DISTRICT SCHOOL BOARD OF PASCO COUNTY
GRADES 6 – 12 ACCESS AND EMERGENCY INFORMATION CARD

MIS Form #4
Rev. 4/17

☐ Updated Info.

Student _____ Student # _____ DOB _____ Grade _____
Last Name First Middle

Primary Phone _____

Home Address _____ City _____ Zip _____

Parent/Guardian _____ Parent/Guardian _____

Cell Phone _____ Cell Phone _____

Email Address _____ Email Address _____

Employed By _____ Employed By _____

Phone At Work _____ Phone At Work _____

Person(s) who will care for child in case parent/guardian cannot be reached; these individuals may sign my child out (photo I.D. required):

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

First and last names of brothers/sisters attending Pasco County Schools _____

Person(s) who MAY NOT legally contact or remove my child from school (provide legal documentation) _____

List any medication(s) your child is currently taking (at home or school) _____

List all health problems and/or allergies (food, medication, sting, etc.) even if previously reported _____

Parent/guardian must notify school cafeteria of food allergies or special nutritional needs of student.

It is the parent/guardian's responsibility to keep the school updated with new information and contact numbers.

PARENTAL CONSENT ON BACK – SIGNATURE REQUIRED

Student _____ Grade _____

MIS Form #415
Rev. 4/17 Back

The School District expects residence information submitted regarding students to be truthful and accurate, and District forms pertaining to residence and household membership shall be verified under penalties of perjury. 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. Additionally, a person who knowingly makes a false declaration under penalties of perjury commits a felony of the third degree, pursuant to Florida Statute 92.525. Providing school officials false information regarding your residence when enrolling your child may result in your child being withdrawn and/or reassigned to the appropriate zoned school, and referral of the matter to law enforcement for possible criminal prosecution. Additionally, falsification of this information may result in the permanent revocation of your child's privilege to engage in extracurricular activities, including organized sports.

Parents/legal guardians are responsible for notifying the school principal if there is a change in residence or parental responsibility of the student within five (5) days, even if the parent thinks the student is still in the school's zone. Failure to give timely notice may result in a reassignment to the student's zoned school and/or loss of eligibility for athletics and other activities.

PARENTAL CONSENT

I hereby give my consent for my child to participate in the School Health Services Program. This means that my child will receive vision, hearing, dental, scoliosis, blood pressure, and height and weight screening at certain grade levels. In addition, the school nurse conducts classroom, individual, and small group presentations on health issues such as abstinence, substance abuse prevention, dating and relationship issues, birth control, and sexually transmitted diseases at certain grade levels. If I object to any of these health screenings or programs, I will notify the school in writing.

In case of accident or serious illness, I want to be contacted by the school. If the school is unable to reach me, I hereby authorize the school to contact the physician or dentist indicated below and to follow his/her instructions. If it is impossible to contact this physician or dentist, the school will take whatever actions are necessary to provide care and treatment for my child, and exchange medical information with the provider as necessary to support the continuity of care for my child. I agree to pay all expenses incurred by the handling of this emergency care. In case of an accident or illness where immediate treatment of my child is not indicated, but where he/she is unable to remain at school, I request that one of the persons listed on the reverse side of this form be contacted and requested to care for my child until I can be reached.

I authorize the District School Board of Pasco County to release and exchange my child's confidential information (e.g., student name, records, and information related to services provided) to agencies of the state of Florida which would allow the District to verify Medicaid eligibility, bill Medicaid for reimbursable Certified School Match services referenced on my child's individualized educational plan (IEP), and receive Medicaid reimbursement for Exceptional Student Education (ESE) services it provides to my child while at school. I understand that my child will continue to receive services referenced on his/her IEP whether or not I give consent.

Physician's Name _____ Phone: _____

Hospital Preference _____ Phone: _____

Dentist's Name _____ Phone: _____

My signature indicates my parental consent, understanding, and agreement.

_____ PRINT -- PARENT/GUARDIAN NAME

_____ PARENT/GUARDIAN SIGNATURE

_____ DATE

Grade: _____

Fivay High School - Home and School Compact Form

Student Name: _____ School Year _____ Parent Email Address _____

"Fivay High School is dedicated to meeting the needs of all students, providing a rigorous academic environment and preparing students to be responsible citizens."

Fivay High School Family Involvement Plan: We believe in the importance of a partnership between home and school for the education of our students. We will maintain open communication with newsletters, planners, phone calls, our website, social media, and parent/teacher conferences. We will attempt to communicate in a language parents can understand and make families aware of the services offered by the Florida Parent Information and Resource Center. Parents and other family members are encouraged to participate through school events and volunteering. By working together, we will make a difference in the lives of our students. This compact is an agreement designed to promote a partnership between the home and the school, which meets the requirement of the Title 1 Federal Guide.

As a family we will:

_____ ensure daily attendance for the entire school day from 7:30 a.m. to 1:55 p.m.
_____ communicate regularly with school personnel and regularly access MyStudent for grade and attendance information.
_____ support the school in developing the positive behaviors including organization, studying, and reading at home.
_____ support classroom learning through volunteering at school and/or attendance and participation at events.
_____ encourage and monitor completion of all class work and homework assignments.

A goal that I have for my student this year:

_____

As a student I will:

_____ come to school on time everyday and remain for the entire day.
_____ follow the FALCON Creed of being focused on academics, always respectful of others, leading by example, committed to excellence, on time and on task, and never defeated.
_____ come to school with a good attitude and ready to learn.
_____ complete and turn in all homework and class work.

My goal this year is:

_____

As a school we will:

_____ mentor students through academic and personal support.
_____ model and promote outstanding character.
_____ provide a safe, positive, and welcoming environment.
_____ establish and maintain a student-focused culture.
_____ develop relationships that create opportunities and connections in the community.
_____ collaborate with all stakeholders to foster unity.
_____ provide regular and current updates of grades and attendance information for your review on MyStudent.

I have received a copy of the District School Board of Pasco County tri-fold "**What Parents Should Know About Title I**" explaining the goals of Title I schools.

Parent/Guardian Signature _____ Date_____

Student Signature_____ Date_____

Administrator Signature Christina U Stanley Date 07/01/17

HEALTHY STUDENT PROGRAM APPLICATION FORM 2017 - 2018

Dear Parent:

Your child is eligible for enrollment in the **Healthy Student Program**, available only at ***selected schools*** in the District where there are extended nursing services. **Healthy Student Program** services are offered at no direct cost to you and all students are eligible, regardless of insurance.

The main purpose of the **Healthy Student Program** is to **improve school attendance** and to **reduce health problems** that occur during the school day. A student may be withdrawn from the **Healthy Student Program** at any time by the parent or the school health services staff with written notice.

The Healthy Student program is the commitment of the Pasco County School District, and is intended as an effort to help students remain in school, ready to learn. Services available to students enrolled in the **Healthy Student Program** may include:

- **Management of acute illness or injury and the administration of limited medications,** following physician guidelines and protocols (i.e. Tylenol, Motrin, Robitussin, Tums, and antifungal ointment, Benadryl, hydrocortisone, etc.).
- **Observation and follow up re: communicable diseases** (i.e. pink eye, ringworm, etc.).
- **A health professional will communicate with you** about your child's particular health findings that may require an evaluation, follow up or referral.
- **Physical Examinations** (ARNP services) for school entry, sports, etc. may be available at limited school sites.
- **Lab screenings** (hematocrit/hemoglobin, anemia, blood glucose, urinalysis, and pregnancy testing) may be available at limited school sites.

Please inform the school nurse of any newly diagnosed health conditions for your child or changes in health status during the school year.

The primary goal of school health services is to support academic success by maintaining the physical and mental well being of your child.

TO ENROLL YOUR CHILD IN THE HEALTHY STUDENT PROGRAM:

- Please complete the application for Healthy Student Program Membership
- Be sure to complete "Student Medical History" section
- Parent signature is required below the "Enrollment Statement"
- Return completed form to the school clinic assistant or school nurse

All medical information remains confidential between you and the health services provider. Records are stored and maintained within the Health Office and are shared with no one as per HIPAA compliance. The Medical Director of the Pasco County Health Department provides oversight for this program.

04/17

Free/Reduced Lunch

Free/Reduced Lunch Online Forms:

1. Before beginning you must have your FOOD STAMP CASE NUMBER and/or GROSS INCOME available prior to starting the online application process.

2. Please submit only ONE application per household.

3. Until your application is processed, you will need to provide your child(ren) a meal from home or send money to purchase school meals.

4. Sign in at: http://www.pasco.k12.fl.us/nutrition/free_reduced/application

5. Click the big blue box that states "Apply Online". Read the information carefully and click on Apply Online.

6. Read the information in the box. Click on "I have read the above and agree" statement. Click "Start".

7. Follow the prompts on the screen until you have completed the application. Once you are done print out your confirmation sheet.

APPLICATION FOR HEALTHY STUDENT PROGRAM MEMBERSHIP 2017 - 2018

Student Name _____ Sex _____ Grade _____ DOB _____
(Last, First, MI)
Student # _____ Home Address _____ Home Phone _____

PERSON TO BE CONTACTED IN CASE OF EMERGENCY:

Parent Name	Place of Business	Business Phone	
Backup Person to be Called		Home Phone #	Cell Phone #

STUDENT MEDICAL HISTORY

List any ALLERGIES to Medications or Food: _____

List any SURGERY/HOSPITALIZATION: _____

_____

List any CURRENT MEDICATIONS: _____

List any MEDICAL / HEALTH PROBLEMS: _____

_____

_____

FAMILY MEDICAL HISTORY: (Circle all that apply and indicate which family members have or have had the condition)

High Blood Pressure _____ Tuberculosis _____ Diabetes _____
Epilepsy _____ Sickle Cell _____ Cancer _____
Heart Problems _____ Asthma _____ Arthritis _____

Name of Family Physician _____ Phone _____

Name of Family Dentist _____ Phone _____

Date of Student's Last Physical Exam _____ Last Dental Exam _____

Is student Medicaid eligible? YES _____ NO _____ Medicaid # _____

Medicaid insurance Plan _____

ENROLLMENT STATEMENT

We agree to enroll _____ in the Healthy Student Program. We understand that the program offers a limited range of HEALTH COUNSELING services on an as-needed basis. We further understand that these services DO NOT REPLACE the services of our family doctor. In case of accident or serious illness, the school policies outlined on the School's Emergency Information Card will be observed. We further understand that student information is confidential except in those instances when professionals are required by law to report child abuse, death threats, suicide risk, and public health concerns.

Parent/Guardian Signature _____ Date _____