MIS 3174
Rec. 02/2020

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

_____

_____
City State Zip Code

ADDRESS: STUDENT MAILING

_____

_____
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)

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)

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".

STUDENT INFORMATION
REQUIRED INFORMATION UPON INITIAL REGISTRATION
OKALOOSA COUNTY SCHOOLS

§1006.07, *Florida Statutes* 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.

SCHOOL NAME:_____STUDENT #_____

HAS THE STUDENT BEEN REFERRED TO MENTAL HEALTH SERVICES?

NO_____YES_____IF YES, EXPLAIN BELOW.

_____
_____
_____
_____
_____

HAS THE STUDENT BEEN EXPELLED FROM SCHOOL IN ANOTHER DISTRICT AT ANY TIME?

NO_____YES_____IF YES, PROVIDE DETAIL.

MONTH/YEAR OF EXPULSION_____DISTRICT_____STATE _____

_____
_____
_____

HAS THE STUDENT BEEN ARRESTED RESULTING IN A CHARGE?

NO_____YES_____IF YES, PROVIDE DETAIL.

_____
_____
_____

LIST JUVENILE JUSTICE ACTIONS INVOLVING THE STUDENT, 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 1 _____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**

PARENT/GUARDIAN # 1 **Custody: Yes No** **May Pick Up: Yes No**

Name: _____ Relationship_____(mother,father, etc.)

Address: _____ Place of Employment: _____

_____ Home/Primary Phone: _____
City State Zip

Cell Phone: _____

E-Mail Address:_____ Work Phone: _____

PARENT/GUARDIAN # 2 **Custody: Yes No** **May Pick Up: Yes No**

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:_____ Relationship_____

May Pick Up: Yes No Sex: F M Home/Primary Phone: _____

Address:_____ Cell Phone: _____

_____ Work Phone: _____
City State Zip

Name: _____ Relationship_____

May Pick Up: Yes No Sex: F M Home/Primary Phone: _____

Address:_____ Cell Phone: _____

_____ Work Phone: _____
City State Zip

Name: _____ Relationship_____

May Pick Up: Yes No Sex: F M Home/Primary Phone: _____

Address:_____ Cell Phone: _____

_____ Work Phone: _____
City State Zip

Name: _____ Relationship_____

May Pick Up: Yes No Sex: F M Home/Primary Phone: _____

Address:_____ Cell Phone: _____

_____ Work Phone: _____
City State Zip

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 _____

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.

SCHOOL USE ONLY
DATA ENTRY

Student Name:_____ Student # _____

Date of Entry:_____ Grade:_____ Teacher Name:_____

Document used to verify Date of Birth _____

S.S.#: _____ Verification: _____

Birth Date: _____ Birth Place: (City, State, Foreign Country)_____

Controlled Open Enrollment: YES NO

If "yes", what is the student's Assignment Code? _____

If "yes", what is the student's Assigned School? _____

GEOCODE:_____ **RESIDENT STATUS CODE:** _____

Date of Home Language Survey: _____ Homeroom Teacher: _____

Transportation Category:_____ FIC Code _____

MORNING: Bus Route:_____ Bus Number _____

AFTERNOON: Bus Route:_____ Bus Number _____

MIS 4226
Rev. 08/2020

OKALOOSA COUNTY SCHOOL, DISTRICT
STUDENT INTERVENTION SERVICES

INFORMED NOTICE OF INDIVIDUAL ASSESSMENT
TO ASSIST IN THE INTERVENTION PROCESS

Student Name:_____Student #_____Grade___DOB _____

We appreciate your recent involvement in discussions and other efforts to improve your child's classroom performance. As a result of those efforts, we are proposing further assessment to obtain additional information about your child's learning and/or behavior, to assist in intervention development. These activities may include:

- ☐ Vision and/or Hearing Screening
- ☐ Speech/Language Screening
- ☐ Observations
- ☐ Interviews/Social History
- ☑ Screening for School Based Mental Health Services
- ☐ Behavior Diagnostic
- ☐ Intellectual Screening
- ☐ Educational Diagnostic
- ☐ Other _____

___ Behavior Contract
X Other

After these assessments have been completed, a member of the assessment team will contact you regarding the results. Based on those results, additional interventions may be identified to assist in your child's success at school.

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

Person	School	Phone

☐ I acknowledge and concur with the proposed assessment.

☐ Please do not proceed. I wish a conference to discuss the proposed assessments.

Parent/Guardian Signature	Date	Telephone Number

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, VA, 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:	*Choose one or more (regardless of ethnicity):*		
❑ Hispanic/Latino	❑ Asian	❑ American Indian or Alaska Native	❑ Black or African American
❑ Not Hispanic/Latino	❑ 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, 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.

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 **2022-2023 - FREE**			
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 **2022-2023 - REDUCED**			
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	6,642	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.

Bridgeway Center

HEALTHY OPTIONS FOR PERSONAL EMPOWERMENT

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

Rev 7/15/22

Uniform Order Form

Student Name _____

Grade Level
_____ Elementary (4th – 5th)
_____ Middle School (6th – 8th)
_____ High School (9th – 12th)

Item	Quantity	Size	Amount
Short Sleeve T-Shirt ($7.00) *(Sizes YM – A5XL)*	_____	_____	_____
Long Sleeve T-Shirt ($12.00) *(Sizes YM – A5XL)*	_____	_____	_____
Sweatshirt ($15.00) *(Sizes YM – A5XL)*	_____	_____	_____
Total			_____

Please make checks payable to: **OKALOOSA ACADEMY**

Uniform Scholarships are available. Please contact the Front Office for more information.

FOR OFFICE USE ONLY:

Payment Received ___Cash ___Check Check Number _____

Payment Date _____

Order Date _____

Date Order Filled _____

SY 2022-2023

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. <u>These individuals will be authorized to act on behalf of yourself and your child</u>. 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 <u>Dispersion of Medication form (MIS 5163)</u> 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 <u>new</u> medication <u>shall not</u> 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

SY 2022-2023

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

MIS 6344
REV. 6/2022

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. As required in Section 381.0056, Florida Statutes, our School Health Services Plan helps to promote health and wellness for children while seeing to enhance their learning. The Okaloosa County School District has contracted with a vendor to assist in providing school health services for all our public schools. Your child's school will be staffed with a health technician or licensed practical nurse who is supervised by a registered nurse. All student health information is kept confidential and is only shared with those staff members who have a legitimate need to know this information to provide for the health and safety of your child.

* 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. Parents are encouraged to seek medical evaluation of problems identified through the screening process. Results of screenings will be available in the school clinic and are available to parents/guardians upon request.

* 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. I understand that I may withdraw this consent to release information for Medicaid reimbursement at any time. I understand that if I refuse to give my consent or withdraw this consent, the school district will continue to provide all required services necessary for my student to receive an appropriate education at no charge to my child in accordance with 34CFR§300.154(d)(2)(v)(D) or other services provided outside of any IEP. If consent is withdrawn, it will become effective on the date of withdrawal and no information will be released after that date.

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.