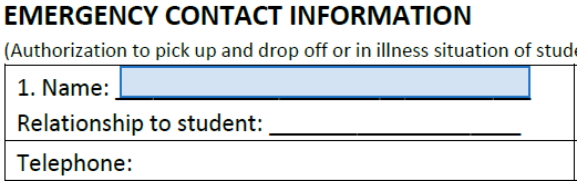
How to E-File for Desktop, Mac, Laptop

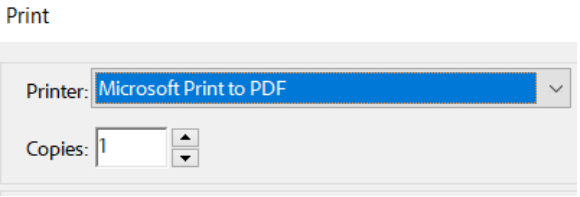
Download and install Adobe Acro Reader or use your favorite pdf reader/filler.
https://www.adobe.com/acrobat/pdf-reader.html

For Adobe Acro Reader use the fill and sign tool from the tools menu to fill out text fields.

Hover the mouse over text fields and click to begin writing. Use the three dot ellipsis menu to select a checkmark when needed.

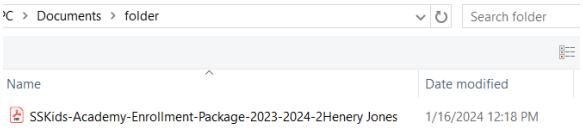


Once filled out Print the document to a pf file using your computer's built-in pdf printer.



Save the file with your child's name after the document's title.

Go to https://sskidsacademy.com/registration and click on Choose file below the download link. Select the saved file from your computer's documents then click on Upload.

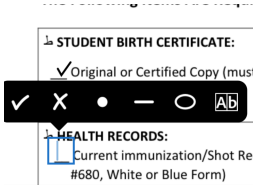


How to E-File using SmartPhone

Download and install the Adobe Fill and Sign app from the app store on your device.

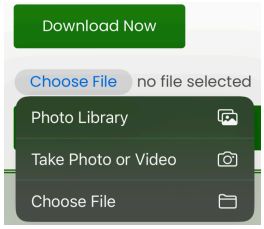
Click select a form to fill to and open this file from your file browser. Or use Open with an App feature from your device's file browser.

Click anywhere on the text fields to begin writing. Use the three dot ellipsis menu to use checkmarks.



Once filled save the document to your device's file browser.

Go to https://sskidsacademy.com/registration and click on Choose file below the download link. Select the saved file from your device's file browser then click on Upload.



Or Return filled and printed copies to the Front Desk.

Admission Application Checklist

Student Name: _____Grade: _____Program: _____

The Following Items Are Required For Each Student:

<table>
<tr><td>

ط STUDENT BIRTH CERTIFICATE:

__ Original or Certified Copy (must be legible)

</td><td>

ط CERTIFIED CUSTODY/GUARDIANSHIP PAPERS (IF APPLICABLE):

__ Legal Transfer of Custody/Guardianship, Journal Entry or Divorce Decree

</td></tr>
<tr><td>

ط HEALTH RECORDS:

__ Current immunization/Shot Records (Form #680, White or Blue Form)

___ Health Exam/Physical (DH 3040) (Yellow or White Form)

</td><td>

ط PARENT/LEGAL GUARDIAN DRIVER LICENSE OR STATE I.D.

__ Originals Only ***(We will make a copy for you)***

</td></tr>
<tr><td rowspan="2">

ط SCHOOL RECORDS (If Applicable):

__ Withdrawal Form from the previous school

__ Last Report/Progress Report Card

</td><td colspan="2">

ط MUST RETURN WITH ENROLLMENT APPLICATION

</td></tr>
<tr><td>

__ Admission Application

__ School Policy

___ Intake/Medical History Form

___ IEP

___ABA Assessments

</td><td>

ط PROOF OF RESIDENCY – (Only One)

__Utility Bill

__Pay Stub form the job

Residential Documentation

</td></tr>
<tr><td>

ط STUDENT INSURANCE

__ Medical Insurance Card (Copy)

</td><td rowspan="2">

ط PRESCRIPTION (If Applicable):

__ Speech & Language Therapy

__ Occupational Therapy

__ Physical Health Therapy

__ Applied Behavior Analysis Therapy

__Mental Health Therapy

</td></tr>
<tr><td></td></tr>
</table>

Documents Verified by: _____Date: _____

SSKids Academy LLC: 704 Goodlette-Frank Road North Naples, Florida 34102

Call or Text: (239)351-6997 Email: sleon@sskidsacademy.com

Admission Application 2023-2024

Date _____

Student Name | First Name _____ Middle Initial _____ Last Name _____

Current Grade _____ Placement Grade _____

Birthplace: _____ State: _____

Birth Date: ___/___/_____ Country: _____

Native/ Primary Language:

English _____ Other: _____

Student's Social Security Number:

#_____ -_____- _____

Student Gender: Male _____

Female _____ Other: _____

The previous school attended

- Include name of preschool, if attended, and if homeschooled

Name of School: _____

School District: _____

City: _____ State: _____

Race
(Choose as many apply)

American _____ African American _____ American Indian _____ Asian _____

Native Hawaiian or Pacific Islander _____ Hispanic/Latino_____ Others: _____

Student's Citizenship: (Check One)

U.S. Citizen_____ Non-Resident Alien_____ Resident Alien _____ Dual National_____

Other please name: _____

Student Lives With:
Mother _____
Father _____
Stepparent _____
Legal Caregiver: _____ Other (explain): _____

SSKids Academy LLC: 704 Goodlette-Frank Road North Naples, Florida 34102
Call or Text: (239) 351-6997 Email: sleon@sskidsacademy.com

What type of current class setting is your child placed in? (Check one)

☐ General Education ☐ Modified Curriculum ☐ Intensive Behavioral Intervention

If checked yes, provide applicable documents

Does the child have evaluation results from? (Check all that apply)

☐ Psychological ☐ Psychiatric ☐Neurological ☐ Office of Social Security benefits ☐ Functional Behavior Assessment ☐ Speech/Language ☐ Occupational ☐ Behavioral Mental Health ☐ Physical ☐ None ☐Others:_____ Most recent evaluation date: _____/_____/_____

If checked yes, provide all applicable documents.

If none checked, does your child need it: ☐ YES ☐ NO

Does the child have an Educational Plan: (Check all that apply)

☐ Section 504 Plan

☐ Individual Education Plan (IEP)

☐ Behavior Intervention Plan

☐ Individual Family Support Plan (IFSP)

☐ None

☐ Other: _____ Most recent plan date: _____/_____/_____

If checked yes, provide documents.

Has the child been:

☐Suspended ☐ Expelled ☐Served Detention ☐None

If checked yes, from what school? _____ (provide applicable documents)

Does the child have a public or charter school recommendation to be placed in alternative schools?

If yes, from what school?_____ (provide applicable documents)

Mother's Parent(s) / Guardian Information

Last Name, _____First Name, _____Middle Name, _____

Circle One: Single Married Divorced Separated Remarried Deceased

Personal Email:	_____
Social Security Number:	#_____ -_____- _____

Home Address Line 1: _____

Street address, P.O. box

Address Line 2: _____

Apartment, Suite, Unit, Building, floor, etc.

City: _____State: _____ Zip Code: _____-_____ Country: _____

Home Phone: (_____) -_____ -_____Cell Phone: (_____) -_____ -_____ Work Phone: (_____) -_____ -_____

Father's Parent(s) / Guardian Information

Last Name, _____First Name, _____Middle Name, _____

Circle One: Single Married Divorced Separated Remarried Deceased

Personal Email:	_____
Social Security Number:	#_____ -_____- _____

Home Address

Address Line 1: _____

Street address, P.O. box

Address Line 2: _____

Apartment, Suite, Unit, Building, floor, etc.

City: _____State: _____ Zip Code: _____-_____ Country: _____

Home Phone: (_____) -_____ -_____Cell Phone: (_____) -_____ -_____ Work Phone: (_____) -_____ -_____

Legal Guardian Information / Other Than Parent

Step-Parent Foster Parent Other: _____

Last Name, _____First Name, _____Middle Name, _____

Circle One: Single Married Divorced Separated Remarried Deceased

Personal Email:	_____
Social Security Number:	#_____ -_____- _____

Home Address

Address Line 1: _____

Street address, P.O. box

Address Line 2: _____

Apartment, Suite, Unit, Building, floor, etc.

City: _____State: _____ Zip Code: _____-_____ Country: _____

Home Phone: (_____) -_____ -_____Cell Phone: (_____) -_____ -_____ Work Phone: (_____) -_____ -_____

Social Worker Full Name: (If Applicable): _____ Phone: (_____) -_____ -_____

Email:_____ Agency: _____

EMERGENCY CONTACT INFORMATION

(Authorization to pick up and drop off or in illness situation of students to dismissed from school)

1. Name: _____ Relationship to student: _____	2. Name: _____ Relationship to student: _____
Telephone:	Telephone:
Email:	Email:

I hereby give no emergency contact information for my child(ren) to pick up and drop off or in illness situation of students to dismissed from the school: INITIAL _____

EMERGENCY MEDICAL AUTHORIZATION

_____I hereby give consent for the following medical care providers and local hospitals to be called:

Doctor: _____Phone: _____

Dentist: _____Phone: _____

Medical Specialist: _____ Phone: _____

Local Hospital: _____ Phone: _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child or any other reasonably accessible hospital. This authorization does not cover major surgery unless the medical opinions of two (2) other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before the surgery is performed.
Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted.

Signature: _____ Date: _____

Authorization For Release of Previous & Current School Records

_____I hereby give consent for the following records conducted by previous schools/organizations and SSKA for my child to be shared with other authorities and service providers (Please check all that apply)

_____All Educational Records:(Academic portfolio, report card, transcript of credits, class daily data collection etc.)
_____All State Standardized Test Scores: (ACT, SAT, i-Ready, school wide exams, placements assessments, etc.)
_____All Medical/Health: (immunization records and waivers, etc.)
_____All Evaluations: (psychological, psychiatric, neurology, behavioral, Autism evaluations etc.)
_____All Therapies: (speech/language, occupational, physical, behavioral evaluations, etc.)
_____All Educational plans: Personal Response To Intervention (PRTI), Personal Learning Plan (PLP), Individual Family Care Plan (INCP), Personal Transition Plan (PTP)
_____All Behavior Plans: Functional Behavior Assessment (FBA), Behavior Intervention Plan (BIP)
_____All school office referrals, detentions, suspensions, tardies, early dismissals, and daily attendance records
_____Other pertinent information:_____

☐ I DO GIVE MY CONSENT TO THE RELEASE OF SCHOOL RECORDS (but not limited too)

First and Last Name of parent /legal guardian/ (aged 18 years and older): _____

Signature: _____ Date: _____

Picture and video consent

Circle your answer

1.May we use your child's photograph in the school printed publications, website, social media that we produce for promotional purposes? Yes / No

☐ I DO GIVE MY CONSENT TO RELEASE PICTURES AND VIDEOS OF MY CHILD.

Complete name of parent /legal guardian/ (student age 18 years and up): _____

Signature: _____ Date: _____

Florida Private School Parental Choice Scholarships

Step Up for Students: Florida Tax Credit (FTC), Family Empowerment Scholarship for Educational Options (FES – EO), Family Empowerment Scholarship unique abilities (FES – UA), Hope Scholarship, Reading Scholarship, Academic Achievement Accessible (AAA), but not limited to.

☐ A) Scholarship: Parents are required to approve quarterly scholarship funds issued accordingly based on attendance verification of their child/children at SSKids Academy. Failure to authorize the payment in a timely manner, SSKA will file a complaint to the Department of Education.

_____Initial

☐ ALL parents and/or guardians are responsible to follow the procedures mentioned in section B and C below.

_____Initial

☐ B) Scholarship: Parents will be responsible to pay the base tuition amount, registration, extracurricular activities, before/after school programs, and lunch (but not limited to), including legal and seasonal holidays, any monies owed to SSKids Academy. Delayed payments will be reported to collection agencies with additional fees and a monthly interest charge of 21% until all payments are paid in full.

_____Initial

☐ C) New parents of SSKids Academy are required to complete registration payment(s). [when applicable]. Failure to comply will include and not limited to the withholding of a student report card/portfolio, transcript of the state exam and school withdrawal form.

_____Initial

☐ D) Non-Tuition Paid Parents: Failure to comply with Tuition Payment Agreement Form and Donation Form will result in parents being responsible to pay owed base tuition amount, registration, extracurricular activities, before/after school programs, lunch, and transportation fees (but not limited to), including legal and seasonal holidays, any monies owed to SSKids Academy. Delayed payments will be reported to collection agencies with additional fees and a monthly interest charge of 21% until all payments are paid in full. Failure to comply will result in withholding of a student report card/portfolio, transcript of the credits and state exam and school withdrawal form.

_____Initial

_____I hereby certify, under penalty of perjury, that all the information that I have given is correct in all respects to the best of my knowledge.

First and Last Name of parent /legal guardian/ (aged 18 years and older): _____

Signature: _____ Date: _____

Technology Use Agreement

As a student at SSKids Academy, I agree to the following rules and code of ethics:

1. I acknowledge that the purpose of school computers and electronic information services are for teaching and learning. I understand that the school owns the computers and that any information I place on the computer is subject to review by the school at any time without notice to me. I will not use technology resources for non-academic purposes.

_____Initial

2. I acknowledge that the software is protected by copyright laws; therefore, I will not make unauthorized copies of software and will not give, lend, or sell copies of software to others.

_____Initial

3. I will not bring software applications, including games, from home to be used on school equipment without prior approval of appropriate school personnel.

_____Initial

4. I acknowledge that the work of others is valuable; therefore, I will protect the privacy of others by not trying to learn their password; I will not copy, change, read, or use files from another user without prior permission from that user; I will not be a party to any electronic plagiarism; I will not attempt to gain unauthorized access to system programs or technology equipment; I will not use technology systems at school or elsewhere to disturb, harass, or cyberbully other users or use inappropriate language in any communications.

_____Initial

5. I will follow my school's procedures for information storage and understand that any information may be deleted from the systems at any time.

_____Initial

8. Parents/guardians and students must realize that students may encounter material on a network/bulletin board that the school does not consider appropriate (vulgar jokes, statements of belief that some might consider immoral, etc.). Although filtering software may be in place, there is no guarantee that all controversial material will be blocked. It is the student's responsibility not to pursue material that the school may consider offensive.

_____Initial

9. The use of school technology is a privilege, not a right. Vandalism or intentional modification of system settings is prohibited. The undersigned below assumes financial responsibility for any damage caused by the student. The system administrators may close an account at any time.

Violations of the rules and code of ethics described above will be dealt with seriously, including loss of technology privileges and/or disciplinary action.

_____Initial

Technology Use Agreement Overview:

● The device and related accessories are property of SSKids Academy and are governed by the Technology Use Agreement and school policies.

● The device must be used only by the student for school use.

● Students must take reasonable precautions for the care and safe keeping of the device while in use. SSKids Academy is not responsible for damage to the device that occurs because of negligence. Student/parent can be fined up to $500 for damages.

● The student will maintain, preserve, and keep the device in good working order and condition.

● The school is not responsible for supporting network connections off campus.

● The device must be returned to the school in the condition it was initially provided to the student considering reasonable use and care.

Signature: _____ Date: _____

FLORIDA DEPARTMENT OF HEALTH

FLORIDA CERTIFICATION OF IMMUNIZATION

Legal Authority: Sections 1003.22, 402.305, 402.313, Florida Statutes; Rule 64D-3.046, Florida Administrative Code

LAST NAME	FIRST NAME	MI	DOB (MM/DD/YY)
PARENT OR GUARDIAN	CHILD'S SS# (optional)	STATE IMMUNIZATION ID# (optional)	

Directions:

- Enter all appropriate doses and dates below.
- Sign and date appropriate certificate (A, B, or C) on form.
- See "Immunization Guidelines for Florida Schools, Childcare Facilities and Family Daycare Homes" for information and instructions on form completion. Guidelines are available at: www.immunizeflorida.org/schoolguide.pdf.

VACCINE	DOE CODE	Dose 1 MM/DD/YY	Dose 2 MM/DD/YY	Dose 3 MM/DD/YY	Dose 4 MM/DD/YY	Dose 5 MM/DD/YY
DTaP/DTP	A					
DT	B					
Tdap	P					
Td	Q					
Polio	D					
Hib	E					
MMR (Combined)	F					
(Separate)	G, H					
		Measles (dose 1)	*Measles (dose 2)*	*Mumps (dose 1)*	*Mumps (dose 2)*	
	I					
		Rubella (dose 1)	*Rubella (dose 2)*			
Hepatitis B	J					
Varicella	K					
Varicella Disease	L					
		Year				
PneumoConju	N					

Select appropriate box(es)
Certificate of Immunization for K-12

Part A-Complete

☐ DOE Code 1: Immunizations are complete K-12 (Excluding 7th grade/middle school requirements)

☐ DOE Code 8: Immunizations are complete for 7th grade

I have reviewed the records available, and to the best of my knowledge, the above named child has adequately been immunized for school attendance, as documented above.

Temporary Medical Exemption **Expiration date:** _____

☐ **Part B-Temporary**

Part B (For children in daycare, family daycare homes, preschool, kindergarten and grades 1 through 12 who are incomplete for immunizations in Part A) **Invalid without expiration date.** DOE Code 2

I have reviewed the records available, and to the best of my knowledge, the above named child has adequately been immunized for school attendance, as documented above.

Permanent Medical Exemption

☐ **Part C-Permanent**

Part C (For medically contraindicated immunizations, list each vaccine and state valid clinical reasoning or evidence for exemption.)

DOE Code 3 _____

I certify the physical condition of this child is such that immunizations as indicated in Part C above are medically contraindicated.

Physician or Clinic Name:

_____

_____

Physician or Authorized Signature: _____

Issued By: _____

Date:

STATE OF FLORIDA
School Entry Health Exam

To Parent/Guardian: Please complete and sign Part I — Child's Medical History.
State law for school entry requires a health examination by a legally qualified professional. Additional requirements may be determined by local school districts.

(Please Print)

Name of Child (Last, First, Middle)		Birth Date	Sex
Address (Street)		School	Grade
City and ZIP Code	Home Telephone Number	Parent/Guardian (Last, First, Middle)	

PART I — CHILD'S MEDICAL HISTORY

To Parent/Guardian: Please check answers to questions 1 through 8 below in the column on the left.
(Please explain any "Yes" answers in the space provided below.)

1. Yes ☐ No ☐ Any concerns about general health (eating and sleeping habits, weight, etc.)?
2. Yes ☐ No ☐ Any other specific illness or social/emotional or behavioral problems?
3. Yes ☐ No ☐ Any allergies (food, insects, medication, etc.)?
4. Yes ☐ No ☐ Any prescription medication (daily or occasionally)?
5. Yes ☐ No ☐ Any problems with vision, hearing, or speech (glasses, contacts, ear tubes, hearing aids)?
6. Yes ☐ No ☐ Any hospitalization, operation, or major illness (specify problem)?
7. Yes ☐ No ☐ Any significant injury or accident (specify problem)?
8. Yes ☐ No ☐ Would you like to discuss anything about your child's health with a school nurse?

To Parent/Guardian: Please explain any "Yes" answers from above.

_____

_____

_____

_____

I am the parent/guardian of the child named above. I give permission for the information on PARTS I and II of this form provided about my child to be reviewed and utilized only by the staff of this school and any school health personnel providing school health services in the district for the limited purpose of meeting my child's health and educational needs.

☒ _____ _____
Signature of Parent/Guardian **Date**

Partnership for School Readiness Recommendations for Prekindergarten and Kindergarten

To Parent/Guardian: Please obtain the services listed below in order to find any problems. Please work with your health care provider to correct or treat any problems that may reduce your child's ability to learn in school. **(These services are recommended but not required.)**

1. Comprehensive Vision Examination (3-5 years of age) Date of Exam: _____ Results of Exam: _____ _____ Health Care Provider: _____ *(check one)* Optometrist ☐ Ophthalmologist ☐	Please describe any corrective action for any problems detected and any accommodations required.
2. Comprehensive Dental Examination Date of Exam: _____ Results of Exam: _____ _____ Dentist: _____	Please describe any corrective action for any problems detected and any accommodations required.
3. Hearing Screening Date of Exam: _____ Results of Exam: _____ _____ Health Care Provider: _____	Please describe any corrective action for any problems detected and any accommodations required.

Name of Child (Last, First, Middle)	Birth Date

PART II — MEDICAL EVALUATION

To be completed and signed by the Health Care Provider ONLY:

The child named above has had a complete history and physical exam on the following date: ____ Month ____ Day ____ Year
(Exam must be within one year of enrollment)

Screening Results:

Height: _____ Weight: _____ BMI%: _____ B/P: _____ Hct/Hgb: _____ Lead: _____ Urinalysis: _____

Vision - Without Glasses	Right 20/_____	Left 20/_____	Passed ☐ Failed ☐ Referred ☐	Hearing – Right	Passed ☐	Failed ☐	Referred ☐
Vision - With Glasses	Right 20/_____	Left 20/_____		Hearing – Left	Passed ☐	Failed ☐	Referred ☐

Gross dental (teeth and gums)	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____
Head/scalp/skin	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____
Eyes/Ears/Nose/Throat	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____
Chest/Lungs/Heart	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____
Abdomen	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____
Postural assessment	☐ Normal	☐ Abnormal	_____	Refer/Tx: _____

TB risk assessment done ☐ ***(Please review Targeted Testing Guidelines listed below.)***

This child has the following problems that may impact the educational experience:

☐ Vision ☐ Hearing ☐ Speech/Language ☐ Physical ☐ Social/Behavioral ☐ Cognitive

Specify: _____

☐ This child has a health condition that may require emergency action at school, e.g. seizures, allergies. Specify below.

(This form will be stored in the child's Cumulative Health Folder and may be accessed by both school and health personnel.)

Recommendations (Attach additional sheet if necessary): _____

(Please Check One)

☐ This child may participate fully in school activities including physical education.

☐ This child may participate in school activities including physical education with the following restriction/adaptation.

(Specify reason and restriction) _____

Signature/Title of Health Care Provider	Date	Address (Please print or stamp)
☒	___/___/___	
Name (Please print or stamp)		

Tuberculosis Targeted Testing Guidelines for Health Care Providers

Tuberculosis Infection Risk:

Review the following risks and administer a Mantoux TB skin test if child is in one or more categories. The TB test is administered confidentially as part of the health examination. ***Do not record administration of any TB test or related information on this form.***

- Recent immigrant (< 5 years), frequent visitor to TB endemic areas
- Close contact to active TB case
- Frequent contact with adults at high-risk for disease, HIV+, homeless, incarcerated, illicit drug user
- HIV+ or have other medical conditions that increase the risk to progress from infection to disease, e.g., chronic renal failure, diabetes, hematologic or any other malignancy, weight loss > 10% of ideal body weight, on immunosuppressive medications

Active TB Disease Risk:

- Does the child exhibit signs/symptoms of tuberculosis (e.g. cough for three weeks or longer, weight loss, loss of appetite)?
- If symptoms are present, work-up or refer for TB disease evaluation.