Established 1915
BROWARD
County Public Schools

Acknowledgment

Policy 5.8, Code of Student Conduct, lists the District's rules for students in Broward County Public Schools. The rules apply to all activities occurring on school grounds, on other sites being used for school activities, and on any vehicles authorized to transport students. Your signature below does not indicate that you agree or disagree with the rules, **but rather that you have reviewed the electronic copy of these rules** (http://www.browardschools.com/codeofconduct). Return this form to school within 3 days from the first day of school or from the date of enrollment. If you would prefer to complete all required forms electronically, please access the Back to School Toolkit (http://browardschools.com/backtoschool).

Parents need to be involved in the education of their children and have the responsibility to:

- Know that for school safety, schools are not required to provide supervision more than 30 minutes prior to the official starting time, nor are they required to provide supervision for more than 30 minutes after the official closing time (F.S. 1003.31 (2)).
- Know that for school safety, for students who ride a school bus, drivers are NOT permitted to let students off the bus except at the designated stop.
- Provide the school with the names of current emergency contact person(s) and/or telephone numbers on an annual basis and when there are changes.
- Notify the school of anything that may affect their child's ability to learn, to attend school regularly, or to take part in school activities.
- Be aware that medicine must be administered in accordance with SB Policy 6305, as may be amended, and that consequences for transmittal and/or sale or attempted sale of over-the-counter medications and possession and/or use of unauthorized medications can be found in SB Policy 5006. SB Policy 6305 outlines the rules regarding over-the-counter and prescription drugs and SB Policy 5006 outlines the consequences for violating those rules. You may view the complete health and suspension and/or expulsion policies, as well as all School Board policies, on the Web at: www.Broward.k12.fl.us/sbbcpolicies.
- Be aware that parents have rights with regard to the privacy and confidentiality of student records that are maintained by schools as defined in Section VIII of this booklet.
- Neither the School Board of Broward County nor its employees will be held liable for items that are prohibited and are lost, stolen, or confiscated; or for wireless communication devices or other personal technology that are lost, stolen, or confiscated.
- Be aware that confiscated items not claimed by the end of the school year will be donated to local charities.
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- Ensure their child demonstrates legal, ethical and responsible use of technology including networks, digital tools, the Internet, and software, as defined in Section IV of this booklet.
- Parents will continue to maintain responsibility for students who reach the age of majority, (18 years or older), for all educational and discipline purposes, with exceptions as provided by statute.

Note: Parental selection for each form within the Code of Student Conduct will be effective until a new form is submitted.

Student Name (PRINT)	Student Signature
Parent/Guardian Name (Print)	Parent/Guardian Signature
Date	

Media Release Form 2018/2019 School Year (All Grades)

As a parent of a student in Broward County Public Schools, I understand that my child may be photographed, videotaped or interviewed by the news media or by the School District for informational and/or promotional purposes. I understand that pictures and interviews may be used on the District's website, in School District publications, external publications and electronic media as indicated below.

You Must Mark a Choice in Both Section A and Section B

(If no choice is marked in both sections, then the choice will default to Choice #1)

Section A - External Outlets/Media

Please Check Choice #1 or Choice #2

1. _____ I **WILL** permit my child to be photographed, videotaped, and/or interviewed by the media when the news media has secured proper authorization from Broward County Public Schools.

2. _____ I **WILL NOT** permit my student to be photographed, videotaped, and/or interviewed by the media.

Section B - Broward County Public Schools

Please Check Choice #1 or Choice #2

1. _____ I **WILL** permit my child to be photographed, videotaped, and/or interviewed for school publications, such as school yearbooks, school newspapers, class pictures, school and/or District websites, social media, BECON TV, or for other communication tools by Broward County Public Schools or its approved vendors. I understand the District may be required to release this information if requested by the media or other members of the public (i.e., public records requests). *Note: Your home address, phone number, email address, child's name, teacher's name and room number may be released in order to facilitate school-based publications.*

2. _____ I **WILL NOT** permit my child to be photographed, videotaped, and/or interviewed for school publications, such as school yearbooks, school newspapers, class pictures, school and/or District websites, social media, BECON TV, or for other communication tools by Broward County Public Schools or its approved vendors.

Student Name (PRINT)	Student Signature	Date
Parent/Guardian Name (PRINT)	Parent/Guardian Signature	Date

FERPA Opt-Out Notification Form 2018/2019 School Year (All Grades)

ATTENTION! Checking items below will prevent the selected information from appearing in school publications, including, but not limited to, the yearbook, even if you provide permission in Section B on the Media Release Form.

For Example: Checking "Student's Name" below may prevent the student's photograph from appearing in the yearbook.

PURPOSES OF DISCLOSURE

"Directory Information" is personally identifiable information that would not generally be considered harmful or an invasion of privacy if disclosed. Pursuant to the Family Educational Rights and Privacy Act (FERPA), The School Board of Broward County, Florida (SBBC) may disclose, in its discretion, directory information of a student in any grade level, if the parent or student age 18 or over did not "opt out" of the disclosure. SBBC reserves the right to release Directory Information only:

(a) to colleges, universities or other institutes of higher education in which the student is enrolled, may seek enrollment or may be recruited;

(b) for school publications, instructional materials and other school communication tools (including, but not limited to, yearbooks, athletic programs, graduation programs, recruitment brochures, theatrical programs, school and District websites, social media, and postings and displays throughout the school facility);

(c) to Broward County health officials for purposes of communicating with parents to address conditions of public health importance as determined by Florida Department of Health (64D-3, F.A.C.), including information to meet or to prepare for a potential or confirmed health threat; and/or

(d) to class reunion committees (and the like) for purposes of class reunion activities.

TYPES OF DIRECTORY INFORMATION

Parents/guardians of students in any grade level, or eligible students (those over the age of 18, emancipated, or attending a postsecondary institution), may opt out of having any or all of the following types of directory information disclosed by indicating, with a check mark (√), those items NOT TO BE DISCLOSED:

____ Student's Name	____Parent's Name	____ Residential Address
____ Telephone Number(s)	____ Date of Birth	____ Place of Birth
____ Major Field of Study	____ School-Sponsored Activities and Sports	____ Height and Weight of Athletic Team Members
____ School Grade Level	____Dates of School Attendance	____ Degrees & Awards*
____ Name of the Most Recent/Previous School or Program Attended		____ Room Number

**Degrees and Awards include exemplary work (including artwork), recognitions of all types, and graduation status (i.e., a list of graduating students), and exclude Grade Point Average (GPA).*

Note: This form must be completed and submitted to the school on an annual basis, regardless of whether any of the above items were checked or not, WITHIN 10 DAYS FROM THE FIRST DAY OF SCHOOL or from the date of enrollment, if a student enrolls after the start of each school year.

Student Name _____ School _____

Parent/Guardian/Eligible Student's Name (Print) _____

Parent/Guardian/Eligible Student's Signature _____

Date _____

For parents in selected occupations:

Note: Pursuant to Florida Statute 119.071, for individuals in certain occupations (as well as their spouses and children), selected personal information is confidential and exempt from public disclosure, only if the individual submits a written request for the exemption. If you are employed in a qualifying occupation and wish to request that your, your spouse's and your child's personal information remain confidential, please schedule an appointment with your child's school in order to complete the Parental Request for Exemption of Personal Information for Selected Occupations form.

Family Life/Human Sexuality Exemption Form 2018/2019 (All Grades)

Florida Statute 1003.42 requires instruction in Human Sexuality Education as part of a Comprehensive Health Education Program. The School Board of Broward County, Florida, has authorized teaching Family Life/Human Sexuality and HIV/AIDS Prevention as a component of Health Education.

The Family Life/Human Sexuality Policy, Policy 5315 states in part:
"It is essential that a universal comprehensive sexual health curriculum that follows the National Sexuality Education Standards be in place in order to make certain every student receives the same quality information necessary to support their education and live a healthy life."

Broward County Public Schools respects the rights of parents and their role in the education of their children. According to Florida Statute 1003.42(3), "Any student whose parent makes written request to the school principal shall be exempt from the teaching of reproductive health or any disease, including HIV/AIDS, its symptoms, development, and treatment. A student so exempted may not be penalized by reason of that exemption."

Only if you wish for your child to be excused from attending this course, should you complete the form below and return it to the school. Your child will then be scheduled into an alternative assignment during the Family Life/Human Sexuality lessons.

We appreciate your interest and cooperation in the implementation of our Comprehensive Health Education Program.

The Family Life/Human Sexuality curriculum will be presented by District trained teachers selected by your school principal and may include presentations from District approved experts in the field of sexually transmitted infection prevention.

You may review the curriculum content and instructional materials by visiting http://www.browardprevention.org/health-wellness/sexual-health/curriculum1/ or by scheduling an appointment with your child's school. Additional parent resources are available at www.browardprevention.org/health-wellness/sexual-health/.

Note: Only if you wish to have your child excused from this course, should this form be completed and submitted to the school on an annual basis, WITHIN 10 DAYS FROM THE FIRST DAY OF SCHOOL or from the date of enrollment, if a student enrolls after the start of each school year. Failure to return this form constitutes permission for your child to participate in the Family Life/Human Sexuality curriculum.

_____ I **DO NOT** want my child to participate in any of the Family Life/Human Sexuality lessons.

School Name _____

Student Name _____ Grade _____

Parent/Guardian Name (Print) _____

Parent/Guardian Signature _____ Date _____

Authorization for Medication Form 2018/2019 (All Grades)

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

Coordinated Student Health Services • 1400 NW 14th Court, Ft. Lauderdale, FL 33311 • (754) 321-1575

Prescription or Over-the-Counter Medication

(THIS SECTION IS TO BE COMPLETED BY THE ATTENDING PHYSICIAN ONLY)

Student Name _____ Date of Birth _____ Grade _____

School _____ Phone # _____ Fax # _____

Allergies _____

Diagnosis _____

MEDICATION	DOSAGE & ROUTE	FREQUENCY	SPECIFIC TIMES	SPECIAL INSTRUCTIONS/ SIDE EFFECTS

List any emergency precautions/health emergencies that should be anticipated for this student; (e.g., allergy triggers, diabetic reactions): _____

There are no extraordinary emergency medical services available at school. Since only CPR and first aid are available until 911 arrives, is this adequate for student survival? ☐ YES ☐ NO, IF "**NO**", specify: _____

Physician's Name (Print) _____ Physician's Signature _____

Physician's Office Address _____

Physician's Telephone # _____ Physician's Fax # _____

Date Completed _____

This information will be obtained by School Board District Personnel

PARENTAL PERMISSION FOR MEDICATION

(THIS SECTION IS TO BE COMPLETED BY THE STUDENT'S PARENT/GUARDIAN)

Student Name _____ Date of Birth _____ Grade _____

I grant the principal or his/her designee the permission to assist or perform the administration of each medication to or for my child during the school day, including when he/she is away from school property for official school events. If my child has been authorized by his/her physician to self-administer their medication(s), I grant permission for my child to self-administer their medication at school and when they are away from school property for official school events. In the event that my child is unable to self-administer their medication, I give permission for the principal/designee to perform the administration of the prescribed medication.

NOTE:

- **Medication must be supplied in the original container**. Ask the pharmacist to divide the medication into two completely labeled containers, providing one for home and one for school.
- Only medications authorized by physician may be administered by school personnel.
- It is your responsibility to notify the school when there is a change in medication regimen.

Parent/Guardian Name (Print) _____ Parent/Guardian Signature _____

Date Signed _____ Home Phone # _____ Work/Cell Phone # (include Ext. if any) _____

Authorization for Treatment Form 2018/2019 (All Grades)

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

Coordinated Student Health Services • 1400 NW 14th Court, Ft. Lauderdale, FL 33311 • (754) 321-1575

Authorization for Treatment

(THIS SECTION IS TO BE COMPLETED BY THE ATTENDING PHYSICIAN ONLY)

Student Name _____ Date of Birth _____ Grade _____

School _____ Phone # _____ Fax # _____

Diagnosis _____ Allergies _____

TREATMENTS DURING SCHOOL HOURS _____

TREATMENT PLAN: _____

PROCEDURE	TYPE	MEDS/FEEDING AMOUNT	FREQUENCY / SPECIFIC TIMES	RATE / FLOW
Catheterization				
Feedings	☐ G-Tube ☐ J-Tube ☐ NG-Tube ☐ Special _____			
Suctioning	☐ Oropharynx ☐ Tracheostomy ☐ Deep ☐ Surface			
Tracheostomy	☐ Tube Replacement ☐ Care (Cleaning)			
CPT				
Oxygen/Misting				
Ventilator				
Nebulizer Tx				
Pulse Oximeter				

Are any of the above procedures required for emergency care? ☐ YES ☐ NO, IF "YES", specify: _____

List any procedures the student has been trained to perform _____

List any limitations/precautionary measures that should be considered; e.g., physical education, outdoor activities, transporting, lifting, moving, special devices/equipment: _____

List any emergency precautions/health emergencies that should be anticipated for this student; (e.g., allergy triggers, diabetic reactions): _____

There are no extraordinary emergency medical services available at school. Since only CPR and first aid are available until 911 arrives, is this adequate for student survival? ☐ YES ☐ NO, IF "NO", specify: _____

Physician's Name (Print) _____ Physician's Signature _____

Physician's Office Address _____

Physician's Telephone # _____ Physician's Fax # _____

Date Completed _____

This information will be obtained by School Board District Personnel

PARENTAL PERMISSION FOR MEDICATION

(THIS SECTION IS TO BE COMPLETED BY THE STUDENT'S PARENT/GUARDIAN)

Student Name _____ Date of Birth _____ Grade _____

I grant the principal or his / her designee the permission to assist or perform the administration of each treatment/procedure to or for my child during the school day, including when he/she is away from school property for official school events. If my child has been authorized by his/her physician to self-administer their medication(s), I grant permission for my child to self-administer their treatment at school and when they are away from school property for official school events. In the event that my child is unable to self-administer their treatment, I give permission for the principal/designee to perform the administration of the prescribed treatment. **NOTE: School personnel may administer only treatments authorized by a physician.** ***It is your responsibility to notify the school when there is a change in treatment regimen.***

Parent/Guardian Name (Print) _____ Parent/Guardian Signature _____

Date Signed _____ Home Phone # _____ Work/Cell Phone # _____ (include Ext. if any)

Authorization for Over-the-Counter (OTC) Topical Products with Parental Approval (All Grades)

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

Coordinated Student Health Services • 1400 NW 14th Court, Ft. Lauderdale, FL 33311 • (754) 321-1575

Authorization for Over-The-Counter (OTC) Topical Products with Parental Approval Form All Grades

Effective for School Year 20_____ - 20 _____

Instructions: Each section must be completed by parent/guardian for student to self-carry and self-administer any of the listed Over-the-Counter Topical Products with parental approval only. The form is void if any section is incomplete.

I. Student/Parent Information

Student's Name (Print Name)	Birth Date	Allergies	Grade

Parent/Guardian (Print Name)	Address:

Home Phone:	Work Phone:	Other Phone:

To Be Completed by Parent/Guardian

NO AEROSOL OR PUMP PRODUCTS PERMITTED

Bug, Insect & Mosquito Repellent Self-carry and self-administration of wipes, towelettes or lotions only Parent Initial: _____	Administer according to the manufacture's label
Sunscreen Products Self-carry and self-administration Parent Initial: _____	Administer according to the manufacture's label

Parental Permission (To be completed by Parent/Guardian only)

By signing below, I (the parent or legal guardian) understand that the over-the-counter topical products with parent only permission will be administered by the student and not by healthcare personnel. I take full responsibility that the topical product that I have signed for is age-appropriate. I understand that I may permit my child to self-carry and self-administer the above listed topical products and I assumed full responsibility for any consequence resulting from topical products administration by my son/daughter. I understand that all topical products must be carried on self, in the original sealed container and clearly labeled with the student's full name. I understand and have discussed with my son/daughter that if he/she inappropriately uses, sells or transmis the topical products, he/she will be issued a consequence as outlined in the District's Discipline Matrix. By signing this form, I assume full responsibility of any consequence resulting from the administration of the above listed topical products. I am also releasing The School Board of Broward County, Florida from any liability that results in my son/daughter inappropriately using, selling or transmitting the topical products identified above.

Parent/Guardian Name (Print) _____

Parent/Guardian Signature _____ Relationship to the Student _____

Home Phone _____ Business/Mobile Number _____

Email Address _____

Florida Heiken Children's Vision Program Form 2018/2019 (All Grades)

FLORIDA HEIKEN *Children's Vision Program*

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA
Coordinated Student Health Services • 1400 NW 14th Court, Ft. Lauderdale, FL 33311 • (754) 321-1575

Florida Heiken Children's Vision Program
(Broward Free Eye Exam & Eyeglasses School Program)

If your child fails a vision screening and is eligible, the Florida Heiken Children's Vision Program and its health care providers may provide him/her with a **FREE**, non-invasive, dilated vision exam, and if needed, **FREE** eyeglasses. To apply to receive this **FREE** service, complete, sign and return this form to your child's school. For more information call 1-888-996-9847 or visit http://miamilighthouse.org/Florida_Heiken_Program.asp.

School (Full Name) _____ Grade_____ Teacher _____ Student I.D. _____

Student's Name_____ Male/Female (Circle One) Student's Date of Birth _____

Address _____ Apt._____ City _____ Zip Code _____

Home Phone _____ Parent/Guardian Day Phone _____

Parent/Guardian Name (Print) _____ E-mail Address _____

Ethnicity (Circle One): African-American Asian Hispanic Native-American White (Non-Hispanic) Haitian Other _____

Spoken Language (Circle One): English Spanish Creole Portuguese Other _____

Has your child seen an eye doctor in the past year? Yes_____ No _____ Does your child wear glasses? Yes _____ No _____

Please list any medication or eye drops your child uses: _____

Please list any allergies your child has: _____

Does your child have any special needs/developmental delays? Yes _____ No _____ Explain: _____

Does your child require any auxiliary aids (such as interpreter, sign language, visual aids, wheelchair, Braille)? Yes _____ No _____ If Yes, please explain: _____

Has your **child** had any of the following:

YES	NO	
☐	☐	Eye Surgery / Injury
☐	☐	Vision Therapy
☐	☐	Headaches
☐	☐	Glaucoma
☐	☐	Diabetes
☐	☐	Sickle Cell
☐	☐	Asthma

Has your child's **family** had any of the following:

YES	NO	
☐	☐	Eye Turn / Lazy Eye
☐	☐	Blindness
☐	☐	Macular Degeneration
☐	☐	Glaucoma
☐	☐	High Blood Pressure
☐	☐	Sickle Cell
☐	☐	Other

Please explain any "YES" answers from above: _____

Consent for eye examinations - By signing below, I authorize Florida Heiken Children's Vision Program to provide my eligible child with a comprehensive dilated eye examination, either at the school site by a mobile Optometrist or at the office of an assigned participating provider.

Notice of privacy practices - By signing below, I understand that the Notice of Privacy Practices for the Florida Heiken Children's Vision Program is available for review, if I should request a copy via phone at (305) 856-9830/ (888) 996-9847.

Mutual exchange of information - By signing below, I authorize the mutual release of information between the Florida Heiken Children's Vision Program and Broward County Public Schools (BCPS) of any and all optometry medical reports on my child to participating program providers, to determine appropriate care. I also authorize BCPS to release any required information on my child's eligibility for the free/reduced lunch program and any missing or unclear information requested to process this application. **I/We release and hold harmless the County School Board of any and all responsibility and liability for any injury or claim resulting from participation in the Florida Heiken Children's Vision Program because of accident or mishap involving the participation of my child/ward in the program.**

LEGAL GUARDIAN SIGNATURE (to receive exam) _____ **Date:** _____

Authorization to bill insurance - If my child has an insurance plan that is accepted and has an opportunity to be seen on a mobile unit visit (only), I hereby authorize Florida Heiken Children's Vision Program to bill my child's insurance for a comprehensive, dilated eye exam and eyeglasses. If prescribed (includes selected frames, clear poly lenses and no add-ons). I understand this will use my child's insurance vision benefit.

Signature (Authorization to bill insurance) _____ Date: _____

The Florida Heiken Children's Vision Program is an equal opportunity organization and does not discriminate against otherwise qualified applicants on the basis of race, color, religion, ancestry, age, sex, marital status, national origin, disability or veteran status.

For School Personnel Use Only:
County: **Broward**
Referring school/agency: _____
Vision Screening Fail Date (Mandatory): _____
Qualifies for Free/Reduced Program (Circle One): YES NO
Signature: _____ **Date:** _____

For Heiken Use Only: Scanned ☐
Account #: _____
Eligibility Status: _____
Eligibility Date: _____
Insurance: _____

School/Agency: Please fax completed form with Heiken Fax Cover Sheet to (305) 856-9840 / 1(888) 980-8474

Established 1915 BROWARD County Public Schools Acknowledgment - Parent Copy

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