K-12
Tutoring Application
2024 - 2025 School Year

Date: ____________________

Student Name: ____
(Please Print Name)

Tribal Member Number: ________________________________

Reservation:

____

Submit application here:
Tutoring@semtribe.com

Jillian Deien
TW Tutoring Coordinator
(954) 989-6840
Ext. 10501

Jan Bishop
Tutoring Program Supervisor
(954) 989-6840
Ext. 10589

If you have any questions, please contact your local Education Department:

Big Cypress
31000 Josie Billie Highway
Clewiston, FL 33440
PH: (863) 902-3200

Brighton/Ft.Pierce
650 Harney Pond Road Suite 112
Okeechobee, FL 34974
PH:(863) 763-3572

Hollywood
3100 N. 63rd Avenue
Hollywood, FL 33024
PH: (954) 989-6840

Immokalee/Naples
295 Stockade Road
Immokalee, FL 34142
PH: (239) 867-5303

Tampa
6401 Harney Road
Tampa, FL 33610
PH: (813) 246-3100

SEMINOLE TRIBE OF FLORIDA
The Education Department

K-12 Application |School Year 2024 – 2025

Student's Name: ______________________________ Member ID #: ____________________

Name of School: ______________________________ Grade Level: ________________

Academic subject(s) in which student needs tutoring: (Be specific as possible ex. Algebra, Chemistry etc.)

____

Reservation: ______________________________ Tutoring Location: ______________________________

Please read, initial, and sign at the bottom. You are acknowledging all policies listed below for optimal program success.

1. First day tutoring begins Tuesday, September 3rd, 2024. _______
2. Students can receive up to 1, 2, 3, 4 hours of tutoring per week. _______
3. Students or parents MUST contact the tutor or tutoring company directly with any cancellations or attendance matters within two (2) hours prior to the scheduled session. (Notifying the Education Department does not suffice for proper cancellation). ________
4. The parent/ guardian will be responsible for weekly signatures to confirm tutoring hours. (If tutoring hours are not confirmed, tutoring will be paused until confirmation is received). _______
5. The Education Department reserves the right to withdraw the enrollment of a student who accumulates more than three (3) unexcused absences. _______
6. No tutoring for the following breaks: Thanksgiving, Winter break, Spring break, and Summer break.________

Parent/Legal Guardian

Name____

Address____

Phone ____

Email Address____

For Office Use Only!

Number of Hours:___________ Completed by: ______________________________

Comments:____

____

Tutoring Company: ____

Tutor Name: ______________________________ Date Received: ____________________ Location: ____________________

SEMINOLE TRIBE OF FLORIDA
The Education Department
Authorization for the Release of Information

The signature below authorizes the release of records and information

Student: ______________________ ______________ ____________________
First *Middle* *Last*

______________________ ____________
Date of Birth *Tribal Member #*

- Monitor Education Progress • Assessments and Referrals • Recognition and Events • Family Services
- Coordinate education services with school, family and other concerned person(s) • CCDT • REC • CBH
- Emergency/Hazards • Tutoring • SPD • Other (*Please specify*):

TO BE RELEASED TO/REQUESTED FROM: Seminole Tribe of Florida's Education Department					
O **BIG CYPRESS** 31000 Josie Billie Hwy Clewiston, FL 33440 (863) 902-3200	O **BRIGHTON/FT. PIERCE** 650 Harney Pond Rd Ste 112 Okeechobee, FL 34974 (863) 763-3572	O **HOLLYWOOD/TRAIL** 3100 N. 63rd Avenue Hollywood, FL 33024 (954) 989-6840	O **IMMOKALEE/NAPLES** 295 Stockade Road Immokalee, FL 34142 (239) 867-5303	O **TAMPA** 6401 Harney Road Tampa, FL 33610 (813) 246-3100	O **Non Resident**

Information to be released:

- Attendance Information • Report Cards/Progress Reports • ESE Reports
- Discipline Records/Actions • Standardized Test Information/Results • Current IEP/504 Plan
- Current Report Card • Assessments and Evaluations • Transcripts
- Psychological Evaluations • Dates and Reasons for Special Program Enrollment/Withdrawals
- Contact Information to STOF Departments

I hereby authorize the above indicated information/records to be disclosed from the Person/Agency and to be released to The Education Department. I understand the information is strictly confidential and will be used for the purposes stated above. I understand that this authorization will remain in effect from the date of signature until the student graduates from high school or until it is revoked by my written consent.

I have been informed and understand my rights regarding the release of these records.

______________________________ ________________
Parent/Guardian Signature *Date*

______________________________ ________________
Advisor Signature *Date*

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

AUTHORIZATION FOR RELEASE AND/OR REQUEST FOR INFORMATION

I hereby request and authorize: ____
(Name of Person, School, or Department)

____ to engage
(Street Address) (City) (State) (Zip) (Telephone #)

in verbal and/or written communication with and release records to : The Seminole Tribe of Florida (Education Department ______
(Name of Person, Job Title and/or School/Agency/Entity)

____ (954) 989-6840_________
(Street Address) (City) (State) (Zip) (Telephone #)

regarding the **information checked below** concerning my child* ____________________________________, whose date of birth is ____________. I understand that information concerning psychiatric, psychological, medical diagnosis, drug or alcohol abuse, economic status, and educational information regarding my child will be released and/or communicated if indicated below. I further understand that this information might contain information regarding my family, in addition to my child.

____ Treatment Plans
____ Treatment / Discharge Summaries
____ Health / Medical Records
____ Case / Progress / Therapy Notes
Academic / School-related Records:
____ Grades
____ Test Scores
____ Attendance
____ Suspensions / Expulsions
____ Exceptional Student Education / Section 504 records
____ Substance Abuse Treatment Records
____ Social and/or Developmental History
____ Psychological and/or Psychiatric Evaluations
____ Restorative Support Services
____ Social Support Services (Food, Clothing, Shelter)
____ Medical Services
____ HIV/AIDS test results or related conditions (to disclose or receive this information, specific individuals must be named above)
____ Other____

For the Purpose of: ____

I acknowledge that all information I authorize to be released or requested will be held strictly confidential and cannot be released by the recipient without an additional written consent. I understand this authorization will expire one (1) year after the date signed, or on ______________, 20____, whichever is earlier. A copy of this authorization is valid in lieu of the original. I further understand I may withdraw my consent in writing at any time.

____________________________________ ____
Print Name of Parent / Guardian / Eligible Student | Signature of Parent / Guardian / Eligible Student | Date

____
Relationship to Child

*Eligible students (age 18 or over) may authorize the release of their education records.

(USE THIS SPACE IF CONSENT IS WITHDRAWN)
I hereby withdraw my previous consent to the release of information about my child.

________________ ____
Date Consent Is Withdrawn | Signature of Parent / Guardian / Eligible Student

Form #4301
REV 04/15
Risk Management