



Established 1915

**BROWARD**  
County Public Schools

# Code of Student Conduct

## ***Summary of Changes*** ***SY 2025-2026***

### **Overall restructuring and realignment of required components to promote clarity:**

Section IV: Rights and Responsibilities of Students - Updated Attendance information and Student Privacy Provisions

Section V: Knowledge and Observation of Rules of Conduct - Wireless Communication Devices

Appendix A: Policy Definitions

Appendix B: Health Insurance Portability and Accountability Act (HIPAA) Notice

Appendix C: Discipline Matrix



# Acknowledgement

SBBC Policy 5090, Code of Student Conduct, lists the District's rules for students in Broward County Public Schools. The rules apply to all activities occurring on school grounds, on other sites being used for school activities, and on any vehicles authorized to transport students. Your signature below does not indicate that you agree or disagree with the rules, **but rather that you have reviewed the electronic copy of these rules** (<http://www.browardschools.com/codeofconduct>). Return this form to school within 3 days from the first day of school or from the date of enrollment. If you would prefer to complete all required forms electronically, please access the Back to School Toolkit from the Focus Parent Portal.

Parents need to be involved in the education of their children and have the responsibility to:

- Know that for school safety, schools are not required to provide supervision more than 30 minutes prior to the official starting time, nor are they required to provide supervision for more than 30 minutes after the official closing time (F.S. §1003.31 (2)).
- Know that for school safety, for students who ride a school bus, drivers are NOT permitted to let students off the bus except at the designated stop.
- Provide the school with the names of current emergency contact person(s) and/or telephone numbers on an annual basis and when there are changes.
- Notify the school of anything that may affect their child's ability to learn, to attend school regularly, or to take part in school activities.
- Be aware that medicine must be administered in accordance with SBBC Policies 6305 and 6305.1, as may be amended, and that consequences for transmittal and/or sale or attempted sale of over-the-counter medications and possession and/or use of unauthorized medications can be found in SBBC Policy 5100. SBBC Policy 6305 outlines the rules regarding over-the-counter and prescription drugs and SBBC Policy 5100 outlines the consequences for violating those rules. You may view the complete health and suspension and/or expulsion policies, as well as all School Board policies, on the Web at: <https://www.browardschools.com/school-board/school-board-policies>
- Be aware that parents have rights with regard to the privacy and confidentiality of student records that are maintained by schools as defined in Section XI of this booklet.
- Neither the School Board of Broward County nor its employees will be held liable for items that are prohibited and are lost, stolen, or confiscated; or for wireless communication devices or other personal technology that are lost, stolen, or confiscated.
- Be aware that confiscated items not claimed by the end of the school year will be donated to local charities.
- Recognize that they are responsible for their student's behavior on the way to and from school and at the bus stop. A safe and respectful learning environment is key to academic achievement; therefore any student's off campus actions that seriously affect a student's ability to learn or a staff member's ability to teach may be handled as a disciplinary infraction. For serious incidents that occur at bus stops and/or that are not on School Board property, parents should contact law enforcement directly. For bullying incidents (see bullying definition, Section V), school officials should be notified and will investigate and/or provide assistance and intervention, as the principal/designee deems appropriate, which may include the use of the School Resource Officer.
- Ensure their child demonstrates legal, ethical and responsible use of technology including networks, digital tools, the Internet, and software, as defined in Section VII of this booklet.
- Parents will continue to maintain responsibility for students who reach the age of majority, (18 years or older), for all educational and discipline purposes, with exceptions as provided by statute.

**Note: Parental selection for each form within the Code of Student Conduct will be effective until a new form is submitted.**

\_\_\_\_\_  
Student Name (PRINT)

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

\_\_\_\_\_  
Parent/Guardian Name (PRINT)

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

# Media Release Form (All Grades) 2025-2026

As a parent of a student in Broward County Public Schools, I understand that my child may be photographed, videotaped and/or interviewed by news media, schools and the District for informational and/or promotional purposes, as indicated below

## You Must Mark a Choice in Both Section A and Section B

(If no choice is marked in a section, then the choice will default to "I WILL NOT permit.")

## Section A - External Outlets / Media

Please Check Choice #1 or Choice #2

1.  I **WILL** permit my student to be photographed, videotaped, and/or interviewed by the news media when the news media has secured proper authorization from Broward County Public Schools.
2.  I **WILL NOT** permit my student to be photographed, videotaped, and/or interviewed by the news media.

## Section B - Broward County Public Schools

Please Check Choice #1 or Choice #2

1.  I **WILL** permit my student to be photographed, videotaped, and/or interviewed for school publications (e.g., yearbooks and school newspapers), school and District communication tools (e.g., websites and social media), BECON-TV, and school events and activities. **Note: To facilitate school publications, the District may disclose information to approved vendors, such as student's name, student's home address, student/parent phone number, grade level, teacher names and classroom numbers. For sporting events, athletic team member positions and jersey numbers may be disclosed.**
2.  I **WILL NOT** permit my student to be photographed, videotaped, and/or interviewed for school publications (e.g., yearbooks and school newspapers), school and District communication tools (e.g., websites and social media), BECON-TV, and school events and activities.

\_\_\_\_\_  
Student Name (PRINT)

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Name (PRINT)

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

# FERPA Opt-Out Notification Form (All Grades) 2025-2026

**ATTENTION!** Checking items below will prevent the selected information from appearing in school publications, including, but not limited to, the yearbook, even if you provide permission in Section B on the Media Release Form. For Example: Checking "Student's Name" below may prevent the student's photograph from appearing in the yearbook.

## PURPOSES OF DISCLOSURE OF DIRECTORY INFORMATION

"Directory Information" is personally identifiable information that would not generally be considered harmful or an invasion of privacy if disclosed. Pursuant to the Family Educational Rights and Privacy Act (FERPA), SBBC may disclose, in its discretion, directory information of a student in any grade level, if the parent or student age 18 or over did not "opt out" of the disclosure. SBBC reserves the right to release the Directory Information only:

- (a) to colleges, universities or other institutes of higher education in which the student is enrolled, may seek enrollment or may be recruited;
- (b) for athletic events, school publications, instructional materials and other school communication tools (including, but not limited to, yearbooks, athletic programs, graduation programs, recruitment brochures, theatrical programs, school and District websites, social media, and postings and displays throughout the school facility);
- (c) to Broward County health officials for purposes of communicating with parents to address conditions of public health importance as determined by Florida Department of Health (64D-3, F.A.C.), including information to meet or to prepare for a potential or confirmed health threat; and/or
- (d) to class reunion committees (and the like) for purposes of class reunion activities.

## TYPES OF DIRECTORY INFORMATION

Parents/guardians of students in any grade level, or eligible students (those over the age of 18, emancipated, or attending a postsecondary institution), may opt out of having any or all of the following types of directory information disclosed by indicating, with a check mark (✓), those items NOT TO BE DISCLOSED:

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

\*Degrees and awards include exemplary work (including artwork), recognitions of all types, and graduation status (i.e., a list of graduating students), and exclude Grade Point Average (GPA).

**Note:** This form must be completed and submitted to the school on an annual basis, regardless of whether any of the above items were checked or not, WITHIN 10 DAYS FROM THE FIRST DAY OF SCHOOL or from the date of enrollment, if a student enrolls after the start of each school year.

Student Name \_\_\_\_\_ School \_\_\_\_\_

Parent/Guardian/Eligible Student's Name (Print) \_\_\_\_\_

Parent/Guardian/Eligible Student's Signature \_\_\_\_\_ Date \_\_\_\_\_

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

For parents in selected occupations:

Note: Pursuant to Florida Statute 119.071, for individuals in certain occupations (as well as their spouses and children), selected personal information is confidential and exempt from public disclosure, only if the individual submits a written request for the exemption. If you are employed in a qualifying occupation and wish to request that your, your spouse's and your child's personal information remain confidential, please schedule an appointment with your child's school in order to complete the Parental Request for Exemption of Personal Information for Selected Occupations form.

# ESSA Opt-Out Form (Grades 11 & 12) 2025-2026

## MILITARY & POSTSECONDARY

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

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

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

### Information disclosed to armed services/military recruiters:

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

### Information disclosed to postsecondary institutions:

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

**Note:** This form must be completed and submitted to the school on an annual basis, regardless of the chosen option, **WITHIN 10 DAYS FROM THE FIRST DAY OF SCHOOL** or from the date of enrollment, if a student enrolls after the start of each school year.

In addition to this form, all 11<sup>th</sup> and 12<sup>th</sup> grade students must also complete the FERPA Opt-Out Notification Form.

**Note:** This form must be completed and submitted to the school on an annual basis, regardless of the chosen option, **WITHIN 10 DAYS FROM THE FIRST DAY OF SCHOOL** or from the date of enrollment, if a student enrolls after the start of each school year.

In addition to this form, all 11<sup>th</sup> and 12<sup>th</sup> grade students must also complete the FERPA Opt-Out Notification Form.

Student Name \_\_\_\_\_ Grade \_\_\_\_\_

School Name \_\_\_\_\_

Parent/Guardian/Eligible Student's Name (Print) \_\_\_\_\_

Parent/Guardian/Eligible Student's Signature \_\_\_\_\_

## Coordinated Student Health Services

### Heather Katcher, Director

1400 NW 14 Court

Fort Lauderdale, Florida 33311

phone: 754-321-1575 • fax: 754-321-1695

[heather.katcher@browardschools.com](mailto:heather.katcher@browardschools.com)

[www.browardschools.com/cshs](http://www.browardschools.com/cshs)

## The School Board of Broward County, Florida

Debra Hixon, Chair  
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Nora Rupert  
Rebecca Thompson  
Dr. Allen Zeman

Dr. Howard Hepburn  
Superintendent of Schools

Dear Parent/Guardian,

This letter is designed to inform you of the health services offered by Broward County Public Schools (BCPS) Coordinated Student Health Services Department.

### School Health Services

BCPS collaborates with the Florida Department of Health (FDOH) in Broward County to ensure the health and safety of your student. Currently, Coordinated Student Health Services provides District level registered nurses who are available to assist in the coordination of school health services and any health concerns you may have. The designated onsite healthcare personnel at your child's school may be contacted directly by calling your child's school clinic. You may also contact Coordinated Student Health Services at 754-321-1575 for any health service-related questions.

### Student Health Services Consent Forms

The Health Services Consent section on the Student Emergency Contact Card (SECC) must be completed, signed, and dated each school year by the parent/guardian to ensure students can receive care for illness/injury in the school clinic (for example: school clinic visits for stomachache, headache, cold/flu symptoms, nosebleed, Band-Aid for cuts and scrapes, etc.) during the school day or during school-sponsored activities.

### When Your Child is Sick

Keeping your child home when they are sick helps your child get well and protects classmates. Please do not send your child to school if they are exhibiting any symptoms listed below:

- Bad cough
- Temperature greater than 100.4 F
- Severe sore throat
- Eye infection
- Diarrhea
- Persistent vomiting
- Rash
- Head lice

Your child must be symptom-free, without vomiting, diarrhea, or fever, for at least 24 hours, without the use of fever-reducing medication, before returning to school. BCPS has partnered with Hazel to provide telehealth services free of charge to all students enrolled in BCPS. Consent is required. Please visit [www.browardschools.com/cshs](http://www.browardschools.com/cshs) for consent and additional information.

### State Mandated Health Screenings

Florida Statute 381.0056 requires that non-invasive health screenings be conducted for all students in KG, 1st, 3rd, and 6<sup>th</sup> grades. If a student does not pass a health screening, a referral letter will be sent home indicating that follow-up is recommended. If you desire to opt your child out of a screening, it

must be in writing. Health screening information is confidential, and the results are filed in each student's cumulative folder. Below are the grade level screenings:

- Vision: Students in kindergarten grades, 1, 3, 6, and new to BCPS up to grade 5
- Hearing: Students in grades kindergarten, 1, 3, 6, and new to BCPS up to grade 5
- Body Mass Index (BMI): Students in grades 1, 3 and 6, and new to BCPS up to grade 5
- Scoliosis: Students in grade 6

### **Health Conditions**

If your child has any of the following health conditions, including, but not limited to, anaphylaxis, asthma, diabetes, cystic fibrosis, and seizures, please inform the school by completing both sides of the Student Emergency Contact Card and a [Health Condition Review](#) form. Depending on the reported health condition, you may be asked to submit documentation from a healthcare provider. Please visit [Coordinated Student Health Services / Chronic Health Conditions \(browardschools.com\)](#) for more information.

### **Medication Administration at School (Prescription/Over the Counter)**

If medication or treatments are medically necessary during the school day, please submit a current [Medication/Treatment Authorization](#) form signed by both a healthcare provider and a parent/guardian to the school. To retrieve the form, visit [www.browardschools.com/healthforms](http://www.browardschools.com/healthforms).

The Diabetes Medical Management Plan (DMMP) is required for students with diabetes and must be completed and signed by both the healthcare provider and parent/guardian. To access the form, visit [www.browardschools.com/healthforms](http://www.browardschools.com/healthforms).

### **Authorization for Selected Over-the-Counter Medication/Products (OTC) with Parental Approval**

Authorization for selected over-the-counter medication for students in grades 9-12 to self-carry can be completed and signed by the parent/guardian. For more information, please visit [www.browardschools.com/healthforms](http://www.browardschools.com/healthforms)

### **Immunizations**

In accordance with Florida Statute 1003.22, all students entering or attending a Florida public or private school—grades Kindergarten through 12—must provide proof of immunization documented on a Florida Department of Health (FDOH) Form DH 680 or DH 681. To ensure your child is ready for school, you may verify that they have the required immunizations by visiting your child's healthcare provider or by contacting the FDOH in Broward at (954) 467-4700. Religious exemptions, if desired, must be issued by the FDOH. For more information, including how to obtain these vaccinations at no cost, please visit <http://www.browardschools.com/vaccinations>.

### **Community Resources**

If you do not have insurance, you may request an application for Florida Kid Care Insurance [KidCare Outreach | Florida Department of Health in Broward \(floridahealth.gov\)](#)

Florida Heiken Children's Vision Program provides vision examinations and eyeglasses when prescribed, to students in need of comprehensive vision services at no cost to the student. Please visit [Heiken-Flyer-English.pdf \(browardschools.com\)](#)

If you have any questions, please contact Coordinated Student Health Services at (754) 321-1575, or visit [www.browardschools.com/cshs](http://www.browardschools.com/cshs)

# 2025-26 Broward County Public Schools Student Emergency Contact Card

This form shall be updated every year

<b>Office Use Only</b>	Student #	Grade Level:	<input type="checkbox"/> Court Order	<input type="checkbox"/> Medical		
	Date Enrolled:		<input type="checkbox"/> Special Needs	<input type="checkbox"/> Other		
<p>In the case of an emergency, it is imperative that the school be able to reach the student's parents (as defined below). Please fill in the information on both sides of this card carefully and accurately. Please use ink and print clearly. The names of both parents of a student (as defined in the Section 1000.21(6), Florida Statutes), the parent(s)/guardian(s) shall be listed on the emergency contact card as persons authorized to pick up the child from school except where a court order has revoked the parental rights, and a certified copy of such court order has been provided to the school office. Both parents shall designate on the Emergency Contact Card those persons authorized to pick up their child from school. No parents shall delete or in any way alter the names provided by the other parent on the Emergency Contact Card.</p>						
<b>Student Information</b>	Last Name:		First:		Middle:	
	Date of Birth:    /    /			Teacher (elementary school only):		
	Home Address:					
	Mailing Address (if different from above):					
	Check any that apply to student residents: <input type="checkbox"/> Medical <input type="checkbox"/> Court Order <input type="checkbox"/> Special needs <input type="checkbox"/> Other					
	Has student changed address since last registration? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	Is there a court order on file that prevents a parent from having contact with the student? <input type="checkbox"/> No <input type="checkbox"/> Yes, contact school					
	Preferred Name(s)/Nickname(s):					
	All staff may refer to my child by the preferred name(s) or nickname(s) listed above on all unofficial documents and during school/district events.					
	Signature:		Date:	Relationship:		
<b>Parent</b>	Last Name:		First:		Cell Phone:	
	Home Address (if different from student):			City, State, Zip:		Home Phone:
	Employer:	Work Phone:		Parent Email:		
<b>Other Parent</b>	Last Name:		First:		Cell Phone:	
	Home Address (if different from student):			City, State, Zip:		Home Phone:
	Employer:	Work Phone:		Parent Email:		
<b>Authorized Release/Contact</b>	Please list the names of persons to whom we may release your child or whom we may contact if we cannot reach you. NO STUDENT WILL BE RELEASED TO ANYONE OTHER THAN THE PERSONS LISTED BELOW. Both parents may designate on the Emergency Contact Card those persons authorized to pick up their child from school. In selecting someone to whom you authorize the release of your child, consider whether this person is prepared to handle any special medical needs required by your child. I/We hereby authorize contact with release of emergency related information, or release of the student to the following persons in the event of illness, evacuation, or other emergency that may occur while the student is in school.					
	Name:		Relationship:		Phone:	
I declare that the information on this card is true and correct. I will notify the school office immediately of any changes:						
Signature:		Date:	Relationship:			
The personal information you provide on this form will be kept confidential (in a protected area) and only used and disclosed by school staff on a need-to-know basis.						

# 2025-26 Broward County Public Schools Student Emergency Contact Card

This form shall be updated every year

Student Last Name:

First:

Middle:

Grade Level:

<b>Health Services Consent</b>	<p><b>Consent for School Clinic Services:</b> Care and treatment for illness and injury (For example: School Clinic Visits for stomachache, headache, cold/flu symptoms, nosebleed, Band-Aid for cuts and scrapes, etc.).</p> <p><input type="checkbox"/> <b>YES</b>, I give consent for my child to receive care from the school nurse, trained healthcare personnel, or trained school staff during the school day and at off-site school activities, including field trips.</p> <p><input type="checkbox"/> <b>NO</b>, I understand that my child will <b>NOT</b> receive any non-emergency care from the healthcare personnel or school staff.</p> <p>If this section is left blank or unsigned, school personnel will <b>NOT</b> be able to care for your child unless there is a medical emergency.</p> <p><b>State Mandated Health Screenings, F.S. 381.0056(3):</b> Students in state-mandated screening grades (Kindergarten, 1<sup>st</sup> Grade, 3<sup>rd</sup> Grade, and 6<sup>th</sup> Grade) will receive specified health screenings for vision, hearing, growth and development, and scoliosis as provided for in the district health services plan. A student will be exempt from any health screening if his or her parent or guardian requests such exemption in writing.</p> <p>I consent to my child receiving health services as indicated above. I understand if consent is granted, BCPS will disclose my child's education records (including medical information) to contracted nursing vendors who provide treatment to my child.</p> <p><b>Signature:</b> _____ <b>Date:</b> _____ <b>Relationship:</b> _____</p>																		
<b>Medical Information</b>	<p>Medical information must be reported every school year and as changes occur. Information regarding health conditions reported in previous years will not be considered current unless indicated below. If you check that your child has a current health condition, you must complete the <i>Health Condition Review Form</i> AND submit documentation from a healthcare provider to your child's school.</p> <p><input type="checkbox"/> <b>My child does NOT have or no longer has any of the health conditions listed below</b></p> <p>Please check all health conditions that are current and have been diagnosed by a healthcare provider:</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;"><input type="checkbox"/> ADD/ADHD</td> <td style="width: 25%;"><input type="checkbox"/> Allergies (Non-life-threatening)</td> <td style="width: 25%;"><input type="checkbox"/> Allergies (Life-threatening)</td> <td style="width: 25%;"><input type="checkbox"/> Asthma (Currently uses daily or emergency medication)</td> </tr> <tr> <td><input type="checkbox"/> Autism</td> <td><input type="checkbox"/> Bleeding disorder</td> <td><input type="checkbox"/> Cancer</td> <td><input type="checkbox"/> Cardiac conditions</td> </tr> <tr> <td><input type="checkbox"/> Cystic fibrosis</td> <td><input type="checkbox"/> Diabetes – Type 1</td> <td><input type="checkbox"/> Diabetes – Type 2</td> <td><input type="checkbox"/> Epilepsy/ Seizure disorders (<b>NOT</b> including seizures from high fever)</td> </tr> <tr> <td><input type="checkbox"/> Kidney disorder</td> <td><input type="checkbox"/> Lupus</td> <td><input type="checkbox"/> Mental/behavioral health conditions</td> <td><input type="checkbox"/> Sickle cell disease (<b>NOT</b> Sickle cell trait)</td> </tr> </table> <p><input type="checkbox"/> Other (Specify): _____</p> <p>Does your child wear glasses/contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No      Does your child wear hearing aid(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Allergies (Non-life-threatening)	<input type="checkbox"/> Allergies (Life-threatening)	<input type="checkbox"/> Asthma (Currently uses daily or emergency medication)	<input type="checkbox"/> Autism	<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cardiac conditions	<input type="checkbox"/> Cystic fibrosis	<input type="checkbox"/> Diabetes – Type 1	<input type="checkbox"/> Diabetes – Type 2	<input type="checkbox"/> Epilepsy/ Seizure disorders ( <b>NOT</b> including seizures from high fever)	<input type="checkbox"/> Kidney disorder	<input type="checkbox"/> Lupus	<input type="checkbox"/> Mental/behavioral health conditions	<input type="checkbox"/> Sickle cell disease ( <b>NOT</b> Sickle cell trait)
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Allergies (Non-life-threatening)	<input type="checkbox"/> Allergies (Life-threatening)	<input type="checkbox"/> Asthma (Currently uses daily or emergency medication)																
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<b>Health Insurance</b>	<p><b>Please check the appropriate box:</b>      <input type="checkbox"/> Private Health Insurance   <input type="checkbox"/> Florida KidCare/ Florida Healthy Kids   <input type="checkbox"/> Medicaid   <input type="checkbox"/> None</p> <p><b>If NONE, do we have your permission to forward the student's name, parent's name, contact information and current health insurance coverage status to Florida KidCare Insurance for health insurance screening to see if you may be eligible for health insurance coverage?</b></p> <p><input type="checkbox"/> Yes, please sign here: _____ <input type="checkbox"/> No</p>																		
<b>Release of Medical Information and Emergency</b>	<p>I hereby authorize for my child's medical information, parental contact information, and other health information (collected from health services provided at school, including information stored electronically) to be shared with health department officials to address conditions of public health importance, including information to meet and to prepare for potential or confirmed health conditions. For students receiving health services from school or District staff and/or contracted partners, I also authorize the District to share my child's identifiable health information and related demographics with the Florida Department of Health to conduct monitoring to assure program compliance by the District and schools, and assess the delivery of services.</p> <p><b>Signature:</b> _____ <b>Date:</b> _____</p> <p>Medical and other information will be disclosed without consent from the parent/eligible student in case of health emergencies, as permissible by the Family Educational Rights and Privacy Act (FERPA). The school will call for emergency medical care as deemed necessary. Emergency transportation to a health care facility, as determined by paramedics, will be authorized.</p>																		
<b>Dismissal Information</b>	<p><b>Regular Dismissal Procedures: On a typical day, how will your child leave school?</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Ride in a car</td> <td style="width: 33%;"><input type="checkbox"/> Ride a school bus</td> <td style="width: 33%;"><input type="checkbox"/> Ride public transportation</td> </tr> <tr> <td><input type="checkbox"/> Attend ON-site after-care program</td> <td><input type="checkbox"/> Attend OFF-site after-care program</td> <td><input type="checkbox"/> Walk or bike home</td> </tr> </table> <p><b>Emergency Dismissal Procedures: In the event of a severe storm or other unscheduled emergency your child is instructed to:</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Walk home</td> <td style="width: 33%;"><input type="checkbox"/> Ride a school bus as usual</td> <td style="width: 33%;"><input type="checkbox"/> Ride public transportation</td> </tr> <tr> <td><input type="checkbox"/> Ride home with parent only</td> <td colspan="2"><input type="checkbox"/> Ride home with person indicated on authorized contact list</td> </tr> </table>			<input type="checkbox"/> Ride in a car	<input type="checkbox"/> Ride a school bus	<input type="checkbox"/> Ride public transportation	<input type="checkbox"/> Attend ON-site after-care program	<input type="checkbox"/> Attend OFF-site after-care program	<input type="checkbox"/> Walk or bike home	<input type="checkbox"/> Walk home	<input type="checkbox"/> Ride a school bus as usual	<input type="checkbox"/> Ride public transportation	<input type="checkbox"/> Ride home with parent only	<input type="checkbox"/> Ride home with person indicated on authorized contact list					
<input type="checkbox"/> Ride in a car	<input type="checkbox"/> Ride a school bus	<input type="checkbox"/> Ride public transportation																	
<input type="checkbox"/> Attend ON-site after-care program	<input type="checkbox"/> Attend OFF-site after-care program	<input type="checkbox"/> Walk or bike home																	
<input type="checkbox"/> Walk home	<input type="checkbox"/> Ride a school bus as usual	<input type="checkbox"/> Ride public transportation																	
<input type="checkbox"/> Ride home with parent only	<input type="checkbox"/> Ride home with person indicated on authorized contact list																		
<b>Siblings and Home Language</b>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;"><b>Last Name:</b></td> <td style="width: 33%;"><b>First:</b></td> <td style="width: 33%;"><b>Grade Level:</b></td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </table> <p><b>Please list any other languages spoken at home:</b></p>			<b>Last Name:</b>	<b>First:</b>	<b>Grade Level:</b>													
<b>Last Name:</b>	<b>First:</b>	<b>Grade Level:</b>																	
<b>Survey Questions</b>	<p><b>Please assist us in understanding the needs of our school community by answering the following questions:</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">Does your child have access to a computer in your home?</td> <td style="width: 20%;"><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Do you have home internet access?</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Does your child have access to the internet on your home computer?</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Do you have internet access outside your home?</td> <td><input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table> <p><b>Please indicate the method of contact you prefer:</b>      <input type="checkbox"/> Phone call   <input type="checkbox"/> Text   <input type="checkbox"/> Email</p>			Does your child have access to a computer in your home?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have home internet access?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Does your child have access to the internet on your home computer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have internet access outside your home?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
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Do you have internet access outside your home?	<input type="checkbox"/> Yes <input type="checkbox"/> No																		

## Health Condition Review

School Year 20\_\_ - 20\_\_

**HAVE YOU COMPLETED THE ANNUAL STUDENT EMERGENCY CONTACT CARD?** Yes  No

Student Last Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

Student First Name: \_\_\_\_\_  
Grade: \_\_\_\_\_

Health conditions are defined as those conditions that last 1 year or more and require ongoing medical attention, limit activities of daily living, or both.

### STUDENT CARE/TRAINING

- Individual Healthcare Plan (IHP) is a plan of action for management of actual and potential healthcare needs during the school day, on field trips, and during school-sponsored activities.
  - An IHP may be developed for students with a *verified* health condition that requires medication, or a procedure, during the school day.
- Emergency Care Plan (ECP) is a step by step set of instructions for what to do in an emergency.
  - An ECP may be developed for students with a potential risk of emergency (i.e., anaphylaxis, seizure, diabetes, asthma).
- As permissible by the Family Educational Rights and Privacy Act (FERPA), health condition information on an ECP will be shared with applicable school staff.
- All conditions must have a documented provider diagnosis except ADD/ADHD, allergies non-life threatening, mental/behavioral health conditions and "others".

### Health Condition:

**ONLY** check current health conditions. \*Indicates conditions that require written documentation of diagnosis from a healthcare provider.

- |   |  |
|---|--|
| <input type="checkbox"/> ADD/ADHD (Attention Deficit / Hyperactivity)<br><input type="checkbox"/> Allergies – nonlife threatening (not severe)<br><input type="checkbox"/> Allergies – life threatening (severe)*<br><input type="checkbox"/> Asthma*<br><input type="checkbox"/> Bleeding Disorder*<br><input type="checkbox"/> Cancer*<br><input type="checkbox"/> Cardiac Conditions*<br><input type="checkbox"/> Cystic fibrosis* | <input type="checkbox"/> Diabetes – Type 1*<br><input type="checkbox"/> Diabetes – Type 2*<br><input type="checkbox"/> Epilepsy / Seizure disorders*<br><input type="checkbox"/> Kidney disorders*<br><input type="checkbox"/> Lupus*<br><input type="checkbox"/> Sickle cell disease*<br><input type="checkbox"/> No current health condition<br><input type="checkbox"/> Other<br>_____<br>_____ |
|---|--|

### Medication Needs Assessment:

Is it medically necessary for your child to receive medication during the school day?

Yes  No

If **Yes**, an Authorization for Medication/Treatment Form completed by a healthcare provider must be submitted for medication administration ([www.browardschools.com/healthforms](http://www.browardschools.com/healthforms)).

Is the student currently taking medication that would be required for an offsite school related or school sponsored activity (including overnight trips) that occur outside of traditional school hours?

Yes  No

Per Florida Statute 1002.20 and School Board Policy 6305, self-carry of student medication is allowed for Metered Dose Inhaler (MDI), epinephrine autoinjector, diabetic supplies and medication, and/or pancreatic enzyme supplements with an Authorization for Medication/Treatment Form completed by a healthcare provider stating that the student is trained and independent.

Does student self-carry ANY medication? Yes  No   
If yes, list the medication: \_\_\_\_\_

Date of diagnosis: \_\_\_\_\_

Signs and symptoms (if any): \_\_\_\_\_

Triggers/Allergens (if any): \_\_\_\_\_

Recent hospitalization related to diagnosis? Yes  No  Date: \_\_\_\_\_

Recent surgery related to diagnosis? Yes  No  Date: \_\_\_\_\_

Activity restriction in school? Yes  No

Additional information (including known student-specific side effects to medication):  
\_\_\_\_\_  
\_\_\_\_\_

Please provide the best contact information, including name and number, for school staff to refer to when communicating about your child's health condition.

Parent/Guardian (Print Name): \_\_\_\_\_

Best Contact Phone Number: \_\_\_\_\_

Parent/Guardian (Signature): \_\_\_\_\_

Relationship to Student: \_\_\_\_\_

\*\*\*\*\*CLINIC USE ONLY\*\*\*\*\*

### PARENT / HEALTHCARE STAFF COMMUNICATION:

Date/Time: \_\_\_\_\_ Medication Authorization Form  Emergency Contact Card  Unable to reach parent/guardian  Letter sent home

Date/Time: \_\_\_\_\_ Medication Authorization Form  Emergency Contact Card  Unable to reach parent/guardian  Letter sent home

Date/Time: \_\_\_\_\_ Medication Authorization Form  Emergency Contact Card  Unable to reach parent/guardian  Letter sent home

Date/Time: \_\_\_\_\_ No verified health condition [Remove from School Application]  Referral (Admin, Social Work, Food & Nutrition, etc.)

The signature below serves as an annual health record review:

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

RN Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Student needs IHP only

Student needs IHP and ECP

No plan required at this time



## 2025-2026

# School Immunization Requirements

Before entering or attending school in-person or virtually (kindergarten through twelfth grade) each child must provide a *Florida Certification of Immunization* (DH 680 form) \*, documenting the following vaccinations:

### Kindergarten through Twelfth Grade:

- Four or five doses of diphtheria-tetanus-pertussis (DTaP) vaccine±
- Three doses of hepatitis B (Hep B) vaccine
- Four or five doses of polio (IPV) vaccine\*\*
- Two doses of measles-mumps-rubella (MMR) vaccine
- Two doses of varicella vaccine†

### Seventh Grade:

In addition to kindergarten through twelfth grade vaccines, students entering or attending seventh grade complete the following:

- One dose of tetanus-diphtheria-pertussis (Tdap) vaccine in grades seven through twelve
- An updated DH 680 form to include Tdap, must be obtained for submission to the school

**Visit your health care provider or pediatrician to obtain a DH 680 Form\*.**

**For information regarding free immunization clinics, visit [browardschools.com/vaccinations](http://browardschools.com/vaccinations)**

**Students without a completed Certificate of Immunization\* indicating compliance with the current required schedule of immunizations will not be allowed to attend classes until this document is provided.**

**Absences due to noncompliance with immunization requirements shall be considered unexcused. (F.S. s. 1003.22(1)) (BCPS Policy 5.5-IV.C.2)**

\* *Students may attend school without a DH 680 form if they have a medical exemption (DH 680-Part B/C form) or religious exemption (DH 681 form).*

± *The fifth dose of DTaP vaccine is not necessary if the fourth dose was administered at age 4 years or older.*

\*\* *If four or more doses are administered before age 4 years, an additional dose should be administered at age 4 through 6 years and at least six months after the previous dose. A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least six months after the previous dose.*

† *Varicella vaccine is not required if varicella disease is documented by the health care provider.*

# Hazel Health Consent Form



Our school district is partnering with Hazel Health, Inc. and Telehealth Services USA d/b/a Hazel Health Services ("Hazel Health Services") to provide access to quality healthcare services for all students. The school nurse or school health representative can initiate a video visit with one of Hazel's healthcare providers in order to ensure there are no delays in care. Complete this form to ensure access to this convenient service.

Complete this form online and learn more about Hazel at: [getstarted.hazel.co/district/broward](https://getstarted.hazel.co/district/broward)



\_\_\_\_\_  
Student's First Name      Student's Last Name      Student's Birthdate  
Month / Day / Year

\_\_\_\_\_  
Student ID Number      Student's Address      City/State/Zip

\_\_\_\_\_  
Parent / Legal Guardian #1 Name      Relationship to Student      Mobile Phone ( )       Preferred      Email       Preferred

\_\_\_\_\_  
Parent / Legal Guardian #2 Name      Relationship to Student      Mobile Phone ( )       Preferred      Email       Preferred

## Required Insurance Information

**How much will a Hazel visit cost me?** Services from Hazel Health are 100% covered, so there is **no cost** to your family.

**Who is covering these services?** Just like a regular healthcare provider, Hazel will bill your student's insurance for services rendered. Anything insurance doesn't cover gets covered by your school district. As a result, there are **no out-of-pocket costs** to your family.

You will not receive a bill for using Hazel's services — no matter what insurance you have, or what your deductible is. Once a visit is completed, you may receive an Explanation of Benefits (EOB) in the mail from your insurance company. This is not a bill; it is simply a record that the visit occurred. No action is needed.

**What if my student does not have health insurance?** If your student is verified by Hazel as uninsured, their care will still be 100% covered.

For more information, please see our FAQs at [www.hazel.co/faq](http://www.hazel.co/faq)

**Please provide your student's insurance information and complete all sections below.** Your insurance information is always kept confidential and is stored securely.

\_\_\_\_\_  
Insurance Company      Member ID Number      Group Number (if applicable)

\_\_\_\_\_  
Policy Holder First Name      Policy Holder Last Name      Policy Holder Birthdate      Relationship to Student

\_\_\_\_\_  
Policy Holder's Address      City/State/Zip

**By checking this box, I attest that my student does not have health insurance coverage at this time.**

**I have read the Hazel Health Services Authorization and Privacy Policy and: (Please check one box below)**

I **GIVE** permission for my student to receive healthcare services from Hazel Health providers.

I **DO NOT give** permission for my student to receive healthcare services from Hazel Health providers.

\_\_\_\_\_  
Parent / Legal Guardian / Legal Representative Signature (Required)      Date

**PLEASE CONTINUE TO PAGE 2 TO INPUT KNOWN ALLERGIES & OTHER HEALTH INFORMATION**

*This consent will remain valid unless revoked by the parent / legal guardian / legal representative.*

Student's First Name

Student's Last Name

Student's Birthdate

**Does your student have any allergies?**

YES  NO Medication allergies Please List: \_\_\_\_\_

YES  NO Food allergies Please List: \_\_\_\_\_

YES  NO Seasonal/Environmental allergies Please List: \_\_\_\_\_

**Is your student currently taking any medications?**

YES  NO Please List: \_\_\_\_\_

**If recommended by Hazel's licensed medical provider, can the following medications (age/weight appropriate) be administered to your student at school?**

- |                              |                             |  |                              |                             |   |
|------------------------------|-----------------------------|--|------------------------------|-----------------------------|---|
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Tylenol™ / Acetaminophen (pain, fever)   | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Cough Syrup (cough)                                 |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Advil™ / Motrin™ / Ibuprofen (pain, fever)   | <input type="checkbox"/>     | <input type="checkbox"/>    | Hydrocortisone Cream (inflammation, itch)           |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Children's Pepto™ / Calcium Carbonate (upset stomach)                                  | <input type="checkbox"/>     | <input type="checkbox"/>    | Zyrtec™ / Cetirizine (allergies, allergic reaction) |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Liquid Pepto-Bismol™ / Bismuth Subsalicylate (nausea, indigestion, upset stomach)      | <input type="checkbox"/>     | <input type="checkbox"/>    | Antibiotic Ointment (cuts, infections)              |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Liquid Antacid / Aluminum Hydroxide / Magnesium Hydroxide, Simethicone (upset stomach) | <input type="checkbox"/>     | <input type="checkbox"/>    | Artificial Tears (eye drops)                        |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Throat Lozenge / Benzocaine / Menthol (cough, sore throat)                             |                              |                             |   |

**Has your student ever had any of the following health conditions or health concerns?**

- |                              |                             |  |                              |                             |                                   |
|------------------------------|-----------------------------|--|------------------------------|-----------------------------|-----------------------------------|
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Acid Reflux (Heartburn)                    | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Genetic disorder                  |
| <input type="checkbox"/>     | <input type="checkbox"/>    | ADD/ADHD (Attention Deficit Disorder)      | <input type="checkbox"/>     | <input type="checkbox"/>    | High Blood Pressure               |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Anxiety                                    | <input type="checkbox"/>     | <input type="checkbox"/>    | Kidney disease                    |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Asthma                                     | <input type="checkbox"/>     | <input type="checkbox"/>    | Migraine Headaches                |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Autism spectrum disorder                   | <input type="checkbox"/>     | <input type="checkbox"/>    | Seizure Disorder                  |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Cognitive/Intellectual delay or disability | <input type="checkbox"/>     | <input type="checkbox"/>    | Sickle Cell Disease               |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Congenital Heart Defect                    | <input type="checkbox"/>     | <input type="checkbox"/>    | Speech/language delay or disorder |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Constipation                               | <input type="checkbox"/>     | <input type="checkbox"/>    | Surgery: Appendix removed         |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Depression                                 | <input type="checkbox"/>     | <input type="checkbox"/>    | Surgery: Ear Tubes                |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Diabetes                                   | <input type="checkbox"/>     | <input type="checkbox"/>    | Surgery: Tonsils removed          |
| <input type="checkbox"/>     | <input type="checkbox"/>    | Eczema                                     | <input type="checkbox"/>     | <input type="checkbox"/>    | Other (please explain): _____     |

**Does your student have a primary care doctor?**

Hazel uses this information to coordinate with your student's doctor and inform them of any Hazel visit. Providing the fax number will allow Hazel to send a visit summary to your student's doctor.

YES  NO \_\_\_\_\_  
 Student's Doctor Phone Fax

## Hazel Health Services School Health Center Authorization

*For purposes of this Notice, when we refer to “you” or “your,” we mean you as a patient (meaning you meet your state criteria for age of majority, emancipated minor, or unaccompanied minor) or you as the provider of information about a minor patient (meaning you are an authorized legal guardian or authorized legal representative of the child).*

Understanding that you may need healthcare treatment, behavioral healthcare, or healthcare screenings at the school or outside the school, you hereby authorize Hazel Health Services, through the Hazel Health Services telehealth service, to initiate and administer such first aid or other medical or behavioral health examination and treatment as shall be deemed appropriate under the circumstances, and you consent to receive such treatment. You understand that you have the right to refuse treatment. Hazel Health will not provide emergency services. In the event of an emergency, the School will follow appropriate protocol to have you treated by a duly qualified medical practitioner. You understand that Hazel Health Services may not always be available due to capacity or other reasons and Hazel Health Services may use third party technology to document and record the provision of clinical services. You authorize Hazel Health Services or its delegates to contact and leave a voicemail, text message, and/or email, leaving protected health or personally identifiable information, such as a diagnosis of you, and/or information that is relevant to Hazel Health's product, services, and partnerships, using the contact information provided by you and/or the School. You may opt out of receiving Hazel texts by replying with the word STOP from the mobile device receiving the text messages or by contacting Hazel Health Services by phone at 1-800-764-2935, by email at [support@hazel.co](mailto:support@hazel.co), or in writing at 8300 Esters Blvd., Ste. 900, Irving, TX 75063. You also understand that the transmission of personal health and/or personally identifiable information may not be secure and may be illegally accessed by a third party. Any medical or demographic information provided to the School may be shared with Hazel Health and Hazel Health Services. Consent is further given to the School to share any student records related to the medical treatment and/or diagnosis to Hazel Health Services.

**1. PURPOSE.** The purpose of this form is to obtain your consent to participate in a telehealth consultation. This consent will authorize medical information about you, including personally-identifiable medical information, to be disclosed to your school District, Health Information Exchanges, Hazel Health and Hazel Health Services and its contractors and medical professionals, administrative staff, and employees of Hazel Health and Hazel Health Services for the purposes of treatment, analysis, research or general administration. This disclosure will also authorize the sharing of information containing personally-identifiable medical information for informational purposes to the School, school District and its employees. You also authorize Hazel Health or Hazel Health Services to use personally-identifiable information for the development and improvement of software, hardware, and related tools designed to improve services provided by medical professionals, administrative staff, contractors and employees of Hazel Health and Hazel Health Services. This consent will also authorize the disclosure of information, diagnosis, and records containing or related to your protected health information for the purposes of billing commercial and insured healthcare payors, state and/or federal healthcare payors, including but not limited to state Medicaid plans. The purpose of the disclosure is to obtain information and/or renumeration for reimbursable medical services.

**a. Texas residents:** By signing this form, you expressly authorize Hazel Health, Hazel Health Services, and any of its contractors, vendors or affiliates to bill Medicaid and any other payors for the specific services performed for you as outlined in your current Admission, Review and Dismissal/ Individualized Education Program (“ARD/IEP”) plan, including under the School Health and Related Services (“SHARS”).

Your ability to receive services outside of the school setting will not be impacted. You may withdraw this consent at any time by emailing [support@hazel.co](mailto:support@hazel.co). You understand that you may choose your provider and you have no obligation to select Hazel Health or Hazel Health Services as a healthcare provider for you. You understand that you are responsible for any out-of-pocket patient responsibility that is not covered by your healthcare payor or other agency. You will have access to all medical information resulting from the telehealth services as provided by applicable law for patient access to medical records.

**2. NATURE OF TELEHEALTH CONSULTATION.** During the telehealth consultation, the following may occur:

**a.** Details of your medical and behavioral health history, examinations, x-rays, and tests may be discussed with other health professionals when medically necessary.

**b.** Physical examination and behavioral assessment of you may take place via a remote medical practitioner through the mobile application, utilizing audio, videos, or photos when medically necessary to deliver care. Not all conditions can be treated by a telehealth consultation.

**c.** Non-medical personnel including school staff, Hazel Health Services employees and/or translators may be present to aid with language and technical implementation of the consultation. You authorize school personnel, including the nurses and non medical personnel to administer medications including over the counter medications

**3. POINT-OF-CARE TESTING.** I consent to point-of-care testing at school when medically indicated.

**a.** Potential complications of point-of-care testing may include temporary discomfort, minor irritation or localized trauma to the affected area.

**4. MEDICAL INFORMATION AND RECORDS.** All existing laws regarding your access to medical information and copies of your medical records apply to this telehealth consultation. Additionally, dissemination, beyond the potential uses listed in this consent, of any patient-identifiable images or information from this telehealth interaction will not occur without your explicit consent except you authorize Hazel Health Services to disclose protected health information about you to school designees, school nurses, physicians, Hazel Health or other healthcare providers and payors for treatment, administration, and billing purposes. You also authorize Hazel Health to maintain and save your medical records consistent with applicable laws and regulations. To obtain a copy of your medical records or access your medical information, please submit your request to [support@hazel.co](mailto:support@hazel.co) or by calling 1-800-76-HAZEL.

**a.** Nevada residents: Pursuant to N.R.S. 629.051, all healthcare records may be destroyed after a period of five years.

**5. CONFIDENTIALITY.** Reasonable and appropriate efforts have been made to eliminate any confidentiality risk associated with the telehealth consultation, and all existing confidentiality protections under federal and state law apply to information disclosed during this telehealth consultation.

**6. RIGHTS.** You may withhold or withdraw consent to telehealth consultations, to the disclosure of personally identifiable information to any state or federal agency or other third party, or to any other services at any time. You acknowledge that you have been advised of your right to receive a copy of this authorization as signatory to the authorization.

**7. RISK, CONSEQUENCES AND BENEFITS.** You are aware of any potential risk, consequences, limitations, and benefits of telehealth. You understand the inherent risks associated with electronic and telecommunication and the potential for technology failure. You have had an opportunity to ask questions about this information and all questions have been answered. You understand the written information provided above. You are choosing to enroll in Hazel Health Services and are not being forced to utilize this program.

## **8. NOTICE TO CLIENT REGARDING COMPLAINTS.**

**a.** California residents: The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of marriage and family therapists. You may contact the board online at [www.bbs.ca.gov](http://www.bbs.ca.gov), or by calling (916) 574-7830.

**b.** Texas residents: Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address: Texas Medical Board, Attention: Investigations, 333 Guadalupe, Tower 3, Suite 610, P.O. Box 2018, MC-263, Austin, Texas 78768-2018. Assistance in filing a complaint is available by calling the following telephone number: 1-800-201-9353. For more information, please visit our website at [www.tmb.state.tx.us](http://www.tmb.state.tx.us).

## **9. AGE OF MAJORITY, EMANCIPATED MINOR, OR UNACCOMPANIED MINOR.**

**a.** California residents: If you are signing this form as a minor on your own behalf, you represent and warrant that you are an emancipated minor in California as defined by Emancipation Minors Law Div 11. Part 6, Chapter 1, 7000, an unaccompanied minor under California law, or at the age of majority in the state of California, or have other legal authority under California law and have capacity to sign this consent.

**b.** All other states: If you are signing this form as a minor on your own behalf, you represent and warrant that you are an emancipated minor in the state where you reside, an unaccompanied minor under the law of the state where you reside, or otherwise have the legal authority under the law of the state where you reside and have the capacity to sign this consent.

## **Notice of Privacy Practices - Hazel Health Services Affiliated Covered Entity**

*For purposes of this Notice, when we refer to “you” or “your,” we mean you as a patient or you as the provider of information about a minor patient.*

### **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices (the “Notice”) describes how Telehealth Services USA or Telehealth Services South d/b/a Hazel Health Services and the members of its Affiliated Covered Entity (collectively “we” or “our”) may use and disclose your protected health information to carry out treatment, payment or business operations and for other purposes that are permitted or required by law. An Affiliated Covered Entity is a group of health care providers under common ownership or control that designates itself as a single entity for purposes of compliance with the Health Insurance Portability and Accountability Act (“HIPAA”). The members of the Hazel Health Services Affiliated Covered Entity will share protected health information with each other for the treatment, payment, and health care operations of the Hazel Health Services Affiliated Covered Entity and as permitted by HIPAA and this Notice of Privacy Practices. For a complete list of the members of the Hazel Health Services Affiliated Covered Entity, please contact the Hazel Health Services Privacy Office.

“Protected health information” or “PHI” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical health or condition, treatment or payment for health care services. This Notice also describes your rights to access and control your protected health information.

#### **USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION:**

Your protected health information may be used and disclosed by our health care providers, our staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to support our business operations, to obtain payment for your care, and any other use authorized or required by law.

#### **TREATMENT:**

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a health care provider to whom you have been referred to ensure the necessary information is accessible to diagnose or treat you.

#### **PAYMENT:**

Your protected health information may be used to bill or obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for your services, such as: making a determination of eligibility or coverage for insurance benefits and reviewing services provided to you for medical necessity.

#### **HEALTH CARE OPERATIONS:**

We may use or disclose, as needed, your protected health information in order to support the business activities of this office. These activities include, but are not limited to, improving quality of care, providing information about treatment alternatives or other health-related benefits and services, development or maintaining and supporting computer systems, legal services, and conducting audits and compliance programs, including fraud, waste and abuse investigations.

**USES AND DISCLOSURES THAT DO NOT REQUIRE YOUR AUTHORIZATION:**

We may use or disclose your protected health information in the following situations without your authorization. These situations include the following uses and disclosures: as required by law; for public health purposes; for health care oversight purposes; for abuse or neglect reporting; pursuant to Food and Drug Administration requirements; in connection with legal proceedings; for law enforcement purposes; to coroners, funeral directors and organ donation agencies; for certain research purposes; for certain criminal activities; for certain military activity and national security purposes; for workers' compensation reporting; relating to certain inmate reporting; and other required uses and disclosures. Under the law, we must make certain disclosures to you upon your request, and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA). State laws may further restrict these disclosures.

**USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION:**

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless permitted or required by law. Without your authorization, we are expressly prohibited from using or disclosing your protected health information for marketing purposes. We may not sell your protected health information without your authorization. Your protected health information will not be used for fundraising. If you provide us with an authorization for certain uses and disclosures of your information, you may revoke such authorization, at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.

**YOUR RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION:**

You have the right to inspect and copy your protected health information.

You may request access to or an amendment of your protected health information.

You have the right to request a restriction on the use or disclosure of your protected health/personal information. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction that you may request, except if the requested restriction is on a disclosure to a health plan for a payment or health care operations purpose regarding a service that has been paid in full out-of-pocket.

You have the right to request to receive confidential communications from us by alternative means or at an alternate location. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

You have the right to request an amendment of your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to our statement and we will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures of your protected health information that we have made, paper or electronic, except for certain disclosures which were pursuant to an authorization, for purposes of treatment, payment, healthcare operations (unless the information is maintained in an electronic health record); or for certain other purposes.

You have the right to obtain a paper copy of this Notice, upon request, even if you have previously requested its receipt electronically by e-mail.

Please contact [privacy@hazel.co](mailto:privacy@hazel.co) to request any of the aforementioned items.

**REVISIONS TO THIS NOTICE:**

We reserve the right to revise this Notice and to make the revised Notice effective for protected health information we already have about you as well as any information we receive in the future. You are entitled to a copy of the Notice currently in effect. Any significant changes to this Notice will be posted on our website.

**BREACH OF HEALTH INFORMATION:**

We will notify you if a reportable breach of your unsecured protected health information is discovered. Notification will be made to you no later than 60 days from the breach discovery and will include a brief description of how the breach occurred, the protected health information involved and contact information for you to ask questions.

**COMPLAINTS:**

Complaints about this Notice or how we handle your protected health information should be directed to our HIPAA Privacy Officer at [privacy@hazel.co](mailto:privacy@hazel.co). If you are not satisfied with the manner in which a complaint is handled you may submit a formal complaint to the Department of Health and Human Services, Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov](http://www.hhs.gov). We will not retaliate against you for filing a complaint.

We must follow the duties and privacy practices described in this Notice. We will maintain the privacy of your protected health information and to notify affected individuals following a breach of unsecured protected health information. If you have any questions about this Notice, please contact us at (415) 424-4266 and ask to speak with our HIPAA Privacy Officer or e-mail at [privacy@hazel.co](mailto:privacy@hazel.co).

# Library Reading Materials Opt Out Form (All Grades) 2025-2026

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA  
LIBRARY MEDIA SERVICES  
**LIBRARY READING MATERIALS OPT OUT FORM**

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As a parent, you always have the right to opt your child out of any library material. Please complete the Opt Out Form.

Upon submission of the Opt Out Form, please discuss this decision with your child to ensure they are aware before visiting the library. Upon the Opt Out Form submission, your child's account will be updated in the library checkout system. It is our goal to make this process easy for parents.

Please contact your building principal if you have questions or need additional information.

\_\_\_\_\_ I **WILL NOT** permit my student to check out library materials.

\_\_\_\_\_  
Student Name (PRINT) Student

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Parent/Guardian Name (PRINT)

\_\_\_\_\_  
Parent/Guardian Signature Date

# Student Housing Questionnaire (SHQ) (All Grades) 2025/2026



Tel #: (754) 321-1566



## STUDENT HOUSING QUESTIONNAIRE (SHQ)

**ATTENTION parents, legal guardians, caregivers, and unaccompanied youth (not living with a parent or legal guardian):** The purpose of this questionnaire is to help identify school-aged children and youth who are experiencing housing instability **who lack a fixed, regular, and adequate nighttime residence** as defined by Subtitle VII-B of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11431 et seq.). According to this federal regulation, Broward County Public Schools is responsible for removing systemic barriers to the education of students experiencing homelessness by implementing the provisions of the law through the Homeless Education Assistance Resource Team (HEART).

**INSTRUCTIONS: ONLY COMPLETE THIS QUESTIONNAIRE IF YOU DO NOT OWN OR LEASE A RENTAL PROPERTY IN YOUR NAME.**

By completing this questionnaire, your school-aged child(ren) (or unaccompanied homeless youth) may qualify for McKinney-Vento services and resources through the HEART program to help ensure educational stability.

**PLEASE RETURN THIS FORM TO YOUR CHILD OR CHILDREN'S SCHOOL(S) IMMEDIATELY!**

### 1. WHO DOES THE STUDENT(S) LIVE WITH? Parent

- Legal guardian  
 An adult (+18) caring for student(s) who is/are currently  
 unable to live with their parent or legal guardian\*  
 I am an **unaccompanied youth**. I do not live with either  
 of my parents or a legal guardian currently.

**\*IMPORTANT: Please contact the student's school to complete the required HEART Caregiver Authorization Form.**

### 2. I CURRENTLY RESIDE IN ONE OF THE NIGHTTIME RESIDENCES LISTED BELOW WITH MY SCHOOL-AGED CHILD(REN)/STUDENTS:

- In an emergency or transitional shelter, abandoned in hospital (A)  
 Sharing housing with a family member or friend (doubled-up) due to loss of housing, economic hardship, or similar reason (B)  
 In a vehicle, park, temporary trailer park or campground due to lack of alternative adequate accommodations; public spaces, abandoned building, substandard housing; bus or train station, public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings or similar setting (D)  
 In a hotel or motel due to lack of alternative adequate accommodation due to loss of housing, financial hardship, or similar reason (E)  
**\* Please check one:**  hotel or motel that I am paying for myself  
 hotel or motel paid for by a social services agency or organization

### 3. WHAT CAUSED YOU AND YOUR CHILD(REN), OR UNACCOMPANIED YOUTH TO LIVE IN YOUR CURRENT NIGHTTIME RESIDENCE?

- Man-made Disaster (D)       Unknown (U)       Pandemic (P)  
 Flooding (F)       Earthquake (E)       Tornado (T)  
 Mortgage Forclosure (M)       Hurricane (H)       Wildfire (W)  
 Tropical Storm (S)  
 Other homeless cause: lack of affordable housing, long-term poverty, unemployment or underemployment, domestic violence, forced eviction, etc. (N)

**PLEASE COMPLETE THE REQUESTED INFORMATION BELOW FOR ALL SCHOOL-AGED CHILDREN (PREK-12) ENROLLED IN, OR SOON TO BE ENROLLED IN A BROWARD COUNTY, FL PUBLIC OR CHARTER SCHOOL. IF YOU HAVE CHILDREN ENROLLED IN MULTIPLE SCHOOLS, PLEASE RETURN A COMPLETED QUESTIONNAIRE TO EACH SCHOOL.**

Student's Full Name (First, Middle Initial, and Last)	Student ID #	M/F	Date of Birth (mm/dd/yyyy)	Grade	School Currently Enrolled

### 4. FLORIDA STATUTE 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.

By signing below, I am attesting that the information provided is accurate and true:

_____ Parent/Guardian Print Full Name		_____ Relationship to student(s)		_____ Signature		_____ Date	
_____ Student(s) Current		_____ City, State, Zip Code		_____ Student(s) Former Address		_____ City, State, Zip Code	
_____ Length of time at current address		_____ Telephone Number		_____ E-mail Address			

I was given authorization by the parent, guardian, caregiver, or unaccompanied homeless youth named above, to complete the SHQ on behalf of the identified student(s) listed above.

_____ Name of person completing this form:	_____ Signature	_____ Title/Organization
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+ Place a clear "X" inside box. If you make a mistake, fill the entire box, and mark the correct box. +

8. Has your child asked you for permission to walk or bike to/from school in the last year?  Yes  No

9. At what grade would you allow your child to walk or bike to/from school without an adult?  
(Select a grade between PK, K, 1, 2, 3 ...)  grade (or)  I would not feel comfortable at any grade

+ Place a clear "X" inside box. If you make a mistake, fill the entire box, and mark the correct box. +

10. Which of the following issues affected your decision to allow, or not allow, your child to walk or bike to/from school?  
(Select one choice per line, mark box with X)

- Distance .....  Yes  No  Not Sure
- Convenience of driving .....  Yes  No  Not Sure
- Time .....  Yes  No  Not Sure
- Child's before or after-school activities .....  Yes  No  Not Sure
- Speed of traffic along route .....  Yes  No  Not Sure
- Amount of traffic along route .....  Yes  No  Not Sure
- Adults to walk or bike with .....  Yes  No  Not Sure
- Safety of intersections and crossings .....  Yes  No  Not Sure
- Crossing guards .....  Yes  No  Not Sure
- Violence or crime .....  Yes  No  Not Sure
- Weather or climate .....  Yes  No  Not Sure

11. Would you probably allow your child to walk or bike to/from school? (Select one choice, mark box with X)  
 My child already walks or bikes to/from school  Yes  No  Not Sure

+ Place a clear "X" inside box. If you make a mistake, fill the entire box, and mark the correct box. +

12. In your opinion, how much does your child's school encourage or discourage walking and biking to/from school?  
 Strongly Encourage  Encourage  Neither  Discourage  Strongly Discourage

13. How much fun is walking or biking to/from school for your child?  
 Very Fun  Fun  Neither  Boring  Very Boring

14. How healthy is walking or biking to/from school for your child?  
 Very Healthy  Healthy  Neutral  Unhealthy  Very Unhealthy

+ Place a clear "X" inside box. If you make a mistake, fill the entire box, and mark the correct box. +

15. What is the highest grade or year of school you completed?  
 Grade 1 through 8 (Elementary)  College 1 to 3 years (Some college or technical school)  
 Grades 9 through 11 (Some high school)  College 4 years or more (College graduate)  
 Grades 12 or GED (High School graduate)  Prefer not to answer

16. Please provide any additional comments below.


# Life Skills and Wellness Student Survey Opt Out (Grades 4-12) 2025-2026

## Life Skills and Wellness (LSW) Student Survey Opt-Out Form

Life Skills and Wellness (LSW) builds confidence and supports mental and emotional health, enabling students to overcome challenges and thrive as they prepare for the 21st-century workplace. As part of the District's School Improvement Plan (SIP), the LSW initiative promotes whole-child-centered support services, helping students succeed academically while building employability skills and resiliency. To guide effective LSW instruction, the District will administer a brief Fall and Spring survey. The data collected will solely be used by authorized BCPS staff to direct school activities and provide personalized LSW services for students. Specifically, the type of formative data collected will focus on self-awareness, self-management, relationship skills, decision-making and resiliency.

To learn more about the LSW Student Survey for grades 4-12, visit the [LSW District website](#) or by scheduling an appointment with your school's LSW Liaison. Additional parent resources and strategies on how to incorporate LSW at home can be found in our [LSW Families and Students Resources](#) page.

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To BE COMPLETED BY THE PARENT/GUARDIAN

Your student will automatically be registered to take the Fall and Spring LSW Surveys. **You only need to complete this form if you would like to opt-out of the LSW Surveys. To opt-out, please check the box, complete the information below, sign the form, and return it to your child's school within 10 days from the first day of enrollment in the school.** Failure to return this form constitutes permission for your child to participate in the LSW Surveys.

I **DO NOT** want my child to participate in the LSW Fall and Spring student surveys.,

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

Date of Birth: \_\_\_\_\_ Grade Level: \_\_\_\_\_ Student # \_\_\_\_\_

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

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

Parent/Guardian/Eligible Student's Signature \_\_\_\_\_ Date \_\_\_\_\_



# Acknowledgement

SBBC Policy 5090, Code of Student Conduct, lists the District's rules for students in Broward County Public Schools. The rules apply to all activities occurring on school grounds, on other sites being used for school activities, and on any vehicles authorized to transport students. Your signature below does not indicate that you agree or disagree with the rules, **but rather that you have reviewed the electronic copy of these rules** (<http://www.browardschools.com/codeofconduct>). Return this form to school within 3 days from the first day of school or from the date of enrollment. If you would prefer to complete all required forms electronically, please access the Back to School Toolkit from the Focus Parent Portal.

Parents need to be involved in the education of their children and have the responsibility to:

- Know that for school safety, schools are not required to provide supervision more than 30 minutes prior to the official starting time, nor are they required to provide supervision for more than 30 minutes after the official closing time (F.S. §1003.31 (2)).
- Know that for school safety, for students who ride a school bus, drivers are NOT permitted to let students off the bus except at the designated stop.
- Provide the school with the names of current emergency contact person(s) and/or telephone numbers on an annual basis and when there are changes.
- Notify the school of anything that may affect their child's ability to learn, to attend school regularly, or to take part in school activities.
- Be aware that medicine must be administered in accordance with SBBC Policies 6305 and 6305.1, as may be amended, and that consequences for transmittal and/or sale or attempted sale of over-the-counter medications and possession and/or use of unauthorized medications can be found in SBBC Policy 5100. SBBC Policy 6305 outlines the rules regarding over-the-counter and prescription drugs and SBBC Policy 5100 outlines the consequences for violating those rules. You may view the complete health and suspension and/or expulsion policies, as well as all School Board policies, on the Web at: <https://www.browardschools.com/school-board/school-board-policies>
- Be aware that parents have rights with regard to the privacy and confidentiality of student records that are maintained by schools as defined in Section XI of this booklet.
- Neither the School Board of Broward County nor its employees will be held liable for items that are prohibited and are lost, stolen, or confiscated; or for wireless communication devices or other personal technology that are lost, stolen, or confiscated.
- Be aware that confiscated items not claimed by the end of the school year will be donated to local charities.
- Recognize that they are responsible for their student's behavior on the way to and from school and at the bus stop. A safe and respectful learning environment is key to academic achievement; therefore any student's off campus actions that seriously affect a student's ability to learn or a staff member's ability to teach may be handled as a disciplinary infraction. For serious incidents that occur at bus stops and/or that are not on School Board property, parents should contact law enforcement directly. For bullying incidents (see bullying definition, Section V), school officials should be notified and will investigate and/or provide assistance and intervention, as the principal/designee deems appropriate, which may include the use of the School Resource Officer.
- Ensure their child demonstrates legal, ethical and responsible use of technology including networks, digital tools, the Internet, and software, as defined in Section VII of this booklet.
- Parents will continue to maintain responsibility for students who reach the age of majority, (18 years or older), for all educational and discipline purposes, with exceptions as provided by statute.

**Note: Parental selection for each form within the Code of Student Conduct will be effective until a new form is submitted.**

\_\_\_\_\_  
Student Name (PRINT)

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

\_\_\_\_\_  
Parent/Guardian Name (PRINT)

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date