THE CALAIS SCHOOL INFORMATION PACKET
2019-2020

Dear Parents/Guardians,

Please complete the enclosed forms and return them to the main office no later than June 21, 2019. These forms are needed to complete the program information for your student and contain important contact and medical information needed in the event of an emergency. **Please note that your student will not be able to attend the 2019 Extended Year Program or 2019-2020 school year without these forms completed and returned to the main office.**

**EXTENDED SCHOOL YEAR DATES/TIMES: JULY 8th to AUGUST 16th, 8:30am-12:30pm.**

Extended School Year runs from Monday through Friday. There are no scheduled vacation days during the summer program.

Please note, up-to-date immunization records, documentation of a current physical (for new incoming students), and a physician's order to administer medication (if applicable) must be provided to The Calais School before your child's first day of the 2019 Extended School Year Program or 2019-2020 school year.

Thank you for taking the time to complete and return these forms. If you have any questions, please contact the school directly at (973) 884-2030. The school office is open daily from 7:30 A.M. until 4:00 P.M.

We appreciate your cooperation and look forward to a happy and productive school year!

Sincerely,
Samantha Helfer and Christina Pedersen
The Calais School Main Office
INFORMATION PACKET CHECKLIST
2019-2020

Please review all of the information contained in this packet about the upcoming school year. Then kindly complete and return the following forms to the Main Office:

☐ Emergency Information Sheet
☐ Email Contact Information Update
☐ Nut-Free Facility Policy
☐ Medical Information Packet
  ☐ Medical Information Sheet
  ☐ Release for Emergency Medical Treatment
  ☐ Request for Prescription Over The Counter or Non-Prescription Medication to be Administered by School Nurse
  ☐ Physical Examination From
☐ Counseling Services Treatment/Medication Update Form
☐ Permission Request/Consent Form for Counseling Services and to Allow Staff to Contact Out-of-School Counselors, Physicians, and Agencies
☐ Consent to Work with School Psychiatrist
☐ Search and Seizure Policy
☐ Cell Phone Permission at School
☐ Therapeutic Video Taping Policy
☐ Movie Rating Form
☐ Audiovisual Release Form
☐ Computer Internet Acceptable Use Policy Agreement
☐ AAT Forms

If your child has allergies or asthma, please complete and return the enclosed treatment plans.

Making a difference... one child at a time.
EMERGENCY INFORMATION
2019-2020

STUDENT: ____________________________ D.O.B. ____________________________

STREET ADDRESS: ____________________________ PHONE: ____________________________

CITY/ZIP/STATE: ____________________________

MOTHER/GUARDIAN'S FULL NAME: ____________________________

Home Address (if different): ____________________________

Email: ____________________________

Home Phone: ____________________________ Cell Phone: ____________________________

Work Phone: ____________________________

Mother’s Place of Employment: ____________________________ Title: ____________________________

FATHER/GUARDIAN'S FULL NAME: ____________________________

Home Address (if different): ____________________________

Email: ____________________________

Home Phone: ____________________________ Cell Phone: ____________________________

Work Phone: ____________________________

Father’s Place of Employment: ____________________________ Title: ____________________________

EMERGENCY CONTACTS (when parents/guardians cannot be reached):

Two contacts (in addition to parents/guardians) MUST be on file.

Name: ____________________________ Phone: ____________________________

Address: ____________________________ Relationship: ____________________________

Name: ____________________________ Phone: ____________________________

Address: ____________________________ Relationship: ____________________________

NJAC 6:29-2.3 REQUIRES THAT EMERGENCY INFORMATION MUST BE ON FILE AT THE TIME A STUDENT BEGINS HIS/HER SCHOOL PROGRAM.

PLEASE NOTIFY SCHOOL OFFICIALS IMMEDIATELY AS TO CHANGES OR MODIFICATIONS TO ANY/ALL INFORMATION STATED.

Making a difference... one child at a time.
ATTENDANCE POLICY

PLEASE DO NOT FORGET TO CALL THE CALAIS SCHOOL AT

(973) 884-2030

FOR EACH DAY YOUR STUDENT WILL BE ABSENT FROM SCHOOL.

If you know in advance of any days your student will be absent, please send a note to the school addressed to your student’s homeroom teacher. The teacher will give the information to the Main Office.

Your student’s safety is our greatest concern. The Calais School Main Office will call your home or office should you not call or send a note to confirm the whereabouts of your student.

FIVE DAY LETTERS

Based on New Jersey state regulations, The Calais School must send an official notification when a student has been absent for five days, regardless of whether the absence was excused or unexcused. A letter will be mailed to your district case manager when your child has been absent for five days.
WEATHER CLOSING OR DELAY NOTICE

Dear Parents and Guardians,

In the past, inclement winter weather conditions have brought to light the fact that many of our drivers are not aware of the means to find out about our school closings or delays. We realize that this information is essential for you to make alternate arrangements. A decision to close or delay a school opening is made as early as possible, usually the evening before or by 5:30 a.m.

All Calais School closings or delays are broadcast on the following radio, cable TV stations and through the “One Call Now” automated phone call system:

NEWS 12Cablevision TV
ABC-7 NY
One Call Now System (see attached form)
Calais website: www.thecalaisschool.org

A recorded telephone message at The Calais School is also available before our personnel arrive to answer the phone. However, because the message is only available on one of our phone lines, we ask you to check the TV messages, website and automated message alert system first to avoid delays. We hope this information is helpful.

Sincerely,
Dr. Diane Manno
Principal
E-MAIL CONTACT/PARENT PORTAL INFORMATION UPDATE

2019-2020

Dear Parents and Guardians,

Please fill out the form below and return to the school office. Should this e-mail address change at any time, notify the office and we will update our call list. This e-mail address will be used to update parents about upcoming events, school closures, and early dismissals.

During the 2015-2016 school year, we began sending student progress reports and report cards home via email to save paper and ensure that you receive your child’s report cards in a timely manner. Going forward in the 2019-2020 school year, ALL student progress reports and report cards will be sent home electronically utilizing our PowerSchool Parent Portal system. If you created a PowerSchool account last year, your username and password will remain the same during the 2019-2020 school year. If you are a new Calais parent, please contact Samantha Helfer in the main office to set up your parent portal account by e-mail at samantha.helfer@thecalaisschool.org.

______________________________

PLEASE CLEARLY PRINT

Student Name _______________________________________________________________

Parent Name __________________________________________________________________

E-Mail Address(s) ____________________________________________________________

Parent/Guardian Signature ____________________________________________________

Making a difference... one child at a time.
Dear Parents and Guardians,

As always, the safety and well-being of all Calais School students is of great importance to all of us. Like many schools, The Calais School has students with serious, life-threatening reactions to many foods. A severe allergic reaction may occur if these children eat, smell, or touch these foods.

To help provide and ensure the health, safety, and welfare of all of our students, please be advised that The Calais School is a “nut-free” building. **Therefore, no nuts of any kind, products made with or containing nuts, or any food manufactured/processed on machinery with nuts may be brought onto the premises.**

Please be careful to read all food labels before sending food into school. If your child should bring a lunch and or snack that does not meet the above guidelines, we will remove the food to protect our students and you will be called to school to provide another food choice.

Your cooperation in this matter is greatly appreciated. I ask that you please respect and adhere to these guidelines for the safety of all Calais School students. If throughout the course of the year you have any questions or concerns about food allergy-related issues, please do not hesitate to contact the school nurse.

Please sign below to acknowledge you understand and will cooperate with this policy. Thank you for your ongoing cooperation and efforts in keeping our school a safe and nurturing environment for all of our children.

Sincerely,

Dr. Diane Manno
Principal

I, Mr./Mrs./Ms. ___________________________ have read, understand, and will fully comply with the above “Nut-Free” Facility Policy. I agree to do my part in keeping the school nut free.

________________________________________
Student’s Name

________________________________________
Signature of Parent/ Guardian

______________________________  _______________________
Date  Making a difference... one child at a time.
THE CALAIS SCHOOL MEDICAL INFORMATION
2019-2020

We look forward to working with your child this school year!

To ensure a safe and healthy environment for all of our students, we ask that you provide us with some information. Please take the time to carefully review the following policies and procedures.

Before your student can begin at The Calais School, please provide the following:

- Up-to-date immunization records
- Documentation from a current physical within the last 365 days (only if your student is new to The Calais School OR your student plans on participating in intramural sports)
- Physician’s orders to administer medication (if applicable)

New physician orders are required by July 1, 2019 for administering medication to students requiring medication during the school year and the Extended School Year (ESY) program. These orders will be valid until June 30, 2020 for the required school year. A physician’s order is also required to administer analgesics or over-the-counter medications.

IF YOU ARE AWARE YOUR CHILD HAS ALLERGIC REACTIONS REQUIRING THE ADMINISTRATION OF AN EPI PEN AN ANAPHYLAXIS EMERGENCY CARE PLAN IS REQUIRED.

If your child has asthma, allergies, or ongoing medical concerns, I encourage you to consult with our school nurse as soon as possible. She is available in person during regular school hours, by phone, (973) 884-2030 ext. 218.

Thank you for your prompt attention and assistance in supplying the required information.

IN ORDER NOT TO DELAY YOUR CHILD’S START DATE PLEASE RETURN THE ATTACHED FORMS AS SOON AS POSSIBLE.

Thank you,
Dr. Diane Manno
Principal
MEDICAL INFORMATION SHEET  
2019-2020

STUDENT______________________________________________________________________ D.O.B.___________________________

FAMILY DOCTOR____________________________________________________________ OFFICE PHONE______________

ADDRESS_____________________________________________________________________________________________________

FAMILY DENTIST___________________________________ OFFICE PHONE_______________________

ADDRESS_____________________________________________________________________________________________________

SPECIALISTS
NAME___________________________________________________________ OFFICE PHONE_______________________

ADDRESS_____________________________________________________________________________________________________

HEALTH INFORMATION

Does your student have any chronic health conditions? YES____ NO____

If yes, please indicate:

___Asthma
___Kidney/Bladder
___Arthritis
___Diabetes

___Type 1 ___Type 2

___Bleeding Disorders

___Internal Irregularities
___Anaphylaxis
___Other Allergy (list):
___Surgical

___Kidney/Bladder
___Arthritis

___Convulsive Seizures
___Wears Glasses

___Sight Impairment
___Deafness

___Anaphylaxis

___Convulsive Seizures
___Wears Glasses

Please explain ALL if yes:____________________________________________________________________________________

PRESCRIPTION MEDICATION: Name and dosage:_______________________________________________________________

________________________________________________________________________________________________________

Time administered: At Home:__________________ At School:____________________

NON-PRESCRIPTION MEDICATION: Name and dosage:____________________________________________________________

________________________________________________________________________________________________________

Time administered: At Home:__________________ At School:____________________

SPECIAL DIETARY RESTRICTIONS OR ADDITIONAL REQUESTS ______________________________________________________

________________________________________________________________________________________________________

________________________________________________________________________________________________________

Signature of Parent/Guardian__________________________________________________ Date

Making a difference... one child at a time.
RELEASE FOR EMERGENCY MEDICAL TREATMENT
2019-2020

Dear Parent or Guardian:

In case of medical emergency, it is imperative that the school be able to insure adequate and appropriate treatment for your child. In order to do so, a medical release is necessary. Please complete the release below and return it immediately to the school.

In the event of a medical emergency requiring professional medical attention while at school, your child will be taken to Morristown Memorial Hospital by ambulance. You will be notified immediately. A designated staff member will accompany the child until you arrive.

Yours sincerely,
Dr. Diane Manno
Principal

******************************************
I, Mr./Mrs./Ms.___________________________________________________ hereby grant permission to

The Calais School to take my child ________________________________________________

to an appropriate medical facility in order that he/she may be provided with emergency medical attention when required. Your signature below is not sufficient for the release of confidential information protected by law.

Special instructions: (Please indicate any allergies to medication, etc.)

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

_____________________________________________        _____________________
Signature of Parent/Guardian                         Date

Making a difference... one child at a time.
To: Parent(s) and/or Guardians  Date: May 2019
From: Dr. Diane Manno  Re: Medication in School

ALL over-the-counter and prescription medications need a physician’s order to be administered by the school nurse.

The following is the school policy for the administration of medication at The Calais School:

If a child is required to take oral medication during school hours and the parent cannot be at the school to administer the medication, the school nurse will administer the medication in compliance with the regulations that follow:

1. A copy of the signed request medication form must be on file prior to the administration of any medication.

2. Written instructions signed by parent and physician shall be required and shall include:
   a. child’s name  e. dosage
   b. name of medication  f. possible side effects
   c. purpose of medication  g. termination date for administering
   d. time to be administered  the medication

2. The school nurse shall:
   a. inform appropriate school personnel of the medication.
   b. keep a record of the administration of the medication.
   c. keep medication in a locked cabinet.
   d. return unused medication to the parent only.

3. The parent/guardian of the child must assume responsibility for informing the nurse of any change in the child’s health or change in medication.

4. A copy of this regulation shall be provided to parents upon their request for administration of medication in the school.

5. Any modifications in these procedures will be forwarded to you as they are established.

NJSA 18A:40-1 et. seq.; NJAC 6:29-1.1 et. seq.

Making a difference... one child at a time.
REQUEST FOR PRESCRIPTION MEDICATION TO BE ADMINISTERED BY SCHOOL NURSE 2019-2020

PARENTAL REQUEST:

I, _________________________ the parent/guardian of __________________________ hereby request that the medication prescribed by my child's physician be administered to my child by the school nurse at the prescribed time below.

_________________________ SIGNATURE OF PARENT
_________________________ DATE

__________________________________________________

ADDRESS

PHONE NUMBER

***************************************************************************************************

PHYSICIAN’S STATEMENT:

In order to protect the health of ______________________________ it is necessary for him/her to have the following medication during school hours.

MEDICATION:

DOSAGE:

Time to be administered:

Purpose of medication:

Possible side effects:

Diagnosis:

I hereby authorize the school nurse to administer the above medication.

_________________________ ____________________________
Physician Signature DATE

____________________________________________________________________________

Physician’s Stamp

Making a difference... one child at a time.
May 2019

Dear Parents/Guardians:

The school nurse is not permitted to dispense over-the-counter medications or ointments without an “order to dispense” signed by a physician. These over-the-counter medications include: aspirin, Tylenol, Advil, antacid tablets, cough or cold medications, non-narcotic analgesics, cough drops as well as topical creams and ointments, and any other similar products.

**Therefore, should you foresee a need for your child to receive any of the above, or similar over-the-counter products, please have your family physician sign an order for our school nurse to dispense such products.** Enclosed is the request form that may be duplicated if necessary.

We thank you for your attention and cooperation in this matter. As always our school nurse will be happy to address any questions or concerns you may have regarding this matter or any other medication dispensing issues.

Sincerely,

Dr. Diane Manno, LCSW, Ed.D.
Principal
REQUEST FOR PRESCRIPTION OR OVER THE COUNTER OR NON-PRESCRIPTION MEDICATION TO BE ADMINISTERED BY SCHOOL NURSE
2019-2020 School Year

PARENTAL REQUEST:

I, __________________________ the parent/guardian of __________________________ hereby request that the medication prescribed by my child’s physician be administered to my child by the school nurse at the prescribed time below.

__________________________________________   ________________________
SIGNATURE OF PARENT                     DATE

__________________________________________   ________________________
ADDRESS                     PHONE NUMBER

********************************************************************************************************

PHYSICIAN’S STATEMENT:

In order to protect the health of __________________________ it is necessary for him/her to have the following medication during school hours.

MEDICATION:

SPECIFIC DOSAGE (not a range):

Time to be administered or specific interval of time for P.R.N.:

Purpose of medication:

Possible side effects:

Diagnosis:

I hereby authorize the school nurse to administer the above medication.

__________________________________________   ________________________
PHYSICIAN’S SIGNATURE                     DATE

__________________________________________
PHYSICIAN’S STAMP

Making a difference... one child at a time.
May 2019

Dear Parents and Guardians:

The Calais School is required by New Jersey law to provide all students between the ages of 10 and 18 a Scoliosis Screening every two (2) years. The Scoliosis Screening will be conducted by our school nurse.

However, as stated in the Guidelines, upon a written request of a parent or guardian, your child will be exempt from the screening and will not be penalized in any way. We do encourage you to have your child screened. The screening is painless and takes only a few moments in the nurse’s office.

**Should you choose not to have your child screened, please sign the form below and return it to school.** If you have questions about Scoliosis Screening, please call the school nurse.

Thank you for your attention and cooperation.

Sincerely,
Dr. Diane Manno
Principal

---

**PLEASE RETURN THIS FORM IF YOU DO NOT WISH YOUR CHILD TO HAVE A SCOLIOSIS SCREENING.**

Date:_______________________

I do not want my child (please print name)____________________________
to have a Scoliosis Screening.

___________________________________  __________________________________
(Please Print Parent/Guardian Name)   (Signature of Parent/Guardian)
Asthma Treatment Plan – Student Parent Instructions

The PACHNJ Asthma Treatment Plan is designed to help everyone understand the steps necessary for the individual student to achieve the goal of controlled asthma.

1. Parents/Guardians: Before taking this form to your Health Care Provider, complete the top left section with:
   - Child’s name
   - Child’s date of birth
   - Parent/Guardian’s name & phone number

2. Your Health Care Provider will complete the following areas:
   - The effective date of this plan
   - The medicine information for the Healthy, Caution and Emergency sections
   - Your Health Care Provider will check the box next to the medication and check how much and how often to take it
   - Your Health Care Provider may check “OTHER” and:
     - Write in asthma medications not listed on the form
     - Write in additional medications that will control your asthma
     - Write in generic medications in place of the brand name on the form
   - Together you and your Health Care Provider will decide what asthma treatment is best for your child to follow

3. Parents/Guardians & Health Care Providers together will discuss and then complete the following areas:
   - Child’s peak flow range in the Healthy, Caution and Emergency sections on the left side of the form
   - Child’s asthma triggers on the right side of the form
   - Permission to self-administer Medication section at the bottom of the form: Discuss your child’s ability to self-administer the inhaled medications, check the appropriate box, and then both you and your Health Care Provider must sign and date the form

4. Parents/Guardians: After completing the form with your Health Care Provider:
   - Make copies of the Asthma Treatment Plan and give the signed original to your child’s school nurse or child care provider
   - Keep a copy easily available at home to help manage your child’s asthma
   - Give copies of the Asthma Treatment Plan to everyone who provides care for your child, for example: babysitters, before/after school program staff, coaches, scout leaders

PARENT AUTHORIZATION

I hereby give permission for my child to receive medication at school as prescribed in the Asthma Treatment Plan. Medication must be provided in its original prescription container properly labeled by a pharmacist or physician. I also give permission for the release and exchange of information between the school nurse and my child’s health care provider concerning my child’s health and medications. In addition, I understand that this information will be shared with school staff on a need to know basis.

__________________________
Parent/Guardian Signature

__________________________
Phone

__________________________
Date

FILL OUT THE SECTION BELOW ONLY IF YOUR HEALTH CARE PROVIDER CHECKED PERMISSION FOR YOUR CHILD TO SELF-ADMINISTER ASTHMA MEDICATION ON THE FRONT OF THIS FORM.

RECOMMENDATIONS ARE EFFECTIVE FOR ONE (1) SCHOOL YEAR ONLY AND MUST BE RENEWED ANNUALLY

☐ I do request that my child be ALLOWED to carry the following medication ______________________ for self-administration in school pursuant to N.J.A.C. 6A:16-2.3. I give permission for my child to self-administer medication, as prescribed in this Asthma Treatment Plan for the current school year as I consider him/her to be responsible and capable of transporting, storing and self-administration of the medication. Medication must be kept in its original prescription container. I understand that the school district, agents and its employees shall incur no liability as a result of any condition or injury arising from the self-administration by the student of the medication prescribed on this form. I indemnify and hold harmless the School District, its agents and employees against any claims arising out of self-administration or lack of administration of this medication by the student.

☐ I DO NOT request that my child self-administer his/her asthma medication.

__________________________
Parent/Guardian Signature

__________________________
Phone

__________________________
Date

The Pediatric/Adult Asthma Coalition of New Jersey encourages you to talk with your child’s doctor about the Pediatric/Adult Asthma Coalition of New Jersey’s Asthma Treatment Plan. The Pediatric/Adult Asthma Coalition of New Jersey’s Asthma Treatment Plan is designed to help everyone understand the steps necessary for the individual student to achieve the goal of controlled asthma.

Sponsored by American Lung Association A New Jersey Affiliate

Making a difference... one child at a time.
**Asthma Treatment Plan – Student**

(This asthma action plan meets N.J. Law N.J.S.A. 10A:43-12.3) **(Physician’s Orders)**

(Please Print)

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Doctor</th>
<th>Parent/Guardian (if applicable)</th>
<th>Emergency Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**HEALTHY (Green Zone) ![Image](image1.png)**

You have all of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work, exercise, and play

And/or Peak flow above _____

---

**CAUTION (Yellow Zone) ![Image](image2.png)**

You have any of these:
- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other: ________

If quick-relief medicine does not help within 15-20 minutes or has been used more than 2 times and symptoms persist, call your doctor or go to the emergency room.

And/or Peak flow from _____ to _____

---

**EMERGENCY (Red Zone) ![Image](image3.png)**

Your asthma is getting worse fast:
- Quick-relief medicine did not help within 15-20 minutes
- Breathing is hard or fast
- Nose opens wide • ribs show
- Trouble breathing and talking
- Lips blue • fingernails blue
- Other: ________

And/or Peak flow below _____

---

**Take daily control medicine(s). Some inhalers may be more effective with a “spacer” – use if directed.**

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>HOW MUCH to take and HOW OFTEN to take it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advair® HFA [45, 115, 220]</td>
<td>2 puffs twice a day</td>
</tr>
<tr>
<td>Albuterol® [0.5, 1.25, 2.5 mg]</td>
<td>1 puff every 4 hours as needed</td>
</tr>
<tr>
<td>Xopenex® [0.083, 0.167, 0.333 mg]</td>
<td>1 puff every 20 minutes</td>
</tr>
<tr>
<td>Combitvent® Respimat®</td>
<td>1 inhalation 4 times a day</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take ________ puff(s) minutes before exercise.

---

**Continue daily control medicine(s) and ADD quick-relief medicine(s).**

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>HOW MUCH to take and HOW OFTEN to take it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albuterol MDI [Pro-air® or Proventil® or Ventolin®]</td>
<td>2 puffs every 4 hours as needed</td>
</tr>
<tr>
<td>Xopenex®</td>
<td>2 puffs every 4 hours as needed</td>
</tr>
<tr>
<td>Albuterol [0.125, 0.25 mg]</td>
<td>1 puff every 20 minutes</td>
</tr>
<tr>
<td>DuNov®</td>
<td>1 puff every 20 minutes</td>
</tr>
<tr>
<td>Xopenex® [Levalbuterol] [0.31 mg, 0.625 mg]</td>
<td>1 puff every 20 minutes</td>
</tr>
<tr>
<td>Combivent® Respimat®</td>
<td>1 inhalation 4 times a day</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

- If quick-relief medicine is needed more than 2 times a week, except before exercise, then call your doctor.

---

**Take these medicines NOW and CALL 911. Asthma can be a life-threatening illness. Do not wait!**

<table>
<thead>
<tr>
<th>MEDICINE</th>
<th>HOW MUCH to take and HOW OFTEN to take it</th>
</tr>
</thead>
<tbody>
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<td>Albuterol MDI [Pro-air® or Proventil® or Ventolin®]</td>
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</tr>
<tr>
<td>Combivent® Respimat®</td>
<td>1 inhalation 4 times a day</td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

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**Permission to Self-administer Medication:**

☐ This student is capable and has been instructed in the proper method of self-administering the non-returbled inhaled medications named above in accordance with N.J. Law.
☐ This student is not approved to self-medicate.

**Physician’s Orders**

<table>
<thead>
<tr>
<th>PHYSICIAN/PH PA SIGNATURE</th>
<th>Physician’s Orders</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>PARENT/GUARDIAN SIGNATURE</th>
<th>Physician’s Orders</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>PHYSICIAN STAMP</th>
<th>Physician’s Orders</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Make a copy for parent and for physician file, send original to school nurse or child care provider.**
Preparticipation Physical Evaluation

**History Form**

*(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep copy of this form in the chart.)*

<table>
<thead>
<tr>
<th>Date of Exam</th>
<th>Date of birth</th>
</tr>
</thead>
</table>

**Name**

**Sex**

**Age**

**Grade**

**School**

**Sport(s)**

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking.

<table>
<thead>
<tr>
<th>Medicines</th>
<th>Pollens</th>
<th>Food</th>
<th>Stinging Insects</th>
</tr>
</thead>
</table>

Do you have any allergies?  □ Yes  □ No  If yes, please identify specific allergy below.

Explain “Yes” answers below. Circle questions you don’t know the answers to.

### General Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has a doctor ever denied or restricted your participation in sports for any reason?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Do you have any ongoing medical conditions? If so, please identify below: □ Asthma □ Anemia □ Diabetes □ Infections □ Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Have you ever spent the night in the hospital?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Have you ever had surgery?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Heart Health Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Have you ever passed out or nearly passed out DURING or AFTER exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Does your heart ever race or skip beats (irregular beats) during exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: □ High blood pressure □ A heart murmur □ High cholesterol □ A heart infection □ Kawasaki disease □ Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Do you get lightheaded or feel more short of breath than expected during exercise?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Have you ever had an unexplained seizure?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Do you get more or short of breath more quickly than your friends during exercise?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Heart Health Questions about your Family

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, aortic stenosis, or congenital heart disease?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Bone and Joint Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Have you ever had any broken or fractured bones or dislocated joints?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Have you ever had a stress fracture?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Have you ever been told that you have or you have had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Do you regularly use a brace, orthotics, or other assistive device?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Do you have a bone, muscle, or joint injury that bothers you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Do any of your joints become painful, swollen, feel warm, or look red?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Do you have any history of juvenile arthritis or connective tissue disease?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete  Signature of parent/guardian  Date


New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71
## Preparticipation Physical Evaluation

### The Athlete with Special Needs: Supplemental History Form

<table>
<thead>
<tr>
<th>Date of Exam</th>
<th>Date of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name</strong></td>
<td><strong>Sex</strong></td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td><strong>Grade</strong></td>
</tr>
<tr>
<td><strong>School</strong></td>
<td><strong>Sport(s)</strong></td>
</tr>
</tbody>
</table>

1. Type of disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident/trauma, other)
5. List the sports you are interested in playing

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. Do you regularly use a brace, assistive device, or prosthesis?
7. Do you use any special brace or assistive device for sports?
8. Do you have any rashes, pressure sores, or any other skin problems?
9. Do you have a hearing loss? Do you use a hearing aid?
10. Do you have a visual impairment?
11. Do you use any special devices for bowel or bladder function?
12. Do you have pain or discomfort when urinating?
13. Have you had autonomic dysreflexia?
14. Have you ever been diagnosed with a heat-related (hyperthermia) or cold-related (hypothermia) illness?
15. Do you have muscle spasticity?
16. Do you have frequent seizures that cannot be controlled by medication?

**Explain “yes” answers here**

---

**Please indicate if you have ever had any of the following.**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Atlantoaxial instability
X-ray evaluation for atlantoaxial instability
Dislocated joints (more than one)
Easy bleeding
Enlarged spleen
Hepatitis
Osteoporosis or osteopenia
Difficulty controlling bowel
Difficulty controlling bladder
Numbness or tingling in arms or hands
Numbness or tingling in legs or feet
Weakness in arms or hands
Weakness in legs or feet
Recent change in coordination
Recent change in ability to walk
Spina bifida
Latex allergy

**Explain “yes” answers here**

---

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

**Signature of athlete**

**Signature of parent/guardian**

**Date**
### Preparticipation Physical Evaluation

**PHYSICAL EXAMINATION FORM**

**PHYSICIAN REMINDERS**

1. Consider additional questions on more sensitive issues
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Have you ever used alcohol or drugs?
   - Have you ever tried cigarettes, chewing tobacco, or dip?
   - During the last 30 days, did you use cigarettes, chewing tobacco, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance supplements?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?

2. Consider reviewing questions on cardiovascular symptoms (questions 5–14).

#### EXAMINATION

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
</table>

**MEDICAL**

- **Appearance**
  - Marfan’s, mitral stenosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperactivity, myopia, MVP, aortic insufficiency
- **Eyes/ears/nose/throat**
  - Pupils equal
  - Hearing
- **Lymph nodes**
- **Heart**
  - Murmurs (auscultation standing, supine, +/– Valsalva)
  - Location of point of maximal impulse (PMI)
- **Pulses**
  - Simultaneous femoral and radial pulses
- **Lungs**
- **Abdomen**
- **Genitalia (males only)**
- **Skin**
  - HSV lesions suggestive of MRSA, tinea corporis
- **Neurologic**

#### MUSCULOSKELETAL

| Neck | Spine | Shoulder/arm | Elbow/forearm | Wrist/hand/fingers | Hip/thigh | Knee | Leg/ankle | Foot/toes | Functional | Gait
|------|------|-------------|--------------|-------------------|----------|------|----------|----------|------------|------
|      |      |             |              |                   |          |      |          |          |            |      |

- Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
- Consider GJL exam if in private setting. Having third party present is recommended.
- Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

- Cleared for all sports without restriction
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for

- Not cleared
  - Pending further evaluation
  - For any sports
  - For certain sports

Reason

Recommendations

I have examined the above-named student and completed the preparticipation physical examination. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. It conditions arise after the athlete has been cleared for participation, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type)

Address

Phone

Signature of physician, APN, PA


New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71.
Making a difference… one child at a time.

PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM

Name ___________________________ Sex ☐ M ☐ F Age __________________ Date of birth ______________

☐ Cleared for all sports without restriction
☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for

☐ Not cleared
☐ Pending further evaluation
☐ For any sports
☐ For certain sports _______________________________
   Reason __________________________________________

Recommendations

EMERGENCY INFORMATION

Allergies ________________________________

Other Information

HCP OFFICE STAMP

SCHOOL PHYSICIAN:

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) ______________________ Date ____________

Address ____________________________________ Phone __________________

Signature of physician, APN, PA ____________________________

Completed Cardiac Assessment Professional Development Module

Date ____________ Signature ____________________________


New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71
Dear Parents and Guardians,

The stages developed for successful counseling services are characterized by the five primary tasks for therapy:

1. Establishing a relationship between the school and the home.
2. Defining the problem.
3. Deciding on the goals for the therapy.
4. Selecting a therapeutic plan.
5. Ongoing therapy and follow-up.

The Individualized Education Plan developed for your student for the 2019-2020 school year states a requirement for counseling services during the school day. In order for these services to be developed in the appropriate manner and be relevant to your student and your family, two things must be established—understanding and agreement between all parties.

By completing the following informed consent form, the process of working together to provide services for your student will begin.

Yours sincerely,

Dr. Diane Manno, LCSW, Ed.D.
Principal
Dear Parents and Guardians,

This year, we are the counselors who will be working with your student. In addition, we are available to meet by appointment with parents to discuss any concerns or problems at home or at school.

We are enclosing a short questionnaire for you to fill out and returned to us as soon as possible. **A NEW FORM MUST BE FILLED OUT EACH YEAR.** It is important for us to have this information and any accompanying release forms so that we can more effectively plan a program for your child.

Good home-school communication is an important resource for the success of our students. We look forward to seeing you during the school year.

Sincerely,

Paul Vitaletti, ED.S. LMFT  
*Assistant Director*  
*Head of Counseling Services*

---

**COUNSELING SERVICES**  
**2019-2020**

**David Leitner, LCSW**  
*Executive Director*

**Dr. Diane Manno, LCSW, Ed.D**  
*Principal*

**Stephen Sokolewicz, M.Ed**  
*Supervisor of Instruction*
COUNSELING SERVICES TREATMENT / MEDICATION UPDATE FORM 2019-2020

<table>
<thead>
<tr>
<th>Student’s Name: ________________________</th>
<th>Home Phone: ________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth: ________________________________</td>
<td>Work Phone: ________________</td>
</tr>
<tr>
<td>Mother’s Name: ________________________________</td>
<td>Cell Phone: ________________</td>
</tr>
<tr>
<td>Address: ______________________________________</td>
<td>Work Phone: ________________</td>
</tr>
<tr>
<td>Father’s Name: ________________________________</td>
<td>Cell Phone: ________________</td>
</tr>
<tr>
<td>Address: ______________________________________</td>
<td>Home Phone: ________________</td>
</tr>
<tr>
<td>Legal Guardian: ________________________________</td>
<td>Cell Phone: ________________</td>
</tr>
<tr>
<td>Parents are: Married________ Separated____ Divorced_____ Widowed______</td>
<td></td>
</tr>
<tr>
<td>Parents are: Married________ Separated____ Divorced_____ Widow ske________</td>
<td></td>
</tr>
<tr>
<td>If divorced/separated:</td>
<td></td>
</tr>
<tr>
<td>Custody arrangement: Full custody:</td>
<td></td>
</tr>
<tr>
<td>Child resides with: Mother________ Father____</td>
<td></td>
</tr>
<tr>
<td>Child resides with: Mother________ Father____</td>
<td></td>
</tr>
<tr>
<td>Joint Custody____</td>
<td></td>
</tr>
<tr>
<td>Joint Custody____</td>
<td></td>
</tr>
<tr>
<td>Visitation established: Yes________ No_______</td>
<td></td>
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<tr>
<td>Visitation established: Yes________ No_______</td>
<td></td>
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<tr>
<td>Special Restrictions____</td>
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<tr>
<td>Special Restrictions____</td>
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<tr>
<td>Transportation:</td>
<td></td>
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<tr>
<td>Only Mother can pick up student: __________</td>
<td></td>
</tr>
<tr>
<td>Transportation:</td>
<td></td>
</tr>
<tr>
<td>Only Mother can pick up student: __________</td>
<td></td>
</tr>
<tr>
<td>Visitation established: Yes________ No_______</td>
<td></td>
</tr>
<tr>
<td>Both parents may pick up student: __________</td>
<td></td>
</tr>
<tr>
<td>Child resides with: Mother________ Father____</td>
<td></td>
</tr>
<tr>
<td>Child resides with: Mother________ Father____</td>
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<tr>
<td>Shared____</td>
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<tr>
<td>Shared____</td>
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<tr>
<td>Custody arrangement: Full custody:</td>
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<tr>
<td>Joint Custody____</td>
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<tr>
<td>Joint Custody____</td>
<td></td>
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<tr>
<td>Visitation established: Yes________ No_______</td>
<td></td>
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<tr>
<td>Visitation established: Yes________ No_______</td>
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<tr>
<td>Special Restrictions____</td>
<td></td>
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<tr>
<td>Special Restrictions____</td>
<td></td>
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<tr>
<td>Child’s age when: Separated________</td>
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<tr>
<td>Divorced________</td>
<td></td>
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<tr>
<td>Divorced________</td>
<td></td>
</tr>
</tbody>
</table>

Is your child currently in treatment? Yes____ No____ (If yes, please sign the enclosed release forms so that contact may be established)

<table>
<thead>
<tr>
<th>Psychiatrist Name: ________________________</th>
<th>Phone: ____________________</th>
<th>Fax: __________</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychologist Name: _________________________</td>
<td>Phone: ____________________</td>
<td>Fax: __________</td>
<td></td>
</tr>
<tr>
<td>Counselor Name: ____________________________</td>
<td>Phone: ____________________</td>
<td>Fax: __________</td>
<td></td>
</tr>
<tr>
<td>Neurologist Name: __________________________</td>
<td>Phone: ____________________</td>
<td>Fax: __________</td>
<td></td>
</tr>
<tr>
<td>Pediatrician Name: _________________________</td>
<td>Phone: ____________________</td>
<td>Fax: __________</td>
<td></td>
</tr>
<tr>
<td>Is your child on medication? Yes____ No____</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is your child on medication? Yes____ No____</td>
<td></td>
<td></td>
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<tr>
<td>Please list names and noticeable side effects, if any:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. _________________ Side effect______________________________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. _________________ Side effect______________________________</td>
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<tr>
<td>3. _________________ Side effect______________________________</td>
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<tr>
<td>4. _________________ Side effect______________________________</td>
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<tr>
<td>5. _________________ Side effect______________________________</td>
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<tr>
<td>6. _________________ Side effect______________________________</td>
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<tr>
<td>7. _________________ Side effect______________________________</td>
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<tr>
<td>8. _________________ Side effect______________________________</td>
<td></td>
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<tr>
<td>Would you be interested in attending a parent support group? Yes_____ No_____</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Would you be interested in attending a parent support group? Yes_____ No_____</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, what time of day would be convenient for you? (Please circle any/all that interest you)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days 10:00-11:00am 1:00-2:00pm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evenings 5:30-6:30pm 6:30-7:30pm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other: __________________________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent Signature: ____________________________</td>
<td>Date________________________</td>
<td></td>
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</tbody>
</table>

Making a difference... one child at a time.
PERMISSION REQUEST/CONSENT FORM FOR COUNSELING SERVICES AND TO ALLOW STAFF TO CONTACT OUT-OF-SCHOOL COUNSELORS, PHYSICIANS, AND AGENCIES
2019-2020

I, _______________________, am the parent/guardian of _____________________, a student at The Calais School. I hereby give my informed consent for the Counseling Team at The Calais School to provide Intervention Services and Group Counseling for the above-named student during the 2019-2020 school year. By signing below, I acknowledge that I have been informed that the counseling services provided are limited to social skills training and issues that impede my child’s ability to function effectively in the school environment. I understand that these services are not to be considered a substitute for ongoing private therapy.

I further understand that by signing below, I hereby give my informed consent for the Counseling Program staff of The Calais School, including consulting psychiatrists, psychologists, counselors, L.D. consultants, nurses, and/or the School Principal and Assistant Principal, to speak to and exchange information with my above-named child’s therapist, physician, and/or agency, _______________________, whose telephone number is _______________________, whenever necessary to provide the above-referenced Intervention and Group Counseling services. The information obtained by such contract will be used solely for counseling services and will remain strictly confidential.

This authorization is voluntary and I may cancel this consent to release information at any time by sending written notice to the Principal of The Calais School, 45 Highland Avenue, Whippany, NJ 07981. I understand that any release which was made prior to my cancellation in compliance with this authorization shall not constitute a breach of my rights and the student’s rights to confidentiality.

By signing this form, I certify that I am a parent/guardian of this individual and fully understand my (our) rights and responsibilities under this agreement.

_________________________  ____________________________
Date  Signature of Parent/Guardian
PERMISSION REQUEST/CONSENT FORM FOR COUNSELING SERVICES AND TO ALLOW STAFF TO CONTACT OUT-OF-SCHOOL COUNSELORS, PHYSICIANS, AND AGENCIES

2019-2020

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_________________________  __________________________
Date                        Signature of Parent/Guardian
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2019-2020

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_________________  ________________________________
Date                     Signature of Parent/Guardian
RELEASE TO WORK WITH SCHOOL PSYCHIATRIST
2019-2020

The Calais School retains Bryan Fennelly, M.D. to work on a consulting basis with our school nurse and social workers. Dr. Fennelly is a Board Certified Child and Adolescent Psychiatrist affiliated with Morristown Memorial Hospital. Dr. Fennelly will be providing additional resources to The Calais School social workers and nurse on a consulting basis.

Please sign and date the release below, which will provide authorization for your child to work with Dr. Fennelly when requested by the school nurse or social workers to provide additional therapeutic information and consultation to the school specialists.

If you have any questions, please feel free to call Dr. Diane Manno, Principal, at The Calais School.

Sincerely,
David Leitner, M.S.S.W., L.C.S.W.
Executive Director

I (parent/guardian) ___________________________ grant permission to The Calais School for Dr. Fennelly and/or Licensed Counselors to work with our child, (print name) ___________________________, on a consultative basis with the school nurse and social workers when requested by the school specialists.

Signed: ___________________________ Date: ___________________________
USE OF RESTRAINT

RETAINT is defined as the use of physical force, without the use of any device or material, that restricts the free movement of all or a portion of a student’s body.

RETAINT DOES NOT INCLUDE:

- Briefly holding a student in order to calm or comfort the student;
- Holding a student’s hand or arm to escort the student safely from one area to another;
- Moving a disruptive student who is unwilling to leave the area if other methods such as counseling, cajoling, etc., have been unsuccessful; or
- Intervening in a fight in accordance with school polices and state law.

RETAINT IS NOT TO BE USED IN THE SCHOOL, UNLESS:

- There is an emergency situation and physical restraint is necessary to protect a student or other person from imminent, serious, physical harm after other less intrusive, non-physical interventions have failed or been determined inappropriate;
- The student’s behavioral intervention plan and/or IEP describe the specific behaviors and circumstances in which physical restraint may be used; or
- The parents of a nondisabled student have otherwise provided written consent to the use of physical restraints while a behavior intervention plan is being developed.

PHYSICAL RETAINT SHALL BE APPLIED ONLY BY SCHOOL PERSONNEL WHO ARE TRAINED IN THE APPROPRIATE USE OF PHYSICAL RETAINT CONSISTENT WITH COMAR 13A.08.04.06. IN APPLYING PHYSICAL RETAINT, SCHOOL PERSONNEL SHALL ONLY USE REASONABLE FORCE AS NECESSARY TO PROTECT A STUDENT OR OTHER PERSON(S) OR PROPERTY FROM IMMINENT, SERIOUS, PHYSICAL HARM OR DESTRUCTION. PHYSICAL RETAINT SHOULD NOT BE USED AS A PUNITIVE MEASURE.

MECHANICAL RETAINT IS STRICTLY FORBIDDEN IN THE SCHOOLS.

WHEN RETAINT IS USED, STAFF IS REQUIRED TO:

- Complete and sign a restraint documentation form;
- File a copy of the form in the student’s educational record;
- Forward a copy of the form to the parent within 24 hours of the incident, unless provided for in a student’s BIP or IEP; and
- Forward copies to the Student’s Child Study Team caseworker.
BEST PRACTICES ALSO SUPPORT:

- Debriefing with staff involved in the incident.

If you have any concerns regarding the use of restraint policy please contact Mr. Steve Sokolewicz at (973) 884-2030 ext. 214.
To: ALL Parents and/or Guardians

Re: Search and Seizure Policy

In compliance with state code, the administration of The Calais School has developed a Search and Seizure policy. This policy is directly based on state law codified in N.J.S.A 18A:36.

This notice is to inform you that The Calais School and its designated representatives will, under the direction of the school Principal, inspect students’ lockers, desks, purses, backpacks and/or other belongings when and if it is deemed that there is reasonable cause for such inspection. The main purpose of this policy is to maintain student safety and compliance with school regulations.

Please be advised that parents will be directly informed, as will the sending district child study team, if and when such a search does take place.

Please read the Search and Seizure policy carefully, and sign this form to indicate that you have done so. Should you have any questions regarding this policy, please call the school and speak directly to the school Principal. Should you wish to read the entire Search and Seizure Manual, it is available to be read at The Calais School.

Thank you,
Dr. Diane Manno
Principal

___________________________________________________
Student’s Name
____________________________________________________
Signature of Parent/ Guardian Date

2019-2020

I, Mr./Mrs./Ms. ____________________________ have read and understand the Search and Seizure Policy.
2019-2020 SEARCH AND SEIZURE POLICY

Because of the surge of violent behavior in schools in the past few years, it has been essential for the Administration to pursue all lawful means at our disposal in order to provide a SAFE environment for our students. This means that we are committed to doing everything within our power to keep guns, weapons, drugs and alcohol out of our school and off school grounds. We at Calais are dedicated to making the school a safe, highly structured and well-disciplined school environment, which is conducive to learning. In order to achieve this, the Administration must be free to engage in searching students' belongings when circumstances warrant such action. We recognize the fact that search and seizure must be balanced against the rights that our students enjoy under the State and Federal Constitutions to be free from unreasonable searches and seizures. Therefore, we have followed the guidelines which have been set out by the New Jersey State Department of Education, in attempt to achieve a delicate balance which will protect the rights of students to be safe. At the same time, we do respect the rights guaranteed to our students under the Fourth Amendment.

The Calais Administration will not tolerate the presence of drugs, alcohol, firearms or any type of weapon on school property, and will use all LAWFUL means to detect, discipline and where appropriate, punish those students who break the rules and endanger other students or staff.

The law, which governs search and seizure, provides the school administration and law enforcement officers the flexibility to protect ALL students from harm, and to enforce the school codes of conduct. Thus, in compliance with the Calais School policy and state code, this means that where there is reasonable suspicion, students' desks, purses, back packs, messenger bags and sundry belongings will be searched. These searches will be conducted under the principal's supervision or designee, as often as may be necessary in order to guarantee the safety and well being of the entire school community.

Parents and students should bear in mind that these searches are not solely to seize drugs or catch students with weapons so that they can be prosecuted. Rather, we hope that these searches will ensure the safest possible environment for all students by preventing and discouraging students from engaging in illegal and dangerous conduct on school grounds.
CELL PHONE PERMISSION AT SCHOOL
2019-2020

The Calais School is aware that many parents permit their children to carry cell phones. The heightened concerns for safety and security are understood. In this growing age of technology, cell phones provide an instant communication connection. However, in order to prevent disruption during the school day, and at the same time respect parent/guardian concerns, a school policy has been implemented.

The policy of the Calais School is that if parents/guardians request that their child carry a cell phone to school, the school will permit them to do so under the following conditions:

1. Cell phones are to be **turned off** when the student arrives at school and are to be out of sight during the entire school day while on school grounds.
2. Cell phones are not to be used at any time unless granted permission by the principal or designee, for an emergency.
3. Text messaging, photo use, internet access or checking messages are strictly prohibited at all times on school grounds.

Violation of this policy can result in the revocation of this privilege. Should you choose to request cell phone possession by your child while at school, please sign and return this form to the school. Please make sure to review this policy with your child.

As always, parents wishing to contact their child by phone are asked to do so through the school office.

I,___________________________________________ request that my child ___________________________________ be given permission to carry a cell phone while at The Calais School. I agree with, and support the policy conditions stated above and in the Student Handbook, and have reviewed this form with my child.

_________________________________________  __________________________
Signature of Parent/Guardian  Date
POLICY ON THERAPEUTIC VIDEO TAPING
2019-2020

As part of The Calais School’s ongoing professional improvement plan, we have found the use of video taping faculty-student interaction a very effective means of providing ongoing feedback to the faculty member. It also provides the student’s therapist with a means of developing a more effective therapeutic program for that student.

These video tapes are to be maintained as confidential information and will be seen only by the student’s teachers, therapist and/or sending school child study team. Video taping may also be made for historical documentation in the development of specific skills as are defined in the Individualized Educational Plan for the student. All tapes will be destroyed when the student leaves our program.

___________________________________________________
I, Mr./Mrs./Ms. ___________________________ have read and understand the above Policy on Therapeutic Video Taping 2019-2020.

___________________________________________
Student’s Name

___________________________________________
Signature of Parent/Guardian  ___________________________  Date
Dear Parents and Guardians,

Please complete the movie permission slip below for your student. This will allow your student to watch movies as they are scheduled, for both educational and entertainment programs.

Please return this form with the other attached information sheets as soon as possible.

Thank you,

Dr. Diane Manno
Principal

I/We hereby give permission for my student________________________

to view/attend movies with these ratings (please select all that apply):

___G
___PG
___PG-13

___________________________  __________________
Signature of Parent/Guardian  Date
We are sending you this parental/guardian consent form to both inform you and to request your permission to photograph, film, videotape, and/or digitally record your child ("photo image") and use/publish your child’s photo image and personally identifiable information for the purpose of acknowledgement of individual or group achievements or to illustrate student activities. Such applications include newsletters and other educational or illustrative publications, yearbooks, or electronic displays and articles; as well as on Internet web sites, social media sites, and/or other online sites related to or by The Calais School and/or its designated affiliates. Pursuant to law, The Calais School will not release any personally identifiable information without prior written consent from you as parent or guardian.

Please note, if your child participates in sports, special programs, or fine and performing arts activities, we strongly encourage you to grant permission to use their photo so they can be recognized for their work. If you, as the parent or guardian, wish to rescind this agreement, you may do so at any time in writing by sending a letter to Dr. Manno, Principal and such rescission will take effect upon receipt by The Calais School. Image usage may extend beyond a student’s enrollment at The Calais School.

Please choose GRANT or DO NOT GRANT.

☐ Yes, I/We want to support The Calais School and GRANT permission for a photo/image that includes this student to be published in newsletters and other educational or illustrative publications; and on Internet web sites, social media sites, and/or other online sites related to or generated by The Calais School and its affiliates.

☐ I/We DO NOT GRANT permission for photo/image that includes this student to be published.

Occasionally local news outlets will cover events or programs at The Calais School. If you would like your child to participate, please indicate below. Please note, you will be advised beforehand that your child has been selected by The Calais School to participate in an interview regarding Calais School programs.

☐ Yes, I/We GRANT permission for news programming outlets to interview my child for use on local television broadcasts or in area newspapers and publish personally identifiable information about my child, including their full name.

I acknowledge that I have carefully read this parental/guardian consent form. I hereby release and discharge The Calais School, its designated affiliates, employees, volunteers, and authorized image/audio recorders, from any and all liability or claims arising out of the use of the photo image(s) and any related materials.

______________________________________________  ________________________
Student’s Name                                                                 Date

______________________________________________  ________________________
Parent’s Name                                                                              Parent’s Signature
Dear Parents and Guardians,

Internet access is available to all students at The Calais School. To ensure that your child has safe access to this service, school policy requires that students and parents sign a Technology and Internet Acceptable Use Policy Agreement. A copy of the agreement and the required signature form are attached. Only the signature form must be returned to the school before your child may access our Internet system. Please keep the Policy Agreement for your record. We recommend that you take some time to familiarize yourself and review the policy with your child.

Thank you for your cooperation and attention to this important document. Please call if you have any questions or concerns.

Sincerely,
Dr. Diane Manno, Ed.D.
Principal
TECHNOLOGY AND INTERNET ACCEPTABLE USE POLICY AGREEMENT
2019-2020

The Calais School is committed to providing a safe opportunity for students to access our computer Internet system. The electronic retrieval of vast amounts of useful educational information has become available through the Internet. However, recognizing that the Internet is neither a regulated nor policed entity, The Calais School requests that students agree to use this resource of information as an aid in the learning process according to the regulations set forth below. Therefore, students and their parents/guardians are required to read, understand, and sign the following “Acceptable Use Policy Agreement” prior to using the school Internet access system.

I agree to abide by the following regulations:

1. PERSONAL SAFETY

   a) I will not post personal contact information about myself or others. Personal contact information includes: names, personal or work addresses, school addresses, telephone numbers or other personal data.

   b) I will not agree to meet with someone I have communicated with on-line without first notifying the classroom teacher, school principal and obtaining my parents' approval and participation.

   c) I will immediately notify my teacher or any other school staff member of any message I receive that is inappropriate or makes me feel uncomfortable.

   d) I will not record audio, video or take pictures of others.

2. ILLEGAL ACTIVITIES

   a) I will not attempt to gain unauthorized access to The Calais School system or to any other computer system through the school system, or go beyond my authorized access. This includes attempting to log in through another person’s account or access another person’s files. These actions are illegal, even if only for the purpose of “browsing.”
b) I will not make deliberate attempts to disrupt the computer system performance or destroy data by spreading computer viruses or by any other means. Further, I understand that these actions are illegal.

c) I will not use The Calais School computer system to engage in any other illegal acts, such as arranging for a sale of illegal, dangerous, or restricted substances or products including: drugs, alcohol, videos, cigarettes, chemicals or other substances or products. Further, I will not engage in any activity that threatens the safety or security of myself or others.

3. SYSTEM SECURITY

a) I am responsible for the use of my individual account and I will take all reasonable precautions to prevent others from being able to use my account. Under no circumstances will I provide my password to another person except the classroom teacher.

b) I will immediately notify the teacher and principal if I should identify a possible security problem. However, I will not go looking for security problems, because this may be viewed as an illegal attempt to gain access.

c) Students may not in any way vandalize technology resources that belongs to The Calais School. Examples of unacceptable behavior include but are not limited to the following:
   - inadvertent spread of computer malware
   - damaging, hacking or destroying networks, computer hardware or software
   - physical abuse to equipment
   - the creation or intentional use of malicious programs

d) I understand that The Calais School uses programs designed to filter and restrict access to sites deemed inappropriate. I will not attempt to disable or go around this Internet filtering program.

e) Students may never share their school e-mail password with anyone else. Stolen or lost passwords can create significant problems for the student and for the school.

4. INAPPROPRIATE LANGUAGE

a) Restrictions against inappropriate language apply to public messages, private messages, and material posted on or downloaded from Web pages.
b) I will not use obscene, profane, lewd, vulgar, rude, inflammatory, threatening, or disrespectful language in any material posted on the Internet.

c) I will not post information that, if acted upon, could cause property damage, pose a danger to others or myself, or cause any form of disruption.

d) I will not engage in personal written attacks, including prejudicial or discriminatory comments or statements.

e) I will not harass another person. Harassment is defined as acting in a manner that distresses or annoys another person. If I am told by a person to stop sending a particular message, I must stop immediately.

f) I will not knowingly or recklessly post false or defamatory information about another person or organization.

5. RESPECT FOR PRIVACY

a) I will not re-post a message that was sent to me privately without permission of the person who sent the message.

b) I will not post private information about another person.

6. RESPECTING RESOURCE LIMITS

a) I will use school technology resources only for educational purposes.

b) I will not download large files unless absolutely necessary, and with the teacher’s permission. If necessary, I will download the file at a time when the system is not being actively used. Further, I will immediately remove the file to a disk or personal computer file.

c) I will not post chain letters or engage in “spamming.” Spamming is defined as sending an annoying or unnecessary message to a large number of people.

I will not use any chat, facetime, or any other real time communications, this includes software and devices.
7. PLAGIARISM AND COPYRIGHT INFRINGEMENT

a) I will not plagiarize or attempt to use works that are accessible on the Internet. Plagiarism is defined as taking the ideas or writings of others and presenting them as my own work.

b) I will respect the right of copyright owners. Copyright infringement occurs when an individual illegally reproduces a work that is protected by a copyright. If a work contains language that specifies acceptable use of that work, I will follow the specific requirements. If I am unsure if the work is covered by a copyright, I will request permission from the author to copy the work.

8. INAPPROPRIATE ACCESS TO MATERIAL

a) The purpose of school technology resources is strictly academic for school assignments and projects. I will not attempt to use The Calais School technology resources to access material that is profane or obscene, including but not limited: pornography, hate material, or materials that advocate illegal acts, violence, or discrimination towards others. A special exception may be granted by the principal and the parent/guardian to access hate literature, if the purpose of access is to conduct research for a class project.

b) If I inadvertently access such information, I will immediately disclose the inadvertent access to the teacher who will report the access to the principal. This will protect me against any allegation that I have intentionally violated the “Acceptable Use Policy Agreement.”

9. PRIVACY RIGHTS OF STUDENTS AND STAFF

The students and staff should have no expectation of privacy or confidentiality in the content of electronic communications or other computer files sent and received on the school computer system or stored in their directory. The school administration may, at any time, review the subject, content, and appropriateness of electronic communications or other computer files, and remove them if warranted. Further, any violation of law will be reported to enforcement officials.
10. OTHER PROHIBITED ACTIVITIES

I will not use The Calais School technology resources for commercial uses or political lobbying activities or any activities that are illegal but not set forth in this document.

Students must always adhere to the license agreements for installing/copying software that is purchased by the school.

11. PENALTIES

The Calais school reserves the right to restrict Internet access or computer use of any person using the school connections or equipment in an inappropriate, abusive, or illegal manner, or in violation of school policy on access to and use of the Internet or local, state or federal law.

Further, violators of this Acceptable Use Policy Agreement are subject to school penalties and procedures delineated in the student handbook and administration protocol. Penalties include detention, in-school suspension, and out-of-school suspension. Students, parents, and teachers must review this document before using the school computer system.
Guidelines for Posting Student Work on the Internet

Student information security is essential when using the Internet. This topic must be an ongoing, thought-provoking discussion in every classroom. The Calais School has developed the following guidelines to assure safe and responsible internet use.

1. Teachers and students may not post Personally Identifiable Information (PII) about themselves or others. Personally Identifiable Information (PII) includes but is not limited to contact information, names, personal addresses, work addresses, school addresses, telephone numbers, or other detailed information.

2. Teachers may only identify student work posted on the Internet by referring to the grade level of the student. EXAMPLE: “A second grade student at The Calais School.”

3. No photographs of any individual or group may be published on the Internet.

4. A Use Policy Agreement must be signed by the student and parent/guardian before any student is permitted to access the Internet.

Consult the Internet Acceptable Use Policy Agreement for details.
TECHNOLOGY AND INTERNET
ACCEPTABLE USE POLICY AGREEMENT
2019-2020

I have read The Calais School Technology and Internet Acceptable Use Policy Agreement and pledge to follow the rules in the agreement.

Student Name (please print) ________________________________

Student Signature __________________________________________ Date________

I, the parent or guardian of the above named student, understand the Policy Agreement regarding the use of The Calais School technology resources and the internet access system, and further understand that The Calais School cannot insure the acceptable use of the system in spite of its efforts to supervise and guide the students.

I give my permission for the student named above to access the Internet using The Calais School computer system.

Parent/Guardian (please print)______________________________

Parent/Guardian Signature________________________________________ Date________

NOTE: THIS PAGE MUST BE RETURNED TO THE CALAIS SCHOOL. THE ATTACHED PAGES THAT DESCRIBE THE POLICY AGREEMENT ARE TO BE RETAINED BY THE PARENT/GUARDIAN AND STUDENT.
ANIMAL-ASSISTED INTERVENTIONS PERMISSION FORM
2019-2020

June 2019

Dear Parent/Guardian:

In association with adjunct services provided to our students, the Animal-Assisted Interventions program is involved in the following: Counseling, Remedial Reading, Occupational Therapy, Speech Therapy, and occasional brief classroom visits. We are aware that some students have allergies and we have worked with our school nurse to take measures to minimize risks and exposure. We realize that some students do not feel comfortable around dogs. Consequently, we do what we can to help them feel most comfortable.

Working with animals has been shown to benefit students in many ways including:

- Improved motivation.
- Improved academic skills such as reading fluency.
- Helped to build trust and provide a sense of security.
- Decreased feelings of isolation and alienation.
- Promotion of character traits that include; caring, cooperation, compassion, empathy, gratitude, humanity, nurturance, patience, perseverance, respect, responsibility, self-control, self-esteem, and service.

All of the dogs that work at Calais have received extensive training and have been screened for a desirable temperament and consistent behavior. Likewise, our students are assessed for appropriate behavior so they can engage safely with an animal. Although working with animals comes with many benefits, it also comes with inherent risks. Dogs are in our school building every day to work with students. To minimize any risk, dogs are carefully monitored and on leashes while they are on school property and students are never left alone with any animal.

We are excited about providing students with the opportunity to work with dogs during the school day. Animal-Assisted Interventions in the related services is provided on a referral basis after careful consideration by our clinical team and AAI Program Director. Although we offer Animal-Assisted Interventions, it will ultimately be up to the Animal Assisted Interventions Team to screen and determine which children receive these services. If you are interested in having your child work with our dogs, please complete and return the permission form below. Without this executed form, your child will not be permitted to work with the dogs within our related services (this refers to Speech Therapy, Occupational Therapy, Remedial Reading & Counseling).

Thank you,

Dr. Diane Manno
Principal
By Signing below, you acknowledge that you have read and are aware of the fact your child attends a school where there are AAI dogs working in our building during school hours.

X

____________________________________________________/__________

Parent/Guardian Signature Date

__________________________________________________
Print Parent/Guardian Name

In addition, please sign below if you are interested in your child being considered to work with the dogs in related services as deemed appropriate by our Animal Assisted Interventions Professionals and Related Services Team. **This refers to Speech Therapy, Occupational Therapy, Remedial Reading & Counseling.

Neither The Calais School nor any of its employees shall assume any responsibility for any intentional conduct of the student that results in a claim, liability or damages arising out of this trip. All claims for intentional conduct are hereby waived. The undersigned will indemnify and save harmless The Calais School and its employees from all liability or damages for claims arising out of intentional and/or contributory negligent conduct of the student and as against The Calais School and its agents and employees. I further hereby release and agree not to sue The Calais School for any liability for damages caused in whole or in part as a result of the intentional or negligent conduct of third parties, not employed by or affiliated with the Calais School.

**All students and parents are to remember that conduct prior to an activity will reflect whether your student may participate. Final approval will be determined by the principal. Fax or e-mailed permission slips will not be accepted.**

I ___________________________________, give permission for my child, ____________________________,

Parent Name Child Name

to participate in Animal-Assisted Interventions within the related services at The Calais School as deemed appropriate.

____________________________________________________/_______________________________________

Parent/Guardian Signature Date
Student’s Name: ____________________________________________

Parent Name: ____________________________ Date: ___________

1. Does your child have a desire to participate in Animal Assisted Interventions (AAI)
   [ ] Yes/Active  [ ] Yes/Passive  [ ] No

2. Does your child have current/past ownership of animals?
   [ ] Cats  [ ] Dogs  [ ] Other: __________________________

3. How does your child feel about past experiences with animals?
   [ ] Enjoyed  [ ] Does not like animals  [ ] Indifferent

4. Does your child have a history of animal abuse/charges and/or animal cruelty (self, witnessed)?
   [ ] No  [ ] Yes  Explain: ________________________________

5. Does your child have a history of aggression towards staff or peers (verbal, physical)?
   [ ] No  [ ] Yes
   [ ] Verbal  [ ] Physical
   [ ] Staff  [ ] Peers

6. Does your child have challenges with impulse control (per chart, staff report and/or observation)?
   [ ] No Problem  [ ] Frequent
   [ ] Intermittent  [ ] History not current

7. Is your child afraid of dogs?
   [ ] No  [ ] Yes

   Explain: ________________________________
8. Is your child allergic to dogs?  

☐ No  ☐ Yes

If YES, please describe the nature and severity of your child’s allergy and his/her reaction.

***Please be as detailed as possible:
__________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________

9. Is your child allergic to any soaps / hand sanitizers?  

☐ No  ☐ Yes

If YES, please describe the nature and severity of your child’s allergy and his/her reaction.

***Please be as detailed as possible:
__________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________
__________________________________________________________________________________________________________________

* If you are interested in having your child work with our dogs within the related services, please complete and return the AAI permission form. Without the permission form, your child will not be permitted to work with the dogs within the related services. Please be advised that there are AAI dogs in our school every day during school hours. ***Related Services refers to Speech Therapy, Occupational Therapy, Remedial Reading & Counseling.

By signing below, I certify all information is true and correct to the best of my knowledge, and that I have read and understand that AAI dogs are present in the school building during school hours.

Signature of Parent: ____________________________ Date: ______________

Signature of Handler(s): ____________________________ Date: ______________
_______________________________ Date: ______________
_______________________________ Date: ______________

Signature above indicates the questionnaire has been completed and education regarding Animal Assisted Interventions (AAI) has been provided to the student and his/her parent/guardian.