



Summary of Changes

Additions

Forms:

- Authorization for Medication Form
- Authorization for Treatment Form
- Authorization for Selected Over-the-Counter (OTC) Medication with Parental Approval Grades 9-12 Form
- Authorization for Over-the-Counter (OTC) Topical Products with Parental Approval Form
- Broward County Public Schools and Broward County Library Library Card Drive Flyer
- Every Student Succeeds Act (ESSA) Opt-Out Form

Clarifying language pertaining to:

- Section II – Reporting Disciplinary Incidents to the State
- Section II – Personal Technology
- Section II – Discrimination and/or Harassment
- Section V – Interscholastic Extracurricular Activities for High School Students
- Section VI – Opting Out of Reciting the Pledge of Allegiance

Revisions

Forms:

- Acknowledgement Form
- Family Educational Rights and Privacy Act (FERPA)

Clarifying language pertaining to:

- Section II – Sexting
- Section II – Unacceptable School Bus Behaviors
- Section IV – Florida Standards Assessment (FSA) Administration
- Section IV – Social Media Usage
- Section VIII – Directory Information
- Section IX – Self-carry and Self-administration of Over-the-Counter Medication for Students in Grades 9-12
- Section IX – Offenses Leading to Suspension and Possible Expulsion
- Section IX – Offenses Leading to Mandatory Expulsion
- Section IX – Definition of Weapons and other Definitions of Infractions
- Appendix – Separation of the Discipline Matrices into Grades K-2; 3-5; 6-8 and 9-12

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-onlineforms>).

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.
- Recognize that they are responsible for their student's behavior on the way to and from school and at the bus stop. A safe and respectful learning environment is key to academic achievement; therefore any student's off campus actions that seriously affect a student's ability to learn or a staff member's ability to teach may be handled as a disciplinary infraction. For serious incidents that occur at bus stops and/or that are not on School Board property, parents should contact law enforcement directly. For bullying incidents (see bullying definition, Section II), school officials should be notified and will investigate and/or provide assistance and intervention, as the principal/designee deems appropriate, which may include the use of the School Resource Officer.
- 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.

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:

- | | | |
|--|---|---|
| <input type="checkbox"/> Student's Name | <input type="checkbox"/> Parent's Name | <input type="checkbox"/> Residential Address |
| <input type="checkbox"/> Telephone Number(s) | <input type="checkbox"/> Date of Birth | <input type="checkbox"/> Place of Birth |
| <input type="checkbox"/> Major Field of Study | <input type="checkbox"/> School-Sponsored Activities and Sports | <input type="checkbox"/> Height and Weight of Athletic Team Members |
| <input type="checkbox"/> School Grade Level | <input type="checkbox"/> Dates of School Attendance | <input type="checkbox"/> Degrees & Awards* |
| <input type="checkbox"/> Name of the Most Recent/Previous School or Program Attended | | <input type="checkbox"/> 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.

ESSA Opt-Out Form (11th & 12th Grades) 2018/2019 School Year

MILITARY & POSTSECONDARY

Pursuant to the Every Student Succeeds Act (ESSA), the District is required to disclose, upon request, **student name, address, and telephone number** of 11th and 12th graders without prior consent to:

- **Armed services/military recruiters** (the District Commander or Senior Officer of the regional or satellite offices of the Armed Forces, including the United States Coast Guard) for their use in mailing notices to students in regard to opportunities available to them in the United States Armed Forces. Confidentiality of the list shall be protected by the armed services personnel responsible for such lists.
- **Institutions of higher education** (postsecondary institutions). Confidentiality of the list shall be protected by the higher education personnel responsible for such lists.

However, parents/guardians and eligible students (those over the age of 18), may opt out of having this information disclosed by indicating their choice below.

Information disclosed to armed services/military recruiters:

1. _____ I **WILL** permit the limited information listed above to be disclosed to armed services/military recruiters.
2. _____ I **WILL NOT** permit the limited information listed above to be disclosed to armed services/military recruiters without my prior permission.

Information disclosed to postsecondary institutions:

1. _____ I **WILL** permit the limited information listed above to be disclosed to postsecondary institutions.
2. _____ I **WILL NOT** permit the limited information listed above to be disclosed to postsecondary institutions without my prior permission.

Note: This form must be completed and submitted to the school on an annual basis, regardless of the chosen option, 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.

In addition to this form, all 11th and 12th grade students must also complete the *FERPA Opt-Out Notification Form* provided in the Code of Student Conduct.

Student Name _____ Grade _____

School Name _____

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

Parent/Guardian/Eligible Student's Signature _____

Date _____

Family Life & Human Sexuality



POLICY 5315
Family Life and Human Sexuality

B

The School Board of Broward County, Florida is committed to protecting the health of all students by providing comprehensive sexual health education that promotes healthy attitudes concerning growth and development, body image, gender and sexuality, dating, relationships and family.



CURRICULUM
Family Life and Human Sexuality
Adopted May 2014

C

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.



DATA
Broward County Public Schools
Youth Risk Behavior Survey

P

- In 2013, 12.0% of BCPS middle school students reported having sexual intercourse.
- In 2013, approximately 41.4% of BCPS high school students reported to have had sexual intercourse.
- In 2013, approximately 28.2% of BCPS high school students reported they were sexually active in the past three months.



RESOURCES
View Policy 5315 and Curriculum

S

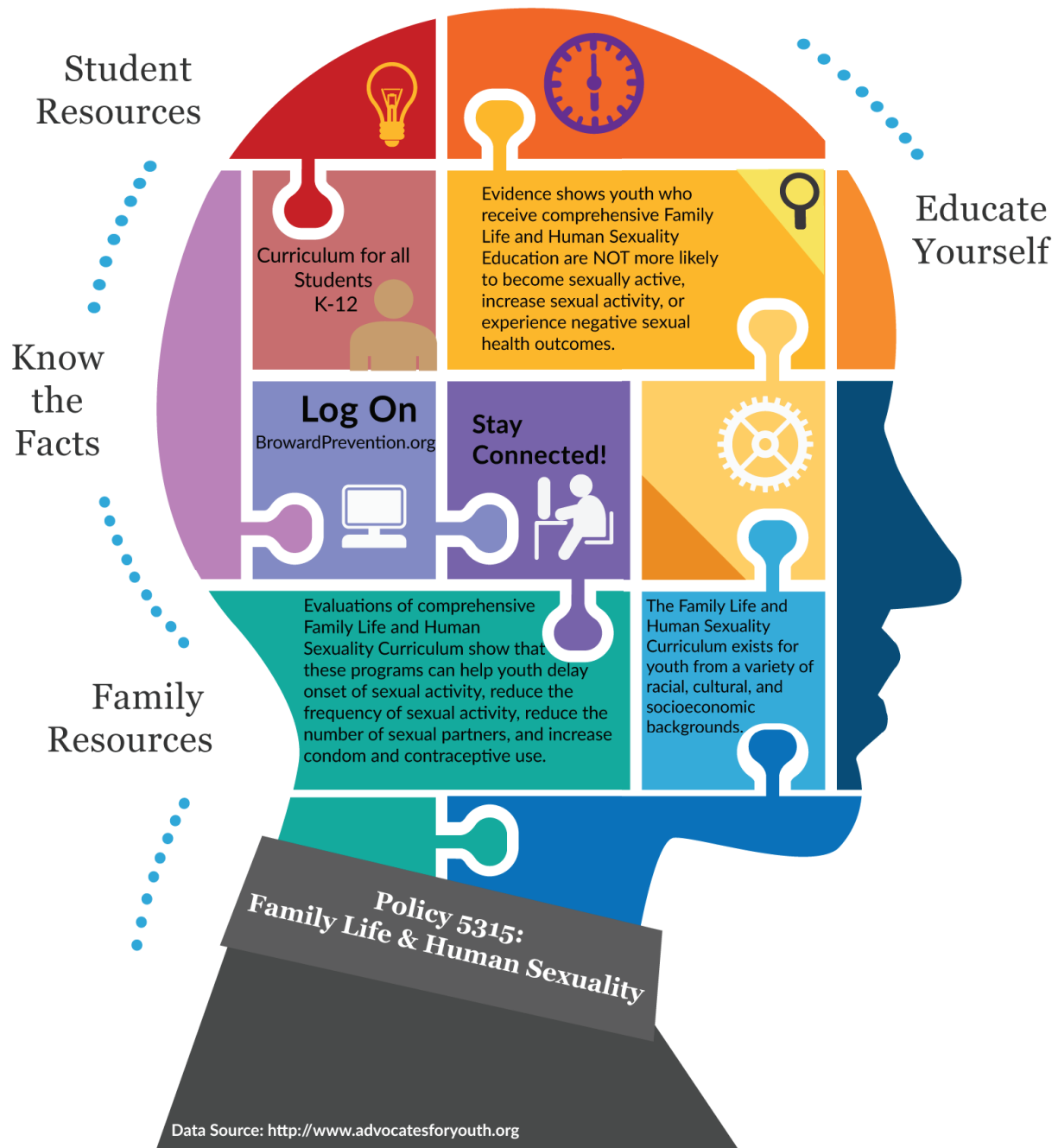
Please visit our website to review the Family Life and Human Sexuality Policy 5315, curriculum and additional parent and student resources.

www.BrowardPrevention.org

www.browardprevention.org/health-wellness/sexual-health/



Broward County Public Schools



What does the curriculum cover?

K-3

The Kindergarten-Third Grade curriculum includes lessons on feelings, positive self image, decision making, sexual abuse prevention and ways to stay healthy.

4-5

The Fourth-Fifth Grade curriculum incorporates lessons on puberty, reproduction, HIV, friendship and self esteem.

6-8

The Sixth-Eighth Grade curriculum contains lessons on topics such as abstinence, communication, decision making, reproduction and HIV.

9-12

The Ninth-Twelfth Grade curriculum includes lessons on abstinence, risk education, sexual exploitation, sexually transmitted infections and healthy communication.

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 _____



THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA
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Coordinated Students Health Services
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Dear Parent,

The following information is to assist you, as the parent/guardian, with providing health information required for your child by Broward County Public Schools. If you should have any questions, please feel free to contact your school.

Medical Examination

All students entering Broward County Public Schools for the first time must have a medical examination performed within one year of registration. The medical examination should be documented on the Florida Department of Health Form 3040 or on the provider's office/medical facility stationery. The appropriate form/stationary should be completed, signed and dated by the healthcare provider.

Communicable Diseases/Illnesses

Please inform the school if your child is out sick with a diagnosed communicable illness such as meningitis, measles, salmonella, etc.

Please keep your child home if your child has:

- Flu-like symptoms
- Fever greater than 100.4 degrees
- Sore throat, coughs, chills, and/or body aches
- Rashes, yellow eye drainage, or greenish-yellow phlegm from a cough or cold, vomiting, diarrhea, etc.

Chronic Health Conditions

If your child has any of the following health conditions, including, but not limited to, asthma, diabetes, cystic fibrosis, sickle cell anemia, seizures, allergic reactions to food, insect bites, etc., please inform the school.

Parents should:

- Document the chronic health condition on the Student Emergency Contact Card and complete the history on the back of the card.
- Meet with school administration to discuss care of the student while at school
- If the student is on medication, provide the school with a current Medication Authorization form signed by the healthcare provider and parent

Note: A Diabetes Medication/Treatment Authorization form must be completed by the healthcare provider and parent for students with diabetes. Students who received insulin via an insulin pump must also complete an Insulin Pump Medication/Treatment Authorization form.

Medication Administration at School (Prescription or Over-the-Counter)

- If your child needs to take over-the-counter (OTC) or prescribed medication at school or on a field trip, an Authorization for Medication/Treatment form must be completed and signed by the healthcare provider and parent
- **Parents** must transport/deliver **ALL** medications to school staff in the original, labeled container (unless your child is authorized to carry their medication per the Authorization for Medication/Treatment form)

Authorization for Selected Over-the-Counter Medication (OTC) with Parental Approval Grades 9-12 Only

- If your child needs to take over-the-counter (OTC) medication at school or on a field trip, an Authorization for Selected Over-the-Counter Medication (OTC) with Parental Approval Only form must be completed and signed by the parent/guardian, student and be notarized
- Self-carry, self-administration of the selected over-the-counter medications only:
 - Tylenol
 - Motrin
 - Allegra
 - Claritin
 - Tums
 - Lactaid
 - Midol

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

- Students in all grade levels are permitted to self-carry and self-administer bug, insect, mosquito repellent (wipes, towelettes or lotions only) and sunscreen (no aerosol products permitted).
- An Authorization for Over-the-Counter (OTC) Topical Products with Parental Approval Only form must be completed and signed by the parent/guardian

Note: Plan ahead for field trips if your child needs medication for an overnight trip that he/she may not normally take at school. Update changes to your child's health condition as they occur.

Immunizations (Please refer to F.S. 1003.22)

- Make sure your child's required immunizations are up to date. If you are not sure, you can check with your healthcare provider or the Florida Department of Health-Broward at (954) 467-4700
- Parents may obtain medical exemptions from their healthcare provider or a religious exemption from the Florida Department of Health-Broward

School Health Centers, Community Resources, Immunizations & Health Care

- Information is available on Broward County Public Schools website at <http://www.browardhealthservices.com/resources/>
- If you do not have insurance, you can request an application for Florida KidCare Insurance at your child's school

Florida Heiken Children's Vision Program

- The Florida Heiken Children's Vision Program provides vision examinations and eyeglasses when prescribed, to students in need of comprehensive vision services at no cost to the student.
- Eligible students for the program must meet the criteria of the Free and Reduced Lunch Program and have failed the vision screening
- The Florida Children's Vision Program consent form will be sent home during the first week of school for parent/guardian signature
- If your child meets the above criteria and you would like your child to participate in the program, please complete, sign and return the consent form to the school

Additional information on school entry requirements is available at <http://www.browardhealthservices.com/parent-information/registration-requirements/>.

If you have any questions, please contact your child's school.

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 | <input type="checkbox"/> G-Tube J-Tube <input type="checkbox"/> NG-Tube Special _____ | | | |
| Suctioning | <input type="checkbox"/> Oropharynx <input type="checkbox"/> Tracheostomy Deep <input type="checkbox"/> Surface | | | |
| Tracheostomy | <input type="checkbox"/> Tube Replacement <input type="checkbox"/> 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 Selected Over-the-Counter (OTC) Medication with Parental Approval (Grades 9-12)

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

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

Authorization for Selected Over-The-Counter (OTC) Medication with Parental Approval Form Grades 9-12

Instruction: Each section must be completed by parent/guardian for student to self-carry or self-administer any of the listed Over-the-Counter (OTC) medication with parental approval only. The form is void if any section is incomplete. This form is to be signed by the parent/guardian, student and notarized.

Instructions: Each section must be completed by parent/guardian for student to self-carry or self-administer any of the selected over-the-counter (OTC) medication with parental approval only. The form is void if any section is incomplete. This form is to be signed by the parent/guardian, student and notarized.

I. Student/Parent Information

| | | | |
|------------------------------|-------------|--------------|--------|
| Student's Name (Print Name) | Birth Date: | Allergies | Grade: |
| Parent/Guardian (Print Name) | | Address: | |
| Home Phone: | Work Phone: | Other Phone: | |

II. Medication (To Be Completed by Parent/Guardian)

THIS REQUEST IS TO BE EFFECTIVE FOR THE SCHOOL YEAR 20____ - 20____ OR FROM _____ TO _____
Only **ONE** medication may be selected. Only **2 doses** of the medication are allowed on person

| Medication to be Administered by Mouth | Dosage and Times | Symptoms | Comments | Expiration Date of Medication |
|--|--|--|--|-------------------------------|
| Acetaminophen (Tylenol) <input type="checkbox"/> YES <input type="checkbox"/> NO | Administer according to the manufacturer's label | For relief of minor aches and pain; (100.4 temperature will not be treated in school) | Student with temperature over 100.4 must be sent home | |
| Calcium Carbonate <input type="checkbox"/> YES <input type="checkbox"/> NO | Administer according to the manufacturer's label | For stomach ache or heart burn | Alert: May cause constipation | |
| Ibuprofen (Advil, Motrin) <input type="checkbox"/> YES <input type="checkbox"/> NO | Administer according to the manufacturer's label | For the relief of body aches & menstrual cramps; (100.4 temperature will not be treated in school) | Alert: Contains no aspirin but should not be given if student has asthma or allergy to aspirin | |
| Midol <input type="checkbox"/> YES <input type="checkbox"/> NO | Administer according to the manufacturer's label | Menstrual cramps | Alert: Aspirin sensitive students should be careful | |
| Allegra <input type="checkbox"/> YES <input type="checkbox"/> NO | Administer according to the manufacturer's label | For relief of the symptoms of seasonal allergies (sneezing, itching, runny nose) | Alert: Avoid taking any other cold or allergy medicine unless your doctor has told you to | |
| Lactaid <input type="checkbox"/> YES <input type="checkbox"/> NO | Administer according to the manufacturer's label | Lactose intolerance | No common side effects when used in small doses | |
| Claritin <input type="checkbox"/> YES <input type="checkbox"/> NO | Administer according to the manufacturer's label | For relief of the symptoms of seasonal allergies (sneezing, itching, runny nose) | Alert: Avoid taking any other cold or allergy medicine unless your doctor has told you to | |

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

By signing below, I (the parent or legal guardian) understand that the selected over-the-counter medications with parent only permission will be self-carried and self-administered by the student. I understand that if I permit my child to self-carry and self-administer medication, I assume full responsibility for any consequence resulting from medication administration by my child. I understand that all medication must be in the original container and clearly labeled with the student's full name. I understand and have discussed with my son/daughter that if he/she uses the OTC medication in excess of the authorized two (2) daily doses, sells or transmits this medication, he/she will receive the consequence as outlined in the District's Discipline Matrix. By signing this form, I assume full responsibility of any consequence resulting from the self-carry and self-administration of the selected over-the-counter medications. I am also releasing The School Board of Broward County, Florida from any liability that results in my son/daughter using the medication in excess of the authorized doses, selling or transmitting any of the medications identified above.

Parent/Guardian Name (Print) _____

Parent/Guardian Signature _____ Relationship to the Student _____

Home Phone _____ Business/Mobile Number _____

Email Address _____

IV. Student Acknowledgement (To be completed by Student only)

Student Name (Print) _____

Student Signature _____

V. To Be Completed by Notary Public Only

STATE OF FLORIDA

COUNTY OF _____

The foregoing instrument was acknowledged before me this _____ day of _____, 20____, by _____.

Personally Known _____ OR Produced Identification _____

Type of Identification Produced _____

(Notary Seal)

Official Notary Signature

Printed Name of Notary

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 transmits 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 _____

Health Screening Opt-Out Form 2018/2019 (Grades KG, 1st, 3rd and 6th)

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

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

Health Screening Opt-Out Form

According to the guidelines established by the Florida Legislature, at the beginning of each year, parents shall be notified of the screening activities available through the **School Health Services Program**. Florida Statue 381.0056(5)(g), mandates health screening to public school students in Kindergarten (KG), 1st, 3rd and 6th grades and for students new to the county. It should be understood that such screenings do not substitute for a thorough examination by a health care provider.

The screenings include vision, hearing, height and weight, Body Mass Index (BMI) and Scoliosis. They are offered in an effort to decrease health barriers to learning and may be performed individually or in groups. **Parents or guardians have the right to opt their child out of the screenings.**

*Note: If you **DO NOT** want your child to receive one or more of the screenings, please check the appropriate box below, print and sign your name, and return this form to your child's school **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 _____ Gender _____

School _____ Grade _____

DO NOT SCREEN:

- Vision (Grades KG, 1st, 3rd and 6th)
- Hearing (Grades KG, 1st and 6th)
- Height and Weight / BMI (Grades 1st, 3rd and 6th)
- Scoliosis (Grade 6th)

Parent/Guardian Name (Print) _____

Parent/Guardian Signature _____

Date _____

Florida Heiken Children's Vision Program 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

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 | |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Eye Surgery / Injury |
| <input type="checkbox"/> | <input type="checkbox"/> | Vision Therapy |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |

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

| YES | NO | |
|--------------------------|--------------------------|----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Eye Turn / Lazy Eye |
| <input type="checkbox"/> | <input type="checkbox"/> | Blindness |
| <input type="checkbox"/> | <input type="checkbox"/> | Macular Degeneration |
| <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell |
| <input type="checkbox"/> | <input type="checkbox"/> | 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.

| | |
|--|---|
| <p>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: _____</p> | <p>For Heiken Use Only: Scanned <input type="checkbox"/> Account #: _____ Eligibility Status: _____ Eligibility Date: _____ Insurance: _____</p> |
|--|---|



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



Broward County Public Schools
Diversity, Prevention & Intervention Department
MTSS/RtI Parent Guide

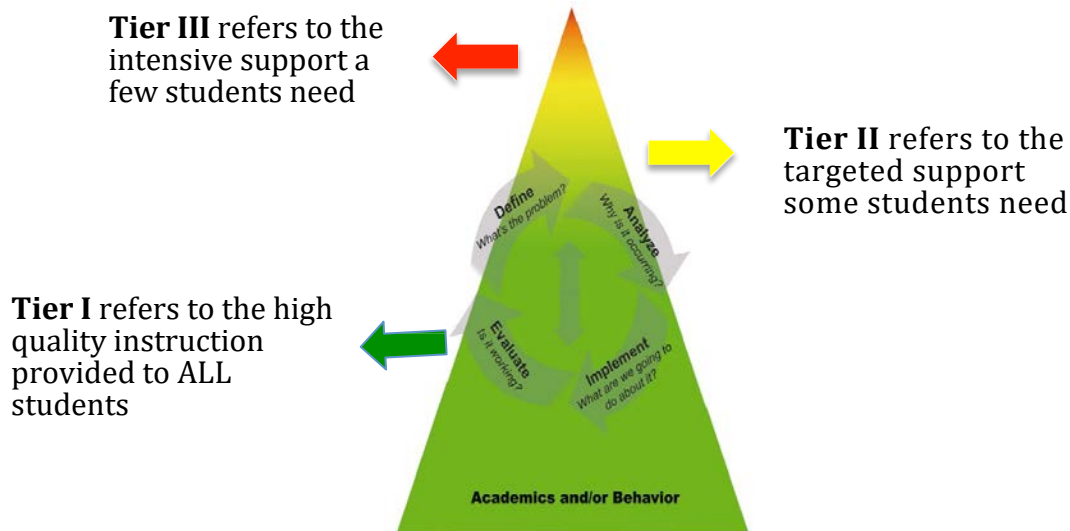


What is Multi-Tiered System of Supports (MTSS)?

MTSS is a term used to describe an evidence-based model of schooling that integrates academic and behavioral instruction and intervention to promote the success of all children.

What is Response to Intervention (RtI)?

RtI is the practice of providing high quality instruction and intervention matched to student need, close monitoring of how a student responds to different types of instruction and support.



How will MTSS/RtI impact my child?

- Multi-tiered System of Supports (MTSS) ensures that your child receives varying levels of academic and behavior supports based upon his or her need
- Your child will be included in early identification of academic or behavioral problems so assistance can be provided at the first signs of difficulty
- Help for your child will increase or decrease depending on his or her needs
- You are encouraged to participate and become involved in planning and providing interventions to help your child
- You will receive frequent updates of your child's progress

www.browardprevention.org/mtssrti/rti/

What do I do if I believe my child is struggling?

- Talk with your child's teacher
- Review and assist with homework assignments
- Ask for regular meetings with your child's teacher
- Celebrate your child's successes
- Learn more about the curriculum, assessments, and interventions being used in your child's school
- Participate in conferences and problem solving sessions for your child



How can I participate in MTSS/RtI?

Families play a critical role in supporting what their children are learning in school. The more parents are involved in student learning, the higher the student achievement. Ask questions to learn more about MTSS/RtI in your child's school:

- Is my child successful? How do I know? If not, why and what can we do differently?
- If needed, how is additional help going to be provided? By whom? How often? For how long?
- How can I participate in problem-solving about my child?
- What can I do to help with the interventions for my child at home?
- How will I know if interventions are working?

Parental Resources

This video for parents introduces the use of problem solving and how it may affect your child. <http://www.florida-rti.org/parentResources/videos.htm>

To review the real "truths" behind common myths of RtI and MTSS, visit the following link: <http://www.florida-rti.org/parentResources/myths/index.htm>

For additional information, please contact Diversity, Prevention & Intervention at 754-321-1655 or visit www.browardprevention.org

<http://www.floridarti.org/parentResources/index.htm>