

EMERGENCY INFORMATION – CONNECTIONS ACADEMY EAST

2019-2020 School Year

(Please fill out completely)

Pupil's LEGAL Name: Last _____ First _____ M.I. _____ Gender: M F

Birth Date: _____ Nickname: _____ Grade in School: _____ Student Cell (____) _____

Guardian/Parent 1 Full Name: _____ Home Phone: (____) _____ Cell: (____) _____

Address: _____ Work Phone: (____) _____

City: _____ Zip: _____

Guardian/Parent 2 Full Name: _____ Home Phone: (____) _____ Cell: (____) _____

Address: _____ Work Phone: (____) _____

City _____ Zip _____

Mother's email: _____ Father's email: _____

Child resides with: _____ both parents _____ mother only _____ father only _____ other/specify _____

Legal Guardian: _____ Mother _____ Father _____ Both Parents or _____ Guardian Name _____

Emergency contact (other than persons listed above): _____ Relationship: _____ Phone: (____) _____

Emergency contact (other than persons listed above): _____ Relationship: _____ Phone: (____) _____

Physician's Name: _____ Phone: (____) _____ Dentist's Name: _____ Phone: (____) _____

List any medical problems: _____

List any Allergies (food, medication, environmental or NONE): _____

Medications@Home (Name/Time/Amount) _____

Medications@School (Name/Time/Amount) _____

Physical Restrictions: _____ Dietary Concerns: _____

Language spoken in home if other than English: _____

If neither parent can be contacted in the case of serious injury or illness, I authorize the school to take such emergency action as may be deemed necessary, including transportation to a hospital or medical center.

Signature of Parent or Guardian _____ Date _____

STUDENT INFORMATION CONTINUED

Pupil's LEGAL Name: Last _____ First _____ Birth Date: _____

OUTSIDE AGENCIES INFORMATION:

Is the student currently seeing a therapist (outside of school)? YES NO If "yes" please specify the following:

Name of therapist: _____ Address: _____

City: _____ Zip Code: _____ Phone Number: _____

Do we have permission to contact this therapist? YES NO

If "yes" please complete a Consent to Release Information form.

Is the student currently seeing a psychiatrist (outside of school)? YES NO If "yes" please specify the following:

Name of psychiatrist: _____ Address: _____

City: _____ Zip Code: _____ Phone Number: _____

Do we have permission to contact this psychiatrist? YES NO

If "yes" please complete a Consent to Release Information form.

Is the student currently involved in the courts? YES NO

Is the student currently involved with a **probation officer**? YES NO

If "yes" please list the probation officer's name: _____

Phone number: _____

Do we have permission to contact the probation officer? YES NO

If "yes" please complete a Consent to Release Information form.

INSURANCE INFORMATION:

Name of Insurance Company: _____ Phone Number: _____

Address of Company: _____

Policy Holder's Name: _____ Birth Date: _____

Group/Policy Number: _____ Employer: _____

Connections Academy East

SCHOOL INFORMATION, PARENTAL WAIVERS & CONSENT FORMS

Please fill out this 6-page form completely **prior to** your child's first day of attendance and **turn it in to the Front Desk**. If you would like a copy of this document for reference, please see the "Forms, Information & Policies" page of your school's website, or request a copy from the Front Desk Staff.

Thank you.

PLEASE NOTE: this form is double-sided and requires multiple signatures.

SCHOOL HOURS

August – May:	Mondays, Tuesdays, Wednesdays & Fridays:	8:30 – 2:30
	Thursdays:	8:30 – 1:30
Summer Term:	Monday, Tuesdays, Wednesdays & Thursdays:	8:30 – 2:30

FOOD

Organic, nutritious, well-balanced lunches and healthy snacks are provided for all students. Please do not send any food to school with your child; this includes drinks, mints, gum, etc.

LATE ARRIVALS & ABSENCES

Please call the Front Desk to inform school staff, **prior to 8:30am** on the day of your child's absence or late arrival, and *indicate whether you would like your child's absence to be **excused or unexcused***. Office hours are from 7:30am – 3:30pm, but messages can be left for the Front Desk Staff at any time.

LATE ARRIVAL & EARLY PICK-UP

If you plan to bring in your child late or pick him/her up early, please notify the Front Desk Staff. In addition, when you arrive, you **must** come to the Front Desk and sign your child in or out. Students cannot be dropped-off or picked-up by anyone other than a parent/guardian or an **adult** who has been approved by his/her parent/guardian. Please fill-out the "Authorization for Alternative Transportation" form if this person will be dropping-off or picking-up your child on a regular basis and is not identified as a Parent or Emergency Contact on your child's "Emergency Information Form".

CABS/BUSES

It is the responsibility of the parent to notify the cab/bus company of the following:

- If your child will be absent in the morning
- If you will be bringing in your child in late, but s/he still needs a ride home
- If you plan to pick up your child early from school

Your child's school district will give you all of the transportation information you require, including the transportation company's contact information. The Front Desk Staff can also provide this information to you at any time.

MEDICATION

Absolutely **NO** medication will be given at school without written permission from a parent/guardian and doctor. This includes over-the-counter medication. Please see the "HIPPA Law and Your Child's Medications" and "Authorization for Administration of Medication at School" forms for more detailed information about this subject.

INSURANCE

Your Connections Academy East will not be liable for any accidents or injuries that occur while your child is at school, or any resulting medical bills. All families are encouraged to maintain either private insurance, insurance available through your public school district, or Medicaid/All Kids.

Your signature below acknowledges that you have read and understand the seven (7) statements above.

Signature of Parent/Guardian

Date

EDUCATIONAL SERVICE COLLABORATIONS

In order to provide educational services for all students, Connections Academy East collaborate with the Illinois State Board of Education, NWEA Measures of Academic Progress and Compass Odyssey. All student information provided remains confidential within these organizations.

Your signature below acknowledges that you have read and understand the statement above.

Signature of Guardian Date

THERAPY & ASSESSMENT PROGRAMS

Connections Academy East provide extensive individual, group and family therapy services for all students as well as diagnostic testing services when needed. All therapy and testing is provided by qualified clinicians some of whom may be Doctoral or Master’s-level Clinical Psychology students. Therapists-in-training are under the direct supervision of Licensed Clinical Psychologists and Licensed Clinical Professional Counselors on staff. Connections Academy East are a well-regarded clinical training sites for therapists in Illinois and beyond.

Your signature below acknowledges that you have read and understand the statement above.

Signature of Parent/Guardian Date

DEPARTURE FROM SCHOOL WITHOUT PERMISSION

The following steps will be taken when a student has been transported to school and then fails to enter the building, and/or leaves the school without permission:

1. Verbal warning to student about risks and consequences of elopement, if possible.
2. Call to Parent/Guardian.
3. School Staff will follow any student who leaves the building indefinitely
4. Local police may be contacted
5. A meeting may be required with School Staff, the school district and the Student and Parent prior to the student returning to school.
6. Chronic elopement behavior may also result in a careful assessment of whether the student continues to be appropriate for this school setting.

Your signature below acknowledges that you have read and understand the statement above.

Signature of Parent/Guardian **Date**

MULTIMEDIA

Periodically, photographs/videos are taken of students during classroom projects, on field trips, at Open House, Field Day, special events, and for the newsletter and yearbook. These photographs are never published in print/on video or any other medium except for the above school purposes, and are only utilized within the context of your Connections Academy East. If you do not give your permission, your child will be separated from classmates during activities that are photographed or videotaped.

- I **DO** give permission for my child to be photographed/videotaped.
- I **DO NOT** give permission for my child to be photographed/videotaped.

Signature of Parent/Guardian

Date

FIELD TRIPS

Periodically, students will be given the opportunity to participate in off-campus activities and events. All school rules apply at these activities and events. Please indicated below whether you do or do not give permission for your child to participate in field trip activities and events that take place within a 10-mile radius of the school. A separate field trip form will be sent for events that are more than 10 miles from school.

- I **DO** give permission for my child to travel within the 10-mile radius.
- I **DO NOT** give permission for my child to travel within the 10-mile radius.

Signature of Parent/Guardian

Date

PERMISSION FOR USE OF SUNSCREEN & INSECT REPELLANT

As long as the weather permits, our physical education program includes going outside. In an effort to be mindful of our students' health and possible sensitivities, we offer the option of having your child protected with sunscreen and/or insect repellent. Ideally, these products would be applied prior to the student coming to school. You may also supply your own product(s) for use at school. Any products brought from home will be kept locked in the nurse's office.

Please indicate by using the check-boxes below whether or not you give permission for your child to use these products at school. Please keep in mind that students will go outside without sunscreen or repellent unless this authorization is provided.

Sunscreen

- YES**, my child may use sunscreen at school at school **NO**, my child may not use sunscreen

Insect Repellant

- YES**, my child may use insect repellant with DEET at school (6-7% DEET)
 YES, my child may use insect repellant applied **without** DEET at school
 NO, my child may not use insect repellant at school

Signature of Parent/Guardian

Date

Connections Academy East

AUTHORIZATION FOR ALTERNATIVE TRANSPORTATION

It is the policy and expectation of the Connections Academy East that all Students are transported to and from school by their district-provided transportation (cab, bus, etc.). However, in the rare event that alternate transportation arrangements need to be made, we require the completion of this consent form by the Parent/Guardian of that Student.

I, _____ hereby authorize my child
Parent/Guardian's Name

_____ to be picked-up from, and/or
Student's Name

dropped off for, school by the following trusted adult(s):

Please note, the individuals identified below must be 18 or older if they are a family member; and 21 or older if they are not a family member. Identification will need to be shown prior to the student being released.

_____	_____	_____
<i>Adult's Name</i>	<i>Phone Number</i>	<i>Relationship to the Student</i>

_____	_____	_____
<i>Adult's Name</i>	<i>Phone Number</i>	<i>Relationship to the Student</i>

_____	_____	_____
<i>Adult's Name</i>	<i>Phone Number</i>	<i>Relationship to the Student</i>

_____	_____	_____
<i>Adult's Name</i>	<i>Phone Number</i>	<i>Relationship to the Student</i>

I understand that I have the right to revoke this consent at any time. If I no longer want my child to be picked-up from and/or dropped off for, school by the by the individual(s) listed above, I must inform a School Staff Member of my wishes (in-person, via phone or in writing). I also understand that this authorization will be valid from the date of signature (below), until September 30th of the following academic year – not to exceed 12 months.

Parent/Guardian's Signature

Date

Authorization for the Administration of Medication at School

Student Name _____ Date of Birth _____

Address _____

PHYSICIAN'S ORDERS: I hereby request that the school nurse, or authorized personnel, administer the medication(s) identified below, as it is medically necessary to do so during school hours.

Medication _____	Dose _____	Time(s) _____
Medication _____	Dose _____	Time(s) _____
Medication _____	Dose _____	Time(s) _____
Medication _____	Dose _____	Time(s) _____
Medication _____	Dose _____	Time(s) _____

Duration of Use: (start date - end date-not to exceed 12 months) _____ to _____

Condition(s) Requiring Medication(s) _____

Possible Side Effects _____

Physician's Signature _____ Date _____

Phone # _____ Fax # _____

.....
PARENT PERMISSION: I hereby give permission to the school nurse, or authorized school personnel, to administer the medication(s) ordered by the physician to the above-named student.

This student is also taking the following medication(s) at home ~ please write dosages & time(s) taken for all prescription and OTC medications:

I have read and understand the "Medication Policies and Procedures" regarding the administration of medication at school.

Parent's/Guardian's Signature _____ Date _____

Home Phone # _____ Work or Mobile Phone # _____

* See "Medication Policies and Procedures" on back*

Connections Academy East Medication Policies and Procedures

(Revised 1/22/2019)

Whenever possible, the parent or guardian should make arrangements for medication to be administered at home, before and/or after school hours. If a student's physical health and/or emotional wellbeing require the administration of medication during school hours, then the school policies and procedures are as follows:

1. Medication(s) are defined as all prescription and non-prescription (over the counter) pharmaceuticals and preparations. This includes but is not limited to; pain relievers, fever reducers, cough drops, eye drops, contact lens solutions, inhalers, allergy medications, skin ointments/lotions.
2. Medication will not be administered at school without a written physician's order and written parent/guardian permission on our school Authorization for the Administration of Medication form.
3. Prescription medication must be provided in the original pharmacy or physician labeled container clearly marked with the student's name and directions for use. Over the counter (OTC) medications must be in the original manufacturer's packaging and clearly marked with the student's name.
4. It is the parent/guardian's responsibility to provide the school with any and all medications/preparations that have been authorized to administer.
5. All student medications (prescription and over the counter) must be **delivered to school by the parent, guardian, or other responsible adult approved by the school administration. The student may not bring in medications, and medication is not to be brought in by the drive of transportation.** You may deliver medications:
 - To the school Monday thru Friday, 7:30 am to 3:30 pm (Tues. – Thur. during summer session).
 - Once per month at Parent Night.
 - Via Federal Express or regular mail addressed to the principal.
6. All medications, which are taken during school hours, will be locked in the nurse's office. An exception may be considered for bronchial inhalers with physician orders and parent permission.
7. The parent/guardian must assume responsibility for informing the school of any change in the student's health, or medications. Written Physician Orders and Parent Permission must accompany changes in medication given at school.
8. The school will act based on the health and medication information provided by the parent/guardian and health care provider(s). It is expected that the information provided is accurate, complete and up-to-date and that any changes will be communicated to the school in an expedited manner.
9. Medication is administered by CAE administrators or trained staff members. When dispensing medication, the medication administrator checks the Authorization for the Administration of Medication form, the student photo, and the log sheet to ensure the correct medication and dosage are provided to the correct student. Upon dispensing medications, the medication administration is logged with time, date and initials of the medication administrator in the Medication Log. The Medication Log includes student name, photo, medication name with dosages and the Authorization for the Administration of Medication form.

Connection's Academy East
Consent to Audio/Video Tape

I authorize the taping of my child (print name), _____
in psychotherapy sessions. I understand that these tapes will be used as a part of my child's treatment plan,
and by my child's therapist for clinical supervision and teaching/training purposes with other therapists and
student therapists. I understand that although my child's voice may be audible and/or likeness may be
visible, his/her full name will not be used, and all listeners/observers will have a professional obligation to
treat the material confidentially. I agree to the use of this tape in the following way(s) – please check (X) as
appropriate:

_____ For formal supervision and/or training within Connection's Academy East and our parent company,
Counseling Connection.

_____ For formal supervision and/or training at the student therapist's graduate program.

Program Name: _____

_____ For formal supervision and/or training at a specified site (from the 4 listed above).

Name of Site(s): _____

This consent will remain valid for one year from signature (unless withdrawn sooner), and may be
reauthorized only by signing a new consent form. Upon expiration of this agreement, I request that – please
check (X) as appropriate:

_____ The tape be destroyed.

_____ The tape be maintained in a confidential library for use as a training tool at Connection's Academy
East, and Counseling Connections, and will not require additional signed consent for its use. Any other use
of this tape will require signed consent for its specific use.

This consent is limited only to the information designated above, and will be used exclusively by the
individual agencies and schools named herein. The purpose of this consent is to assist in providing treatment
for your child; and training and supervision for student therapists. I understand that I have the right to revoke
this authorization at any time by submitting such a request in writing. I also understand that my refusal to
consent to audio/video taping will not interfere with my child's treatment, or education, in any way.

Signature of Parent/Guardian

Date

Signature of Student (if 12 years or older)

Date

Signature of Witness

Date

Connection's Academy East
300 S. Waukegan Road Lake Forest Illinois 60045
Phone ~ 224.544.5920
Fax ~ 224.544.5921

CONSENT TO RELEASE
EDUCATIONAL, MENTAL/PHYSICAL HEALTH AND LEGAL INFORMATION

Name

Date of Birth

I authorize, and request, the free oral and/or written exchange of the following Educational, Mental/Physical Health and Legal information regarding the student named above:

- Educational Reports & Information (e.g., Individualized Education Plans (IEP); Social/Developmental Histories; Progress Reports & Information; Disciplinary Reports; IWAS/SIS Data)
- Mental Health Information (e.g., therapeutic summaries; psychological evaluations; psychiatric reports; monthly progress reports to physicians, substance abuse evaluations and progress notes)
- Medical Reports & Information (e.g., medical/physical forms/reports; laboratory results)
- Re-release of records from physicians, mental health professionals, hospitals, partial hospitalization programs, and outpatient treatment programs which were obtained during the time the student was enrolled at our school

TO THE FOLLOWING:

- The student's home school district # _____ and its agents COOP _____ Other _____

I further authorize the home school district and the organizations checked above to release all said information to CAE.

I understand that this authorization will be valid from the date of signature, until September 30th of the following academic year (not to exceed 12 months). It is limited to only the information designated above, which will be released from, and to, only the individual(s), agencies and school(s) named herein. The purpose of this release of information is to assist in providing continuity of care. I understand that I have the right to revoke this consent at any time by submitting such a request in writing. I also understand that I have the right to inspect and copy the information disclosed. I understand that my refusal to consent to the release of the information specified above will prevent disclosure of such material to the individual(s) and school(s) named herein, and, as such, may reduce the accuracy and quality/completeness of care provided. I authorize the information to be released via e-mail, knowing there are risks to confidentiality in the use of e-mail.

Signature of Parent/Guardian

Date

Signature of Student (if 12 years or older)

Date

Witness

Date

Connection's Academy East
300 S. Waukegan Road Lake Forest Illinois 60045
Phone ~ 224.544.5920
Fax ~ 224.544.5921

CONSENT TO RELEASE
EDUCATIONAL, MENTAL/PHYSICAL HEALTH AND LEGAL INFORMATION

Name Date of Birth

I authorize, and request, the free oral and/or written exchange of the following Educational, Mental/Physical Health and Legal information regarding the student named above:

- Educational Reports & Information (e.g., Individualized Education Plans (IEP); Social/Developmental Histories; Progress Reports & Information; Disciplinary Reports; IWAS/SIS Data)
- Mental Health Information (e.g., therapeutic summaries; psychological evaluations; psychiatric reports; monthly progress reports to physicians, substance abuse evaluations and progress notes)
- Medical Reports & Information (e.g., medical/physical forms/reports; laboratory results)
- Re-release of records from physicians, mental health professionals, hospitals, partial hospitalization programs, and outpatient treatment programs which were obtained during the time the student was enrolled at our school

TO/FROM:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ **Fax or E-mail** _____

AND

Your Child's Home School District and its agents

I further authorize the home school district and the agency/person listed above to release all said information to CAE.

I understand that this authorization will be valid from the date of signature, until September 30th of the following academic year (not to exceed 12 months). It is limited to only the information designated above, which will be released from, and to, only the individual(s), agencies and school(s) named herein. The purpose of this release of information is to assist in providing continuity of care. I understand that I have the right to revoke this consent at any time by submitting such a request in writing. I also understand that I have the right to inspect and copy the information disclosed. I understand that my refusal to consent to the release of the information specified above will prevent disclosure of such material to the individual(s) and school(s) named herein, and, as such, may reduce the accuracy and quality/completeness of care provided. I authorize the information to be released via e-mail, knowing there are risks to confidentiality in the use of e-mail.

Signature of Parent/Guardian

Date

Signature of Student (if 12 years or older)

Date

Witness

Date

CONNECTIONS ACADEMY EAST

FUNCTIONAL BEHAVIORAL ASSESSMENT CONSENT FORM

Dear Parent/Guardian,

As part of your child's placement, a Functional Behavior Assessment (FBA) will be conducted by the School Team. An FBA is the process of:

- ✓ Identifying behavior(s) that interfere with learning
- ✓ Identifying environmental factors which impact behavior(s) that interfere with learning
- ✓ Determining the cause/function of the behavior(s) that interfere with learning
- ✓ Developing a hypothesis of the function of behavior(s) that are interfering with learning

The purpose of the FBA is to gather relevant data to plan for and determine the needs regarding a possible Behavior Intervention Plan, which must be developed anytime a student exhibits behaviors that interfere with learning (his or her learning or the learning of others).

A FBA may include, but is not limited to, the following indirect as well as direct methods:

Indirect:

Review of student cumulative records- health, medical, and educational

Direct:

Structured interview with school personnel and/or student
Observations and data collections regarding student behavior

I give consent for an FBA to be completed for my child. I further understand that my consent is voluntary and can be revoked.

I do not give consent for an FBA to be completed for my child.

Reasons (Optional): _____

Parent/Guardian Signature

Date

Witness Signature

Date

SPECIAL TREATMENT TECHNIQUES

The Staff at the Connections Academy East believe that a student's development will progress as long as the child experiences a supportive, structured, consistent, stimulating environment. When behavioral and/or emotional disabilities are impeding academic success, our staff utilize a variety of strategies to help the students learn the academic, social and emotional management skills necessary for success within the school environment.

Throughout the school day, the staff utilize a point sheet to acknowledge the positive, pro-social and notable efforts that each student makes. They also help the students to identify problems and areas of struggle, utilize the point sheet to explain why their behavior is impeding their ability to be successful in the classroom. They will point out the negative effects the problem is creating, suggest alternative behaviors and help the student practice these within a nurturing setting.

At times, the student may persist with disruptive or inappropriate behaviors. When this occurs, the student will be asked to leave the activity, but remain within the proximity of the group while taking a "time out" in the hallway.

If the behavior continues to disrupt the group, the student may be referred to the Behavioral Intervention Services (BIS) office for a more intensive level of support. Our Behavioral Intervention Specialists are trained in crisis intervention, conflict resolution, and teaching students the skills to better manage their impulses; more effectively get their needs met; and practice pro-social, appropriate ways to cope with and express their thoughts and feelings.

If a student is acting in a manner that indicates the possibility of physical harm to him/herself or others, it may be appropriate for the staff to engage in a "therapeutic hold" of the student in order to prevent this outcome. The safety and dignity of the child, as well as the safety of peers and staff, is of paramount importance in this process; and it is always as unobtrusive and brief as possible. Consistent staff training in crisis prevention and non-violent physical intervention techniques is provided by the Connections Academy East and is required of all Staff Members. If a therapeutic hold is necessary to maintain care, welfare, safety, and security of students and staff, the following will occur:

1. A senior staff member will be present during the intervention
2. The school nurse and the student's therapist will be notified
3. The school nurse or designee will conduct a wellness check
4. Parents will be notified the same school day
5. NCI paperwork will be completed including:
 - a. Behavior Intervention Referral Form (precipitating classroom events, antecedents, interventions used)
 - b. School Incident Report (narrative by all staff involved in the hold, including therapist, nurse, and senior staff member evaluating the child immediately after the hold)
 - c. Student Intervention Form (behavior intervention form completed by student)

6. The student's team engages in a discussion of current behavioral concerns and an analysis of the effectiveness of the current Behavior Intervention Plan at the next Functional Behavioral Assessment meeting
-

The Connections Academy East follows all procedures specified in the 23 Illinois Administrative Code C.H.I.S. Subpart B Section 1.285. At times, the nature of the threats to self or others may necessitate:

- Contacting an emergency assessment team who will evaluate for hospitalization; or referring the student and parent to a local Emergency Room so the student can be evaluated for hospitalization.
- Contacting the local Police Department
- Contacting the student's psychiatrist, outside therapist, probation officer, caseworker, etc. for additional support.
- An informal parent meeting and/or formal staffing may be required prior to the student returning to school.
- Chronic threatening or aggressive behavior may also result in a careful assessment by the team as to whether or not the student continues to be appropriate for Connections Day School.

We do not endorse the use of time-out/padded rooms, mechanical restraint or harsh/punitive interventions. The Connections Academy East does not engage in therapeutic holding of a student as a consequence, or for any other reason aside from a clear indication that a student is a threat to him/herself or others. Overall, we believe that students can learn to act in safe and appropriate manner with the positive guidance of nurturing adults, who adhere to the clear rules, boundaries and expectations established within the school.

SPECIAL TREATMENT TECHNIQUES

Signature page

We thank you for taking the time to read and review the Special Treatment Techniques of our schools. If you have any further questions, please contact your principal.

Your signature below acknowledges that you have read, understand, and have received a copy of the Special Treatment Techniques outlined above.

Signature of Parent/Guardian

Date

Connections Academy East

RECEIPT & ACKNOWLEDGMENT

I have received a copy of Connections Academy East **Student & Parent Handbook** (*updated: July, 2019*), and have read through the provisions set therein with my child.

I understand the provisions of this handbook, and have discussed all questions, comments and concerns with the Senior Staff Members at Connections Academy East, **Mrs. Elaina Shannon** (Principal), **Mr. Brad Piech** (Assistant Principal), **Dr. Ruth Tompkins** (Senior Clinical Psychologist) or **Dr. Carlos Garcia** (Assistant Senior Clinical Psychologist). Administrative staff can be reached at **224-544-5920** or through **email**. Please call the front desk, or see the school website for specific phone extensions and email addresses.

I understand that the school has the right to change, modify, alter or cancel any provision of the handbook without notice; and that the handbook supersedes all policies, written or oral, that may have been in effect.

I have kept a copy of this handbook, and know that I can find it on the school website, so that I may refer to it at any time.

Parent/Guardian Printed Name

Parent/Guardian Signature

Student Printed Name

Student Signature

Date