Polk Full- Time Virtual

900 Lowry Avenue
Lakeland, FL 33801
Phone: 863-665-4538 Fax: 863-665-5272

April 2017

Parent/Guardian:

All students registering with Polk Full-Time Virtual need to have the following documents for enrollment. Please call our office at 863-665-4538 to schedule an appointment to complete the registration process.

The following documents are required for students transferring from an out of county public school (including virtual programs) to enroll in a Polk County school:

- Birth Certificate
- Immunization record (Immunization 680 Form)
- A physical dated within one year, if this is the first time in a Florida school. Two proofs of residence

Upon initial enrollment in a school, the student or parent must produce two current (within 90 days) documents reflecting the correct residential street address. Post office boxes, private mail box addresses or commercial establishment addresses are insufficient. Examples of acceptable documents reflecting name and residential street addresses are as follows:

- Apartment or home lease agreement, mortgage document, property tax record, rent receipt, home owners insurance
- Current utility bill (electric, gas, water), cable, home or cell phone bill
- Voter registration document , State of Florida identification card
- Proof of government benefits (disability, Medicare, food stamps, Department of Children and Families (DCF) correspondence)
- Current Florida driver's license, automobile registration, automobile insurance

If any TWO of the documents listed above cannot be provided because the parent and student live with someone else, an Affidavit of Residence may be used. The Affidavit of Residence must be notarized by a notary public of the State of Florida. Two proofs of residence from the owner/lease holder who signs the form will be needed.

The following documents are required for students transferring from a Polk County school:

- Up to date Immunization record for incoming 1th graders immunization 680 Form) Two proofs of residence (see list above)

Michelle Henninger
Director

Omayra Rivera
Principal Secretary

POLK FULL-TIME VIRTUAL

Student Information

Last Name	First Name	Middle Name	Student ID: 5300 –

Ethnicity: Are you Hispanic/Latino? Yes ☐ No ☐	Race: Mixed

Grade	Gender	Age	Birth Date (mm/dd/yyyy)
	Male		

Physical Address	City	State	Zip

Mailing Address (If different from physical)	City	State	Zip

Phone Number Cell Number	Student's Email

Parent/Guardian Information

With whom does student lives? Guardian

Mother's Name	Home Phone Number	Cell Number

Address	City	State	Zip

Mother' Email

Father's Name	Home Phone Number	Cell Number

Address	City	State	Zip

Father's Email

Guardian's Name	Home Phone Number	Cell Number

Address	City	State	Zip

Guardian's Email

School Information

Last School Attended	Address	Year(s) Attended 9

programs: Gifted Gifted Gifted

- The virtual education department and eligibility for enrollment is verified.
- Subject to district, state, and Department of Education regulations
- The enrollment period for the 2017-2018 school year closes July 14, 2017

I am requesting support for the following (pending eligibility):

☐ Internet Access ☐ Technology Equipment

Parent Signature: _____ Date: _____

Student Signature: _____ Date: _____

Virtual Education, Dwight Smith Center: 900 Lowry Ave, Lakeland. FL 33801
Phone: 863-665-4538 Fax: 863-665-5272

Emergency and Contact Information Form

2017-2018

Student ID: _____

Grade: _____ Gender: Female Please Print Legibly

Student: _____ Birth Date: _____ / _____ / _____
Last First Middle MM DD YYYY

Residence Address: _____ Bus#___ Car ☐ Walker ☐ Court Order ☐
Street City ZIP -Check one-

Mailing Address (if different than residence): _____
Street/PO City ZIP

Home Phone: _____ Cell Phone: _____ Work Phone: _____

At which telephone number would you like to be contacted if you student is absent? _____
The phone number MUST be a phone number for Contact 1 or 2 below.

Contact must be Parent or Guardian	Contact 1 Parent/Guardian	Contact 2	Contact 3	Contact 4
Relation to student: -Circle One-	Guardian Other:_____	Guardian Other:_____	Guardian Other:_____	Guardian Other:_____
First Name:				
Last Name:				
Home Phone:				
Cell Phone:				
Work Phone:				
Preferred number to call:	Work	Work	Work	Work
Email:				
Notify in Emergency	No	No	No	No
Pick Up Allowed	No	No	No	No
Records Access Allowed*	No	No	No	No
Lives With	No	No	No	No
Personal Contact Allowed At School	No	No	No	No

*Must have court order to deny records access to parent/guardians.

Brother(s)/Sister(s) also attending this school:

Name: _____ Grade: _____ Name: _____ Grade: _____

Name: _____ Grade: _____ Name: _____ Grade: _____

Parental Consenting case of serious accident or illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to contact one of the adults listed above whom I have designated to notify in an emergency. In the event the emergency contacts cannot be reached, the school may make whatever arrangements are necessary to provide care and treatment for my child. When necessary, and in the event that I or any of the emergency contacts cannot be reached, school personnel have my permission to request transport of my child to the nearest emergency room. Under such circumstances, school personnel have my permission to release the information on this form to emergency personnel. I understand and agree that I will be responsible for any emergency medical services fees.

In case of accident or illness where, in the Best Judgment of school personnel, emergency treatment of my child is not needed, but where he/she is unable to remain at school, I request the school to contact me to pick up my child. If the school is unable to contact me, I understand that one of the adults listed above whom I have designated to notify in an emergency and who are also designated to pick up my child will be contacted. I understand that it is my responsibility to notify my child's school of any changes in the information recorded on this form and to provide the school with information if there are any custody restrictions involving my child.

I certify that the information provided on the emergency information form is accurate, true, and correct.

_____ _____ _____
Date Enrolling Parent / Guardian Signature Relationship to student

CONFIDENTIAL MEDICAL INFORMATION FORM 2017-2018

Students Name _____ Polk ID # _____ Grade _____ Teacher_____

Birth Date: _____ / _____ / _____ Sex: Male Home Phone # (1) _____ Phone # (2) _____

	Parent or Guardian must complete this page. (Sign the back of this form and return the form the school)* Please mark the check box next to a condition or illness that applies to your child. Use the "Comments" Section on the back of this page for additional explanations or health information. Note: For medication questions, Please mark the "yes" box only if child is taking medication now.
1.	Allergies (Please check all that apply) Specify reaction to allergy or allergen: *Name medications for allergies: _____ *Does child need a special diet? (If yes, the school will require a Diet Modification Form for a Doctor. (Please Obtain the Diet Modification Form On-line or from the school nutrition manager.)
2.	Asthma☐ Diagnosed at what age? Under doctor's care now No List Triggers: Takes medication for asthma. (Name medications):
3.	Attention Deficit/Hyperactivity Disorder (ADD/ADHD) ☐ Takes Medications ☐ List Medications:
4.	Blood Disorder Bleeding Conditions Please Specify:
5.	Cancer☐ Explain:
6.	Cystic Fibrosis☐ Takes Medication☐ List Medications:
7.	Diabetes☐ Does child require insulin? Yes☐ No☐ List Medications:
8.	Digestive Disorder☐ List reasons:
9.	Head Injury (serious)☐ Explain:
10.	Hearing Problem☐ Uses hearing aid? Yes☐ No☐
11.	Heart Conditions☐ Explain: Is child under doctor's care for this condition? Yes☐No☐ Explain:
12.	High Blood Pressure (Hypertension) ☐ Takes Medication? Yes☐No☐ Name medications:
13.	Hypoglycemia (low blood sugar) ☐ Takes Medication? Yes☐No☐ Name Medications:
14.	Kidney or Bladder Disorder☐ Explain:
15.	Mental Health Condition☐ Takes Medication? Yes☐No☐ Name Medications:
16.	Migraines. Under doctors care for migraines? Yes☐No☐ If Yes, List medications:
17.	Muscle/ Bone/ Mobility disorder. Yes☐No☐ Explain
18.	Respiratory condition (other than asthma). Explain: Name Medications:
19.	Seizure Disorder. Type of seizure (s): How long ago was last seizure?
20.	Surgery? Yes☐No☐ Explain: Date:
21.	Vision Problems? Yes☐No☐ Explain:
22.	Other Medical conditions not listed(explain): Other Medications not listed above(please list):
23.	My child does not have any of the listed conditions or illnesses above. ☐
Please explain any medical conditions that may affect your child's school performance or program participation?	

Additional Comments or other health information:_____
_____
_____

Does student have Medicaid? Yes☐No☐ Doctors Name: _____ Phone #: _____

Parental Consent

In Case of serious accident or illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to contact one of the adults listed above whom I have designated to notify in an emergency. In the event the emergency contacts cannot be reached, the school may make whatever arrangements are necessary to provide care and treatment for my child. When necessary, and in the event that I or any of the emergency contacts cannot be reached, school personnel have my permission to request transport of my child to the nearest emergency room. Under such circumstances, school personnel have my permission to release the information on this form to emergency personnel. I understand and agree that I will be responsible for any emergency medical services fees.

In case of accident or illness where in the best judgment of school personnel, emergency treatment of my child is not needed, but where he/she is unable to remain at school, I request the school to contact me to pick up my child. If the school is unable to contact me, I understand that one of the adults listed above whom I have designated to notify in an emergency and who are also designated to pick up my child will be contacted, I understand that is my responsibility to notify my child's school of any changes in the information recorded on this form and to provide the school with information if there are any custody restrictions involving my child.

I certify that the information provided on this Emergency and Contact Information Form is accurate, true, and correct.

Enrolling Parent / Guardian Signature: _____ Date: _____

PARENTAL CONSENT

School: _____ Grade: _____

Students Full Name: _____ Date of Birth: _____

I hereby give consent for my child to participate in the School Health Services Program. This program includes emergency care, health appraisal at school and monitoring for communicable diseases. It also includes the following health screenings: vision screening in grades Pre-K, K, 1, 3, 6, and summer programs; hearing screening in grades Pre-K, K, 1, 6; growth and development, Body Mass Index (BMI) screening in grades Pre-K, 1, 3, 6; blood pressure screening for Head Start Pre-K; and scoliosis screening in grade 6. In addition, individual vision and/or hearing screening may be conducted at any grade level to rule out vision and/or hearing difficulties.

I am aware that in order for my child to receive any medication or medical treatment at school, I must provide a new Authorization for Medication/Treatment signed by myself and my child's doctor each school year. All medications must be brought to school by an adult. All medications and/or treatment, equipment or supplies must be supplied by the parent/guardian.

In case of serious accident or illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to contact one of the adults listed on the Emergency and Contact Information Form whom I have designated to notify in an emergency. In the event the emergency contacts cannot be reached, the school may make whatever arrangements are necessary to provide care and treatment for my child. When necessary, and in the event that I or any of the emergency contacts cannot be reached, school personnel have my permission to request transport of my child to the nearest emergency room. Under such circumstances, school personnel have my permission to release the information on this form to emergency personnel. I understand and agree that I Will be responsible for any emergency medical services fees.

In case of accident or illness where, in the best judgment of school personnel, emergency treatment of my child is not needed, but where he/she is unable to remain at school, I request the school to contact me to pick up my child. If the school is unable to contact me, I understand that one of the adults fisted on the Emergency and Contact Information Form whom I have designated to notify in an emergency and who are also designated to pick up my child will be contacted.

I understand and agree that certain educational records of my child may be shared with the School Board's health care partners as needed to provide and evaluate health 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 who have a legitimate educational purpose for accessing such treatment records. I understand and agree that it is my responsibility to notify the school of any changes in the information recorded on this form.

I certify that the information I have provided on this Medical Information Form is accurate, true and correct. I understand the school keeps all medical information and records confidential.

Date: _____ Enrolling Parent/Guardian Signature: _____

Print Enrolling Parent/Guardian Name: _____

The School Board of Polk County, Florida, prohibits any and all forms of discrimination and harassment based on race, color, sex, religion, *national origin, marital status, age, homelessness,* or *disability* or *other basis prohibited by law in any* of *its programs, services, activities* or *employment. To file concerns, you may contact the Office of Equity & Compliance in the Human Resource Services Division at (863) 534-0513.*

If you require any type of accommodation to complete the application process due to a disability, please call the Human Resource Services Division at (863) 534-0781. If you are deaf or hard of hearing, please contact the Polk County School District by calling Florida Relay Service at 1-800-955-8771.

The Mission of Polk County Public Schools is to provide a high quality education for all students.

Part III Forms to Be Returned To School 6GX53-8014

APPENDIX C - STUDENT IMAGE AND TECHNOLOGY OPT-OUT FORM

Student Name ——— ——— ———
(Please print) Last Name First Name MI Student ID# Grade

(Not Social Security number)

Date of Birth ——— School———

Students will have the privileges listed below unless this Image and Technology Opt-Out Form is Submitted by the Parent/Guardian.

Published is defined as viewable by the public and/or within the District through a variety of Electronic Media (ie, web site, television, video, etc.). This may include any combination of the options below.

Please place a check in the blank provided tor each of the following items of which you do NOT want your Child to participate and sign at the end of this document.

1. ☐ My child does not have my permission to access the school/district networked computers, which Include the Internet.(other than as described below)

The use of technology, which includes the Internet, will be provided to access State and District mandated assessments and related material according to Board Policy 4.009 and Florida Statutes 1008.22, 1008.24, and l008.385. Regardless of whether you opt-out or not, your child will have access to this technology.

The Polk. County School District provides internet filters and talkers great care to block access to inappropriate material. Although a conscious effort is made to deter access to materials that are inappropriate in the school environment, no safeguard is foolproof. Students are responsible for avoiding access to inappropriate material.

2. ☐ My child does not have my permission to be photographed or videotaped.

By checking #2, your child's photograph will not be in the yearbook nor will he/she be videotaped for the School news show or other school/district video productions.

3. ☐ My child does not have my permission to have photo/video image published.

4. ☐ My child does not have my permission to have \ work published.

5. ☐ My child does not have my permission to have his/her first and last name appear ALONG Their work produced, photo and/or video image.

By checking *#5,* your child's photo and name together will not be included in news about honors, awards, and accomplishments.

The Image and Technology Opt-Out Form will become a part of the student's cumulative record.

Parent/Guardian Name(s)

_____

(Please print) Last Name First Name MI

Parent/Guardian Signature_____ Date_____

Family Agreement

By signing below, you are indicating your acceptance/agreement to the following conditions and expectations:

*To be successful in the program, students require the daily in person support of a dedicated learning coach. The learning coach must provide supervision, commit the necessary time to support and engage the student in academic activities.

*Students and learning coaches must commit adequate time to the program (4-6 hours in elementary, 6-8 hours secondary) in order to be successful.

*Students are required to participate in all mandatory aspects of the program: live online lessons, recorder lessons, face-to-face lessons, intervention sessions, testing, ESE services, etc. Transportation is the responsibility of the parent/guardian for all virtual related activities.

*I understand that my student or I are required to log in for attendance every school day. Students are permitted 9 unexcused absences per semester. Failure to comply with attendance requirements may result in truancy measures, failing grades, loss of credit and /or removal from the program.

*We are here to serve as a team for your student's academic success. The failure to be academically successful or to meet program requirements will prompt additional face to face requirements, meetings with guidance/administration and possible withdrawal or the denial of re-enrollment the following school year.

_____	_____	_____
Student Name	Student Signature	Date
_____	_____	_____
Parent/Guardian Name	Parent/Guardian Signature	Date

Michelle Henninger
Director

Omayra Rivera
Secretary

The following contract is to inform all parties of the student attendance policies at Polk Full-Time Virtual. All parties acknowledge awareness of the following student attendance requirements:

1. By law, I am required to attend school until I reach the age of 16 and to the age of 18 if my parents do not sign a waiver for me to drop out. **(Attendance in the virtual program is based upon pace charts, work samples, assignment submissions, face to face sessions, and participation in real –time webinars)**

2. Students between the ages of 16-18years must comply with compulsory attendance requirements unless the Declaration of I Intent to Terminate School Enrollment Form has been completed.

3. Terminating school enrollment prior to graduation has been shown to negatively impact career opportunities and earnings.

4. Students (starting at the age of 14) will have driving privileges revoked or suspended for non-attendance.

5. Florida law requires High School Students to be present in class to receive credit. A passing grade alone does not meet this requirements.

6. Florida Statute 1003.24 makes parents/legal guardians are responsible for ensuring their children attend school, and criminal prosecution against the parent may be instituted as provided by the law.

7. Polk County School Social Worker for assistance will be made when there is a pattern of non-attendance.

8. Referral to the School Social Worker for assistance will be made when there is a pattern of non-attendance.

9. Parents will be required to attend school meetings to discuss patterns of non-attendance and complete an intervention plan.

_____	_____	_____
Student Signature	Parent Signature	School Signature
_____	_____	_____
Printed Name	Printed Name	Printed Name
_____	_____	_____
Date	Date	Date

Please click here to send this document to the office.