel or motel

☐ none of the above - check If none of the above circumstances apply
STOP! YOU DO NOT HAVE TO ANSWER THE REMAINING QUESTIONS (in McKinney Vento section).
Sign and date this section and move on to **Federal State Indicators**.

If you did check any of the first 4 circumstances above, please complete the rest of the McKinney Vento section.
Is the student:
☐ a migrant (student whose family moves between districts to work or see seasonal jobs)
☐ an unaccompanied youth? (student who is not in the physical custody of a parent or guardian)
☐ relocating from another county If yes, name county: _____ Last School: _____
☐ residing in the place listed above due to a natural or manmade disaster? If yes, check the appropriate box below)

☐ Mortgage Foreclosure (M)
☐ Natural Disaster - Flooding (F)
☐ Natural Disaster - Hurricane (H)
☐ Natural Disaster - Tropical Storm (S)
☐ Pandemic (Major) - (P)
☐ Natural Disaster - Tornado (T)
☐ Natural Disaster - Wildfire/Fire (W)
☐ Man-made Disaster (Major) - (D)
☐ Other, i.e. lack of affordable housing, long-term poverty, unemployment or underemployment, lack of affordable healthcare, medical illness, forced eviction, etc. (O)

Section B: Student Information Enter the names of all school-aged AND preschool-aged (3 & 4 yrs. old) children in your family. Indicate if the student will need transportation to/from school or ESE.

Name (First Last)	Gender	School Name	Grade	Is bus needed?	Student # (office use)

Section C: Address Confirmation (Current nighttime residence, guardian information)

Parent/Caregiver/Unaccompanied Youth: _____
Address: _____
City: _____ State: _____ Zip: _____ Email: _____
Phone Number: _____ Cell Number: _____

By signing below, I declare that the information above is correct and true and I am aware that:

- I must notify my child's school within 5 days should my residence change.
- This residency questionnaire only applies to the rights unte the McKinney-Vento Act and in now way nullifies behavioral proceedings or School Board policies regarding attendance or reassignment.
- Anyone who knowingly makes false statements in writing with the intent to mislead shall be guilty of a misdemeanor and is punishable as provided in sections 775.082, 775.083; 837.06, Florida Statutes.

Parent/Caregiver/Unaccompanied Youth Signature: _____ Date (MM/DD/YYYY): _____

Occupational Survey - Migrant Department (Title 1, Part C)

We are interested in providing help to children and families who have 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 these families by answering the following questions:

Have you or anyone in your family worked or looked for work outside your hometown, (even for short periods), during the last 3 years in one of the following occupations?

(Circle **Y** for Yes and **N** for No)

Y N *Farming (plowing, planting, cultivating, harvesting and processing of farm crops)
Y N *Dairy work (feeding, milking, and rounding up)
Y N *Poultry or egg work
Y N *Planting pine trees/pine bailing
Y N *Nursery work, planting, potting, pruning
Y N *Commercial fishing (fresh/saltwater, crabbing, shrimping, clamming, etc.)
Y N *Processing fish products

If you answered NO to **ALL** of the questions above, **STOP**, sign, and continue to **Student Transportation**. If none apply, do not answer the remaining questions in this section.

If yes to any of the above, answer the questions below:

(Circle **Y** for Yes and **N** for No)

Y N Do you have other children under the age of 22?
Y N Are you or your spouse under the age of 22?
What is the father's present occupation? _____
What is the mother's present occupation? _____

Parent Signature _____ Date (MM/DD/YYYY): _____

Required Documents

To finalize your enrollment, provide hard copies of the following documents to your school:

- Birth Certificate
- Social Security Card
- Immunization Form
- Physical Form
- 2 Proofs of Residency

Student Support Services

Interagency Release of Information

Between the Alachua County Public Schools and Outside Agencies/Providers

I, _____, hereby authorize Full Name

_____

_ Name of Agency and/or Provider

_____ _____

Address City State Zip Telephone

To share/release the information marked below:

About _____ _____/_____/_____ Student's Full Name Date of Birth

To and From: _____

_____ _____

Address City State Zip Telephone

Please share/release the following records:

Psychological Evaluation Educational Evaluation
Grades/Educational Tests Current Withdrawal Grades Medical
Evaluation/health Records Other: _____ Medications
Treatment Issues

These records are being shared for the purpose of:

To assist in the treatment/education program of the student
Other

This information is for professional use only and will be handled in a manner to respect and protect confidentiality.

I further understand that I have the privilege of revoking this at any time, providing I submit written notice. However, this will not affect information released prior to revocation.

Your signature on this form authorizes release of the above records. This form shall be valid for one calendar year from the signature date below or a single disclosure.

_____ _____

Students' Legal Name Parent or Guardian (Signature)

_____ _____

Date of Birth Date

Micanopy Academy

Permission Form to Walk to Downtown Micanopy

My child, _____, has permission to participate in class field trips to the Town of Micanopy including, but not limited to, the library, ice cream and sandwich shops, the Historical Museum, and the Cemetery. Parents will be given at least 24 hour notice before a field trip. Unless a parent informs the school that they do not wish for their child to participate, this form provides permission. Students will walk to and from the location.

List any health concerns for your student:_____ Please accept this form as a consent signature for a physician or hospital to give emergency treatment for an injury or illness to my child if medical attention is needed. I understand that all necessary precautions will be taken by Micanopy Academy for the welfare and safety of my child, and I will not hold Micanopy Academy or staff responsible in case of injury to my child.

_____ Yes, I give permission.

_____ No, I do not give permission.

Consent and Release Form
Authorization to Photograph or Record Student

I hereby grant Micanopy Academy, its employees or agents, permission for my child to be photographed and/or recorded in connection with school activities. I understand the photographs and/or recordings may be used for purposes including, but not limited to, the yearbook, public service announcements, school publicity, school Facebook pages, and other programs shown to the general public.

I understand that my execution of the Authorization serves as a waive of privacy rights otherwise available pursuant to the Section 1002.22, Florida Statutes, and other applicable law, for the purposes herein expressed. I hereby certify that I am the parent or legal guardian of the child.

_____ Yes, I give permission for all. _____ Yes, I give permission for the Yearbook only.

_____ No, I do not give permission.

Parent Name Parent Signature/Date _____