Dear Parent/Guardian,

I will be conducting several mandated health screenings in the upcoming weeks. I am NOT here to replace your child/children's primary health care provider. The consent gives me the right to assess your child/children, provide routine medication, provide first aid, and provide health education.

Parents I need your help in signing and returning all consent/waiver forms by **February 22,2021.** I will coordinate days and times that are best for us all to operate smoothly and safely.

Option 1:

- **Print and complete forms**
- **Email to imorley@chisouthfl.org**

Option 2:

- **Print and drop off completed forms to Perrine Elementary Monday-Friday from 8:00 AM to 3:30 PM**

Option 3:

- Return completed forms via U.S. Mail to

  Perrine Elementary

  8851 SW 168TH, St

  Palmetto Bay, FL 33157

  ATTN: Nurse

Option 4:

- **Copies of the forms will be available at the school for you to complete Monday-Friday from 8:00 AM to 3:30 PM.**

Those parents who wish to opt out of screenings please send me an email at imorley@chisouthfl.org with your child/children's name stating you wish to opt out

Best Regards,

Your School Nurse

Hearing & Vision Screening

According to the guidelines established by the Florida Legislature, at the beginning of each school year, parents shall be notified of the screening activities available through the School Health Services Program.

School Board Policy 2410 - School Health Services Programs, mandates hearing screening for the students in grades kindergarten, first and sixth, and for students entering Florida schools for the first time in grades second, third, fourth, and fifth. Also, vision screening is mandated for students in grades kindergarten, first, third and sixth, and for students entering Florida schools for the first time in grades second, fourth, and fifth in accordance with priorities reflected in the local county health plan, subject to the availability of staff and funds,

It should be understood that such screenings do not substitute for a thorough examination by a health care provider, but are tests that can be given with ease to large numbers of apparently healthy children in an attempt to identify those children who are in need of a more thorough examination.

It is requested that you provide the school with written notification if you do not want your child to participate in the screening program.

Sincerely,

Principal

cot,

cucscl10Q

BMI Screening

Dear Parent/Guardian:

Each year, children in specified grades are measured for height and weight to monitor their physical growth and development. For the school year 2020-2021, this is being taken a step further in the Miami-Dade County Public Schools by calculating your child's Body Mass Index (BMI). This calculation tells us if a child is in the normal range for weight, or is outside the norm and has increased potential to develop certain chronic health conditions during the childhood or adulthood. BMI is the recommended screening method for children and adolescents. It is based upon a child's age and gender, calculated using a child's height and weight, and compared to standardized growth charts. BMI screening is an additional school health service to assist in appraising, protecting, and promoting the health of your child. It is intended to encourage good nutritional habits and healthy physical activity,

The school health staff will conduct this routine screening. If you do not want your child to participate please notify the school in writing.

If your child participates in this initiative, you will receive a copy of the BMI screening results, and explanation of the results. In addition, the 2020-2021, school year will include information and activities that focus on healthy lifestyles and wellness.

Sincerely,

Hearing & Vision Screening

Según las regulaciones establecidas por la Legislatura de la Florida, al principio de cada año escolar, se debe informar a los padres sobre los exámenes de salud que se ofrecen a través del School Health Serices Program (Programa de Servicios de Salud Escolar).

La Póliza de la Junta Escolar 2410 - El Programa Escolar de Servicios de Salud requiere que todos los estudiantes de kindergarten, primero y sexto grados así como todos que se matriculen por primera vez, en el segundo, tercero, cuarto y quinto grados de las escuelas de la Florida, reciban un examen de la audición. Asimismo, el examen de la visión es requerido para los estudiantes de kindergarten, primero, tercero y sexto grados, y para los que se matriculen por primera vez en segundo, cuarto y quinto grados las escuelas de la Florida. De acuerdo con las prioridades reflejadas en el plan de salud local del condado y sujeto a la disponibilidad de personal y fondos, en otros grados se conducirán exámenes de salud y pruebas, tales como de la visión, la audición, crecimiento y desarrollo y, nutrición.

Se sobreentiende, que dichos exámenes no constituyen un sustituto para un examen completo de salud proporcionado por un médico o centro de salud, pero su administración a grandes grupos de niños aparentemente saludables, sirven para identificar a los que necesitan recibir un examen más completo.

Si usted no quiere que su hijo(a) participe en este programa, le pedimos que envíe una notificación por escrito a la escuela.

Atentamente,

Director (a)

FM-6582S

Principal

Modelo de carta enviada por la escuela a los padres de familia

Estimados padres de familia o tutores:

Todos los años se toma el peso y se mide la estatura de los niños que cursan ciertos grados específicos para observar su desarrollo y crecimiento físicos. Para el curso escolar de 2020-2021, las escuelas públicas del condado Miami-Dade tomarán una medida adicional al calcular el índice de masa corporal (Body Mass Index, o BMI, por sus siglas en inglés) de su hijo o hija. Dicho cálculo determina si su hijo o hija está en el nivel normal de peso o si está fuera de lo normal y tiene un mayor potencial de contraer ciertas enfermedades crónicas durante la niñez o en la edad adulta El BMI es el método de examen masivo que se recomienda para los niños y los adolescentes. El mismo se basa en la edad y el sexo del niño o de la niña y se calcula por medio del peso y la estatura en comparación con tablas de crecimiento estandarizadas. El examen masivo del BMI es un servicio de salud escolar adicional que ayuda a evaluar, proteger y promover la salud de los estudiantes. Tiene el objeto de estimular los buenos hábitos de nutrición y las actividades físicas saludables.

El personal de salud de la escuela realizará dicho examen médico de rutina. Si no desean que su hijo o hija participe, por favor, notifíquenlo a la escuela por escrito.

Si su hijo o hija participa en esta iniciativa, recibirán una copia de los resultados del examen masivo del BMI y una explicación de los mismos. Además el curso escolar de 2020-2021, incluirá información y actividades centradas en estilos de vida saludable.

Atentamente,

Director o Directora

Hearing & Vision Screening

Dapré régleman ki etabli nan Lejislati Florid la, nan kömansman Chak ane leköl, nou dwe mete paran okouran aktivite depistas medikal ki disponib atravö Pwogram Sévis Sante nan Leköl.

Rég 2410 Komisyon Konséy Leköl mande pou fé zöröy pou elév nan klas jadendanfan, premye ak sizyém ane eskolö, e pou elév ki ap antre leköl nan Florid la pou premye fwa nan dezyém, twazyöm, katriyöm ak senkyöm ane eskolö. Epitou depistaj pou vizyon obligatwa pou elév nan klas jadendanfan, premye, twazyém ak sizyém ane eskolé e pou elév ki ap antre leköl nan Florid la pou premye fwa nan dezyöm, katriyém e senkyém ane eskolé, dapré priyorite ki prezante nan plan sante County lokal la, ki sijé dapré fon e anplwaye ki disponib.

Nou dwe konprann konsiltasyon sa yo pa ka ranplase yon egzamen konplé nan sant medikal, men konsiltasyon sa yo kab fét byen fasil pou yon gran nonb timoun ki paret ansante nan entansyon pou n idantifiye timoun ki nan nesesite pou yon egzamen pi konplé.

Yo mande pou w voye fö leköl la konnen pa ekri si w pa vle pitit ou patisipe nan pwogram konsiltasyon an.

Sensöman,

Diretké (tris)

FM-6582H

Rev. (10-20)

Echantiyon Lèt lekòl la voye bay paran

Chè Paran/Gadyen:

Chak ane, yo mezire wotè e gwosè timoun ki nan ane eskolè espesifik pou yo siveye si y ap grandi fizikman e devlopman yo. Nan ane lekòl 2020-2021, la, se pra'l yon etap pi wo nan Miami-Dade Public Schools yo nan kalkile "Body Mass Index (BMI)" (Endèks Mas Kò) pitit ou a. Kalkilasyon sa a di nou si yon timoun nan ran pwa nòmal li, oubyen sil andeyò règ nan e sil ogmante nòm nan oubyen potansyalite pou I devlope sèten maladi kwonik pandan li te timoun oubyen lè li vin granmoun. BMI se yon metòd depistaj yo rekòmande pou timoun ak adolesan. Li baze sou laj ak sèks yon timoun, kote yo sèvi ak pwa e wotè yon timoun pou kalkile, e konpare I avèk tablo estanda pou devlopman. Depistaj BMI la se yon sèvis sante adisyonèl pou ede evalye, pwoteje, e pwomote estati sante pitit ou. Entansyon an se pou ankouraje bonjan abitid nitrisyonèl ak aktivite pou sante fizik.

Se anplwaye sante nan lekòl la k ap fè depistaj la pa woutin. Si w pa VIe pitit ou patisipe, silvouplè avize lekòl la alekri.

Si pitit ou patisipe nan inisyatif sa a, w ap resevwa yon kopi rezilta depistaj BMI la ak eksplikasyon sou rezilta yo. Anplisdesa, nan ane lekòl 2020-2021, la ap gen enfòmasyon ak aktivite k ap konsantre sou estil lavi ansante ak byennèt.

Sensèman,

Direktè (tris)

GENERAL CONSENT FOR CLINICAL SCHOOL HEALTH SERVICES

STRICTLY CONFIDENTIAL – FOR HEALTHCARE USE ONLY

PRINT THE FOLLOWING INFORMATION FOR THE STUDENT – PATIENT CHART NUMBER_____

STUDENT NAME_____ D.O.B.____/____/____ SEX: M____ F____ AGE_____

RACE/ETHNICITY_____ GRADE_____ SCHOOL I.D._____ PHONE NUMBER_____

ADDRESS_____

MEDICAL HISTORY - *CIRCLE if applicable and EXPLAIN.*

DIABETES ASTHMA ALLERGY TO MEDICATION / FOODS OTHER_____

LIST CHRONIC DISEASES, HOSPITALIZATIONS, SURGERIES:

_____

Name of Primary Care Physician (if applicable) _____ Phone # _____

IF STUDENT IS COVERED BY MEDICAID, KIDCARE, OR PRIVATE MEDICAL INSURANCE, **please provide the following information:**

MEDICAID #_____ KIDCARE #_____

Insurance Name_____ Policy #_____ Group #_____

PARENT/LEGAL GUARDIAN INFORMATION:

MOTHER NAME_____ DOB_____ CONTACT NUMBER_____

FATHER NAME_____ DOB_____ CONTACT NUMBER_____

LEGAL GUARDIAN NAME_____ DOB_____ CONTACT NUMBER_____

FINANCIAL ASSESSMENT:

Do you need assistance in obtaining insurance for your child? **Yes** **No** (*Circle One*) What is your monthly household income? INCOME: $_____

MIGRANT AND SEASONAL FARMWORKER ELIGIBILITY

Does head of household work in agriculture? Planting, harvesting fruits or vegetables, working at a packing house or nursery? **Yes** **No** (*Circle One*)

CLINICAL SCHOOL HEALTH SERVICES

The School Health Team MAY provide the following services with Parental/Legal Guardian consent (Check all that apply)

- ☐ Grade Level Screenings
- ☐ Hypertensive Screening
- ☐ Pediculosis/ Scabies Screening
- ☐ Development/Social/Emotional Behavioral Health Screening and ESE Supports
- ☐ Chronic Disease Management
- ☐ Nursing Assessment and Counseling/Obesity Intervention
- ☐ Health Education
- ☐ Child Specific Training
- ☐ Medication Administration/ Education and Management
- ☐ Telehealth Services (selected schools only)
- ☐ Immunization Follow-up
- ☐ School Health Staff Consultation
- ☐ Individualized Health Care Plan
- ☐ Oral Health Services
- ☐ First Aid Medical Services
- ☐ Record Review

☐ I do *not* want my child to receive any of the above school health services

(Please refer to your school health team for any additional questions or concerns regarding the school health services)

General Consent for School Health Services and Treatment

By signing below, I hereby consent and authorize the (**Community Health of South Florida, Inc.**), the nurses and clinical personnel of the school health team to conduct any examination necessary and to provide school health services and treatment to the above named Student, including any examination, laboratory and diagnostic tests, and/or injections, vaccines, and/or any other school health service or treatment which in their judgment may be deemed necessary or advisable for the diagnosis and treatment of the above named student's medical condition.

I understand that the results of medical information obtained while my child receives treatment at the school health facility is confidential and will not be disclosed to anyone without my written permission or a court order as required by applicable federal and state laws. I understand Florida laws require the school healthcare team to provide the Department of Health with a report of those individuals diagnosed with communicable diseases. Therefore, I authorize the school healthcare team to report to the Department of Health whenever my child is diagnosed as having a communicable disease. I further understand that my child and/or I will be notified of any such diagnosis. Without written notification to change my preferences related to my child's treatment, I understand that this consent expires on the date that my child is no longer enrolled in the school.

I consent to the use and release of medical information as necessary for treatment, payment and healthcare operations of the school health team, including to the treating provider, guarantor of accounts, or third party payors for which I have assigned benefits or which may otherwise reimburse for the provision of services, and if requested to my primary care physician or any other healthcare provider for purposes of continuity of care.

I _____ am related to the Child as _____ and I am
(Print Name) (Mother, father, legal guardian)

Legally authorized to sign this document _____ Date: _____
(Signature of parent / legal guardian)

WITNESS (Print name) _____ Date: _____

WITNESS (Signature) _____ Date: _____

Revised 5.2012, 5.2013, 4.2014, 8.2015,8.2016,7.25.18.4.22.18.6.20.19

Obligations of Activity Participants
Waiver, Release & Hold Harmless

COVID-19 and Voluntary Third-Party Extracurricular Activities

Summer 2020 and School Year 2020-21

Extra-Curricular Activity: _____

Parent/Guardian's Name: _____

Participating Child(ren)'s Name: _____

_____

I desire to participate or allow my child(ren) ("Activity Participant") to participate in one or more voluntary extracurricular activities being held on the campus(es) of the School Board of Miami-Dade County, Florida ("School Board"). I acknowledge that the novel coronavirus known as COVID-19 has been declared as a worldwide pandemic and is believed to be contagious and spread by person-to-person contact, including in Miami-Dade County. I further acknowledge that federal, state, and local agencies recommend social distancing and other measures to prevent the spread of COVID-19.

The School Board will have third-party organizations ("Organizations") conducting certain extracurricular activities, including summer camps, on its campus(es) beginning in the Summer of 2020 and continuing into the 2020-21 school year. I understand that if I or my child(ren) choose to participate in these Organizations' activities (hereinafter "Activity"), the Activity will be controlled, organized, contracted, staffed and insured independent of the School Board, and will be conducted with the safety protocols these Organizations deem appropriate under the circumstances at the time, which may be subject to change. I understand that the School Board will not be responsible for implementing, supervising, or informing the Activity Participant(s) of this Organization's safety protocols, and that it is solely my responsibility, as well as the Activity Participant's, to adhere to all state, federal, and local safety protocols, as well as those the Organization provides.

In an effort to ensure the safety and wellness of our school community, I understand the importance of Activity Participants, including my child(ren), being healthy and safe when they participate in the Activity. By signing below, I agree that I will:

- Perform daily temperature checks on my child(ren) to screen for fever before arrival to the Activity. Fever is defined as a temperature over 100.4 F or 38.0 C. If my child(ren) has a fever, I will not permit my child(ren) to participate in the Activity until he/she has been without a fever for at least 72 hours.

- Make a visual inspection of my child(ren) for signs of illness which could include: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea, flushed cheeks, rapid breathing or difficulty breathing (without recent physical activity), fatigue, or extreme fussiness. If my child(ren) has exhibited any of these signs or symptoms, I will not permit my child(ren) to participate in the Activity until he/she has been without signs or symptoms for at least 72 hours.

- Confirm that my child(ren), before and while participating in the Activity, has not tested positive for COVID-19 in the past 14 days, is not waiting for test results based on a diagnosed or suspected case of COVID-19, and has not within 14 days returned from an area subject to CDC Level 3 Travel Health Notice.

- Confirm that my child(ren), before and while participating in the Activity, has not been in contact with someone who has either tested positive for COVID-19 in the past 14 days, is waiting for test results based on a diagnosed or suspected case of COVID-19, or has returned from a highly impacted area subject to a CDC Level 3 Travel Health Notice. If my child(ren) has been in contact with such a person, including from the same household, I will not permit my child(ren) to participate in the Activity until 14 days have elapsed since the time of contact.

- Promptly pick up my child(ren), or arrange for pickup, if signs or symptoms of illness are present. I understand that children are to remain home until illness-free for at least 72 hours without the use of medicine.

By signing this document, I acknowledge and affirm all of the statements above. I also understand that I or my child(ren) may unavoidably be exposed to or infected by COVID-19 as a result of participation in the Activity, and that such exposure or infection may result in personal injury, illness, sickness, and/or death. I understand that the risk of exposure or infection may result from the actions, omissions, or negligence of myself, my child(ren), these Organizations, School Board staff, volunteers, or agents, other Activity participants, or others not listed, and I acknowledge that all such risks are known to me.

In consideration of my and/or my child(ren) being able to participate in the Activity, I, on behalf of myself and my child(ren), as well as anyone entitled to act on my behalf, hereby knowingly and voluntarily forever waive, release, and hold the School Board and its employees and agents harmless from any and all claims, suits, liability, actions, judgments, attorneys' fees, costs, and any expenses of any kind resulting from injuries or damages, grounded in tort or otherwise, that I and/or my child(ren), or my or our representatives, sustain during or related to my child(ren)'s participation or involvement in the Activity.

If this Waiver, Release and Hold Harmless or any portion thereof is determined to be invalid or unenforceable for any reason, the remaining provisions of this Waiver, Release, and Hold Harmless, as well as any other agreement(s) concerning my or my child(ren)'s participation in this Activity, shall be unaffected and remain in full force and effect.

Signature of Parent/Guardian	Signature of Activity Participant
Print name of Parent/Guardian	Print name of Activity Participant
Date of signature	Date of signature

Exención de Responsabilidad por las Obligaciones de los Participantes de la Actividad

Actividades Extracurriculares y Voluntarios de Terceros durante el COVID-19

Verano del 2020 y Curso Escolar del 2020-21

Actividad Extra-Curricular: _____

Nombre del Padre de Familia / Tutor: _____

Nombre del / de los Niño(s) que Participan: _____

_____

Deseo participar o permitir que mi(s) hijo(s) ("Participante de la Actividad") participen en una o más actividades extracurriculares voluntarias que se llevan a cabo en el/los recinto(s) de la Junta Escolar del Condado Miami-Dade, Florida ("Junta Escolar"). Reconozco que el nuevo coronavirus conocido como COVID-19 ha sido declarado una pandemia mundial y se cree que es contagioso y se contagia por contacto de persona a persona, incluso en el Condado Miami-Dade. Además, reconozco que las agencias federales, estatales y locales recomiendan el distanciamiento social y otras medidas para prevenir la propagación del COVID-19.

La Junta Escolar tendrá organizaciones de terceros ("Organizaciones") que llevarán a cabo ciertas actividades extracurriculares, incluidos los campamentos de verano, en su(s) recinto(s) a partir del verano del 2020 y continuarán hasta el curso escolar del 2020-21. Entiendo que si yo o mi(s) hijo(s) eligen participar en las actividades de estas Organizaciones (en adelante, "Actividad"), la Actividad será controlada, organizada, contratada, dotada de personal y asegurada independientemente de la Junta Escolar, y se llevará a cabo con los protocolos de seguridad que estas organizaciones consideran apropiados según las circunstancias del momento, que pueden estar sujetos a cambios. Entiendo que la Junta Escolar no será responsable de implementar, supervisar o informar a los Participantes de la Actividad de los protocolos de seguridad de esta Organización, y que es mi exclusiva responsabilidad, así como la del Participante de la Actividad, cumplir con todos los protocolos de seguridad estatales, federales y locales, así como los que proporciona la Organización.

En un esfuerzo por asegurar la seguridad y el bienestar de nuestra comunidad escolar, entiendo la importancia de que los Participantes de la Actividad, incluido(s) mi(s) hijo(s), estén sanos y seguros cuando participen en la Actividad. Al firmar a continuación, acepto que yo:

- Realizaré controles diarios de temperatura en mi(s) hijo(s) para detectar fiebre antes de llegar a la Actividad. La fiebre se define como una temperatura superior a 100.4 F o 38.0 C. Si mi(s) hijo(s) tiene(n) fiebre, no permitiré que participe(n) en la Actividad hasta que haya(n) estado sin fiebre durante al menos 72 horas.

- Haré una inspección visual de mi(s) hijo(s) en busca de signos de enfermedad que podrían incluir: fiebre o escalofríos, tos, falta de aire o dificultad para respirar, fatiga, dolores musculares o corporales, dolor de cabeza, nueva pérdida de sabor u olfato, dolor de garganta, congestión o secreción nasal, náuseas o vómitos, diarrea, mejillas sonrojadas, respiración rápida o dificultad para respirar (sin actividad física reciente), fatiga o irritabilidad extrema. Si mi(s) hijo(s) ha(n) exhibido alguno de estos signos o síntomas, no permitiré que participe(n) en la Actividad hasta que no haya(n) estado sin signos o síntomas durante al menos 72 horas.

- Confirmaré que mi(s) hijo(s), antes y durante su participación en la Actividad, no ha(n) dado positivo por COVID-19 en los últimos 14 días, no está(n) esperando los resultados de la prueba basados en un

caso diagnosticado o sospechoso de COVID-19, y no ha(n) regresado dentro de los 14 días de un área sujeta al Aviso de Salud de Viaje de Nivel 3 de los CDC.

- Confirmaré que mi(s) hijo(s), antes y durante su participación en la Actividad, no ha(n) estado en contacto con alguien que haya dado positivo por COVID-19 en los últimos 14 días, esté esperando los resultados de la prueba en función de un caso diagnosticado o sospechoso de COVID-19, o ha(n) regresado de un área altamente impactada sujeta a un Aviso de Salud de Viaje de Nivel 3 de los CDC. Si mi(s) hijo(s) ha(n) estado en contacto con dicha persona, incluso del mismo hogar, no permitiré que mi(s) hijo(s) participen en la Actividad hasta que hayan transcurrido 14 días desde el momento del contacto.

- Recogeré inmediatamente a mi(s) hijo(s), o haré arreglos para que lo(s) recojan, si hay signos o síntomas de enfermedad. Entiendo que los niños deben permanecer en casa hasta que estén libres de enfermedades durante al menos 72 horas sin el uso de medicamentos.

Al firmar este documento, reconozco y afirmo todas las declaraciones anteriores. También entiendo que yo o mi(s) hijo(s) podemos estar expuestos o infectados inevitablemente por COVID-19 como resultado de la participación en la Actividad, y que dicha exposición o infección puede provocar lesiones personales, enfermedades, y/o muerte. Entiendo que el riesgo de exposición o infección puede ser el resultado de acciones, omisiones o negligencia por parte de mí, mis hijos, estas Organizaciones, el personal de la Junta Escolar, voluntarios o agentes, otros participantes de la Actividad u otros que no figuran en la lista, y Reconozco que todos estos riesgos son conocidos por mí.

Teniendo en cuenta que yo y/o mi(s) hijo(s) podemos participar en la Actividad, yo, en mi nombre y el de mi(s) hijo(s), así como cualquier persona que tenga derecho a actuar en mi nombre, por este medio renuncio consciente y voluntariamente para siempre, exonero y eximo de responsabilidad a la Junta Escolar y a sus empleados y agentes de todos y cada uno de los reclamos, demandas, responsabilidades, acciones, juicios, honorarios de abogados, costos y cualquier gasto de cualquier tipo que resulte de lesiones o daños, basado en agravio u otros, yo y/o mi(s) hijo(s), o mi o nuestros representantes, sostenemos durante o relacionados con la participación de mi(s) hijo(s) en la Actividad.

Si se determina que esta Exención o cualquier parte de la misma es inválida o inaplicable por algún motivo, las disposiciones restantes de esta Exención, así como cual(es)_quier(a) otro(s) acuerdo(s) relacionado con mi participación o la de mi(s) hijo(s) en esta Actividad no se verá afectada y permanecerá en pleno vigor y efecto.

Firma del Padre de Familia / Tutor	Firma del Participante de la Actividad
Nombre Escrito del Padre de Familia / Tutor	Nombre Escrito del Participante de la Actividad
Fecha de la firma	Fecha de la firma

Obligasyon Patisipan nan Aktivite yo
Dispans, Liberasyon, Dechajman Responsablite

COVID19 ak Aktivite Volontè Andeyò Orè Lekòl Antite Endepandan ap Òganize Ete 2020 ak Ane Lekòl 2020-21

Aktivite Andeyò Orè Lekòl _____

Non Paran/Gadyen _____

Non Timoun ki Ap Patisipe a(yo) _____

_____

Mwen vle patisipe oubyen pèmèt pitit mwen (Patisipan nan Aktivite) a patisipe nan youn oubyen plis aktivite volontè andeyò orè lekòl ki fèt sou kanpous Komisyon Konsèy Lekòl Miami-Dade County, Florid ("Komisyon Konsèy Lekòl"). Mwen rekonèt nouvo 'coronavirus' yo rele COVID-19 la, yo deklare li kòm yon pandemi, yo kwè li kontajye e moun ka transmèt li bay moun, nan zòn tankou Miami-Dade County. Anplis, mwen rekonèt ajans federal, eta ak lokal yo rekòmande distans sosyal ak lòt mezi pou fè prevansyon kont pwopagasyon COVID-19 la.

Komisyon Konsèy Lekòl la ap gen òganizasyon ("Òganizasyon") endepandan ki ap òganize kèk aktivite andeyò orè lekòl, tankou kan ete, sou kanpous li yo, kòmanse nan Ete 2020 an e yo ap kontinye nan ane lekòl 2020-2021 an. Mwen konprann si mwen menm oubyen pitit mwen chwazi patisipe nan aktivite Òganizasyon sa yo, (yo rele "Aktivite"), yo ap kontwole, òganize, kontrakte, ofri pèsonèl pou Aktivite a endepandamman de Komisyon Konsèy Lekòl la, e yo ap fè li selon pwotokòl sekirite Òganizasyon yo, yo jije ki apwopriye selon sikonstans moman an, ki kapab chanje. Mwen konprann Komisyon Konsèy Lekòl la pap responsab pou enplemantasyon, sipèvizyon, oubyen enfòmasyon pou Patisipan nan Aktivite a konsènan pwotokòl sekirite Òganizasyon sa a, e se responsablite pa mwen sèlman, ansanm ak Patisipan nan Aktivite a, pou n suiv tout pwotokòl sekirite eta, federal, ak lokal yo, ansanm ak pwotokòl Òganizasyon an ofri.

Nan yon efò pou asire sekirite ak byennèt kominote lekòl nou an, mwen konprann enpòtans Patisipan nan Aktivite yo, tankou pitit mwen yo, pou yo ansante e ansekirite pandan y ap patisipe nan Aktivite a. Nan siyen anba a, mwen dakò mwen ap:

- Tcheke tanperati pitit mwen chak jou pou fè depistaj lafyèv avan yo rive nan Aktivite a. Yo defini lafyèv kòm yon tanperati ki depase 100.4 F oubyen 38.0 C. Si pitit mwen gen lafyèv, mwen pap pèmèt li patisipe nan Aktivite a jiskaske lafyèv la tonbe pou omwen 72 èdtan.

- Fè yon enspeksyon vizyèl sou pitit mwen pou detekte siy maladi tankou: lafyèv oubyen frison, grip, souf kout oubyen difikilte pou respire, fatig, doulè nan misk oubyen nan kò, tèt fè mal, nouvo pèt gou oubyen abilite pou pran sant, gòj fè mal, nen bouche oubyen nen koule, noze oubyen vomisman, dyare, woujisman nan vizaj, respirasyon rapid oubyen difikilte pou respire (san ou pa sot fè okenn aktivite), fatig, oubyen ajitasyon ekstrèm. Si pitit mwen prezante youn nan siy oubyen sentòm sa yo, mwen pap pèmèt li patisipe nan Aktivite a jiskaske li pa gen okenn siy oubyen sentòm pou omwen 72 èdtan.

- Konfime pitit mwen, avan e pandan y ap patisipe nan Aktivite a, pa t teste pozitif pandan 14 dènye jou yo, li pa gen rezilta egzamen l ap tann baze sou dyagnostik oubyen ka sispèk COVID-19, e nan espas 14 jou li pa t retounen sot nan yon zòn ki nan lis CDC sou Notifikasyon Sante Nivo 3 pou Moun k Ap Vwayaje.

- Konfime pitit mwen, avan e pandan y ap patisipe nan Aktivite a, pa t an kontak avèk yon moun ki te oubyen teste pozitif pou COVID-19 nan 14 dènye jou yo, ap tann baze sou dyagnostik oubyen ka sispèk COVID-19, e nan espas 14 jou li pa t retounen sot nan yon zòn ki trè afekte e ki nan lis CDC sou Notifikasyon Sante Nivo 3 pou Moun k Ap Vwayaje. Si pitit mwen te an kontak avèk yon moun, ki gen ladan moun ki nan menm kay la, mwen pap pèmèt li patisipe nan Aktivite a jiskaske 14 jou fin pase depi lè kontak la te fèt.

- Rapidman al chèche pitit mwen, oubyen fè aranjman pou yon moun vin chèche li, si li prezante siy oubyen sentòm maladi a. Mwen konprann pitit mwen dwe rete lakay jiskaske li pa malad pou omwen 72 èdtan san li pa pran medikaman.

Nan siyen dokiman sa a, mwen rekonèt e mwen konfime tout deklarasyon ki anwo yo. Mwen konprann tou pitit mwen kapab ekspoze oubyen enfekte ak COVID-19 yon fason li pa ka evite akoz li ap patisipe nan Aktivite a, e lefètke li ekspoze oubyen li enfekte, sa ka lakoz blesi pèsonèl, maladi e/oubyen lanmò. Mwen konprann risk pou pitit mwen ekspoze oubyen enfekte kapab se rezilta aksyon, omisyon, oubyen neglijans mwen menm, pitit mwen oubyen Òganizasyon sa yo anplwaye Komisyon Konsèy Lekòl la, volontè, oubyen ajan, lòt patisipan nan Aktivite a, oubyen lòt moun ki pa nan lis la, e mwen rekonèt mwen okouran risk sa yo egziste.

Lè mwen konsidere pitit mwen kapab patisipe nan Aktivite a, mwen menm, nan non pa mwen e nan non pitit mwen, ansanm ak nenpòt moun ki gen dwa pou l aji nan non mwen, nan dokiman sa a, mwen volontèman e kosyamman dispanse, libere e mwen dechaje Komisyon Konsèy Lekòl la pou toutan de tout reklamasyon, pousuit nan lajistis, responsablite, aksyon, jijman, frè avoka, frè, ak nenpòt depans sou kèlkeswa fòm nan ki ka soti nan blesi oubyen domaj, baze sou responsablite ou non, mwen menm e/oubyen pitit mwen, reprezantan mwen oubyen reprezantan yo, viktim pandan oubyen anrapò ak patisipasyon oubyen enplikasyon pitit mwen nan aktivite a.

Si yo detèmine Dispans, Liberasyon, Dechajman Responsablite sa a oubyen kèlkeswa pòsyon ki ladan envalid oubyen inaplikab pou kèlkeswa rezon an, pwovizyon ki rete nan Dispans, Liberasyon, Dechajman Responsablite sa a, ansanm ak kèlkeswa lòt akò konsènan patisipasyon mwen menm oubyen pitit mwen nan Aktivite sa a, pa ta dwe afekte e yo ta dwe kenbe tout fòs ak efè yo.

Siyati Paran/Gadyen	Siyati Patisipan nan Aktivite a
Enprime Non Paran/Gadyen	Enprime Non Patisipan nan Aktivite a
Dat Siyati a	Dat Siyati a

GENERAL CONSENT FOR CLINICAL SCHOOL HEALTH SERVICES

STRICTLY CONFIDENTIAL ~ FOR HEALTHCARE USE ONLY

PRINT THE FOLLOWING INFORMATION FOR THE STUDENT – PATIENT **CHART NUMBER**_____

STUDENT NAME_____ **D.O.B**____/____/____ **SEX**: M____ F____ **AGE**_____

RACE/ETHNICITY_____ **GRADE**_____ **SCHOOL I.D.**_____ **PHONE NUMBER**_____

ADDRESS_____

MEDICAL HISTORY - *CIRCLE if applicable and EXPLAIN.*

DIABETES **ASTHMA** **ALLERGY TO MEDICATION / FOODS** **OTHER**_____

LIST CHRONIC DISEASES, HOSPITALIZATIONS, SURGERIES:

_____

Name of Primary Care Physician (if applicable) _____ Phone # _____

IF STUDENT IS COVERED BY MEDICAID, KIDCARE, OR PRIVATE MEDICAL INSURANCE, please provide the following information:

MEDICAID #_____ **KIDCARE #**_____

Insurance Name_____ Policy #_____ Group #_____

PARENT/LEGAL GUARDIAN INFORMATION:

MOTHER NAME_____ **DOB**_____ **CONTACT NUMBER**_____

FATHER NAME_____ **DOB**_____ **CONTACT NUMBER**_____

LEGAL GUARDIAN NAME_____ **DOB**_____ **CONTACT NUMBER**_____

FINANCIAL ASSESSMENT:

Do you need assistance in obtaining insurance for your child? **Yes** **No** (*Circle One*) What is your monthly household income? INCOME: $_____

MIGRANT AND SEASONAL FARMWORKER ELIGIBILITY

Does head of household work in agriculture? Planting, harvesting fruits or vegetables, working at a packing house or nursery? **Yes** **No** (*Circle One*)

CLINICAL SCHOOL HEALTH SERVICES

The School Health Team MAY provide the following services with Parental/Legal Guardian consent (Check all that apply)

- ☐ Grade Level Screenings
- ☐ Hypertensive Screening
- ☐ Pediculosis/ Scabies Screening
- ☐ Development/Social/Emotional Behavioral Health Screening and ESE Supports
- ☐ Chronic Disease Management
- ☐ Nursing Assessment and Counseling/Obesity Intervention
- ☐ Health Education
- ☐ Child Specific Training
- ☐ Medication Administration/ Education and Management
- ☐ Telehealth Services (selected schools only)
- ☐ Immunization Follow-up
- ☐ School Health Staff Consultation
- ☐ Individualized Health Care Plan
- ☐ Oral Health Services
- ☐ First Aid Medical Services
- ☐ Record Review

☐ I do *not* want my child to receive any of the above school health services

(Please refer to your school health team for any additional questions or concerns regarding the school health services)

General Consent for School Health Services and Treatment

By signing below, I hereby consent and authorize the (**Community Health of South Florida, Inc.**), the nurses and clinical personnel of the school health team to conduct any examination necessary and to provide school health services and treatment to the above named Student, including any examination, laboratory and diagnostic tests, and/or injections, vaccines, and/or any other school health service or treatment which in their judgment may be deemed necessary or advisable for the diagnosis and treatment of the above named student's medical condition.

I understand that the results of medical information obtained while my child receives treatment at the school health facility is confidential and will not be disclosed to anyone without my written permission or a court order as required by applicable federal and state laws. I understand Florida laws require the school healthcare team to provide the Department of Health with a report of those individuals diagnosed with communicable diseases. Therefore, I authorize the school healthcare team to report to the Department of Health whenever my child is diagnosed as having a communicable disease. I further understand that my child and/or I will be notified of any such diagnosis. Without written notification to change my preferences related to my child's treatment, I understand that this consent expires on the date that my child is no longer enrolled in the school.

I consent to the use and release of medical information as necessary for treatment, payment and healthcare operations of the school health team, including to the treating provider, guarantor of accounts, or third party payors for which I have assigned benefits or which may otherwise reimburse for the provision of services, and if requested to my primary care physician or any other healthcare provider for purposes of continuity of care.

I _____ am related to the Child as _____ and I am
(Print Name) (Mother, father, legal guardian)

Legally authorized to sign this document _____ Date: _____
(Signature of parent / legal guardian)

WITNESS (Print name) _____ Date: _____

WITNESS (Signature) _____ Date: _____

Revised 5.2012, 5.2013, 4.2014, 8.2015,8.2016,7.25.18.4.22.18.6.20.19