

OKALOOSA COUNTY SCHOOL DISTRICT  
Student Intervention Services  
Student Medical Information & Parent Consent  
Please print all information clearly in ink

MIS 6344  
REV. 6/2022

Student \_\_\_\_\_  
(Last) (First) (M.I.) (DOB-M/D/Y)

School \_\_\_\_\_ Grade \_\_\_\_\_

How does your child get to school? Car \_\_\_\_\_ Walk \_\_\_\_\_ Bus # \_\_\_\_\_

Student's Address \_\_\_\_\_

Student Lives with \_\_\_\_\_

Mother/Guardian's Name \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Father/Guardian's Name \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Specialist \_\_\_\_\_  
(Name and office number) (Name and office number)

**Emergency Contact Persons:**  
Please list relatives or friends, who have your permission to check your child out of school, and their phone number during school hours. In the event of an emergency in which we are unable to locate the parents, emergency contact persons will be contacted. **These individuals will be authorized to act on behalf of yourself and your child.** If an extreme emergency situation occurs, we will call 911 and your child will be transported to the nearest emergency facility. The student's parent / guardian will be financially responsible for the cost of student's emergency transport.

Name/Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name/Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name/Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name/Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Does your child have any medical conditions the school should be aware of?  No  Yes, if yes, give diagnosis and explain:  
\_\_\_\_\_  
\_\_\_\_\_

Medication Currently Prescribed:	Reason/use for medication:
_____	_____
_____	_____
_____	_____

School Board Policy requires that any medication taken by students during school hours and administered by school personnel:  
1) Must be accompanied by a Dispersion of Medication form (MIS 5163) signed by a parent or legal guardian; 2) Medication must be brought by parent / guardian in its original container properly labeled; 3) First dosage of any new medication shall not be administered during school hours due to the possibility of an allergic reaction; and 4) Parent must provide necessary equipment and supplies needed to administer medication.

**PLEASE COMPLETE BOTH SIDES OF THIS DOCUMENT**

OKALOOSA COUNTY SCHOOL DISTRICT
Student Intervention Services
Student Medical Information & Parent Consent

Student \_\_\_\_\_ (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (M.I.)

PARENTAL CONSENT FOR SCHOOL HEALTH SERVICES

The School Health Services Program is designed to appraise, protect and promote the health of our students, as well as provide preventative and emergency school-based health services, in accordance with The School Health Services Plan for the Okaloosa County School District.

\* Please indicate if you want your child to participate in these school health room services by checking yes or no.

- Basic First Aid and Emergency response \_\_\_ YES \_\_\_ NO
Assistance with medication administration and health care procedures \_\_\_ YES \_\_\_ NO
Nursing / health assessments \_\_\_ YES \_\_\_ NO
Referrals and follow-up for suspected or confirmed health problems \_\_\_ YES \_\_\_ NO

In the event of an accident or serious illness, you will be contacted by the school. If the school is unable to reach you, the school will contact the emergency contacts on the previous page and will take whatever actions are necessary to provide emergent care and treatment for your child, and exchange medical information with the emergency provider as necessary to support the continuity of care for your child.

Florida Statute 381.0056(7)(d), mandates regular health screenings for public school students. The screenings include Vision- PreK, 1st & 3rd, Hearing - PreK, Kg, 1st & 6th, Height and Weight (BMI) - PreK, 1st, 3rd, & 6th and Scoliosis - 6th grade only.

\* Please indicate if you want your child to participate in these screenings by checking yes or no.

- Vision \_\_\_ YES \_\_\_ NO Hearing \_\_\_ YES \_\_\_ NO
Scoliosis - \_\_\_ YES \_\_\_ NO Height & Weight (BMI) \_\_\_ YES \_\_\_ NO

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

PRINT - PARENT / GUARDIAN

SIGNATURE - PARENT / GUARDIAN

DATE

MEDICAID BILLING CONSENT

FOR STUDENTS COVERED UNDER STATE MEDICAID PROGRAMS ONLY

I understand and give my consent to the school district to share information about my child with the State Medicaid Agency (State of Florida Agency for Health Care Administration), its fiscal agent, and the school district's Medicaid billing agent or billing facilitator for the school district to verify Medicaid eligibility, seek Medicaid reimbursement, and satisfy audit and review requests related to services provided to my child.

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

PRINT - PARENT / GUARDIAN

SIGNATURE - PARENT / GUARDIAN

DATE

The above consent will remain in effect until the parent / guardian submits a new Student Medical Information / Consent Form or the following school year.

STUDENT ENROLLMENT INFORMATION  
STUDENT SERVICES  
THE SCHOOL DISTRICT OF OKALOOSA COUNTY

REGISTRATION DATE: \_\_\_\_\_ GRADE \_\_\_\_\_

NAME: (LEGAL) \_\_\_\_\_  
LAST JR. /II FIRST MIDDLE NICK NAME

ADDRESS: STUDENT RESIDENCE \_\_\_\_\_ ADDRESS: STUDENT MAILING \_\_\_\_\_

City State Zip Code City State Zip Code

STUDENT'S HOME / PRIMARY PHONE NUMBER: \_\_\_\_\_ Published? YES NO

SEX: \_\_\_\_\_ ETHNICITY: Is student Hispanic or Latino? YES NO

RACE (Mark all that apply): White \_\_\_\_\_, Black / African American \_\_\_\_\_, Native Hawaiian / Pacific Islander \_\_\_\_\_, Asian \_\_\_\_\_, American Indian/Alaskan Native \_\_\_\_\_, \*Racial Categories are Federally Defined

DATE OF BIRTH: \_\_\_\_\_ BIRTH PLACE: \_\_\_\_\_  
MM/DD/YY City/State/Foreign Country

IMMIGRANT STUDENT: By federal definition, an Immigrant Student is between the ages of 3 and 21, was not born in the US, the District of Columbia or Puerto Rico and has not attended a school in the US for more than 3 full academic years. If your child was not born in the US, please provide the date your child entered a school in the United States: Month \_\_\_\_\_ Date \_\_\_\_\_ Year \_\_\_\_\_

**Important note: Military bases located overseas are not a US territory or possession.**

DOES STUDENT LIVE OUT OF COUNTY? YES NO If "YES", in which county? \_\_\_\_\_

HOW SHOULD THE STUDENT BE DISMISSED IN THE AFTERNOONS?

Bus: \_\_\_\_\_ Car Rider: \_\_\_\_\_ Walker: \_\_\_\_\_ Daycare: \_\_\_\_\_

NAME OF LAST SCHOOL ATTENDED: \_\_\_\_\_

Address of School: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

PRIOR DISTRICT: \_\_\_\_\_ PRIOR STATE: \_\_\_\_\_ PRIOR COUNTRY: \_\_\_\_\_

HAS STUDENT PREVIOUSLY ATTENDED A FLORIDA SCHOOL BEFORE? YES NO

If Yes, which county? \_\_\_\_\_ Last year attended: \_\_\_\_\_

HAS STUDENT PREVIOUSLY ATTENDED AN OKALOOSA COUNTY SCHOOL BEFORE? YES NO

If Yes, which school? \_\_\_\_\_ Last year attended: \_\_\_\_\_ Student ID# \_\_\_\_\_

HAS YOUR CHILD BEEN RETAINED? YES NO If "yes", in which grade (s)? \_\_\_\_\_

KINDERGARTEN STUDENTS ONLY: PRE-SCHOOL OR DAY CARE ATTENDED (IF ANY): \_\_\_\_\_

Enrolling Parent/Guardian \_\_\_\_\_  
(Print)

\_\_\_\_\_  
(Signature)

### ADDITIONAL SERVICES

IF STUDENT IS CURRENTLY ENROLLED IN ANY OF THE FOLLOWING PROGRAM(S) PLEASE CHECK ALL THAT APPLY: DOES STUDENT HAVE A CURRENT IEP? Yes No

Title I       Gifted       Intellectual Disability       Traumatic Brain Injury  
 Speech Impaired       Visually Impaired       Emotional / Behavioral Disability       Other Health Impaired  
 Language Impaired       Orthopedically Impaired       English Language Learner       Other  
 Hearing Impaired       Autism Spectrum       Specific Learning Disabilities       504 Plan

With whom does the student live? \_\_\_\_\_

Name		Relationship	
<b>PARENT/GUARDIAN # 1</b>	<b>Custody: Yes    No</b>	<b>May Pick Up: Yes    No</b>	
Name: _____	Relationship _____	(mother, father, etc.)	
Address: _____	Place of Employment: _____		
_____	Home/Primary Phone: _____		
City      State      Zip	Cell Phone: _____		
E-Mail Address: _____	Work Phone: _____		

<b>PARENT/GUARDIAN # 2</b>	<b>Custody: Yes    No</b>	<b>May Pick Up: Yes    No</b>	
Name: _____	Relationship _____	(mother, father, etc.)	
Address: _____	Place of Employment: _____		
_____	Home/Primary Phone: _____		
City      State      Zip	Cell Phone: _____		
E-Mail Address: _____	Work Phone: _____		

IS EITHER PARENT IN A UNIFORMED MILITARY SERVICE? YES NO

If Yes, which Service? \_\_\_\_\_ Which Base? \_\_\_\_\_

Employment Physical Address \_\_\_\_\_  
(Street Number and/or Name or Building Number)

IS EITHER PARENT EMPLOYED ON FEDERAL PROPERTY? YES NO

If Yes, which property? \_\_\_\_\_ Employment Physical Address \_\_\_\_\_  
(Street Number and/or Name or Building Number)

SIBLINGS CURRENTLY ATTENDING THIS SCHOOL:

_____	Name	_____	Grade	_____	Name	_____	Grade
_____	Name	_____	Grade	_____	Name	_____	Grade

Enrolling Parent/Guardian \_\_\_\_\_  
(Print)

\_\_\_\_\_  
(Signature)

**CONTACT INFORMATION**

**STUDENT NAME:** \_\_\_\_\_

**EMERGENCY CONTACT (OTHER THAN PARENTS)**

Name: \_\_\_\_\_

May Pick Up: Yes No Sex: F M

Address: \_\_\_\_\_

City State Zip

Relationship \_\_\_\_\_

Home/Primary Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Name: \_\_\_\_\_

May Pick Up: Yes No Sex: F M

Address: \_\_\_\_\_

City State Zip

Relationship \_\_\_\_\_

Home/Primary Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Name: \_\_\_\_\_

May Pick Up: Yes No Sex: F M

Address: \_\_\_\_\_

City State Zip

Relationship \_\_\_\_\_

Home/Primary Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Name: \_\_\_\_\_

May Pick Up: Yes No Sex: F M

Address: \_\_\_\_\_

City State Zip

Relationship \_\_\_\_\_

Home/Primary Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

**Enrolling Parent/Guardian** \_\_\_\_\_

(Print)

\_\_\_\_\_  
(Signature)

### STUDENT SOCIAL SECURITY NUMBER

Florida Statute 1008.386 **requires** school districts to request the social security number for each student enrolled. No student may be denied enrollment or graduation when a social security number is not provided.

Student Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

### VERIFICATION

The student's Social Security Number must be verified by one of the following:

1. The social security number card or a copy was presented.

Signature of School Official \_\_\_\_\_ Date \_\_\_\_\_

2. Bank statements, insurance records or other similar documents containing the student's social security number were presented.

Signature of School Official \_\_\_\_\_ Date \_\_\_\_\_

3. Enrolling Parent/Guardian signed statement

**I attest that the social security number that I have provided for the above named student is accurate.**

Signature of Enrolling Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

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**I refuse to provide the social security number for the above named student.**

Signature of Enrolling Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**\*\*You are requested to provide voluntarily your Social Security Number (SSN) to assist the Okaloosa County School District (OCSD) in identifying your student records and effectively communicating them to the Florida Department of Education, other educational institutions or organizations as indicated in writing by the student or parent / legal guardian. When using your SSN, OCSD will disclose your SSN only in a manner that doesn't permit personal identification of you by individuals other than representatives of OCSD, the Florida Department of Education or other organizations as specifically indicated by the student or parent / legal guardian. By providing your SSN, you are consenting to the uses identified above. Provision of your SSN and consent to its use is not required and, if you choose not to do so, you will not be denied any right, benefit, or privilege provided by law.**

### STUDENT EXAM AND IMMUNIZATION INFORMATION

Student Name: \_\_\_\_\_

**PLEASE NOTE:** Florida Statutes require that each child who is entitled to admittance to Kindergarten or any other initial entrance into a Florida Public School must present certification of a school entry medical examination performed within the twelve months prior to enrollment in school. THIS CERTIFICATION MUST BE PRESENTED WITHIN 30 SCHOOL DAYS OF ENROLLMENT

A child shall be exempt from the requirements upon written request of the parent or guardian stating objections on religious grounds.

DATE OF EXAM: \_\_\_\_\_ CURRENT DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

#### IMMUNIZATION REQUIREMENTS FOR ENTRANCE

As per State Statutes, a child who is entering Okaloosa District Schools for the first time MUST present one of the four certificates below:

- A. Certification of immunization for poliomyelitis, diphtheria, rubella, rubella, pertussis, tetanus, varicella (PK-02), hepatitis B (PK-05 & 07-12) and mumps. DH FORM: DH 680A, or DH 680A & B (Grade 7-12)
- B. Certificate of exemption for religious reasons. DH FORM: DH 681.
- C. Certificate of exemption for medical reasons. DH FORM: DH 680C.
- D. Certificate of 30 day exemption obtained from the school (MIS4124) OR DH FORM: DH 680B obtained from the Okaloosa County Health Department.

Enrolling Parent/Guardian \_\_\_\_\_ (Print) \_\_\_\_\_ (Signature)

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#### SCHOOL USE ONLY DATA ENTRY

Immunization Status: \_\_\_\_\_

School Physical: \_\_\_\_\_

Vaccine Expiration Status: \_\_\_\_\_  
(The date Temporary Medical Exemption, DH 680B, expires).

SCHOOLS: FILL IN ALL AVAILABLE DATES FOR VACCINE STATUS ON PANEL "S404".

2022-2023

**FREE AND REDUCED-PRICE SCHOOL MEALS FAMILY APPLICATION**

**PART 1. ALL HOUSEHOLD MEMBERS**

Names of all household members (First, Middle Initial, Last)	Student ID	Place a check in the box below if child is a foster, homeless, migrant, runaway, or Head Start child. If each child attending school is a foster, homeless, runaway, migrant or in Head Start, skip to part 4 to sign this form.					Place a check in the box if NO income
		Foster	Homeless	Migrant	Runaway	Head Start	

**PART 2. BENEFITS**  
 IF ANY MEMBER OF YOUR HOUSEHOLD RECEIVES [State SNAP], [FDPIR] OR [State TANF Assistance], PROVIDE THE NAME AND CASE NUMBER FOR THE PERSON WHO RECEIVES BENEFITS AND SKIP TO PART 4. IF NO ONE RECEIVES THESE BENEFITS, SKIP TO PART 3.  
 NAME: \_\_\_\_\_ PROGRAM NAME \_\_\_\_\_ CASE NUMBER: (NOT EBT CARD NUMBER) \_\_\_\_\_

**PART 3. TOTAL HOUSEHOLD GROSS INCOME (BEFORE DEDUCTIONS).** List all income on the same line as the person who receives it. Check the box for how often it is received. RECORD EACH INCOME ONLY ONCE.

1. NAME (LIST ONLY HOUSEHOLD MEMBERS WITH INCOME)	2. GROSS INCOME AND HOW OFTEN IT WAS RECEIVED																				
	Earnings from work before deductions.	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Welfare, child support, alimony	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Social Security, SSI, V.A., retirement benefits	Weekly	Every 2 Weeks	Twice Monthly	Monthly	All other income (such as Unemployment) benefits	Weekly	Every 2 Weeks	Twice Monthly	Monthly	
(Example) Jane Smith	\$200	X				\$150		X			\$0					\$0					
	\$					\$					\$					\$					
	\$					\$					\$					\$					
	\$					\$					\$					\$					
	\$					\$					\$					\$					

**PART 4. SIGNATURE AND LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER (ADULT MUST SIGN)**  
 An adult household member must sign the application. If Part 3 is completed, the adult signing the form also must list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box. (See Statement on the back of this page.)

I certify (promise) that all information on this application is true and that all income is reported. I understand that the school will get Federal funds based on the information I give. I understand that school officials may verify (check) the information. I understand that if I purposely give false information, my children may lose meal benefits, and I may be prosecuted. I understand my child's eligibility status may be shared as allowed by law.

Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Email: \_\_\_\_\_  
 Last four digits of Social Security Number: \*\*\* - \* \* - \_\_\_\_\_  I do not have a Social Security Number

The information contained within this application may be shared with other Federal/Local health programs for which your child(ren) may qualify, however your permission is required. This will not affect your eligibility for school meals. May school officials share the information within this application with other programs?  No  Yes

**PART 5. CHILDREN'S ETHNIC AND RACIAL IDENTITIES (OPTIONAL)**

Choose one ethnicity:  
 Hispanic/Latino  Not Hispanic/Latino

Choose one or more (regardless of ethnicity):  
 Asian  American Indian or Alaska Native  Black or African American  
 White  Native Hawaiian or other Pacific Islander



**\*\*\*\*\*DO NOT FILL OUT THIS PART. THIS IS FOR SCHOOL USE ONLY\*\*\*\*\***

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24 Monthly x 12

Total Income: \_\_\_\_\_ Per:  Week,  Every 2 Weeks  Twice A Month  Monthly  Year Household size: \_\_\_\_\_

Categorical Eligibility: \_\_\_\_\_ Eligibility: Free \_\_\_\_\_ Reduced \_\_\_\_\_ Denied \_\_\_\_\_ Date Withdrawn \_\_\_\_\_

Reason for denial or withdrawal: \_\_\_\_\_  **Check if Error Prone Application**

Determining Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Confirming Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Verifying Official's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced-price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The last four digits of the social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced-price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.*

*The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the basis of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)*

*If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202)690-7442 or email at [program.intake@usda.gov](mailto:program.intake@usda.gov).*

*Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service 800) 877-8339; or (800) 845-6136 (Spanish).*

*USDA is an equal opportunity provider and employer.*

Date of Contact	Staff Initials	Name of Household Member Contacted	Detailed Information Received

# INSTRUCTIONS FOR APPLYING

*A HOUSEHOLD MEMBER IS ANY CHILD OR ADULT LIVING WITH YOU.*

**IF YOUR HOUSEHOLD RECEIVES BENEFITS FROM [State SNAP], [State TANF], OR [THE FOOD DISTRIBUTION PROGRAM ON INDIAN RESERVATIONS (FDPIR)], FOLLOW THESE INSTRUCTIONS:**

**Part 1:** List only household members and the name of each child's school (if known).

**Part 2:** List the case number for any household member (including adults) receiving [State SNAP], [State TANF], or [FDPIR] benefits.

**Part 3:** Skip this part.

**Part 4:** Sign the form. The last four digits of a Social Security Number are **not** necessary.

**Part 5:** Answer this question if you choose.

**IF NO ONE IN YOUR HOUSEHOLD GETS [State SNAP], [State TANF], OR [FDPIR] BENEFITS AND IF ANY CHILD IN YOUR HOUSEHOLD IS HOMELESS, A MIGRANT OR RUNAWAY, OR IN HEAD START FOLLOW THESE INSTRUCTIONS:**

**Part 1:** List all household members and the name of each child's school (if known). If any child you are applying for is homeless, migrant, in Head Start or a runaway check the appropriate box and call Sandra Arteaga 833-3521.

**Part 2:** Skip this part.

**Part 3:** Complete only if a child in your household isn't eligible under Part 1. See instructions for All Other Households.

**Part 4:** Sign the form. The last four digits of a Social Security Number are not necessary if you didn't need to fill in Part 3.

**Part 5:** Answer this question if you choose.

**IF YOU ARE APPLYING FOR A FOSTER CHILD, FOLLOW THESE INSTRUCTIONS:**

**If all children in the household are foster children:**

**Part 1:** List all foster children and the school's name for each child. Check the box indicating the child is a foster child.

**Part 2:** Skip this part.

**Part 3:** Skip this part.

**Part 4:** Sign the form. The last four digits of a Social Security Number are **not** necessary.

**Part 5:** Answer this question if you choose.

**If some of the children in the household are foster children:**

**Part 1:** List all household members and the name of each child's school (if known). For any person, including children, with no income, you must check the "No Income" box. Check the box for each foster child. If any child you are applying for is homeless, migrant, in Head Start or a runaway check the appropriate box and if you have questions call **850-864-3133**.

**Part 2:** Skip this part.

**Part 3:** Complete only if a child in your household isn't eligible under Part 1. See instructions for All Other Households.

**Part 4:** Adult household member must sign the form and list the last four digits of their Social Security Number (or mark the box if s/he doesn't have one).

**Part 5:** Answer this question if you choose.

**ALL OTHER HOUSEHOLDS, INCLUDING WIC HOUSEHOLDS, FOLLOW THESE INSTRUCTIONS:**

**Part 1:** List all household members and the name of each child's school (if known). For any person, including children, with no income, you must check the "No Income" box. If any child you are applying for is homeless, migrant, Head Start, a foster child or a runaway check the appropriate box and call **Okaloosa Academy Charter School 850-864-3133**

**Part 2:** Skip this part.

**Part 3:** Follow these instructions to report total household income from this month or last month.

- **Section 1—Name:** List all household members with income.
- **Section 2—**
  - **Gross Income and How Often It Was Received:** For each household member listed in section 1, list each type of income received for the month. You must tell us how often the money is received—weekly, every other week, twice a month or monthly.
  - **Earnings:** Be sure to list the **gross income**, not the take-home pay. Gross income is the amount earned *before* taxes and other deductions. You should be able to find it on your pay stub or your boss can tell you.
  - **Income received from welfare, child support, and alimony:** List the amount each person received.
  - **Income received from retirement benefits, Social Security, Supplemental Security Income (SSI), Veteran's benefits (VA benefits), and disability benefits:** List the amount each person received.

- **All Other Income:** List Worker's Compensation, unemployment or strike benefits, regular contributions from people who do not live in your household, and any other income. Do not include benefits from WIC, Federal education and foster payments received by the family from the placing agency. For ONLY the self-employed, under *Earnings from Work*, report income after expenses. This is for your business, farm, or rental property. If you are in the Military Privatized Housing Initiative or get combat pay, do not include these allowances as income.

Your children may qualify for free or reduced-price meals if your household income falls at or below the limits on this chart:

FEDERAL ELIGIBILITY INCOME CHART For School Year <b>2022-2023 - FREE</b>			
Household size	Yearly	Monthly	Weekly
1	17,667	1,473	340
2	23,803	1,984	458
3	29,939	2,495	576
4	36,075	3,007	694
5	42,211	3,518	812
6	48,347	4,029	930
7	54,483	4,541	1,048
8	60,619	5,052	1,166
Each additional person:	6,136	512	118

FEDERAL ELIGIBILITY INCOME CHART For School Year <b>2022-2023 - REDUCED</b>			
Household size	Yearly	Monthly	Weekly
1	25,142	2,096	484
2	33,874	2,823	652
3	42,606	3,551	820
4	51,338	4,279	988
5	60,070	5,006	1,156
6	68,802	5,734	1,324
7	77,534	6,462	1,492
8	86,266	7,189	1,659
Each additional person:	8,732	728	168

**Part 4:** Adult household member must sign the form and list the last four digits of their Social Security Number (or mark the box if s/he doesn't have one).

The information contained within this application may be shared with other Federal/Local health programs for which your child(ren) may qualify, however your permission is required. This will not affect your eligibility for school meals. May school officials share the information within this application with other programs? Check the appropriate box.

**Part 5:** Answer this question if you choose.

**OKALOOSA COUNTY SCHOOL DISTRICT  
STUDENT INTERVENTION SERVICES**

**REQUIRED INFORMATION UPON INITIAL ENROLLMENT**

Student Name: \_\_\_\_\_ School \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_\_\_\_

Florida Statute 1006.07(1)(b) requires that at the time of registration in a school in the Okaloosa County School District, each student discloses information pertaining to referrals to mental health services. In addition, students are required to provide information regarding previous school expulsions, arrests resulting in a charge, and any actions taken by the Department of Juvenile Justice. Information provided on this document is subject to the Family Educational Rights and Privacy Act (FERPA). Your school can provide additional information regarding this act and the use of information collected on this document.

**HAS THE STUDENT BEEN REFERRED TO MENTAL HEALTH SERVICES? \_\_\_ NO \_\_\_ YES**  
If YES, please explain below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HAS THE STUDENT BEEN EXPELLED FROM SCHOOL IN ANOTHER DISTRICT AT ANY TIME?**  
\_\_\_ NO \_\_\_ YES If YES, please provide detail:

**MONTH/YEAR OF EXPULSION \_\_\_\_\_ DISTRICT \_\_\_\_\_ STATE \_\_\_\_\_**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HAS THE STUDENT BEEN ARRESTED RESULTING IN A CHARGE? \_\_\_ NO \_\_\_ YES**

If YES, please explain below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**LIST JUVENILE JUSTICE ACTIONS INVOLVING THE STUDENT, IF ANY AND EXPLAIN.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent/Guardian Name

Parent/Guardian Signature

Date

Phone Number

**OKALOOSA COUNTY SCHOOL DISTRICT  
STUDENT INTERVENTION SERVICES**

**INFORMED CONSENT FOR SCHOOL BASED MENTAL HEALTH SERVICES SCREENING**

Student Name: \_\_\_\_\_ Student # \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_\_\_\_

Your student was identified as appropriate for a School Based Mental Health Screening due to:

- Behavior Contract
- Registration Documentation
- Title IX
- Other \_\_\_\_\_

By signing this consent, you are agreeing for your student to have a screening with your School Based Mental Health Provider (SBMHP). The screening is a clinical interview with the use of a tool called the Children's Functional Assessment Rating Scale – CFARS. Your SBMHP will ask your student about their history, difficult experiences, their thoughts and emotions, and other areas of concern. With the information from this clinical interview, the information you provide as a parent/guardian, and information provided by your student's school staff, your SBMHP will determine eligibility as indicated by the State of Florida. If eligible, your student can qualify for School Based Mental Health Services (SBMHS) and will need your signed consent for services. As part of the screening, your SBMHP will need to connect with you to gather additional information. You can view the screening tool at <http://outcomes.fmhi.usf.edu/cfars.cfm>.

If you have questions, or to request a conference to discuss the proposed assessment, you may contact:

Name of School Contact	School	Phone
------------------------	--------	-------

- I read and understand the above statement and agree with the proposed assessment. I consent for my student to receive the School Mental Health Services Screening.
- Please do not proceed. I wish to schedule a conference to discuss the proposed assessments and will reach out to the school.

Parent/Guardian Name	Parent/Guardian Signature	Date	Phone Number
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## Informed Consent for Treatment or Services

Student's Name:

Social Security Number:

Insurance Provider:

Insurance ID or Subscriber #:

Parent / Guardian Phone Number:

Parent / Guardian Email:

Date of Consent: \_\_\_\_\_

I, the parent or legal guardian of, \_\_\_\_\_, a student at Okaloosa Academy Charter School, hereby authorize staff of Bridgeway to provide treatment services, as required by the expectations for alternatively placed students.

Treatment services can include by are not limited to: •

- ✓ Adolescents Outpatient Mental Health-Substance Abuse- individual or group services
- ✓ Case Management for youth involved with DJJ
- ✓ Crisis Management / stabilization
- ✓ Telehealth services (consent included with this signature)

While the goal of service is to improve your youth's condition, there are no guarantees with treatment. It is possible that no change will occur, or that your symptoms may worsen. Please discuss with your treatment provider and any concerns you have about your child's condition and symptoms.

I have been informed of the reason or purpose of the treatment to be provided, alternative treatment modalities, the approximate length of time it will take to complete the treatment or services, and that consent can be revoked orally or in writing prior to or during the treatment period by me or an authorized representative. I have read and fully understand the above Informed Consent and Choice for Treatment and Services Information. My signature below indicates my consent to participate in the services indicated above. No guarantee or assurance has been made to me as to the results that may be obtained.

Telehealth allows my practitioner to diagnose, consult, treat, and educate using interactive audio, video, or data communication regarding my treatment. I hereby consent to participating in services via Telehealth with Bridgeway Center.

I understand that I have the following rights under this agreement:

I have the right to confidentiality with Telehealth under the same laws that protect confidentiality of my protected health information for in-person services. Any information disclosed by me during the course of my treatment is generally confidential, except in instances of mandatory abuse or neglect reporting, or in instances where my safety or the safety of others is a concern.

I understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our treatment sessions or other communications by my practitioner regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons. Bridgeway Center will have HIPAA compliant safeguards in place to protect my confidentiality at all times.

I have read and understand the information provided above. I have the right to discuss any of this information with my practitioner and to have any questions I may have regarding my treatment answered to my satisfaction.

I understand that I can withdraw my consent to Telehealth by providing written notification to Bridgeway Center. My signature below indicates that I have read this Agreement and agree to its terms.

---

Parent / Guardian Name (Printed)

---

Parent / Guardian Signature

---

Date

## OKALOOSA ACADEMY CHARTER SCHOOL

### **Title I Program School – Parent Compact 2022-2023**

The Okaloosa Academy Charter School and the parents of students participating in activities, services, and programs funded by Title I, Part A of the *Elementary and Secondary Education Act* agree that this compact outlines how the parents, school staff, and students will share the responsibility for improved student academic achievement and the means by which the school and parents will build and develop a partnership that will help children meet or exceed Okaloosa Academy Charter School's standards. This School-Parent Compact is in effect for the 2022-2023 school year.

#### **School Responsibilities:**

We, as the faculty and staff of Okaloosa Academy Charter School, will:

- ❖ Provide high-quality curriculum and instruction delivered by certified and highly-qualified staff in a supportive and effective learning environment that enables the participating children to meet the state's achievement standards
- ❖ Hold parent-teacher conferences during which this compact will be discussed as it relates to the individual child's achievement.
- ❖ Provide parents with periodic reports about their child's progress.
- ❖ Offer parents reasonable access to classroom teachers and administrators.
- ❖ Communicate and work with families to support students' learning.

#### **Parent Responsibilities:**

I, as a parent, will support my child's learning in the following ways:

- ❖ Value and support my child's attendance at school.
- ❖ Ensure daily participation in class work.
- ❖ Stay informed about my child's education and communicate with the school.

---

Parent signature

#### **Student Responsibilities:**

I, as a student, will share the responsibility to improve my academic achievement and meet the state's high standards in the following ways:

- ❖ Cooperate with my teachers in school and be responsible for my behavior.
- ❖ Complete all of my assignments on time.
- ❖ Participate to the best of my ability in all of my classes.
- ❖ Read independently or with my family on a regular basis.
- ❖ Let my teachers and family know when I need help.

---

Student signature



**OKALOOSA COUNTY SCHOOL DISTRICT**  
**INSTRUCTIONAL SERVICES**

**PARENTAL RELEASE FOR USE OF STUDENT IMAGES  
IN ALL FORMATS**

I (we) authorize the School Board of Okaloosa County, Okaloosa County, Florida, and those acting with its permission and under its authority (collectively referred to as "School Board"), to use and publish recognizable images of my child, \_\_\_\_\_, in any medium deemed appropriate by the School Board, including, but not limited to:

- a. Web Pages
- b. Newspapers
- c. TV (Broadcasts to homes)
- d. Multimedia presentations
- e. Pictures for professional journals

I (we) release and discharge the School Board, and all persons acting with its permission and authority, from any liability by virtue of use of photographs so long as same are used for an educational purpose by the School Board.

I (we) warrant that we are the guardian and/or parents of \_\_\_\_\_ and have full rights to contract on behalf of said child.

Please indicate any exceptions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Parent

\_\_\_\_\_  
Date

# OKALOOSA ACADEMY CHARTER SCHOOL

## DRESS CODE

Pants or shorts any color – no holes, rips, tears or frays – must have belt loops and student **MUST WEAR A BELT** at all times. Athletic shorts may **NOT** be worn underneath belted pants or shorts. Pants and shorts are expected to be worn at the natural waistline.

School (OACS) t-shirt short or long sleeve – Student may wear a solid color long sleeve t-shirt under school shirt. No hooded t-shirts and No logos on sleeves may be worn.

Tennis shoes, crocs or slides are acceptable shoes.

**NO HOODIES OR JACKETS** are allowed inside the school unless it is issued by OACS. Other hoodies and jackets may be worn to school, but will be hung up before entering the school and retrieved at the end of the school day.

Cell phones may be brought to school, but they will be placed in bins and stored in the front office until the end of the school day. No other electronics should be brought to school (ear buds, head phones, etc.). The school **IS NOT** responsible for lost or stolen phones or electronics.

**NO BACKPACKS** or **BOOKBAGS** are allowed on school premises. Student will be provided all necessary supplies in the classroom.

By signing the acknowledgement below, the student and parent/guardian agree that the student will abide by the OACS DRESS CODE stated above as long as they are a student at OACS. If at any time the student arrives at school inappropriately dressed, the parent will be contacted and the appropriate clothing will need to be brought to the school in order for the student to attend class.

ACKNOWLEDGMENT OF SCHOOL DRESS CODE:

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

**OKALOOSA ACADEMY  
TRANSPORTATION SCHEDULE  
2022-2023**

**BAKER/CRESTVIEW/SHALIMAR**

<u>Pickup</u>	<u>Dropoff</u>		<u>City</u>	<u>Bus</u>
5:55	3:55	Milligan Assembly of God	Baker	Weekly
6:05	3:45	New Beginnings Church	Cview	Weekly
6:15	3:20	Shoffner Blvd / Hwy 90	Cview	Weekly
6:20	3:25	Tom Thumb / National Guard Armory	Cview	Weekly
6:25	3:30	Long Drive / Brackin Street	Cview	Weekly
6:30	3:35	McDonalds / Hwy 85 North	Cview	Weekly
6:40	3:10	Life Point Church (behind donut shop)	Cview	Weekly
6:45	3:05	Central Baptist Church / Pearl Street	Cview	Weekly
6:52	2:58	Hope House - S. Rayburn / Alpine Road	Cview	Weekly
6:55	2:55	Brookmeade @ Crestview Physical Therapy	Cview	Weekly
7:05	2:45	Ashley / Villacrest (off P J Adams)	Cview	Weekly
**	2:10	Shalimar Subway ( <u>PM BUS</u> )	Shalimar	Weekly

**NICEVILLE/VALPARAISO/SHALIMAR/FWB**

<u>Pickup</u>	<u>Dropoff</u>		<u>City</u>	<u>Bus</u>
6:35	3:00	Niceville Walmart @ Chick-fil-a	Nville	Crumbly
6:40	2:55	John Sims Parkway @ Tropical Smoothie	Valp	Crumbly
6:45	2:50	Cornerstone Worship Center (Valp Pkwy)	Valp	Crumbly
7:00	**	Courthouse Annex - Shalimar ( <u>AM BUS</u> )	Shalimar	Crumbly
7:05	2:35	Racetrack Road / Eglin Pkwy (Publix-near Eglin Pkwy)	FWB	Crumbly
7:10	2:30	Racetrack Road @ Big Lots	FWB	Crumbly
7:15	2:25	Eglin Pkwy / Mariner Plaza (AJs on the Bayou)	FWB	Crumbly
7:20	2:20	Eglin Pkwy / Uptown Station (Winn Dixie)	FWB	Crumbly
7:25	2:15	Hollywood Blvd / Carson Dr @ Movelt Storage	FWB	Crumbly
7:30	2:10	Hollywood Blvd / Robinwood @ Keller Tires	FWB	Crumbly
7:40	2:00	Beal Pkwy @ Walmart (Side Parking Lot - Auto Service)	FWB	Crumbly
7:45	1:55	Beal Pkwy @ Kohl's (Side Parking Lot)	FWB	Crumbly
**	1:50	Lewis Turner Blvd @ Country Corner ( <u>PM BUS</u> )	FWB	Crumbly

**FWB/DESTIN**

<u>Pickup</u>	<u>Dropoff</u>		<u>City</u>	<u>Van</u>
6:05	2:25	Hwy 98 / Memorial Dr (Raceway)	FWB	Scott
6:15	2:30	Santa Rosa Blvd / Bluefish Drive	Okal. Island	Scott
7:00	2:30	Benning Dr / Kelly St (Childcare Network)	Destin	Scott
7:35	2:10	Beal Parkway @ Tractor Supply	FWB	Scott/Walton
7:40	**	Lewis Turner Blvd @ Country Corner ( <u>AM VAN</u> )	FWB	Scott

**MARY ESTHER/FWB**

<u>Pickup</u>	<u>Dropoff</u>		<u>City</u>	<u>Van</u>
6:30	2:05	Hwy 98 @ Arby's	Mary Esther	White
6:40	2:10	Hwy 98 / Roby's Rd	Mary Esther	White
6:45	2:20	Hwy 98 @ Parish Point McDonalds	Mary Esther	White

# OKALOOSA ACADEMY CHARTER SCHOOL

## Regular Bell Schedule

7:30-7:45	Student Check In / Breakfast / Homeroom
7:45-8:45	1 <sup>st</sup> Period
8:47-9:47	2 <sup>nd</sup> Period (PE – Elementary)
9:49-10:49	3 <sup>rd</sup> Period (PE – Middle School)
10:51-11:51	4 <sup>th</sup> Period (PE – High School)
10:51 – 11:06	1 <sup>st</sup> Lunch (Elementary)
11:11 – 11:31	2 <sup>nd</sup> Lunch (Middle School)
11:36 – 11:51	3 <sup>rd</sup> Lunch (ESE)
11:53-12:53	5 <sup>th</sup> Period (PE – ESE)
11:58-12:18	4 <sup>th</sup> Lunch (High School)
12:55-1:55	6 <sup>th</sup> Period
1:55	Student Dismissal

## Early Release Bell Schedule

*(Early Release – 1<sup>st</sup> Friday of the Month)*

7:30-7:45	Student Check In / Breakfast / Homeroom
7:45-8:35	2 <sup>nd</sup> Period (PE – Elementary)
8:37-9:27	3 <sup>rd</sup> Period (PE – Middle School)
9:29-10:19	4 <sup>th</sup> Period (PE – High School)
10:21-11:30	5 <sup>th</sup> Period (PE – ESE)
10:25-10:40	1 <sup>st</sup> Lunch (Elementary)
10:40-10:55	2 <sup>nd</sup> Lunch (Middle School)
10:55-11:10	3 <sup>rd</sup> Lunch (ESE)
11:10-11:25	4 <sup>th</sup> Lunch (High School)
11:30	Student Dismissal

(Revised 7/29/22)