Florida School for the Deaf & the Blind

Do More. Be More. Achieve More.

APPLICATION FOR STUDENT EVALUATION

207 N. San Marco Avenue, St. Augustine, FL 32084, Toll Free: 1-800-344-3732, Local: 904-827-2220, Fax: 904-827-2218

Last Name of Child: _____ First: _____ Middle: _____

Date of Birth: *Month/Day/Year* _____ Is Child Hispanic or Latino? Yes ☐ No ☐ Race: _____ Sex: _____

Place of Birth: (City) _____ (State) _____

Parent/Guardian Personal Information:

	Father	Mother	Guardian
Title:	☐ Mr. ☐ Other	☐ Ms. ☐ Other	☐ Mr. ☐ Mrs. ☐ Other
LastName:			
FirstName:			
Address:			
City/State/Zip:			
County:			
Is this your permanent address? Yes ☐ No ☐			
Home Phone:			
Video Phone:			
Work Phone:			
Fax:			
Cell Phone:			
Email Address:			

* *Which is the best number above to contact you?* _____

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?	☐	
	Blind/Visually Impaired?	☐	
	Dual-Sensory Impaired (Deaf-Blind)?	☐	
Is your child being served in a Special Education Class in his/her local school?			Yes ☐ No ☐
Is your child in a program for the Deaf/Hard of Hearing?			Yes ☐ No ☐
Is your child in a program for the Blind/Visually Impaired?			Yes ☐ No ☐
Please list other Exceptional Student Education (ESE) programs or services your child receives:			

Please include a copy of the most recent Individual Education Plan (IEP)

PERMISSION FOR RELEASE OF INFORMATION

Name of Child: _____ Date of Birth: _____

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
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 disenrollment if the student is found eligible based on incomplete or inaccurate information.**

SIGNATURE OF PARENT/GUARDIAN: _____ **DATE:** _____

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

FSDB Form# 2013-01
6D-3.002(1)(c), F.A.C.

HEALTH SUMMARY

NAME OF CHILD: _____ DATE OF BIRTH: _____ SEX: _____

CAUSE OF DEAFNESS OR BLINDNESS: _____

ALLERGIES TO MEDICATIONS: _____

ALLERGIES TO FOODS: _____

ALLERGIES TO OTHER THINGS: _____

PRESENT HEALTH OF YOUR CHILD: _____

PRESENT HEALTH PROBLEMS OR CONCERNS: _____

BEHAVIORAL OR PSYCHOLOGICAL PROBLEMS AND TREATMENT (excessive fears, hyperactivity, etc.): _____

PAST ILLNESS OR INJURIES: _____

PAST SURGERIES: _____

SPECIAL DIET:

ACTIVITY RESTRICTIONS:

MEDICATIONS YOUR CHILD IS RECEIVING:

SPECIAL MEDICAL TREATMENTS YOUR CHILD NEEDS:

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.

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FLORIDA SCHOOL FOR THE DEAF AND THE BLIND

Tuberculosis Questionnaire

Name of Child_____ Date of Birth _____

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	I 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 has your child had any of these symptoms or problems? or has your child been around anyone sick with TB?			
Was your child born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia?			
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? 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?			

Has your child been tested for TB? Yes___ (specify date ____/___) No___
Has your child ever had a positive TB skin test? Yes___ (specify date ____/___) No___

For school/healthcare provider use only

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PPD administered Yes___ No___

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

Type of service provider (e.g., 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 _____

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PROOF OF FLORIDA RESIDENCY

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 as the actual physical presence in a place as the parent, legal guardian, or adult applicant's place of abode, with the intention to remain there permanently or for an indefinite period of time. Actual presence of the parent, legal guardian, or adult applicant for the sole purpose of receiving free education shall not be considered residence.

A. PARENT'S RESIDENCY

I, _____, am the parent or legal 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

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

My permanent legal address is:

_____

STREET CITY STATE ZIP

SIGNATURE: _____ **DATE:** _____

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ESOL QUESTIONNAIRE

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

NAME OF YOUR 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	☐
BLIND/VISUALLY IMPAIRED	☐
DUAL-SENSORY IMPAIRED (DEAF-BLIND)	☐

WHAT IS YOUR CHILD'S NATIONAL ORIGIN: _____

WHAT IS THE ETHNIC OR NATIONAL ORIGIN OF PARENTS:

MOTHER: _____ FATHER: _____

HOME LANGUAGE SURVEY

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 SPEAK MOST FREQUENTLY A LANGUAGE OTHER THAN ENGLISH? YES ☐ NO ☐

4. WHEN DID THE STUDENT ARRIVE IN THE US? Month _____Day _____Year_____

5. WHEN DID THE STUDENT ENTER A US SCHOOL? Month _____Day _____Year_____

DATE COMPLETED: _____

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