

SANTA ROSA COMMUNITY SCHOOL
GULF BREEZE HIGH 2017 SUMMER PROGRAM

CLASS NAME:			
STUDENT INFORMATION	Child's Name: _____	Sex: M or F	
	DOB: _____	Age: _____	Grade: _____
	Address: _____		City/State/Zip: _____
	Home Phone: _____	Doctor's Name: _____	Phone #: _____
PARENT/GUARDIAN INFORMATION	Mother's Name: _____	Father's Name: _____	
	Address: _____ <i>(If different from child)</i>		Address: _____ <i>(If different from child)</i>
	Place of Work: _____		Place of Work: _____
	Work Phone: _____		Work Phone: _____
	Cell Phone: _____		Cell Phone: _____
	Email Address: _____		Email Address: _____
CONTACTS	Persons to be contacted if parents cannot be reached (must list 2) and are also authorized to remove child from facility (must be at least 16 years of age).		
	Name	Phone	Relationship
	1. _____	_____	_____
	2. _____	_____	_____
	3. _____	_____	_____
Health Information	Does your child need a medicine release form? <input type="checkbox"/> YES <input type="checkbox"/> NO		
	Special instructions/Health Problems: <i>(anything to benefit the care of your child)</i> _____		
	For persons with disabilities, please indicate in the space provided on the application any special accommodation needs such as sign language interpreter, preferred seating, etc. Prior notification of at least one week is needed for arrangements to be made for an interpreter.		
Office Use ONLY	DRIVER'S EDUCATION STUDENTS ONLY: Does the student have any physical or other health related impairment that would impede the student from the normal operation of a motor vehicle. <input type="checkbox"/> YES <input type="checkbox"/> NO If so, please provide an explanation on the back of this sheet and attach any other useful information or documentation for consideration.		
	Date: _____	Receipt #: _____	Book #: _____
	Fee Paid: _____		

 Parent or Legal Guardian Signature

SCHOOL USE ONLY 2016-2017
 TEACHER: _____
 BUS # _____
 *SPECIAL CONSIDERATION _____

SANTA ROSA COUNTY SCHOOLS STUDENT HEALTH CARD

School: _____
 Student ID# _____
 Grade: _____
 HB Teacher: _____

Please complete in INK. **Please contact the school when Student Health Card information changes.**

STUDENT _____ RACE _____ SEX: M F BIRTHDATE: ____/____/____
 (Last) (First) (Middle) Mo/Day/Year

MAILING ADDRESS: _____ HOME PH: _____
 (Street) (City) (State) (Zip)

RESIDENTIAL ADDRESS: _____ EMAIL: _____
 (Street) (City) (State) (Zip)

STUDENT LIVES WITH: BOTH PARENTS _____ FATHER _____ MOTHER _____ GUARDIAN _____

MOTHER or
 GUARDIAN NAME _____ Work Location _____ Work Ph: _____ Cell: _____

FATHER or
 GUARDIAN NAME _____ Work Location _____ Work Ph: _____ Cell: _____

ALLERGIES OR CHRONIC MEDICAL CONDITIONS _____

Does the above condition require intervention/documentation on the part of the school? YES _____ NO _____

*Special Considerations (Medications, Transportation, etc) _____

Doctor: _____ Doctor Ph#: _____ Student has Medicaid Insurance Coverage: YES _____ NO _____ If yes, Medicaid#: _____

Student has other Insurance Coverage: YES _____ NO _____ Company _____ Policy # _____

FLORIDA KID CARE: Child health insurance you can afford! For more information call 1-888-540-5437 or go to www.floridakidcare.org

The Santa Rosa County School Board and the Santa Rosa Department of Health will provide services that include, but are not limited to vision, hearing and scoliosis screening, height/weight checks, body mass index assessments and health education programs. By my signature on this card, I acknowledge receipt of the Notice of Privacy Practices Act in the Student Code of Conduct and authorize designated Santa Rosa County School District personnel, SRC Health Department School Health personnel, and any other healthcare agencies to provide such services and emergency care for my child and/or exchange medical information as necessary to support the continuity of my child, to verify Medicaid eligibility, bill Medicaid for reimbursable Certified School Match services referenced on my child's Individual Education Plan (IEP) and receive Medicaid reimbursement for Exceptional Student Education (ESE) services the IEP provides to my child while at school and/or Certified County Health Department Match Services the IEP provides while my child is at school. I understand my child will continue to receive services referenced on his/her IEP whether or not I give consent. Parents have the right to withdraw their consent to disclosure of their child's information to Medicaid at any time. Withdrawal of consent or refusal to provide consent does not relieve Santa Rosa District of the requirement to ensure that all IEP services are provided at no cost to parents.

WHEN PARENT OR GUARDIAN CANNOT BE REACHED, PLEASE CONTACT ONE OF THE PERSONS LISTED BELOW. IN CASE OF EMERGENCY, the individual listed below may be requested to pick up your child.

Designee: _____ Relationship: _____ Phone # _____

Designee: _____ Relationship: _____ Phone # _____

When a parent, guardian, or other designated individual cannot be reached or cannot provide transportation, I hereby authorize school officials to transport my child as the situation dictates. In an Emergency Situation, this may include transport to the nearest Emergency Care Facility for treatment as necessary.

PLEASE NOTE: In order to assure the authenticity of the Parent/Guardian Signature, the Santa Rosa County School District requires that the signature be signed by two (2) non-family witnesses or notarized below.

WITNESSES in Lieu of NOTARY

Parent/Guardian Signature _____ Date _____

Witness _____ Date _____

Witness _____ Date _____

< OR >

NOTARIZATION

Parent/Guardian Signature _____ Printed Name of Parent/Guardian _____

Notary Signature/Commission Expires/State _____

Personally Known _____ Produced I.D. _____

Date _____

Every school district in Florida is required to report to the Florida Department of Education each year student data by military status that is set by the federal government. The Department of Education does not report individual student data to the federal government but does report the total number of students in various categories in each school. These reports help us keep track of changes in student enrollments and ensure that all students receive the educational programs and services to which they are entitled. One of the following describes the military family in the household in which my student resides. Please, circle "YES" or "NO" for each of the three responses:

Yes	No	Active Duty Member of the uniformed services
Yes	No	Member or Veteran who was medically discharged or retired for a period of one year or less
Yes	No	Member who died on active duty or as a result of injuries sustained on active duty for a period of one year or less after death

Parent/Guardian Comments: _____
 School Administration Comments: _____

ACCEPTABLE USE POLICY AGREEMENT FOR STUDENTS (2016-17 School Year)
Santa Rosa County School Board

63-11-32
Rev. May '16

School: _____ Teacher: _____ Grade: _____

Student LAST Name (Please print): _____

Student FIRST Name (Please print): _____

Student MIDDLE Name (Please print): _____

Parent/Guardian Name (Please print): _____

Parent/Guardian Phone #: _____

Upon signing this document you affirm that it is not reasonable that the Santa Rosa School District can directly supervise your child every minute he or she is on the computer. Therefore, you agree that when your child is not directly supervised, he or she will obey all school computer use policies, civil and criminal laws. In the event your child notifies you they are receiving computer messages threatening death, bodily harm, or destruction to property, you agree to report this event immediately to both law enforcement and the Santa Rosa School District.

As parent/guardian of this student, I understand the risks associated with allowing my child to use the Internet and MS Office 365. Furthermore, in signing this policy, I affirm that the school district made a reasonable attempt to educate me on the known potential risks of using the Internet and MS Office 365 and the school's rules and goals of Internet use. Based on this adequate notice, I agree not to hold the Santa Rosa School District responsible for materials acquired or contacts made on the network.

I have reviewed these responsibilities with my child, and he or she clearly understands this acceptable use policy and has agreed to obey all school procedures, civil, and criminal laws. By signing below,

I hereby grant I hereby do not grant

permission to the Santa Rosa School District to provide network and Internet access at school.

Please be advised that if you check no your student will not be permitted to use the district Internet access for research and exploration, but your child will still be instructed through the use of Internet-based educational software deemed vital to your child's educational success, including educational usage of Office 365.

Parent Signature _____ Date _____

For a variety of reasons (academic activities, athletics, clubs, etc.) your child's name, individual student picture/video image, and/or creative work(s), may appear on a school- or district-related website. Please understand that once this information is placed on the Web, we cannot guarantee that the information will not appear on other sites. Also, some activities may involve a classroom to classroom video exchange, for example, students studying volcanoes could use O365 Skype for Business and video equipment to see and talk to students in a classroom near Kilauea (Hawaii). By signing this section,

I hereby grant I hereby do not grant

permission to the Santa Rosa School District to place my child's name, individual student picture/video/webcam image, and/or creative work(s) on a school- or district-related site.

Parent Signature _____ Date _____

Please sign in both places and return this page to the teacher. Retain the first three pages for your records.