LAKE WALES CHARTER SCHOOLS
LWCharterSchools.com

Polk Avenue Elementary
110 East Polk Avenue
Lake Wales, FL 33853
2025-2026 School Year
Home of the Cardinals

- You must complete one application for each child you wish to enroll (Both pages)
- To be valid, the application must be complete, signed by a parent or guardian, and dated
- Print legibly
- Incomplete applications will be returned, if possible
- Enrollments are set by grade level, racial balance, and physical space
- Polk Avenue Elementary School will give preference to students in the current school attendance zone
- It is your responsibility to advise the school if you have a change of address and/or phone number

STUDENT INFORMATION

Student ID # 5300 ☐☐☐☐☐☐

Student Social Security # ☐☐☐ ☐☐ ☐☐☐☐

Gender M ☐ F ☐

Date of Birth (MM/DD/YYYY) ☐☐☐☐☐☐☐☐

Current Grade ☐☐

Applying for Grade ☐☐

STUDENT'S LEGAL NAME

Last Name

First Name

Middle Name

Current School

Ethnic Code – Choose only one code from the list and circle. Is your child Hispanic/Latino? Y N

White
Black/African American
American Indian
Asian
Hawaiian/Pacific Islander

Check ALL that apply

- ☐ Regular Education Student
- ☐ School Employee's Child
- ☐ Board Member's Child
- ☐ Alpha/Gifted Student
- ☐ ESE Student
- ☐ ESOL Student
- ☐ Other: _____

HOME ADDRESS

Street Address (If applicable, include Apartment #)

City

State

Zip Code

MAILING ADDRESS – IF DIFFERENT FROM STREET ADDRESS

Street Address (If applicable, include Apartment #)

City

State

Zip Code

FAMILY INFORMATION – Parent/Guardian living in the same household as the student)

Last Name

First Name

Home Telephone Number

Work Telephone Number

For Office Use Only!

_____
Date Received

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Please check the following if requested:

☐ Bus Transportation is needed

PRIORITIES – Please list any sibling(s) (brother, sister – half or step) in the same household currently enrolled/applying to Polk Avenue Elementary School

Last Name | First Name | Middle Name

Date of Birth (MM/DD/YYYY) | Current Grade | Sibling presently: ☐ Enrolled ☐ Applying/Waiting List

Last Name | First Name | Middle Name

Date of Birth (MM/DD/YYYY) | Current Grade | Sibling presently: ☐ Enrolled ☐ Applying/Waiting List

Last Name | First Name | Middle Name

Date of Birth (MM/DD/YYYY) | Current Grade | Sibling presently: ☐ Enrolled ☐ Applying/Waiting List

Last Name | First Name | Middle Name

Date of Birth (MM/DD/YYYY) | Current Grade | Sibling presently: ☐ Enrolled ☐ Applying/Waiting List

Signature of Parent/Guardian: _____ Date: _____

***Must be signed or application will be returned**

Mail Completed and Signed Applications to:

Polk Avenue Elementary
Home of the Super Cardinals
110 East Polk Avenue
Lake Wales, Fl 33853

The Lake Wales Charter Schools, Inc. is an equal opportunity institution for education and employment.

Polk Avenue Elementary
Student Entry Form

Student #: _____

Walker____ **Car Rider** _____
Bus# _____ **Day Care** _____

Legal Student Information

_____ _____ _____ _____
Last Name **First Name** **Middle Name** **Social Security #**

Home Address:

_____
Street address

_____
City, State Zip

Mailing Address:

_____
Street address or P.O. Box

_____
City, State Zip

Ethnicity: Are you Hispanic/Latino? ( )**YES** ( )**NO** **Language** spoken at home:_____

Race: Check at least one. **(NOTE: Hispanic/Latino is not a race)**
( )White ( )Black/African American ( )American Indian/Native Alaskan ( )Asian ( )Native Hawaiian /Pacific Islander

Grade: _____ **Sex:** ( ) M ( ) F **Migrant /Farm Worker:** ( ) YES ( ) NO

Date of Birth: _____ **Place of Birth:** _____ _____ _____ _____
City **County** **State** **Country**

Name and Address of previous school /Pre-K:

_____

_____

_____ _____ ____
City **County** **State**

Has the student ever been enrolled in a Polk County School? ( ) Y or ( ) N

Has the student ever been retained? ( ) Y or ( ) N what grade? _____

Is the student enrolled in an ESE Program? ( ) Y or ( ) N

Is the student enrolled in the ESOL program? ( ) Y or ( ) N

Family Information:
Student lives with: ( ) Both Parents ( ) Mother only ( ) Father only ( ) Parent and Step Parent
Documentation Required: ( ) Surrogate Parents ( ) Legal Guardian ( ) Guardian Ad Litem ( ) Other

Father	**Mother**	**Guardian**
Name: _____	Name: _____	Name: _____
Home Phone: _____	Home Phone: _____	Home Phone: _____
Cell Phone: _____	Cell Phone: _____	Cell Phone: _____
Work Phone: _____	Work Phone: _____	Work Phone: _____
		Relation: _____

Siblings that attend school (please note the school they attend):

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

Does the student have an illness or physical condition of which the school should be aware of? ( ) YES ( ) NO
If **yes**, please explain: _____
Is the student currently taking medication? ( ) YES ( ) NO If **yes**, please identify: _____

Is your family residing in any of the following situations?
( ) Sharing the housing of others due to loss of housing or economic hardship?
( ) Living in a hotel or motel due to loss of housing or economical hardship?
( ) Staying in a shelter? Name of shelter: _____
( ) Staying in substandard housing; without electricity, running water, health code violations, etc.?
( ) Sleeping in a car, campground, park, or public space?

****

(For office use)
Teacher_____ Grade_____ Date_____ Affidavit_____

Admitting Personnel_____ Records request date_____

Polk Avenue Elementary

Hoja de Datos del Estudiante

 # de Autobús _____

 # de Estudiante: _____

Caminante ____ **Automóvil** ____

Información básica del Estudiante

Cuido: _____

_____ Apellido

_____ Nombre

_____ Segundo nombre

_____ # Seguro Social

Dirección residencial:

_____ Dirección de la calle

_____ Ciudad, Estado código postal

Dirección Postal

_____ Dirección de la calle o P.O. Box

_____ Ciudad, Estado código postal

Teléfono del Hogar: _____

Grado: _____ **Sexo**_____

Por favor escoja uno: ( ) Negro ( ) Blanco ( ) Hispano ( ) Multirracial Negro ( ) Multirracial No- Negro ( ) Asiático ( ) Indio

Idioma del Estudiante: _____

Idioma de los Padres: _____

Fecha de Nacimiento: _____

Lugar de Nacimiento _____ Cuidad / Condado Estado

Nombre y dirección de la Escuela anterior /Pre-K:

_____

_____

Alguna vez el estudiante ha sido matriculado en una escuela Del Condado de Polk? Si o No

El estudiante ha repetido algún grado? Si o No Que grado? _____

El estudiante matriculado esta en el programa de ESE? Si o No (Estudiante con discapacidad)

Información de la Familia

Estudiante vive con ( ) Ambos Padres ( ) Madre ( ) Padre ( ) Padrastro ( ) Madrastra ( ) Guardián

Padre	**Madre**	**Guardián**
Nombre: _____	Nombre: _____	Nombre: _____
Teléfono del trabajo: _____	Teléfono del trabajo: _____	Teléfono del trabajo: _____
Teléfono del hogar: _____	Teléfono del hogar: _____	Teléfono del hogar: _____
Teléfono del celular: _____	Teléfono del celular: _____	Teléfono del celular: _____

Hermanos que asisten a esta escuela u otra:

Relación: _____

Nombre: _____ Grado: _____ Nombre: _____ Grado: _____

Nombre: _____ Grado: _____ Nombre: _____ Grade: _____

El estudiante tiene alguna condición física la cual la escuela necesita saber? Si o No
Cual es? _____
El estudiante toma medicamentos actualmente? Si o No Cual? _____

Su familia vive en alguna de estas acomodaciones actualmente?

___ Compartiendo casa con otros debió a perdida de hogar o razones económicas?
___ Viven en un hotel o motel debido a perdida de hogar o razones económicas?
___ Viviendo en un albergue? Nombre de albergue? _____
___ Viviendo en una casa deficiente sin electricidad o agua?
___ Durmiendo en un carro, campamento o espacio publico?

****

Para uso solamente de la oficina:

Teacher: _____ Date: _____ Affidavit: _____

Admitting Personnel: _____ Records Requested Date: _____

LAKE WALES CHARTER SCHOOLS

2025-2026 Student Residency Questionnaire

The answers to this housing questionnaire help in determining eligibility for services that may be provided through the federal McKinney-Vento Act, 42 U.S.C 11435. The McKinney-Vento Program provides certain rights to families who are experiencing housing transition.

PLEASE ONLY COMPLETE THIS FORM IF YOU ARE EXPERIENCING HOUSING TRANSITION. *Housing transition can mean that due to financial hardship, your family is living in a hotel, a home where you have a mortgage or lease but the home is bug infested or has other conditions causing it to be inadequate for living, a vehicle, shelter, or living with friends and family without a legal or valid lease. For more information on what qualifies under the McKinney-Vento Act, visit www.lwcharterschools.com/mckinneyvento.*

Please list ALL students within the family, (including pre-K children) enrolling at ANY school.					
Student Name (First, Middle Initial, Last)	**Student ID#**	**M/F**	**DOB**	**Grade**	**School**

FAMILY INFORMATION – PLEASE NOTE ALL SECTIONS MUST BE COMPLETED

Name of Parent(s)/ Legal Guardian(s):			
Current Student Nighttime Street Address:		**City/ Zip Code**	
Former Student Nighttime Street Address:		**City/ Zip Code**	
How long have you been at this address?		**Phone Number**	
		Email	
Do you or have you previously worked in agriculture, fishing, lumber, or dairy at any time during the last 3 years?		**YES** ○	**NO** ○

TEMPORARY LIVING SITUATION INFORMATION – PLEASE NOTE ALL SECTIONS MUST BE COMPLETED

Check only ONE box that applies to your situation:

- ○ Staying with another family member or friend due to financial hardship and do not have a valid lease. (B)
- ○ Staying in a motel or hotel due to financial hardship or inability to find affordable permanent housing. (E)
- ○ Sleeping in a vehicle, trailer park or campground, abandoned building, or other substandard housing. (D)
- ○ Staying in an emergency or transitional shelter. (A)
- ○ Rent or own with valid lease, *but* due to financial hardship home is inadequate (no bed/kitchen, bugs, water leak, etc.). (D)
- ○ If the above do not apply, describe where the student/s most recently spent the night:

Check only ONE box that applies to the cause of your living situation:

- ○ Economic hardship **due to COVID pandemic** (illness, loss of job, etc.) that resulted in loss of housing (P)
- ○ Economic hardship or other circumstances **(NOT related to the COVID pandemic)** such as lack of affordable housing, long-term poverty, unemployment, medical concerns, domestic violence, etc. (N)
- ○ Mortgage Foreclosure (M)
- ○ Lost our housing due to a natural disaster (hurricane, flood, fire, etc.) and have no place else to go. Please indicate the natural disaster type here: _____ (E, F, H, S, T, or W)
- ○ Lost our housing due to a manmade disaster (mold, poison gas release, etc.) and have no place else to go (D)
- ○ If the above do not apply, describe the cause of your temporary living situation: _____

_____

Please continue residency questionnaire ⟶

LAKE WALES CHARTER SCHOOLS

2025-2026 Student Residency Questionnaire

UNACCOMPANIED HOMELESS YOUTH (UHY):

The enrolling student(s) is/are:

- ◯ Staying with a parent or legal guardian
- ◯ Not staying with a parent or legal guardian and not staying with an adult who is acting as the student's parent as defined in s. 1000.21(5), Florida Statutes.
- ◯ Not staying with a parent or legal guardian, but staying with an alternate adult.
  - Caregiver Name: _____
  - Caregiver Phone: _____
  - Relationship to Student: _____

The undersigned certifies that the information provided is accurate to the best of their knowledge.
Please note that Florida Statutes 837.06 provides that whoever knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty shall be guilty of a misdemeanor of the second degree.

_____ _____ _____

Signature of Person Completing This Form ***Printed Name of Person Completing This Form*** ***Date***

Please indicate the role of the person completing this form.

- ◯ ***Parent/Guardian or Unaccompanied Youth***
- ◯ ***Caregiver for Youth***
- ◯ ***LWCS Staff Member on behalf of the student***
- ◯ ***Local Agency on behalf of family (Please indicate agency):***

_____

MCKINNEY-VENTO ACT RIGHTS

Students who qualify under the McKinney-Vento Act are entitled to the following rights:

- ***Immediate enrollment (even if you lack proof of residency or other documents and are working on obtaining these documents).***
- ***Free meals while at school.***
- ***School stability with the option to remain in the school of origin (school last attended) and school of origin feeder pattern while in housing transition.***
- ***Transportation to school if current housing location is over 2 miles.***
- ***Rights are awarded for the current school year. If the student(s) continue to experience housing transition after July 1, 2026, please complete this questionnaire again for the 2026-2027 school year.***

For additional information on the McKinney-Vento Program and rights under the federal McKinney-Vento Act, please contact 863-456-4484 or email MVProgram@lwcharterschools.com.

FOR LWCS STAFF ONLY:

- **All Student Residency Questionnaire (SRQ) forms should be provided to the district liaison for coding and emailed to MVProgram@lwcharterschools.com.**
- **Copies of SRQs should be contained in a master file at the school site.**
- **Date verified in FOCUS: _____**

Additional Notes:

LAKE WALES CHARTER SCHOOLS

LAKE WALES CHARTER SCHOOLS
HOME LANGUAGE SURVEY

(For official use only)
ID Number: _____

TO BE COMPLETED BY THE PARENT OR GUARDIAN OF A STUDENT ENTERING A FLORIDA PUBLIC SCHOOL FOR THE FIRST TIME

ANY "YES" ANSWER WILL RESULT IN TESTING TO DETERMINE ELIGIBILITY FOR ESOL SERVICES

Student's Last Name: _____ Student's First Name: _____

School Name: _____ Date of Birth: ___/___/_____

Date Entered U.S. School: ___/___/_____ Current Grade: _____

Country of Birth: _____ Gender: _____

The information provided on this form is used solely to offer appropriate educational services.

PLEASE ANSWER THE FOLLOWING QUESTIONS:

a. Does the student have a first language other than English? Yes ☐ No ☐ What language? _____

b. Is a language other than English spoken at home? Yes ☐ No ☐ What language? _____

c. Does the student most frequently speak a language other than English? Yes ☐ No ☐ What language? _____

_____ _____
Parent/Guardian Signature Date

What are the primary languages spoken in the child's home?
☐ English ☐ Spanish ☐ Haitian Creole ☐ Portuguese ☐ Vietnamese ☐ Chinese

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ESPAÑOL

ESCUELAS DEL CONDADO DE POLK
ENCUESTA DEL IDIOMA DEL HOGAR

A SER COMPLETADO POR EL PADRE O TUTOR DEL ESTUDIANTE QUE INGRESA A UNA ESCUELA PÚBLICA DE FLORIDA POR PRIMERA VEZ

CUALQUIER RESPUESTA "SÍ" RESULTARÁ EN PRUEBAS PARA DETERMINAR LA ELEGIBILIDAD PARA LOS SERVICIOS DE ESOL.

Apellido del Estudiante _____ Nombre del Estudiante: _____

Nombre de la Escuela: _____ Fecha de nacimiento: ___/___/_____

Fecha de Ingreso a la escuela en EE. UU. ___/___/_____ Grado actual: _____

País de nacimiento: ___/___/_____ Género: _____

La información proporcionada en este formulario se utiliza únicamente para ofrecer servicios educativos adecuados.

FAVOR DE CONTESTAR LAS SIGUIENTES PREGUNTAS:

a. ¿Tiene el estudiante un primer idioma que no sea el inglés? Sí ☐ No ☐ ¿Cuál idioma? _____

b. ¿Se habla en el hogar otro idioma que no sea el inglés? Sí ☐ No ☐ ¿Cuál idioma? _____

c. ¿Habla el estudiante con más frecuencia otro idioma que no sea el inglés? Sí ☐ No ☐ ¿Cuál idioma? _____

_____ _____
Firma del Padre/Tutor Fecha

¿Cuáles son los idiomas principales que se hablan en el hogar del niño?
☐ Ingles ☐ Español ☐ Haitiano ☐ Portugués ☐ Vietnamés ☐ Chino

CONFIDENTIAL MEDICAL INFORMATION FORM 2025 – 2026

POLK COUNTY PUBLIC SCHOOLS
STUDENTS FIRST

Student's Name_____ **Polk ID#**_____ **Grade** _____ **Teacher**_____

Birth Date_____ **Sex**_____ **Home phone # (1)** _____ **ph.#(2)** _____ **Bus #** _____
MM/DD/YYYY

Physician's Name_____ **Physician's Phone Number**_____

	Parent or Guardian must complete this page, sign the back of this form, and return the form to the school. Please mark the check box next to any condition or illness that applies to your child. **Note: For medication questions, please mark the "yes" box only if child is taking medication now.**
1.	**Allergy to**: ☐ Food:_____ **Allergy to:** ☐ Medicine:_____ **Allergy to:** ☐ Ants, ☐ Wasps, ☐ Bee stings, ☐ Environmental or other. Please list: _____ **Specify reaction to allergy or allergen:** ☐Rash, ☐Swelling, ☐Hives, ☐Trouble Breathing, ☐Vomiting, ☐Diarrhea, ☐ Other_____ ☐ **Takes medication for any allergies.** Name medication(s):_____ **Does child need a special diet?** ☐ Yes ☐ No (If yes, the school will require a Diet Modification Form from a doctor. Obtain the Diet Modification Form on-line or from the School Nutrition Manager.)
2.	☐ **Asthma. History of:** ☐ **Yes Under doctor's care now?** ☐ **Yes** ☐ **No List triggers:** _____ ☐**Takes medication for asthma**. Name medication(s):_____
3.	☐ **Attention Deficit/Hyperactivity Disorder** (ADD/ADHD). ☐ **Takes medication**. Name medication(s):_____
4.	☐ **Autism Spectrum Disorder** ☐ **Diagnosed by Medical Doctor** ☐ **Takes medication**. Name medication(s) _____
5.	☐ **Autoimmune Disease (Lupus, etc.) Explain:** _____
6.	☐ **Blood disorder** ☐ **Sickle cell anemia** ☐ **Bleeding condition.** Specify: _____
7.	☐ **Cancer.** Explain:_____
8.	☐ **Cystic Fibrosis** ☐ **Takes medication.** Name medication(s):_____
9..	☐ **Diabetes. Does child require insulin?** ☐ **Yes** ☐ **No Does child require insulin <u>at school</u>?** ☐ **Yes** ☐ **No** ☐ **Takes medication.** Name medication(s):_____ ☐ **Hypoglycemia (low blood sugar).** ☐ **Takes medication.** Name medication(s)_____
10.	☐ **Digestive disorders.** Explain:_____
11.	☐ **Head injury (serious).** Explain:_____
12.	☐ **Hearing** problem ☐ **Uses hearing aid.** ☐ **Right ear** ☐ **Left ear**
13.	☐ **Heart condition.** Explain: _____ **Under doctor's care for this condition?** ☐ Yes ☐ No; **Any physical restrictions?** ☐ Yes ☐ No If yes, explain:_____
14.	☐ **High Blood Pressure (Hypertension)** ☐ **Takes medication.** Name medication(s)_____
15.	☐ **Kidney or bladder disorder.** Explain: _____ ☐ **Requires catheterization. Explain or type of catheterization:** _____
16.	☐ **Mental Health Condition.** Specify: _____ ☐ **Takes medication.** Name medication(s)_____
17.	☐ **Migraines.** Under doctor's care for migraines? ☐ Yes ☐ No; ☐ **Takes medication.** Name medication(s)_____
18.	☐ **Muscle/bone/mobility disorder.** Explain:_____
19.	☐ **Seizure Disorder. Type of seizure(s):**_____ **How long ago was the last one?** _____ ☐ **Takes medication**. Name medication(s)_____
20.	☐ **Vision** problems. Explain:_____ ☐ Glasses ☐ Contacts
21.	☐ **Other medical condition not listed.** Explain:_____ ☐ Other **medications** taken not listed above:_____
22.	☐ **My child does <u>not</u> have any of the listed conditions or illnesses.**

Additional comments or other health information:

_____

_____

Parent Consent for School Health Services
School Year 2025 – 2026

Student's Name_____ **Polk ID#**_____ **Grade** _____ **Teacher**_____

The Florida Department of Education and the Florida Department of Health work in cooperation to coordinate the School Health Services Program as mandated in Florida Statute sections 381.0056, 281.0057, and 402.3026. Pursuant to Florida Statute 1001.42: A parent/guardian MUST opt-in yearly for their child to receive school Health Services/Clinic Services. Please indicate if you want your student to be able to receive the services indicated below. Circle "yes" or "no".

YES	NO	**I want my child to be able to access care in the clinic due to illness or injury. School health/clinic services may include: first aid, emergency care *, health appraisals, nursing assessment, health counseling, referral and follow-up, health promotion, disease and injury prevention, basic health education provided in the clinic, and health consultations.** If "NO", the student will NOT receive health/clinic services as outlined above, including, but not limited to, temperature checks, first aid, etc.
YES	NO	**I want my child to participate in individual student screenings related to learning, behavior and/or social emotional well-being as needed by the school problem-solving team to ensure proper instruction and intervention in these areas. This may also include an individual vision and/or hearing screening to rule out vision difficulties affecting learning.**

* There is not an option to withhold/decline consent for emergency care. In emergency situations, school personnel will contact Emergency Medical Services and provide emergency care until EMS arrives. Once EMS arrives, they will take whatever action is deemed necessary for the health and safety of your child. Parents are financially responsible for any emergency care and/or transportation your child needs.

This consent DOES NOT AUTHORIZE invasive screening or procedures (COVID-19 testing, blood draw, vaccinations, etc.), preventative health care, medication administration, mental health counseling, therapy (physical therapy, occupational therapy, etc.) or other services that require specific parental direction and consent (administration of medication, medical procedures, medical management of chronic health conditions, etc.)

For your child to receive any medication or medical treatment at school, you must consent to health services/clinic visits and provide a new Authorization for Medication/Treatment signed by you and your 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.

You are also required to complete the Emergency and Contact Information Form and update information annually or any time the information changes. School personnel will contact you to pick up your child if he/she is unable to remain at school due to illness or accident. If school personnel are unable to reach you, one of the adults listed on the Emergency and Contact Information Form designated to pick up your child will be contacted.

NOTICE: The following state mandated health screenings are provided: vision screening in grades PreK, K, 1, 3, 6; hearing screening in grades PreK, K, 1, 6; growth and development/Body Mass Index (BMI) screening in grades PreK, 1, 3, 6; blood pressure screening for Head Start PreK; and scoliosis screening in grade 6. If you do not want your child to participate in any of the screenings above, please complete the School Health Screening Opt-Out Form available at your child's school. You may also access the form from the district's website (https://polkschoolsfl.com/policiesandforms). The opt-out form must be completed and submitted each school year that you do not want your child to participate in the mandatory health screenings.

Polk County Public Schools will only share student medical information from education records in accordance with law. It may be necessary to share some information about your child with the School Board's health care partners to provide and evaluate health services or obtain emergency medical treatment. Your child's education records may also be shared with school officials who have a legitimate educational purpose for accessing such treatment records. Therefore, it is your responsibility to notify the school of any changes in the information recorded on this form.

I certify that I consent to or decline Health Services/Clinic Services as indicated above, that the information on this Medical Information Form is accurate, and that I understand the school keeps all medical information and records in accordance with Florida law.

Date: _____ Enrolling Parent/Guardian Signature: _____

Print Enrolling Parent/Guardian Name:_____