

Labelle High School

4050 E Cowboy Way
Labelle, Florida 33935
(863) 674 - 4120

Principal: Mrs. Tammy Bass

School Counselor: Ms. Michelle Zimmerly (9th)

Assistant Principal: Mrs. Jennifer McClain

School Counselor: Mrs. Euratta Blackmon (10th)

Assistant Principal: Mr. James Brown

School Counselor: Mrs. Miranda Rincon (11th)

Dean: Mrs. Tomika Breese

School Counselor: Ms. Angie Hough (12th)

Registrar: Mrs. Noemi Chairez

Email: Chalrezn@hendry-schools.net

To register as a student at this school, you must complete a registration packet and submit the required documents to the school.

Required Documents:

___ Registration Packet

___ Birth Certificate

___ Florida certificate of immunization

___ State of Florida School Entry Form (Florida Physical)

___ Proof of Florida residency (FL driver license, light bill, rental receipt, etc)

___ Discipline/Attendance records

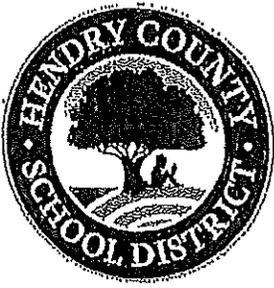
___ Copy of school transcriptions or academic history (grade 8-12), from all schools attended

___ Current report card or progress report for transfer grades

___ Copy of IEP, 504, ESE or special accommodations (if applicable)

___ Controlled open enrollment form (students that RESIDE OUTSIDE OF HENDRY COUNTY)

****Please return all documents to the Guidance Department****



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Hendry County School District

RESIDENCE STATEMENT

I hereby certify that I am a resident of Hendry County and that the location of my current Residence is:

I have lived at this location since: _____

I understand that children are not eligible to be enrolled in Hendry County Schools unless I actually live with the geographical boundaries of the county or have a release from the county of residence Board of Education.

Signature of Parent or Guardian

Date

What is the student's primary language? _____
 What is the parent's primary language? _____
 What is the parent's preferred spoken language? _____
 What is the parent's preferred written language? _____
 Is there a court order barring either parent from accessing the student at school? Yes No
 Is there a Temporary Restraining Order, Permanent Restraining Order, Order of No contact or other court order that restricts or impacts access to the student by anyone? Yes No

Please provide the school with a copy of any applicable court orders

The student has been arrested or prosecuted for a violation of a criminal statute resulting in a charge Yes No
 The student has been expelled from school. Yes No
 The student has a referral for mental health services associated with a school expulsion, arrest resulting in a charge, or a juvenile justice action? Yes No

Definitions:

Please answer BOTH questions 1 and 2.

1. Is your child Hispanic or Latino? (Please, mark only one.)
 - No, my child is not Hispanic or Latino
 - Yes, my child is Hispanic or Latino – A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

2. What is your child's race? (Please, mark all that apply, however mark at least one.)
 - American Indian or Alaska Native – A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.
 - Asian – A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, e.g., Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
 - Black or African American – A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."
 - Native Hawaiian or Other Pacific Islander – A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
 - White – A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

FOR OFFICE USE ONLY	
Zone:	_____
School:	_____
Orig. Entry Date:	_____
Student ID:	_____
Florida ID:	_____
Date Entered:	_____
Grade:	_____
HR Teacher:	_____
Bus Number:	_____
Birth Verification:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Custody:	_____
Immunization:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Physical:	<input type="checkbox"/> No <input type="checkbox"/> Yes
Exceptional Education	
<input type="checkbox"/>	Gifted
<input type="checkbox"/>	Physically Impaired
<input type="checkbox"/>	Physical Therapy
<input type="checkbox"/>	Occupational Therapy
<input type="checkbox"/>	Speech/Lang Impaired
<input type="checkbox"/>	IND
<input type="checkbox"/>	Deaf/HH
<input type="checkbox"/>	VI
<input type="checkbox"/>	EBD
<input type="checkbox"/>	SLD
<input type="checkbox"/>	OHI
<input type="checkbox"/>	TBI
<input type="checkbox"/>	ASD
<input type="checkbox"/>	DD -- before age 6
Other programs in which child was enrolled:	
<input type="checkbox"/>	RTI
<input type="checkbox"/>	ESOL

Signature of Parent/Legal Guardian _____ Date _____

Social Security Number Note: FL Statute 1008.386 -- When a student enrolls in a public school in this state, the district school board shall request that the student provide his or her social security number and shall indicate whether the student identification number assigned to the student is a social security number. A student satisfies this requirement by presenting his or her social security card or a copy of the card to a school enrollment official. However, a student is not required to provide his or her social security number as a condition for enrollment or graduation. The Commissioner of Education shall assist school districts with the assignment of student identification numbers to avoid duplication of any student identification number.

The School Board of Hendry County, Florida prohibits any policy or procedure, which results in discrimination on the basis of race, sex, national origin, marital status, disability, age, or religion. Individuals who wish to file a discrimination and/or harassment complaint, or individuals with disabilities requesting accommodations under the Americans With Disabilities Act (ADA) may call the equity officer at (863) 674-4350.

**Hendry County District Schools
Health Card**

Student: _____ Birthdate: _____ Phone(s): _____

Last First Middle

Schools: LES COES UES LMS LHS WES CES EES CMS CHS Grade _____

Teacher: _____

Physical Address: _____

Mailing Address: _____

Doctor's Name: _____ Dentist's Name: _____

Allergies: _____ Glasses/Lenses _____ No _____ Yes

Chronic/Serious health problems: _____

Is this student on Medication? No Yes If yes, what medication: _____

WE MUST HAVE A PHONE NUMBER OF SOMEONE TO CONTACT DURING THE SCHOOL DAY:

Please list contact persons in order of importance in relation to the student. Parents or guardians should be primary contacts. Please also include anyone approved to sign the student out from school, care for the student in case parent/guardian cannot be reached, and/or pick the student up from school, event, or in case of an emergency situation. If you wish to receive school and district notifications and/or want others to receive notifications via text message and/or call out, be certain to include mobile and home phone numbers. If you and/or other contacts only have a mobile phone line, be certain to include that phone number in *both* home and mobile fields.

Name: _____ Relation: _____ Employer: _____

Home phone: _____ Work phone: _____ Mobile Phone: _____

Email: _____ Desired Notification Method: Text Call-out Both None

Approved for student sign out/pick up: No Yes / Person has primary joint or no legal custody of child.

Name: _____ Relation: _____ Employer: _____

Home phone: _____ Work phone: _____ Mobile Phone: _____

Email: _____ Desired Notification Method: Text Call-out Both None

Approved for student sign out/pick up: No Yes / Person has primary joint or no legal custody of child.

Name: _____ Relation: _____ Employer: _____

Home phone: _____ Work phone: _____ Mobile Phone: _____

Email: _____ Desired Notification Method: Text Call-out Both None

Approved for student sign out/pick up: No Yes / Person has primary joint or no legal custody of child.

Name: _____ Relation: _____ Employer: _____

Home phone: _____ Work phone: _____ Mobile Phone: _____

Email: _____ Desired Notification Method: Text Call-out Both None

Approved for student sign out/pick up: No Yes / Person has primary joint or no legal custody of child.

In case of an accident or serious illness, I request the school contact me. If the school is unable to reach me or persons listed, I hereby authorize the school to contact the physician or dentist indicated on this form and follow his instructions. If it is impossible to contact this physician or dentist, the school may make whatever arrangements are necessary to provide care and treatment for my child.

Signature of Parent or Guardian

Date

NOTICE OF SCREENING: Non-invasive screening (vision, hearing, growth, blood pressure, scoliosis) will be done in selected grades. If you DO NOT wish for your child to participate, you must notify the school in writing.

Hendry County Health Department (DOH) and its partners will provide state-mandated vision screenings to public school students in your School District. If the vision screening shows a need for a follow-up vision examination, and if your child is eligible or otherwise financially qualified, Florida Heiken Children's Vision Program (FHCVP) may provide a FREE dilated vision examination, which may cause blurry near vision and some light sensitivity for up to 4-6 hours. Sunglasses are provided to alleviate any discomfort. The DOH partners are required by law to maintain the privacy of your child's protected health information, except for the limited cases below. **If you would like your child to receive these vision services, you do not need to respond** and in doing so, you are also agreeing to a mutual exchange of information between the FHCVP, referring providers, DOH and Hendry County Public Schools of any and all necessary information to enable your child to receive services and you agree to release and hold harmless the County School Board, Miami Lighthouse for the Blind & Visually impaired and the FHCVP providers from any and all responsibility and liability for any injury or claim resulting from your child's participation in the FHCVP. If you DO NOT want your child to receive these vision services, you are required to **notify the school in writing of the specific services that are being declined by September 30th of each school year or within 10 days of enrollment.**

Tarjeta de salud de las escuelas del distrito del condado de Hendry

Estudiante: _____ Fecha de nacimiento: _____ Teléfono (s): _____
Última Primera Intermedia
Escuela: LES COES UES LMS LHS WES CES EES CMS CHS Grado: _____
Maestro: _____
Dirección física: _____
Dirección postal: _____
Nombre de Médico: _____ Nombre del dentista: _____
Alergias: _____ Anteojos / lentes _____ No _____ Sí
Problemas de salud crónicos / graves: _____
¿Está este estudiante tomando medicamentos? _____ No _____ Sí En caso afirmativo, qué medicamento: _____

DEBEMOS TENER UN NÚMERO DE TELÉFONO DE ALGUIEN PARA CONTACTAR DURANTE EL DÍA ESCOLAR:

Enumere las personas de contacto en orden de importancia en relación con el estudiante. Los padres o tutores deben ser los contactos principales. Incluya también a cualquier persona aprobada para que el alumno salga de la escuela, cuide al alumno en caso de que no se pueda contactar al padre / tutor, y / o recoja al alumno de la escuela, evento o en caso de una situación de emergencia. Si desea recibir notificaciones de la escuela y del distrito y / o desea que otros reciban notificaciones por mensaje de texto y / o llamada, asegúrese de incluir números de teléfono móvil y de casa. Si usted u otros contactos solo tienen una línea de teléfono móvil, asegúrese de incluir ese número de teléfono en *ambos* Casa y campos móviles.

Nombre: _____ Relación: _____ Empleador: _____
Teléfono de la casa: _____ Teléfono del trabajo: _____ Teléfono móvil: _____
Correo electrónico: _____ Método de notificación deseado: __ Texto __ Llamar __ Ambos __ Ninguno
Aprobado para la salida / recogida del estudiante: __ No __ Sí / La persona tiene custodia __ primaria __ conjunta o __ Ninguno.

Nombre: _____ Relación: _____ Empleador: _____
Teléfono de la casa: _____ Teléfono del trabajo: _____ Teléfono móvil: _____
Correo electrónico: _____ Método de notificación deseado: __ Texto __ Llamar __ Ambos __ Ninguno
Aprobado para la salida / recogida del estudiante: __ No __ Sí / La persona tiene custodia __ primaria __ conjunta o __ Ninguno

Nombre: _____ Relación: _____ Empleador: _____
Teléfono de la casa: _____ Teléfono del trabajo: _____ Teléfono móvil: _____
Correo electrónico: _____ Método de notificación deseado: __ Texto __ Llamar __ Ambos __ Ninguno
Aprobado para la salida / recogida del estudiante: __ No __ Sí / La persona tiene custodia __ primaria __ conjunta o __ Ninguno

Nombre: _____ Relación: _____ Empleador: _____
Teléfono de la casa: _____ Teléfono del trabajo: _____ Teléfono móvil: _____
Correo electrónico: _____ Método de notificación deseado: __ Texto __ Llamar __ Ambos __ Ninguno
Aprobado para la salida / recogida del estudiante: __ No __ Sí / La persona tiene custodia __ primaria __ conjunta o __ Ninguno

En caso de accidente o enfermedad grave, solicito que la escuela se comunique conmigo. Si la escuela no puede comunicarse conmigo o con las personas que figuran en la lista, autorizo a la escuela a comunicarse con el médico o dentista indicado en este formulario y seguir sus instrucciones. Si es imposible contactar a este médico o dentista, la escuela puede hacer los arreglos necesarios para brindarle atención y tratamiento a mi hijo.

Firma del padre o tutor

Fecha

AVISO DE EXAMEN: El examen no invasivo (visión, audición, crecimiento, presión arterial, escoliosis) se realizará en grados seleccionados. Si NO desea que su hijo participe, debe notificar a la escuela por escrito. El Departamento de Salud del Condado de Hendry (DOH) y sus socios proporcionarán exámenes de la visión obligatorios por el estado a los estudiantes de las escuelas públicas de su distrito escolar. Si el examen de la vista muestra la necesidad de un examen de seguimiento de la vista, y si su hijo es elegible o está calificado financieramente de otro modo, el Programa de visión para niños Florida Heiken (FHCVP) puede proporcionar un examen de visión dilatada GRATUITO, que puede causar visión borrosa cercana y algunos sensibilidad a la luz por hasta 4-6 horas. Se proporcionan gafas de sol para aliviar cualquier molestia. La ley requiere que los socios del DOH mantengan la privacidad de la información de salud protegida de su hijo, a excepción de los casos limitados a continuación. Si desea que su hijo reciba estos servicios para la vista, no necesita responder y, al hacerlo, también acepta un intercambio mutuo de información entre el FHCVP, los proveedores de referencia, el DOH y las Escuelas Públicas del Condado de Hendry de todos y cada uno. Información necesaria para permitir que su hijo reciba servicios y usted acepta liberar y eximir de responsabilidad a la Junta Escolar del Condado, el Faro de Miami para Ciegos y Discapacitados Visuales y los proveedores del FHCVP de toda responsabilidad por cualquier lesión o reclamo que resulte de su hijo participación en el FHCVP. Si NO desea que su hijo reciba estos servicios de la vista, debe notificar a la escuela por escrito sobre los servicios específicos que se rechazarán antes del 30 de septiembre de cada año escolar o dentro de los 10 días posteriores de la inscripción.



**Junta Escolar del Condado de Hendry
Cuestionario de Vivienda Estudiantil 2025-2026**

Date: _____
Initials: _____

Este cuestionario está diseñado para cumplir con los requisitos de la Ley de Éxito Estudiantil: Título IX/Parte A. Las respuestas a las preguntas a continuación nos ayudarán a determinar si su estudiante puede calificar para servicios de apoyo educativo adicionales. **POR FAVOR, ESCRIBA CON LETRA DE MOLDE MUY CLARA, COMPLETE UN FORMULARIO POR FAMILIA** y devuelva el cuestionario a la oficina principal de su escuela.

- ¿Cuántos niños/jóvenes hay en su hogar (incluso si no están inscritos en la escuela)? _____
- Nombres de los estudiantes matriculados en la escuela (desde preescolar hasta grado 12) o no matriculados en la escuela, incluidos aquellos de 1 a 4 años.

Nombre de estudiante:

Primer Nombre MI Apellido Fecha De Nacimiento Grado Escuela

Otros niños/jóvenes en su hogar (incluso si no están inscritos en la escuela):

Primer Nombre	MI	Apellido	Fecha De Nacimiento	Grado	Escuela

3. Nombre del padre, tutor o joven no acompañado (en letra en molde): _____

- Dirección de la calle (ubicación de la casa): _____
- Tiempo en esta dirección: _____
- Dirección anterior: _____
- Dirección de correo: _____
- Teléfono: _____ Teléfono móvil: _____ Teléfono de trabajo: _____

La firma siguiente certifica que la información proporcionada es exacta.

Firma del padre, tutor o joven no acompañado: _____ Fecha: _____

4. Complete la Sección de Residencia Nocturna colocando una "X" en la casilla correspondiente para responder "Sí" o "No".

Residencia Nocturna	YES	NO	CODE
1. Mi familia vive en un refugio de emergencia o de transición (por ejemplo, un remolque de FEMA).			A
2. Mi familia comparte la vivienda con otras personas por pérdida de vivienda, dificultades económicas o motivo similar; vivienda compartida.			B
3. Mi familia vive en un automóvil, parque, parque de casas rodantes temporal o campamento debido a la falta de alternativas de alojamiento adecuadas; espacio público; edificio abandonado; vivienda deficiente; estación de autobús o tren; o lugar público o privado no diseñado ni usado comúnmente como alojamiento regular para dormir para seres humanos o entornos similares.			D
4. Mi familia vive en un hotel o motel por falta de alternativas de alojamiento adecuadas.			E
Complete si el estudiante es un joven no acompañado:			
1. Un niño/joven en mi hogar es menor de 16 años y no está acompañado (no está bajo la custodia física de un padre o tutor) o yo soy un joven no acompañado menor de 16 años.			<input type="checkbox"/>
2. Un niño/joven en mi hogar tiene 16 años de edad o más y no acompañado (joven que no está bajo la custodia física de un padre o tutor) o yo soy un joven no acompañado de 16 años de edad o más.			<input type="checkbox"/>

Marque una casilla. Motivo de la vivienda temporal o del desplazamiento familiar:

- | | | |
|---|---|--|
| <input type="checkbox"/> Desastre provocado por el hombre (mayor) (D) | <input type="checkbox"/> Incendio forestal (W) | <input type="checkbox"/> Desempleo (N) |
| <input type="checkbox"/> Terremoto (E) | <input type="checkbox"/> Inundación (F) | <input type="checkbox"/> Huracán (H) |
| <input type="checkbox"/> Ejecución hipotecaria (M) | <input type="checkbox"/> Tornado (T) | <input type="checkbox"/> Pandemia (importante) (P) |
| <input type="checkbox"/> Tormenta tropical (S) | <input type="checkbox"/> Otras causas de la falta de vivienda (N) | <input type="checkbox"/> Desconocida (U) |

Si respondió "Sí" a cualquiera de las preguntas anteriores, un representante educativo podría contactarlo para averiguar si su hijo o usted, como joven no acompañado, son elegibles para recibir servicios educativos adicionales. Instrucciones para el personal escolar: Haga una copia de esto para sus registros y envíela a Programas Federales - Liaison McKinney-Vento.



Director of ESE and Student Services
Lynnette White

Parental Consent for Healthcare

As required by F.S. 1014.06(1), parents or legal guardian must authorize healthcare services to be provided for their child by a healthcare practitioner or their delegate, as defined in F.S. 456.001 and 1006.062, should the need arise for such treatment, while their child is under the supervision of the school.

A "yes" response will authorize such treatments including, but not limited to major or minor injury or illness reported or observed while the child is at school. This does not authorize the dispensing of medication or school screenings such as vision, hearing, scoliosis, or height and weight. These services require a separate consent which was included in the original registration paperwork.

Failure to respond will result in an indication of "no" for healthcare treatment.

A "no" response will result in calls to the parent or guardian for the child to be picked up for all medical concerns. This will be for all instances where students are feeling ill have a headache or injuries such as cuts, scrapes, bumps, or bruises. EMS will be called for any situation deemed serious.

Emergency services will be provided to all students according to the standards found in the Florida Department of Health Emergency Guidelines for Schools at: <https://www.floridahealth.gov/programs-and-services/childrens-health/school-health/reports-information.html>

Do you authorize healthcare services? Yes No

Childs Name (print) _____ ID # _____

Parent/Legal Guardian Name (print) _____

Parent/Legal Guardian Signature _____

Date: _____ Grado _____

dated: 03/03/25



Director of ESE and Student Services
Lynnette White

Consentimiento de padres para atención médica

Según lo exige FS 1014.06(1), los padres o guardianes legales deben autorizar a que un profesional de salud o su delegado provea servicios de atención médica a su hijo, según se define en FS 456.001 y 1006.062, en caso de que surja la necesidad de dicho tratamiento, mientras su hijo está bajo la supervisión de la escuela.

Una respuesta "sí" autorizará dichos tratamientos, incluidos, entre otros, lesiones o enfermedades mayores o menores informadas u observadas mientras el niño está en la escuela. Esto no autoriza la dispensación de medicamentos o exámenes escolares tales como visión, audición, escoliosis o altura y peso. Estos servicios requieren un consentimiento por separado que se incluyó en la documentación de registro original.

La falta de respuesta dará lugar a una indicación de "no" para dichos tratamientos.

Una "no" resultará en llamadas a los padres o guardianes para que recojan al niño en cualquier caso de problemas médicos, o en caso que los estudiantes se sientan enfermos, tengan dolor de cabeza o lesiones como cortes, raspaduras, golpes o moretones. Se llamará a BMS para cualquier situación que se considere grave.

Se proporcionarán servicios de emergencia a todos los estudiantes de acuerdo con los estándares que se encuentran en las Pautas de emergencia para escuelas del

Departamento de Salud de Florida en: <https://www.floridahealth.gov/programs-and-services/childrens-health/school-health/reports-información.html>

¿Autoriza servicios de salud? Sí No

Nombre del niño (letra de imprenta) _____ ID# _____

Nombre de padre/guardián legal (letra de imprenta) _____

Firma de padre/guardián legal _____

Fecha: _____ Grado _____

Revised: 03/03/25



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Director of ESE and Student Services
Lynnette White

Parental Consent to Release Personally Identifiable Information for Medicaid Reimbursement

Student Name: _____ Student ID#: _____ DOB: _____ Grade: _____ School: _____

Our school district 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.

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).

Consent given or denied (please read, initial, and sign and date at the bottom):

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 34 CFR § 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 information shared may include my child's name, date of birth, address, primary special education disability (if applicable), Social Security number, Florida Medicaid identification 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. 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.

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.

Parent/Guardian's Name (printed): _____

Parent/Guardian's Signature: _____ Date signed: ____/____/____



HCSD Parent and Student Chromebook Damage/Loss Acknowledgement

The educational program at your students school includes a Chromebook that will be issued to your students for their use. We are very excited to be able to make these powerful tools available to our students. We also understand that both students and parents are concerned about keeping these tools secure and in good working order.

Like textbooks, team uniforms and other school property issued to your student there is a responsibility to take appropriate care of these valuable resources. You can find specific expectations for care and use of in the District's Acceptable Use Policy (AUP) and the Students Procedures for Technology and Device Usage. Providing chromebooks to students represents an increased cost to the District and liability to students and parents. We know that loss and accidents will happen. In accordance with District procedures, regulations, and practices we will require that a fine be levied to cover the repair or replacement cost of District property. With computing devices, like Chromebooks, the cost of loss or damage can be significant. Students who cause damage to school property shall be subject to disciplinary measures, and their parents shall be financially liable for such damage to the extent of the law.

If the student did not exercise proper care and/or take appropriate precautions, as described in the Student Procedures and AUP, and this behavior resulted in damage to or loss of the Chromebook the cost of the repair or replacement will be the responsibility of the student/parent.

Fees will be assessed as follows:

- Chromebook \$275.00 (full replacement value)
- Screen replacement \$50.00
- Keyboard replacement \$55.00
- Charger replacement \$30.00

The student will be issued a replacement or temporary replacement Chromebook. Payment or other resolution agreement due to financial hardship must be made with administration. The student may also be subject to disciplinary measures. If payment or resolution agreement is not made, the Board reserves the right to withhold a report card or credits from any student whose payment of such fine is in arrears, The board may also report to the appropriate juvenile authorities any student whose damage of school property has been serious or chronic in nature.

THEFT: If the Chromebook is stolen, the District will require that a police report be submitted. Fraudulent reporting of theft will be turned over to the police for investigation. A student making a false report will also be subject to disciplinary action.

I have read and understood the Chromebook Damage/Loss Program Procedures, Student Procedures for Technology and Device Usage, and Acceptable Use Policy.

Student Name: _____ ID#: _____ Grade Level: _____ Signature: _____

Parent/Guardian Name: _____ Signature: _____

Device Barcode #: _____

Acknowledgement Form

Dear Parent or Guardian:

The Code of Conduct clearly identifies most of the student behavior problems prevalent in school, school activities and school transportation and the policies for acceptable use of electronic resources and communication. This document also outlines the consequences for student misconduct and inappropriate behavior.

This document is not intended to be read from a negative point of view but rather with the attitude that parents and students deserve to know the rules and then act accordingly.

Any student, parent or guardian alleging unfair or discriminatory treatment may file a written complaint with the school and the Hendry County School District (HCSD). Complaint forms are available at every school, the main district office and the sub district office, and may be downloaded from the HCSD's website at www.hendry-schools.org.

Students are also expected to adhere to the policies and procedures outlined in the School Board of Hendry County Information Technology Policies and Procedures Manual. A copy of this manual can be downloaded from the HCSD's website at www.hendry-schools.org and is also available at every school.

After reading the Code of Conduct, please sign and return this form to the school within five days but no later than August 29, 2025.

Name of Student _____ Grade _____

Parent/Guardian _____ Date _____

Parent Email Address _____

Teacher _____

Formulario de Reconocimiento

Estimado padre o tutor:

El Código de Conducta Estudiantil identifican claramente la mayoría de los problemas de conducta de los estudiantes que prevalecen en la escuela, las actividades escolares y el transporte escolar y las políticas para el uso aceptable de los recursos electrónicos y la comunicación. Este manual también describe las consecuencias de la mala conducta de los estudiantes y el comportamiento inapropiado.

Este manual no está pensado para ser leído desde un punto de vista negativo, sino con la actitud de que los padres y los estudiantes merecen conocer las reglas y luego actuar en consecuencia.

Cualquier estudiante, padre o tutor que alegue un tratamiento injusto o discriminatorio puede presentar una queja por escrito ante la escuela y el Distrito Escolar del Condado de Hendry (HCSD). Los formularios de quejas están disponibles en todas las escuelas, la oficina principal del distrito y la oficina del subdistrito, y se pueden descargar del sitio web de HCSD en www.hendry-schools.org.

También se espera que los estudiantes se adhieran a las políticas y procedimientos descritos en el Manual de Procedimientos y Políticas de Tecnología de la Información del Consejo Escolar del Condado de Hendry. Se puede descargar una copia de este manual del sitio web de HCSD en www.hendry-schools.org y también está disponible en todas las escuelas.

Después de leer el Código de Conducta Estudiantil, firme y envíe este formulario a la escuela dentro de los cinco días pero antes del 29 de agosto del 2025.

Nombre de estudiante _____ Grado _____

Padre _____ Fecha _____

Correo electrónico de los padres _____

Profesor _____

Request for Alternative School Nutrition

Student's Name: _____

DOB: _____

School: _____

I certify that the above listed student has the following medical or other special dietary needs that must be accommodated by the food service program:

Medical Condition:

- Allergy _____
- Unable to Chew _____
- Nothing by Mouth (tube fed) _____
- Diabetes _____
- Other _____

Foods to be omitted:

- Milk _____
- Milk Products _____
- Citrus Products _____
- Sugar _____
- Peanuts _____
- Other _____

Please provide comments regarding food preparation; food substitutes or other comments:

Physician's Signature

Date



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