Student #:	School/ Teacher:	Date:	Grade Level:	Entry Code:

Student Registration Form

Only the parent/guardian (F.S. §1000.21(5)) who registers the student (i.e., completes this form) may withdraw the student from his/her current school, unless there is documentation of extenuating circumstances indicating otherwise. If the information below changes, it is the parent's/guardian's responsibility to notify the school in writing within 10 school days. The personal information you provide on this form will be kept confidential (in a protected area) and only used and disclosed by school and District staff on a need-to-know basis.

Student's Last Name (Legal)	First Name (Legal)	Middle Name	Affirmed Name

Student's Primary Home Address	Apt #	City	Zip Code	Gender
				☐ Male ☐ Female

Home Phone #	Student's Cell Phone #	Student's E-mail Address

SSN *Not required for enrollment or graduation. F.S. §1008.386 requires SBBC to request the SSN for its information management system.	Date Student First Entered School in USA	Date of Birth	Birthplace (City/State/Country)

Student Lives With	Ethnicity	Race (Check all that apply)
☐ One Parent ☐ Legal Guardian ☐ Both Parents (same address) ☐ Independent Student ☐ Both Parents (different address) ☐ Other: ____________	☐ Non-Hispanic or Non-Latino ☐ Hispanic or Latino	☐ White ☐ Native American/Native Alaskan ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black/African-American

Registering Parent's Last Name (Legal)	First Name (Legal)	Driver License #	Relationship to Student

Registering Parent's Work Phone #	Registering Parent's Cell Phone #	Registering Parent's E-mail Address

Non-Registering Parent's Last Name (Legal)	First Name (Legal)	Driver License #	Relationship to Student

Non-Registering Parent's Work Phone #	Non-Registering Parent's Cell Phone #	Non-Registering Parent's E-mail Address

Non-Registering Parent's Home Address	Apt #	City	State	Zip Code

Home Language Survey (If the answer is "Yes" to any of these questions, the student must be tested for English proficiency.)

	Question	
☐ Yes ☐ No	Is a language other than English used in the home?	If "yes", which language?
☐ Yes ☐ No	Does the student have a first language other than English?	If "yes", which language?
☐ Yes ☐ No	Does the student most frequently speak a language other than English?	If "yes", which language?

The student's primary residence is: (Check only one)	
☐ ***owned*** by the parent/guardian.	☐ ***shared*** with someone by choice (not due to financial hardship) with a valid Affidavit of Shared Residency.
☐ ***rented*** with a valid lease agreement. Expiration Date: ____________________	☐ ***shared*** with someone due to loss of housing, economic hardship or similar reason. (McKinney-Vento eligible)

Is the student's primary residence a:		Does the student live or is either parent employed:	
☐ Yes ☐ No	Public space, vehicle of any kind, bus or train station, abandoned building, substandard housing, or similar setting?	☐ Yes ☐ No	In low rent housing (such as Section 8 subsidized housing)?
☐ Yes ☐ No	Transitional/emergency shelter?	☐ Yes ☐ No	On Indian Lands?
☐ Yes ☐ No	Hotel/motel, trailer park, or camping ground due to lack of alternative adequate accommodations?	☐ Yes ☐ No	On federal property, a federally owned military installation, or NASA owned property?

Is either parent:	
☐ Yes ☐ No	An active duty member of the uniformed services, including the National Guard and Reserve? If yes, which division?______________________________
☐ Yes ☐ No	A veteran, medically discharged, or killed while on active duty from the uniformed services? If yes, which division?______________________________
☐ Yes ☐ No	Employed in agriculture or fishing industries anytime in the past three years?

Has the student previously been:			
☐ Yes ☐ No	Enrolled in Broward County Public School?	☐ Yes ☐ No	Retained (repeated the same grade)?
☐ Yes ☐ No	Enrolled in a Charter School in Broward County?	☐ Yes ☐ No	In Exceptional Student Education (ESE)?
☐ Yes ☐ No	Enrolled in a Home Education program?	☐ Yes ☐ No	On a 504 plan?
☐ Yes ☐ No	Expelled from school?	☐ Yes ☐ No	In an ESOL program?
☐ Yes ☐ No	Convicted of a felony?	☐ Yes ☐ No	In a Magnet program?
☐ Yes ☐ No	Involved in the Juvenile Justice System?	☐ Yes ☐ No	In Foster Care?
☐ Yes ☐ No	Referred for mental health services?	☐ Yes ☐ No	In a Gifted program?

Previous School Name(s)	City/State/Country	Year(s) Attended	Grade(s)	Type
				☐ Public ☐ Private ☐ Charter ☐ Home Ed
				☐ Public ☐ Private ☐ Charter ☐ Home Ed

The above information is correct and complete to the best of my knowledge. In the event of a change of name, address, or phone, I will notify the school office in writing within ten (10) days. I understand that students whose parents are found, after appropriate investigation, to have submitted fraudulent information in an effort to enroll a student in a school to which the student is not assigned shall be immediately withdrawn by the school and the parent must enroll the student in the appropriate boundaried school or follow the reassignment procedures. I have read and understand that I must submit appropriate proof of residency documentation, per School Board Policy 5.1. 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. Florida Statutes §92.525 provides that whoever knowingly makes a false declaration under penalties of perjury is guilty of the crime of perjury by false written declaration, a felony of the third degree.

Print Registering Parent Name	Registering Parent Signature	Date

Broward County Public Schools

Student Emergency Contact Card

This form shall be updated every year

For Office Use Only:	☐ *Medical*
School #:	☐ *Court Order*
Student #:	☐ *Special Needs*
Date Enrolled:	☐ *Other*

In the case of an emergency, it is imperative that the school be able to reach the student's parent (as defined below). Please fill in the information on both sides of this card carefully and accurately. Please use ink and print clearly. The names of both parents of a student (as defined in the Section 1000.21(5), Florida Statutes), the registering parent and the non-registering parent, of a student shall be listed on the emergency contact card as persons authorized to pick up the child from school except where a court order has revoked the parental rights and a certified copy of such court order has been provided to the school office.
Both parents shall designate on the Emergency Contact Card those persons authorized to pick up their child from school. No parent shall delete or in any way alter the names provided by the other parent on the Emergency Contact Card.

Grade:

Student Identification Number:

Student:

Section			
Student Information	Last Name:	First:	Middle:
	Teacher (elementary school only):	Gender: ☐ Male ☐ Female	Grade Level:
	Home Address:	City, State, Zip:	Home Phone:
	Mailing Address (If different from above):	City, State, Zip:	Student Cell Phone:
	Date of Birth: / /	Student lives with:	Student Email:
	Check any that apply to student residence: ☐ Medical ☐Court Order ☐Special needs ☐Other	Has student changed address since last registration? ☐ Yes ☐ No	Is there a court order on file that prevents a parent from having contact with the student? ☐ No ☐ Yes, contact school
Registering Parent	Last Name:	First:	Cell Phone:
	Home Address (if different from student):	City, State, Zip:	Home Phone:
	Employer:	Work Phone:	Parent email:
Other Parent	Last Name:	First:	Cell Phone:
	Home Address (if different from student):	City, State, Zip:	Home Phone:
	Employer:	Work Phone:	Parent email:

Authorized Release/Contact

Please list the names of persons to whom we may release your child or whom we may contact if we cannot reach you. NO STUDENT WILL BE RELEASED TO ANYONE OTHER THAN THE PERSONS LISTED BELOW. In selecting someone to whom you authorize the release of your child, consider whether this person is prepared to handle any special medical needs required by your child. I/We hereby authorize contact with, release of emergency related information, or release of the student to the following persons in the event of illness, evacuation, or other emergency that may occur while the student is in school.

Name:	Relationship:	Phone:

I declare that the information on this card is true and correct. I will notify the school office immediately of any changes.

Signature: Date: Relationship:

Non-Registering Parent Authorized Release/Contact

This section may be completed only by the non-registering parent in order to designate additional persons who may pick up the student. The registering parent may not alter this section of this card. The non-registering parent may not alter any other portion of this card.

Name:	Relationship:	Phone:

I declare that the information on this card is true and correct. I will notify the school office immediately of any changes.

Signature: Date: Relationship:

The personal information you provide on this form will be kept confidential (in a protected area) and only used and disclosed by school staff on a need-to-know basis.

Broward County Public Schools Student Emergency Contact Card

Student Last Name: First: Middle:

Medication Information

Does your child take medication? ☐ Yes ☐ No	If your child requires medication at school, all medication sent to the school must be in the original prescription container with a current date and the child's name. Also, a "Medication/Treatment Authorization" form, must be completed and signed by the physician and the parent and must be on file at the school.	
Medication:	Dosage:	Hour(s) Given:

Health Insurance and Providers

Please check appropriate box: ☐ Family Health Insurance ☐ Florida Kid Care ☐ Florida Healthy Kids ☐ None

If NONE, do we have your permission to forward the parent's name and phone number to Florida Kid Care Insurance for health insurance screening to see if you may be eligible for health insurance coverage? If Yes, please sign here:

Physician:	Phone:
Dentist:	Phone:
Health Plan/Group name:	Phone:

Medical Information

Medical Conditions	Please check all that apply:
☐ Asthma. If checked, uses inhaler?	☐ Yes ☐ No ☐ On daily medication
☐ Seizures. If checked, on medication?	☐ Yes ☐ No
☐ Diabetes. If checked, insulin dependent?	☐ Yes ☐ No

☐ Movement limitations (specify):

☐ Recent illness/hospitalization/surgery (describe:

☐ Severe Allergies. If checked, specify Type:	Allergies require:
☐ Food/environmental:	☐ EpiPen
☐ Insect stings/bites:	☐ Benadryl
☐ Medicines/Drugs:	☐ Other:

Does your child wear glasses/contacts? ☐ Yes ☐No Does your child wear hearing aid(s)? ☐ Yes ☐ No

Release of Medical Information and Emergency Treatment

I hereby authorize for my child's medical information, parental contact information, and other health information (collected from health services provided at school, including information stored electronically) to be shared with emergency personnel and health department officials to address conditions of public health importance, including information to meet and to prepare for potential or confirmed health conditions. For students receiving health services from school or District staff and/or contracted partners, I also authorize the District to share my child's identifiable health information and related demographics with the Florida Department of Health to conduct monitorings to assure program compliance by the District and schools, and assess the delivery of services.

Parent Signature: Date:

Medical and other information will be disclosed without consent from the parent/eligible student in case of health emergencies, as permissible by the Family Educational Rights and Privacy Act (FERPA). The school will call for emergency medical care as deemed necessary. Emergency transportation to a health care facility, as determined by paramedics, will be authorized.

Dismissal Information

Regular Dismissals Procedures. On a typical day, how will your child leave school?

☐ Ride in Car	☐ Ride School Bus	☐ Ride Public Transportation
☐ Attend ON-site after-care program	☐ Attend OFF-site after-care program	☐ Walk or Bike ride home

Emergency Dismissals Procedures. In the event of a severe storm or other unscheduled emergency your child is instructed to:

☐ Walk home	☐ Ride School Bus as usual	☐ Ride Public Transportation
☐ Ride home with parent only	☐ Ride home with person indicated on authorized contact list	

Siblings and Home Language

Last Name:	First Name:	Grade level:

Please list any other languages spoken at home:

Survey Questions

Please assist us in understanding the needs of our school community by answering the following questions. Please check all that apply:

Does your child have access to a computer in your home?	☐ Yes ☐ No
Do you have home internet access?	☐ Yes ☐ No
Does you child have access to the internet on your home computer?	☐ Yes ☐ No
Do you have internet access outside your home?	☐ Yes ☐ No

Please indicate the method of contact you prefer: ☐ Phone call ☐ Text ☐ Email

BROWARD County Public Schools
Established 1915

Acknowledgement

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 (https://www.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 and 6305.1, 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: http://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.

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 2019/2020 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 student to be photographed, videotaped, and/or interviewed by the news 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 news media.

Section B - Broward County Public Schools

Please Check Choice #1 or Choice #2

1. ____ I **WILL** permit my student to be photographed, videotaped, and/or interviewed for school publications, such as school yearbooks, school newspapers, 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: Student's name, teacher's name and room number may be released in order to facilitate school-based publications.***

2. ____ I **WILL NOT** permit my student to be photographed, videotaped, and/or interviewed for school publications, such as school yearbooks, school newspapers, 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 2019/2020 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 OF DIRECTORY INFORMATION

"Directory Information" is personally identifiable information that would not generally be considered harmful or an invasion of privacy if disclosed. Pursuant to FERPA, 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 the 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 athletic events, 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	___ Jersey Number and Team Position
___ 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 ______________

Note: Regarding former students, SBBC shall continue to honor any valid request to opt out of the discloure of directory information made while a student was in attendance, unless the former student rescinds the opt out request (34 CFR 99.37(b)).

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) 2019/2020 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 written 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 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 ____________________

Authorization for Medication Form 2019/2020 (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 2019/2020 (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 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)

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) ☐ YES ☐ NO	Administer according to the manufacture'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 ☐ YES ☐ NO	Administer according to the manufacture's label	For stomach ache or heart burn	Alert: May cause constipation	
Ibuprofen (Advil, Motrin) ☐ YES ☐ NO	Administer according to the manufacture'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 ☐ YES ☐ NO	Administer according to the manufacture's label	Menstrual cramps	Alert: Aspirin sensitive students should be careful	
Allegra ☐ YES ☐ NO	Administer according to the manufacture'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 ☐ YES ☐ NO	Administer according to the manufacture's label	Lactose intolerance	No common side effects when used in small doses	
Claritin ☐ YES ☐ NO	Administer according to the manufacture'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)

____
Offical 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 ____

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

AUTHORIZATION FOR RELEASE AND/OR REQUEST FOR INFORMATION

I hereby request and authorize: ____
(Name of Person, School, or Department)

____ to engage
(Street Address) (City) (State) (Zip) (Telephone #)

in verbal and/or written communication with and release records to : ______________________
(Name of Person, Job Title and/or School/Agency/Entity)

____
(Street Address) (City) (State) (Zip) (Telephone #)

regarding the **information checked below** concerning my child* ______________________, whose date of birth is ____________. I understand that information concerning psychiatric, psychological, medical diagnosis, drug or alcohol abuse, economic status, and educational information regarding my child will be released and/or communicated if indicated below. I further understand that this information might contain information regarding my family, in addition to my child.

____ Treatment Plans
____ Treatment / Discharge Summaries
____ Health / Medical Records
____ Case / Progress / Therapy Notes
____ Student Identification Number

Academic / School-related Records:

____ Grades
____ Test Scores
____ Attendance
____ Suspensions / Expulsions
____ Exceptional Student Education / Section 504 records

____ Substance Abuse Treatment Records
____ Social and/or Developmental History
____ Psychological and/or Psychiatric Evaluations
____ Restorative Support Services
____ Social Support Services (Food, Clothing, Shelter)
____ Medical Services
____ HIV/AIDS test results or related conditions (to disclose or receive this information, specific individuals must be named above)

____ Other____

For the Purpose of: ____

I acknowledge that all information I authorize to be released or requested will be held strictly confidential and cannot be released by the recipient without an additional written consent. I understand this authorization will expire one (1) year after the date signed, or on _______________, 20____, whichever is earlier. A copy of this authorization is valid in lieu of the original. I further understand I may withdraw my consent in writing at any time.

______________________________________ ______________________________________
Print Name of Parent / Guardian / Eligible Student Signature of Parent / Guardian / Eligible Student Date

____
Relationship to Child

*Eligible students (age 18 or over) may authorize the release of their education records.

(USE THIS SPACE IF CONSENT IS WITHDRAWN)

I hereby withdraw my previous consent to the release of information about my child.

______________________ ______________________________________
Date Consent Is Withdrawn Signature of Parent / Guardian / Eligible Student

Form #4301
REV 07/18
Risk Management

BROWARD COUNTY PUBLIC SCHOOLS (BCPS)
AFFIDAVIT of SHARED HOUSING

INSTRUCTIONS: The purpose of this form is to request that the following school-age child(ren), who are residing with their parent/guardian at the residential address below, be permitted to enroll in the boundaried school as long as the stated address is the bona fide legal address of the student(s) and parent/legal guardian.

Please, complete this form, sign under oath before a notary, and return it to the front office of your child(ren)'s school.

SECTION I: To be completed by the parent/guardian in a shared housing situation.

Name of Boundaried School: ______________________________

Name of Parent/Guardian: ______________________________

Name of Student: ______________________ Date of Birth: _____/_____/________Grade: ________

Name of Student: ______________________ Date of Birth: _____/_____/________Grade: ________

Name of Student: ______________________ Date of Birth: _____/_____/________Grade: ________

Residential Address: ______________________ City: ______________ Zip: __________

It is understood that:

- Absent an approved alternative method of assignment or reassignment, all students in BCPS shall be assigned annually to the school within the attendance boundaries which have been established by the School Board.
- Two proofs of residence from Column B shall be provided by the parent/guardian
- One proof of residence from both Columns A and B shall be provided by the homeowner/lessor
- If a change in the bona fide legal residence occurs, it is the responsibility of the parent/legal guardian and homeowner/lessor to notify the school within 10 business days.
- **The information provided by the undersigned is accurate.**
    - **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.**
    - **Florida Statutes §92.525 provides that whoever knowingly makes a false declaration under penalties of perjury is guilty of the crime of perjury by false written declaration, a felony of the third degree.**
- **Providing false information is a fraud and will result in withdrawal of the student(s) from the boundaried school.**
- This document shall be renewed every quarter at schools whose enrollment is at or exceeding 102% of permanent capacity, or annually at all other schools.
- Families who are unable to provide proof of residence due to extenuating circumstances shall complete this form on an annual basis.

______________________	______________________	______________________
Signature of Parent/Guardian	Print Name of Parent/Guardian	Telephone Number

County of Broward
State of Florida

I hereby certify that on this ______ day of _______________, 20______, the above subscribers personally appeared before me and made oath that the foregoing facts are true to the best of their knowledge, information and belief, under penalty of perjury. Each subscriber is known to me or provided the following identification ______________________.

My Commission Expires: ______________________________

Notary Signature: ______________________________

Section II: To be completed by the person who owns or leases the shared residence.

As the homeowner or lessor of the residence listed on this form, I acknowledge that the above-named individual(s) and their school-age child(ren) are residing at this address and not for the purpose of attending the above-named boundaried school in Broward County. I agree to provide one supporting document from Column A and one from Column B from Section III below.

______________________________	______________________________	______________________________
Signature of Homeowner/Lessor	Print Name of Homeowner/Lessor	Telephone Number

County of Broward
State of Florida

I hereby certify that on this ______ day of _______________, 20______, the above subscribers personally appeared before me and made oath that the foregoing facts are true to the best of their knowledge, information and belief, under penalty of perjury. Each subscriber is known to me or provided the following identification ___________________________________.

My Commission Expires: ____

Notary Signature: ____

Section III: To be completed by school staff.

Please identify the proofs of residence documentation provided by the:

Homeowner/Lessor				Parent/Guardian	
Column A (Check One)		**Column B** (Check One)		**Column B** (Check Two)	
☐	Property Tax Bill	☐	Utility Bill	☐	Utility Bill
☐	Homestead Exemption Card	☐	Telephone or Cellular Phone Bill	☐	Telephone or Cellular Phone Bill
☐	Deed	☐	Homeowners or Condominium Association Letter	☐	Homeowners or Condominium Association Letter
☐	Mortgage Statement	☐	Declaration of Domicile Form	☐	Declaration of Domicile Form
☐	Home Purchase Contract	☐	Florida Drivers License	☐	Florida Drivers License
☐	Notarized Lease	☐	Florida Identification Card	☐	Florida Identification Card
		☐	Automobile Registration	☐	Automobile Registration
		☐	Automobile Insurance	☐	Automobile Insurance
		☐	Credit Card Statement	☐	Credit Card Statement
		☐	Bank Account Statements	☐	Bank Account Statements
		☐	US Postal Service Change of Address Request	☐	US Postal Service Change of Address Request

If proof of residence was not completed during registration, the family was provided with:		
☐	30-Calendar Day Grace Period	Due Date: _______/_______/20_______
☐	Referral to the Homeless Education Program	
☐	Referral for document completion support (e.g., Student Services Department, ESOL)	
☐	Referral to the Demographics Department for investigation	
☐	Other: ____	