Coral Shores High School

2024-2025 Off-Campus Lunch Pass Agreement

Student Name (PRINT): _____Grade: _____ Lunch: _____

Please read below and initial each item to indicate that you have read and accept the terms below.

Initial in the blanks below

1. Only seniors and juniors who have met the established academic and attendance requirements determined by the Monroe County School Board will be eligible to leave campus to eat lunch.

_____ ***A. Academic & Other Requirements***

- Seniors must maintain an unweighted GPA of 2.0
- Juniors must maintain an unweighted GPA of 3.0
- GPAs will be reviewed at the end of each semester.
- Students cannot have any outstanding obligations such as Chromebook, textbooks, library books, athletic uniforms, or equipment etc....
- Students may not have any discipline issues and must follow attendance rules.

_____ ***B. Attendance Requirement***

- No more than four excused or unexcused days in any one class during a nine-week period.
- No more than two unexcused tardies to any single class during a nine-week period.
- School related absences or tardies do not count toward these totals.
- Students may not have more than one tardy to the class following off-campus lunch during a nine-week period.

_____ 2. Eligible students **may not provide transportation or encourage any student who has not completed off-campus lunch permission forms to leave campus for lunch**.

_____ 3. Students cannot give rides to or get rides from students in approved academic internship programs if those students need to go to their internship after lunch.

_____ 4. Students leaving for off-campus lunch **MUST INDIVIDUALLY present Off-Campus Passes before leaving campus** and **MUST INDIVIDUALLY collect them upon return to campus**.

_____ 5. Students leaving for sports/activities immediately after or during lunch do not need to leave their Off-Campus Passes if their names were on the game day/activity roster.

_____ 6. Eligible students leaving campus for lunch that cannot return to school from lunch because of illness or any other reason, **must have a parent call the school office immediately.**

_____ 7. **Students are not allowed to bring food back to campus for themselves or other students.**

_____ 8. **OSS, ISS, Administrative Detention, or Obligations will result in the loss of the student's Off-Campus Lunch privilege** as determined by school administrators.

_____ 9. The initial cost of an off-campus lunch pass is $10. The cost to replace a lost pass is $10.

_____ 10. This form must be signed by a parent or guardian and be **notarized**.

INFORMATION BELOW TO BE COMPLETED BY STUDENT

I have read the rules of this agreement and agree with them. I understand that not adhering to these rules may result in the immediate revocation of my Off-Campus Lunch Pass.

Student Name (PRINT): _____

Student Cell Phone Number: (_____)_____

Student Signature: _____ Date: _____

INFORMATION BELOW TO BE COMPLETED BY PARENT/GUARDIAN

I have read and understand the rules pertaining to Coral Shores High School Off-Campus lunch privilege and do hereby give (*PRINT Student's Name*) _____, permission to leave campus during his/her scheduled time for lunch. I am aware that I will assume liability for other passengers in my child's automobile. I will not hold the school responsible for any injuries that may occur when my child is off-campus for lunch.

Parent/Guardian Name (PRINT): _____

Parent/Guardian Cell Phone Number: (_____)_____

Parent/Guardian Signature: _____ Date: _____

INFORMATION BELOW TO BE COMPLETED BY PARENT/GUARDIAN

This form must be notarized. If this form is not notarized, it will not be accepted by Coral Shores High School.

Notary Signature: _____ Date: _____

Notary Seal: **Notary Expiration Date: _____**

Office Use Only:

Method of payment: _____Cash _____Revtrak

Data Card Complete (Must have Signature):_____

Health History Complete: _____

Medical Consent (Notarized): _____

Scan the QR code to access RevTrak and purchase your lunch pass!

CONSENT FOR MEDICAL TREATMENT

(Required for students when participating in athletics, student activities, and any field trips that are outside Monroe County)

_____ _____

SCHOOL DATE

The patient and others whose signatures are attached below do hereby consent to any and all medical and surgical treatments including anesthesia and operations, which may be deemed advisable by physician and surgeons. The intention hereof being to grant authority to administer and to perform all and singularly any examinations, treatments, anesthetic, operations and diagnostic procedures, which may now, or during the course of the patient's care be deemed advisable or necessary. We also agree that the patient when admitted is to remain in the hospital until a physician recommends the patient's discharge.

In witness of our consent and agreement to the matters stated in the three preceding sentences, we have subscribed our signatures below.

_____ _____

Minor - Patient Father

_____

Mother

_____

Guardian(s)

_____

Date

STATE OF FLORIDA)
)SS
COUNTY OF_____)

Sworn to and subscribed before me this_____day of _____, in the year of the Lord _____.

_____

Notary Public
State of Florida at Large

My Commission expires_____

**** If there are any specific medical practices which are prohibited in regards to religious convictions please list below:

MONROE COUNTY STUDENT MEDICAL INFORMATION & PERMISSION FORM

SCHOOL: _____ **SCHOOL PHONE #** _____

Policy and procedure in the event a child requires medical treatment while on any school sponsored trip is to contact the parents to advise them of the situation and obtain consent and direction on how to proceed. In the event of an emergency, and should we be unable to reach you, your signature below would grant permission for routine emergency treatment.

INSURANCE INFORMATION

Student's Full Name: _____

Health insurance Carrier: _____ Policy # _____

I agree that in the event emergency treatment is provided for my child, I will pay any transportation or medical expenses not covered by my insurance company or if I do not have insurance, I agree to pay all such expenses incurred.

IMPORTANT MEDICAL INFORMATION

Please check all that apply:

_____Heart Disease _____Diabetes _____High Blood Pressure _____Epilepsy

_____Allergies _____Other (please list below) _____Medication/s (please list below)

_____

_____

PARENT/GUARDIAN PHONE NUMBERS

Father: _____ Ph: _____

Mother: _____ Ph: _____

Other: _____ Ph: _____

I/we grant the school staff the right to order emergency medical treatment for my/our child and I/we understand that any and all financial responsibility of such services rests with me/us. Finally, I/we agree to hold harmless the school staff and school program for all actions taken on behalf of my/our child.

_____ _____

Parent(s) / Guardian(s) Signatures (s) Date

***If any program or event requires a student to leave the county, this form and the Consent for Medical Treatment form (MCSD-ADM002) must be executed.**

2024-2025

Dear Parent/Guardian:

Your child's school offers school health services to enrolled students. These services are made possible through an agreement between the Monroe County School District and the Florida Department of Health-Monroe. Some of the services are mandated by Florida Statutes.

Your school has a nurse and/or a health support specialist that works in the school health room. It is important to understand that the clinic staff is not always at the school when it is open. It is also very important to remember that *"School Health services SUPPLEMENT, rather than replace" the routine health care your child receives from a parent and/or your physician. *FS381.0056(2)*

Here is a generalized list of health services available:

- First Aid for minor injuries/accidents/illnesses
- Immunization status and health history review
- Vision/hearing/dental/height/weight/BMI/scoliosis screenings for specific grade levels
- Assistance with administration of doctor ordered medications. Even over the counter medications require a prescription and a signed parent permission slip.
- Assistance with minor, complex, or chronic health conditions and/or doctor ordered procedures

Please complete the attached STUDENT HEALTH HISTORY form and return it to the school health staff. The form has two important purposes-
It informs the health staff of the presence of any health concern AND supplies the health staff with contact information so we can reach you, especially in the case of an emergency. This form is required for your child to be seen in the clinic.

If you do NOT want your child to receive school health services, you MUST notify the school in WRITING. Please do not hesitate to contact your school health staff for any questions or concerns you have regarding your child's health.

Sincerely,

Your School Health Staff

HEALTH HISTORY/EMERGENCY CONTACT FORM 2024-2025

This is required information that will be kept in *the SCHOOL HEALTH CLINIC*

STUDENT'S NAME: _____GRADE: _____
DATE OF BIRTH: _____ SEX: _____ HOMEROOM TEACHER: _____
PARENT/GUARDIAN NAME: _____ HOME PHONE: _____
Parent/Guardian Address: _____ WORK PHONE: _____
Parent's cell phone number(s) _____ _____

EMERGENCY CONTACT if unable to reach parent/guardian: _____
RELATIONSHIP: _____HOME PHONE : _____ WORK PHONE: _____
Emergency contact's cell phone number(s) _____ _____

STUDENT'S PHYSICIAN: _____ PHYSICIAN PHONE NUMBER _____

CHECK ANY THAT CURRENTLY APPLY TO YOUR CHILD	**PLEASE DESCRIBE**
1. ____ Eye or Vision problems	1. _____
2. ____ Ear/Hearing problems	2. _____
3. ____ Lung/Breathing problems, asthma, etc.	3. _____
4. ____ Heart problems/surgery/blood pressure problem	4. _____
5. ____ Kidney/bladder problems, surgery, etc.	5. _____
6. ____ Bone, joint or muscle problems	6. _____
7. ____ Neurological problems, seizures, etc.	7. _____
8. ____ Spine or back problems, surgery, etc.	8. _____
9. ____ History of emotional/mental health problems treatments or hospitalizations	9. _____
10. ____ Alcohol/drug use/abuse or treatment	10. _____
11. ____ Diabetes (Type I or Type II)	11. _____
12. ____ Cancer	12. _____
13. ____ ADD/ADHD	13. _____
14. ____ Sickle Cell Disease or bleeding disorders	14. _____
15. ____ Cystic Fibrosis	15. _____
16. ___ Autism Spectrum Disorders	16. _____
17. ___ Lupus	17. _____

18. List **any chronic or long term condition**_____
19. List any surgery, date and reason _____
20. List any hospitalization in the past five years_____
21. List **any restrictions on activity/physical handicaps**_____
_____
22. List **all daily medication your child takes** _____
_____
23. List all **allergies to medications**, food products or insect stings your child has _____
Please specify those that are **severe** _____
Does your child have an Epi-Pen? _____Will you be providing one for the school? ☐ Yes ☐ No

MY CHILD (STUDENT'S FULL NAME): _____ has my permission to take part in the School Health Services Program. I understand that my child will receive emergency care in the school, if needed and health services at school that *may* include:

* First aid for minor injuries, accidents, or illnesses
* Use of otoscopes (to look in ears), tongue depressors (to look at back of throat), tympanic thermometers (to take temperature by ear), or oral thermometers (to take temperature by mouth) to assess/screen for illness and refer as necessary
* Vision, hearing, height-weight, dental and scoliosis screenings
* Assistance with administration of doctor ordered medications
* Assistance with doctor ordered minor, complex, or chronic health conditions or procedures

I authorize the School District of Monroe County, Florida to release and exchange my child's confidential information to agencies of the State of Florida to determine Medicaid eligibility and if applicable to 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 it provides to my child while at school. I understand that my child will receive services referenced on his/her IEP whether or not I give consent.

I understand that in case of an accident or serious injury, first aid will be administered, and I will be contacted. If I cannot be reached, I understand the contact the person/s listed on this form as emergency contacts, will be contacted.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

IF YOU DO NOT WANT YOUR CHILD TO BE SEEN IN THE CLINIC, PLEASE ATTACH A WRITTEN NOTICE TO THIS FORM