Dear Magnet Family,

Congratulations on your student's acceptance into a Hillsborough County Public Schools' Magnet Program!

Magnet Students and families before you have collaborated to establish our Magnet Schools as exceptional places of learning that celebrate innovative lessons, academic success, and diversity. We are proud of our accomplishments and are excited by your family's contribution to our continued success. The privilege of being a part of the great program to which you have been accepted comes with certain responsibilities. In accepting this Magnet School placement, you have agreed to be mindful of the following:

Students will:

- Be aware of and follow all school rules, routines, and procedures.
- Be aware of and follow all transportation system rules, routines, and procedures.
- Arrive on time every day prepared with all necessary supplies, books, and materials.
- Complete all classwork and homework assignments.
- Follow the dress code and uniform requirements established by the school.
- Actively contribute to a positive, safe, and cooperative school environment.

Parents/Guardians and family members will:

- Be aware of and follow all school routines and procedures.
- Be aware of and follow all transportation system routines and procedures.
- Monitor the timely completion of homework assignments.
- Ensure students follow dress code and uniform requirements established by the school.
- Communicate with school personnel in a civil manner.
- Provide accurate and up-to-date contact information.
- Contribute to a positive, safe, and cooperative school environment.

All of the above must be honored this school year to ensure that your student's Magnet School assignment and/or the privilege of Magnet bus transportation is maintained throughout the year.

Working together means we will ALL have a fun, safe, and successful school year!

Please sign to acknowledge your understanding of the above

Student_____ Date_____

Parent_____ Date_____

Principal _____ Date _____

Magnet School Representative _____ Date _____

Hillsborough County
PUBLIC SCHOOLS
Preparing Students for Life

Student Code of Conduct Acknowledgement Form

I have been notified that I can review the Student Code of Conduct online at: http://www.sdhc.k12.fl.us/conduct

I have received, read, understand and agree to abide by the Student Code of Conduct

_____ _____
Student Signature Date

I/we have read the Student Code of Conduct and discussed it with my student.

_____ _____
Parent/Guardian's Signature Date

The Student Code of Conduct has been established to communicate the expectations for student behavior at school or school activities. Failure to return this acknowledgement will not relieve a student or the parent/guardian(s) from the responsibility of abiding by the Code of Conduct.

2022-2023 Hillsborough County Public Schools
Student Likeness Release Form

Hillsborough County
PUBLIC SCHOOLS
Preparing Students for Life

School: _____ Student ID Number: _____

Student Name (Last, First): _____

Homeroom Teacher: _____ Grade: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Email: _____

Dear Parent/Guardian:

Throughout the school year, certain Hillsborough County Public School partners and media members may be involved with special events or activities at your child's school.

Hillsborough County Public Schools also may wish to interview, photograph, or videotape your child for promotional and educational reasons to utilize in publications and special district events. Before your child can participate in any of the above events or activities, you must give your permission by signing and returning this likeness release form to your child's school.

Please select only one option below:

☐ **I give my permission** for my child to be interviewed, photographed, or videotaped by the school/district, school/district partners or sponsors, and/or members of the general news media and expressly authorize and grant my consent to such parties the right to use my child's physical likeness, other identifying characteristics, information, and/or recordings of his/her voice in any media, including but not limited to, broadcast, cable, print, and/or digital, and for any purpose including but not limited to entertainment, news, education, advertising, marketing and promotion without compensation thereof.

☐ **I do not give permission** for my child to be interviewed, photographed, or videotaped by the school/district, school/district partners or sponsors, and/or members of the general news media; nor for his/her name to be published in school/district publications, on the internet, or in news Publications or broadcasts.

☐ **I give my permission ONLY** for my child to be photographed for and his/her name be published in the 2022-2023 school yearbook.

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____ Date: _____

Hillsborough County
PUBLIC SCHOOLS
Preparing Students for Life

PARENT/GUARDIAN WITHHOLD/DECLINE CONSENT FOR SCHOOL HEALTH SERVICES
School Year 2022-2023

THIS FORM MUST BE COMPLETED, SIGNED, AND RETURNED TO THE SCHOOL NURSE IN ORDER TO WITHHOLD/DECLINE CONSENT FOR ANY SPECIFIC HEALTH SERVICE EACH SCHOOL YEAR

- In accordance with Florida House Bill 1557, Parental Rights in Education, each school district, at the beginning of the school year, must notify parents/guardians of each health care service offered at their child's school and provide parents the option to withhold consent or decline any specific service.
- Emergency health needs means onsite evaluation, management, and aid for illness or injury pending the student's return to the classroom or release to a parent, guardian, designated friend, law enforcement officer, or designated health care provider. There is not an option to withhold/decline consent for emergency health needs (F.S. 381.056; F.S. 768.13).
- Parental/Guardian written consent is required every school year for employees to administer prescribed medication, conduct medical procedures and/or medical treatment. Written consent is also required for The Healthy Student Program, vision and dental programs at participating schools, and specific health services i.e., school entry and sports physicals.

Print all information using ink

Student Information

First Name	Middle Name	Last Name	Student Birth Date	Gender

Street Address	Apartment Number	City	State	Zip Code

Parent/Guardian Information

First Name	Middle Name	Last Name	Relationship to Student (parent or guardian)

Street Address	Apartment Number	City	State	Zip Code

Home Phone Number	Work Phone Number	Cell Phone Number	Email Address	Student ID Number

PARENT/GUARDIAN WITHHOLD/DECLINE CONSENT FOR SCHOOL HEALTH SERVICES
School Year 2022-2023

Please indicate below which services you withhold/decline consent.	I withhold/decline the healthcare services marked below
Nurse Assessment	☐
Nutrition Assessment	☐
Health Counseling	☐
Referral and Follow-Up of Suspected and Confirmed Health Problems	☐

***Annual Health Screenings for Grades KG, 1st, 3rd, and 6th**

Parent/guardian of kindergarten, 1st, 3rd, and 6th grade students receive a separate written notification for scheduled health screenings from their school. At that time, parent/guardian will have the option to decline the state mandated health screening.

Parent/Guardian (PRINT)_____

Parent/Guardian (SIGNATURE)_____Date_____

STUDENT'S FIRST & LAST NAME PRINT: _____Date of Birth: _____

(Must be completed annually)

Hillsborough County
PUBLIC SCHOOLS
Preparing Students for Life

MEDICAID
Certified School Match Program
Reimbursement for School-based Services

What is the Florida Medicaid Certified School Match program?

Since 1997, Hillsborough County Public Schools has participated in a federal and state-funded Medicaid reimbursement program. The Florida Medicaid Certified School Match (MCSM) program helps to ensure students with an Individual Educational Program (IEP) receive needed health care (medical, emotional, and transportation-related) services at school.

The program assists school districts by providing partial reimbursement for these medically related services provided to students at school.

In July 2020, current guidelines expanded to include general education students who have a Plan of Care (i.e., Health Care Plan, Behavioral Plan, 504 Plan, etc.) or the need for crisis intervention. Although the partial reimbursement is only available for students who are Medicaid eligible, services are provided to all students with a plan of care regardless of their Medicaid eligibility status.

What types of services does the MCSM program cover?

Counseling	Crisis Intervention	Nursing
Child Outreach Screening	Occupational Therapy	Case Management
Speech/Language Therapy	Physical Therapy	Assessments
Special Education	Transportation	Evaluations Developmental Testing
Orientation & Mobility	Assistive Technology	

Is there a cost to me?

NO – Services are provided to students while at school with NO cost to the parent/guardian.

Will it affect my family's Medicaid benefits?

NO – The program does NOT impact a family's Medicaid services, funds or limits. Because Florida operates the MCSM program differently than the Family-Related Medicaid Coverage plans the school plan does not affect your family's Medicaid benefits in any way.

How does Hillsborough County Public Schools use the reimbursement money received from Medicaid?

The funds received from Medicaid for speech/language therapy, occupational/physical therapy, counseling, nursing services, and psychoeducational evaluations are used to support student services and Exceptional Student Education (ESE) programs.

How can I help ensure my school district receives benefits from the MCSM program?

Federal regulations require that the parent/guardian:

- Be fully informed about the Medicaid Certified School Match program
- Fully understand that consent is voluntary and can be withdrawn at any time.
- Permit Hillsborough County Public Schools to share necessary information to bill for Medicaid eligible services included in your child's IEP, 504 or Plan of Care.
- Your child will receive the services written in your child's IEP, 504, or Plan of Care at Hillsborough County Public Schools expense regardless of your consent to allow us to bill Medicaid. You may revoke consent at any time.

Hillsborough County
PUBLIC SCHOOLS
Preparing Students for Life

Parental Consent to Release Personally Identifiable Information for Medicaid Reimbursement

Hillsborough County Public Schools wishes to seek reimbursement for certain services provided to your child by accessing Medicaid. We must obtain your written informed consent for the purpose of releasing certain information related to seeking Medicaid reimbursement. Medicaid reimbursement helps the school district fund costs of providing special education, related services and any other services allowable by Medicaid.

Consent given or denied (please read, mark with an X your choice, sign and date at the bottom):

Individual Educational Plan (IEP) Services
The Individuals with Disabilities Education Act of 2004 (IDEA) permits school districts to seek reimbursement from Medicaid for services provided at school (Title 34, section 300.154(d)(2)(iv)(A)-(B), Code of Federal Regulations [CFR]).

Non-IEP Services
School districts are also allowed to seek reimbursement from Medicaid for services provided under the Florida Administrative Code Medicaid rule for school-based services (Rule 59G-4.035).

☐ **I understand and give my consent** to the school district to share information about my child with the State Medicaid Agency (State of Florida Agency for Health Care Administration), its fiscal agent, and the school district's Medicaid billing agent or billing facilitator for the school district to verify Medicaid eligibility, seek Medicaid reimbursement, and satisfy audit and review requests related to services provided to my child.

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

The records to be released or exchanged may include IEPs, assessment and eligibility records, related service therapy records and logs, transportation logs, progress notes, and nursing reports or records.

The information shared may include my child's name, date of birth, address, primary special education disability (if applicable), Florida Medicaid identification number, Social Security number, and the type and amount of health services provided, including the times and dates services were provided. Services may include assistive communication services, physical therapy services, occupational therapy services, speech therapy services, hearing and language therapy services, behavioral services, transportation services, and nursing services.

☐ **I understand and do NOT give my consent** to the school district to share information about my child in order for the school district to verify Medicaid eligibility, seek Medicaid reimbursement, and satisfy audit and review requests related to services provided to my child

Student/Child's Information

Student ID	Full Name (printed)	Date of Birth

Parent/Guardians Information

Name (printed)	Signature	Date