RISE ACADEMY

Joseph Hibbett, School Principal • Melissa Lameier, Vice Principal

Tammy Dorgan, School Counselor

Dear Parents/Guardians:

WE HAVE A NEW NAME! Welcome to RISE Academy! On behalf of the staff at RISE academy, we are excited to welcome you to the 2020/2021 school year. Our goal is to create a collaborative partnership with our families and community to ensure that our students are successful.

WE HAVE A NEW VICE PRINCIPAL! Mrs. Lameier comes to us with 19 years of educational experience. She has worked in alternative schools, special education, vice principal positions. She was played a vital role in starting the Covington Alternative School, Principal at the Phoenix Program alternative school, and served as Vice Principal at RA Jones 12 years. Mrs. Lameier already has taken our program to the next level!!!!!!!!

NEW CHANGES for communication according to school protocol for the 2020/2021 school year.

1. **Safety**: The Northern KY Health Department along with the Boone County School District is requiring the following for all students and visitors upon entering the building.
   a. MASK--The student must wear a mask when entering the building, traveling within the building (i.e. going to lunch or the bathroom), and when within 6 feet of school occupants.
   b. TEMPRATURE CHECK—The students will have their temperatures checked with a forehead scanning device when entering the building; this also applies to visitors. Any student with a temperature will remain in a holding room with an administrator until they are picked up. Any visitor with a temperature will not be permitted in the building.
   c. Any intentional violation of following these safety procedures (MASK, TEMPRATURE, 6ft. DISTANCING) the student will sent home. These are “0 TOLERANCE” items for the safety and well-being of all school occupants.

2. **Dress Code Change**: Students are not permitted to wear any clothing item with a hood i.e. “Hoodies” **Explanation**: Due to the increased amount of dress code referrals we encountered last school year (students in school are not allowed to wear items on their head.)

3. **Cell Phones**: Students are to turn in their cell phones upon entering the school to the administrator in their assigned lock boxes. The student will receive their phone during dismissal. **NO EXCEPTIONS**.
   a. If a parent/guardian needs to communicate with their child they may call the school and visa-versa.
   b. “If a student is caught with their cell phone” see student handbook under cell phone policy.

4. **How to pick up my child**:
   a. Call the school upon arrival: 859-282-2163
   b. The school will verify you identity and your students.
   c. Your student will be dismissed to your car.

5. **DAILY SCHEDULE**:
    a. Students are permitted in the building starting at 720 am
    b. Students actual school day will begin at 8 am and end at 2 pm. This is an adjustment to help with transportation.
    c. If you chose for your student to attend school they will either come on Mon. Tue. Or TR. FRI. No students will be in the building on Wednesday. We will notify you once we get what day your student is attending from the District Office. This is in accordance with the Boone Co. School District's Hybrid Schedule AA C BB schedule.
    d. Any student who chose the Virtual option must adhere to the Virtual School Programming guidelines in order to be in good standing:
        a. Must log in 4 hours a day / 20 hours a week minimum
        b. Must maintain pacing / 1 class takes 4 approximately weeks
        c. Must respond to emails or Edgenuity messages promptly
        d. Must participate in school/state testing
        e. Must participate in school conferences
            a. Social Emotional Groups 2 times a week

6. **The Student Handbook**: https://docs.google.com/document/d/1F7QK_7q67KAX508FZYF5Tt7JX3cl6SMkpxY35sRFRMs/edit?usp=sharing

7. **The Phase System and Transitioning**: We will be utilizing a level system to support students in their academic growth along with social/emotional wellness. The level system will help determine when a student is ready to transition into a less restrictive program.

8. **Terroristic Threats**: Please review our school's protocol in accordance with state law in dealing with terroristic threats. **This is very important that your student understands the severity of this offense and the consequences thereof.**

NEW THIS YEAR!!! We have hired a former Notre Dame Professor of Social Psychology, Dr. Bill Webb, as an education consultant to aid us in building a Restorative Justice culture**. Our objective is to establish a culture of communal caring and accountability wherein individuals are able to achieve greater awareness of the thoughts, feelings, and actions necessary to assume effective ownership of their lives and, consequently, their education. ***SPECIAL NOTICE*** ** If a student refuses to participate in building a climate of communal caring and accountability through restorative justice then he/she may not be eligible to transition to: HOME SCHOOLS, GRADUATION, INTERNSHIP OPPORTUNITIES, OR MAY BE PLACED ON A VIRTUAL OR EVENING PROGRAM APART FROM STUDENTS WHO WANT TO SUCCEED.

Sincerely,

Dr. J.M. Hibbett
Principal
RISE ACADEMY
Joseph.Hibbett@boone.kyschools.us

Intensive Outpatient Program at

CHNK
BEHAVIORAL HEALTH

The **Intensive Outpatient Program (IOP)** at CHNK Behavioral Health provides a highly structured, trauma-informed approach to therapeutic care. Our licensed therapists use evidence-based practices to help children and adolescents recognize, manage, and overcome mental health challenges and substance use disorders.

CHNK's IOP offers a unique treatment option that empowers participants to make connections, strengthen coping skills, and develop individualized strategies for making positive change in their lives. Youth and families who participate in the IOP receive the knowledge, resources, and support needed to navigate mental health challenges in their everyday lives, including in the home, in the school, and in social settings. These challenges might include:

- Severe anxiety and/or depression
- Suicidal thoughts or a tendency for self-harm
- An active addiction or experimentation with drugs or alcohol
- Drastic changes in mood, behavior, or personality
- A recent, significant decline in grades
- A history of trauma
- Recent hospitalization for mental health concerns
- Involvement with the Department of Juvenile Justice
- Difficulty with social functioning among peers
- Complex home lives that are having negative impact
- An apparent inability to navigate a traditional school setting

Program participation currently takes place in a telebehavioral health setting, via smartphone, tablet, or computer. In-person participation will again be an option in the future, based on pandemic-related guidance. Participation is typically three to eight weeks in duration, but your unique needs and care plan goals will determine the length of time you engage in the program.

CHNK offers open enrollment for the IOP, but each group is limited in size to ensure individualized attention can be given to each participant. CHNK accepts Medicaid and most commercial insurance.

For more information about CHNK's Intensive Outpatient Program or to schedule an assessment, please call our care team at **1.844.YES.CHNK** (937.2465) or email **gethelp@chnk.org**.

CHNK
BEHAVIORAL HEALTH

OUTPATIENT SERVICES
525 W. Fifth Street, Suite 219
Covington, KY 41011

www.chnk.org

Targeted Case Management at

CHNK BEHAVIORAL HEALTH

CHNK offers **Targeted Case Management** (TCM) as part of our robust continuum of care for individuals and families in need of mental health and addiction services. Many times a client receiving therapeutic care from CHNK might also benefit from access to social, educational, or medical services. A targeted case manager helps connect the client (and their family) to these services by working with the client and their therapist to develop an individualized care plan. The case manager also monitors progress and collaborates with other providers to help each client achieve their personalized care plan goals.

Who is eligible for Targeted Case Management services?

Anyone - regardless of age - is eligible for TCM if they have been diagnosed with a mental health disorder or they are receiving therapeutic care for a mental health need. Medicaid typically covers this type of care.

Who provides the TCM services at CHNK?

CHNK's team of certified case managers specializes in working with clients who have mental health, substance use, and/or chronic co-occurring disorders. The team is supported by a program manager and clinical supervisor.

Where do TCM services take place, and for how long?

CHNK is dedicated to removing barriers to treatment. Your assigned case manager will meet you wherever is most convenient and comfortable for you and your family - in your home or office, at one of CHNK's three locations in Northern Kentucky, or in a community setting. We can also provide treatment via telehealth sessions if you have access to a smartphone, tablet, or computer. Based on your unique needs, your case manager will meet with you several times per month, usually for about three months; these sessions are to help you progress towards achieving the goals in your care plan.

What are some examples of the services a targeted case manager provides?

Our case managers strive to help clients access all the services needed to meet the goals outlined in their care plans. Based on your specific needs, this may include:

- Acting as a school liaison, such as joining you for Individualized Education Program (IEP) meetings and safety meetings
- Connecting you to community resources that can assist with food, clothing, and shelter needs
- Supporting your search for employment, including assistance with building a resume, completing applications, and preparing for job interviews
- Helping with transportation needs
- Helping to find and keep housing
- Making referrals for needed medical, dental, and psychiatric services
- Crisis planning

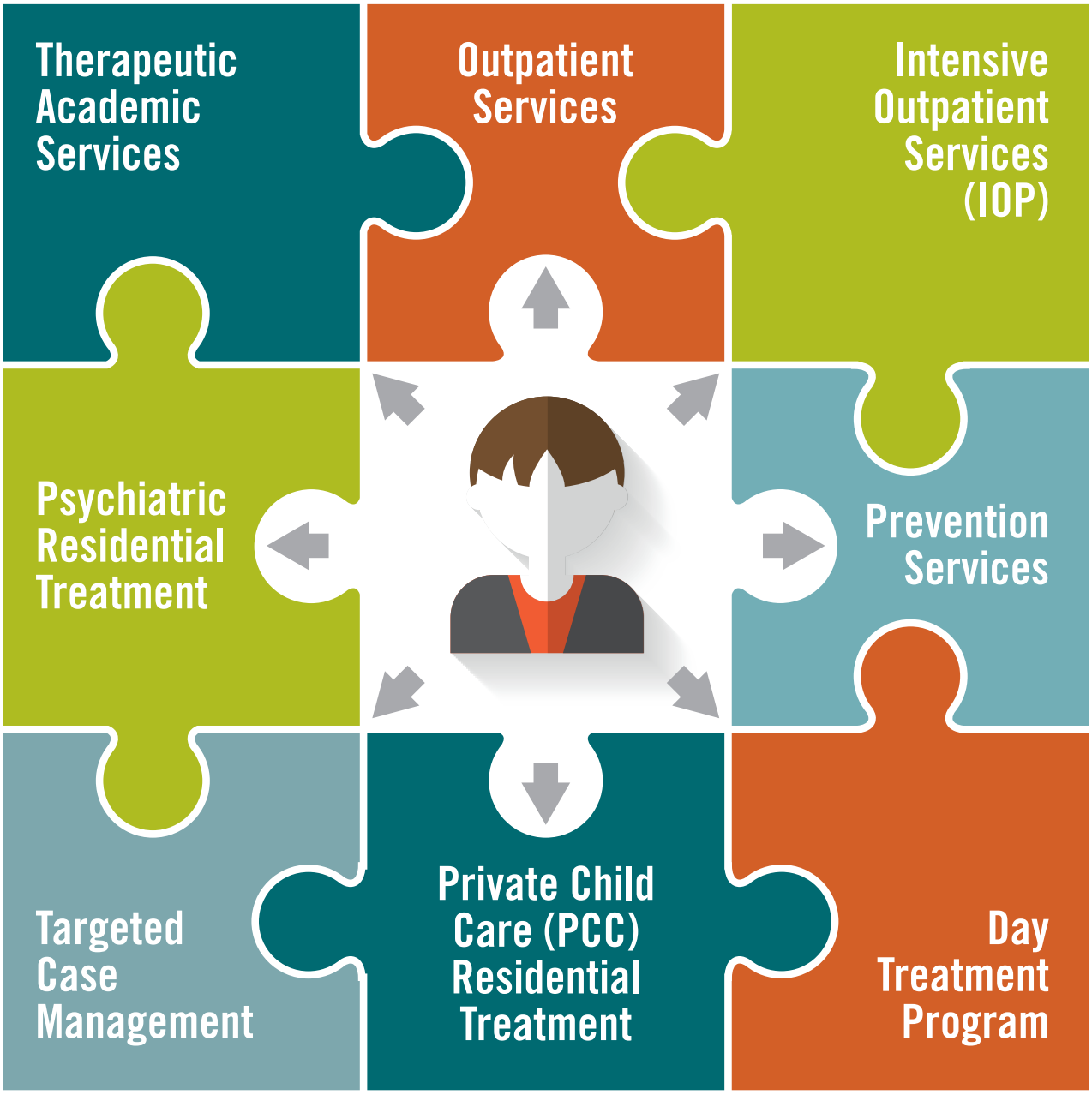
For more information about CHNK's Targeted Case Management services or to schedule an assessment, please call our care team at **1.844.YES.CHNK** (937.2465) or email **gethelp@chnk.org**.

CHNK BEHAVIORAL HEALTH

OUTPATIENT SERVICES
525 W. Fifth Street, Suite 219
Covington, KY 41011

www.chnk.org

The Continuum of Care at CHNK Behavioral Health



CHNK brings hope and opportunity to those in need through our **behavioral health continuum of care**.

That's another way of saying we provide:
the right services, at the right time, in the right place, and at the right level.

CHNK BEHAVIORAL HEALTH

MAIN CAMPUS
200 Home Road, Devou Park
Covington, KY 41011

BURLINGTON CAMPUS
4836 Idlewild Road
Burlington, KY 41005

OUTPATIENT SERVICES
525 W. Fifth Street, Suite 219
Covington, KY 41011

859.261.8768 | www.chnk.org | info@chnk.org

www.chnk.org
GetHelp@chnk.org

CHNK
BEHAVIORAL HEALTH

Phone: 859.292.4140
Fax: 859.261.0490

REFERRAL FORM

Referral Source Name *(Point of Contact)*:	Referral Source Agency / Organization Name:	Date:
Referral Source Type: ☐ Parent/Legal Guardian ☐ Youth/Self ☐ School ☐ DCBS/Child Welfare ☐ Health/Medical Provider Other (please specify):		
Referral Source email:		Referral Source Ph#:
Referral Source Street Address *(Physical Address)*:		City, State, Zip:
		County:

Reason for Referral *(please check all that apply)*:

☐ Behavior Problems at Home ☐ Behavior Problems / Disciplinary Referrals at School ☐ Court / DJJ Involvement
☐ Drug and/or Alcohol Use ☐ Mental Health Concerns / Symptoms ☐ Runaway Behaviors
☐ Skipping School / Truancy ☐ Tobacco Use ☐ Other *(please specify)*:

Currently in services with another provider *(If yes, who?)*

PROGRAM REFERRED TO: ☐ Outpatient ☐ PRTF ☐ Intensive Outpatient Program

Client Information:

Legal Name:	DOB:	SSN:
Alias or Nickname:	Ethnicity: Race:	Gender Identity: ☐ Female ☐ Male ☐ Transgender
Street Address:	City, State, & Zip:	
School Name & District:	School County:	Youth's Grade:

Parent/Guardian Information (If Applicable):

Primary Caregiver / Legal Guardian Name(s):

Relationship to Youth: ☐ Parent ☐ Self ☐ Relative ☐ DCBS/State Worker ☐ Other *(please specify)* ☐ Grandparent ☐ Legal Guardian

Parent / Guardian's Street Address: ☐ *Same as youth*	Parent / Guardian's City, State, Zip:
Primary Ph#: ( ) Alternate Ph#: ( )	Email:

Insurance Information:

Primary Insurance:	Member ID#:	Group #:
Subscriber's Name / Name on Card:		Subscriber's DOB:
Primary Insurance Phone #:	Relationship to Subscriber: ☐ Self ☐ Child	
Secondary Insurance:	Member ID #:	Group #:
Subscriber's Name / Name on Card:		Subscriber's DOB:
Secondary Insurance Phone #:	Relationship to Subscriber: ☐ Self ☐ Child	

CHNK USE ONLY	
	Date Referral Received:
Contact Attempt #1 Date:	Results:
Contact Attempt #2 Date:	Results:
Contact Attempt #3 Date:	Results:
Notes:	

Children's Home Northern Kentucky

Outpatient Services

Informed Consent for Treatment & Authorizations

Child's Name: _____ D.O.B.: _____

I, _____ (print name), give consent for the above named child to be treated by *Children's Home of Northern Kentucky (CHNK)* and do hereby give full permission and authorize Children's Home of Northern Kentucky, to bill _____ (Name of insurance company) for services rendered by *Children's Home of Northern Kentucky.*

By signing this document I also agree to the following statements below:

1. To receive screening, comprehensive assessment, psychiatric evaluation, medication evaluation and/or participate in individual, group and family therapy. I understand that the Children's Home of Northern Kentucky has agreements with local colleges to accept Bachelor, Master's level interns and Doctoral & that these interns will participate in the child's treatment. I agree that my child's sessions may be observed &/or recorded as part of training for interns or therapists under supervision.

2. For Children's Home of Northern Kentucky staff to provide education in the area of HIV/AIDS, diabetes, sexually transmitted infections, birth control, and/or substance use and psychotropic medications.

3. To be transported by approved CHNK staff for purposes related to my treatment.

4. For the Children's Home of Northern Kentucky staff and such assistants (photographers, reporters and other media staff) as may be engaged during my child or family's participation in CHNK programs to Photograph, Video Tape, Audio Tape, obtain story and/or Televise, (a media consent form will be utilized when needed)

5. I acknowledge and agree that the media above may be used for Clinical Case Consultation / Supervision Purposes or Clinical Supervision for CHNK interns or therapists working toward Independent Licensure.

6. I agree the name of my child and family may be used to identify the above said material(s) and may be published and republished as long as the child's rights to confidentiality and privacy are not violated.

7. I agree that all resulting material(s) concerning the above named client remain the property of the Children's Home of Northern Kentucky as indicated above.

8. I understand that children and their families receiving services from Children's Home of Northern Kentucky have the right to confidentiality / privacy.

9. I understand that there are limits to confidentiality, including situations where staff may be required by law to share information about my child/family because of a safety risk. These exceptions to confidentiality include:
   a. suspicion of abuse or neglect of a child, adult, or elderly person,
   b. concern about a person being a risk to him/herself or others (including threats toward public property),
   c. When records are court-ordered or staff are subpoenaed to testify in court.

10. I acknowledge and understand that Children's Home of Northern Kentucky and the referring agency may exchange information regarding my child's treatment, progress and case (Release of Information form & signature required).

11. I hereby authorize the referring agency to provide Children's Home of Northern Kentucky all necessary billing information. (copy of medical card) for the services my child receives.

Children's Home Northern Kentucky

Outpatient Services

12. I understand that I am responsible for understanding information about my health insurance policy and providing such information to Children's Home of Northern Kentucky, for correct billing. I am also responsible to notify Children's Home of Northern Kentucky in the case of change of my health insurance status – inclusive benefits and any information I receive relating to care I have or will receive in this office.

13. I understand that Children's Home of Northern Kentucky will be providing services and billing my health insurance for those services at various times during the course of services. I understand that ultimately I am responsible for all payment relating to any and all charges relating to treatment and services that I have received at Children's Home of Northern Kentucky.

14. I understand that the policy of Children's Home of Northern Kentucky requires payment in full for all services rendered at the time of visit, unless other financial arrangements have been made. I understand the above information and agree that my health history and related information was completed correctly to the best of my knowledge and understand that it is my responsibility to alert Children's Home of Northern Kentucky of any change in my medical status or insurable coverage.

15. I give permission for staff from Children's Home of Northern Kentucky to contact me as follows:

___ E-mail, my preferred e-mail address is _____

___ Phone: leave a detailed voice message at _____. The best time to contact me is _____ am/pm.

___ Phone: leave a voice message requesting a return phone call.

The undersigned does agree to observe and abide by all of the statements made above.

_____ _____ _____

Parent/Guardian Signature *Date* *Relationship*

_____ _____

Witness Signature *Date*

_____ _____

Client Signature Date

Children's Home Northern Kentucky

200 Home Rd., Devou Park
Covington, Ky. 41011

Copy provided to client?
☐ Yes ☐ No
☐ Refused
Client Initialed: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name: _____ D.O.B: _____ SSN#: _____

I understand by signing this form, I am authorizing the Children's Home of Northern Kentucky's Champions Program Staff to obtain and/or exchange information concerning the above named client with the following:

ACE Alternative School
Name of Person and Organization

99 Center St. Florence KY
Complete Mailing Address, Phone & Fax Numbers

The information to be released is:
- ☐ Assessment
- ☐ Psychiatric Evaluation
- ☐ Summary of Treatment
- ☐ Medications
- ☐ School Evaluation
- ☐ Drug/Alcohol Assessment
- ☐ Psychological Assessment
- ☐ Educational Information
- ☐ Legal Issues/concerns
- ☐ Drug/ Alcohol Treatment Summary
- ☐ Other: _____

The information may be exchanged via:
- ☐ In Person / Phone conversations
- ☐ Fax
- ☐ E-mail
- ☐ Written correspondence

Purpose for Release:
- ☐ Report Client Progress
- ☐ To obtain collateral information in treatment of this client
- ☐ Verify client attendance
- ☐ Other: _____

Regarding Dates: _____

Duration of Consent:
☐ 90 day ☐ One year ☐ Other: _____ ☐ Expiration Date: _____

X _____ X _____

Client Signature Date Signature of Parent/Guardian of minor, if required Date

_____ _____

Witness Signature Date

The client of age or parent/guardian may withdraw consent for release of information at any time.
Copies of signed consent given to client; originals to give info and copies to receive info are placed in case file.

I withdraw consent for release of information.

_____ _____

Individual served of age or Parent/Guardian name, if required Date of withdraw

Authorization is not required to share information permissible under federal laws and regulations or to comply with laws regarding mandatory reporting of suspected abuse, neglect or exploitation, or assessment that there is a danger of serious harm to self or others. This information has been disclosed to you from records protected by federal confidentiality rules, set forth at 42 C.F.R. part 2 et seq. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. part 2, et. seq. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

WELCOME TO

BOONE COUNTY SCHOOLS

A Distinguished District

Student Name: _____

Registration Date: _____

The following is a list of information that will be needed to enroll your child in our school district. These items are needed in addition to the registration forms provided:

Required at time of enrollment

_____ Student Enrollment/Emergency Information Form

_____ Legal Custody Papers (if applicable)

_____Proof of Residency at enrolling address in parent/guardians name

a. Drivers license
b. Lease, contract, mortgage, etc.
c. Utility bill

_____ Adjudication/Expulsion Affidavit Form (most will check #4 and sign)

_____ Transportation Card (SpEd Only - Prior to riding bus)

_____ Social Security Card or waiver

_____ Permission to Videotape/Photograph/Publish Release Form

New students Only (out of district)

_____ Certified Birth Certificate

_____ Immunization Certificate

_____ Preventative Health Care Examination Form

Every graduate ready for College, Career and Life.

Boone County Schools
District Office
8330 US Hwy 42
Florence, KY 41042
(p) 859-283-1003
(f) 859-282-2376
www.boone.kyschools.us

2019-2020 Boone County Schools
Student Enrollment/Emergency Information

Office Use Only
School: _____
Start Date: _____
Teacher: _____

Legal Name of Student (Please Print) _____ (Last) _____ (First) _____ (Middle) Suffix _____ (Jr., III, etc)

Grade: _____ Date of Birth: _____ ☐ Male ☐ Female SS# (Optional) _____
Has your child repeated a grade? ☐ Yes ☐ No If yes, which grade? _____

Birthplace: (Country) _____ (County) _____ (State) _____

Student Address: (Street) _____ (Apt #) _____ (City) _____ (State) _____ (Zip) _____
(Check only if applicable*) ☐ Shelter ☐ Motel ☐ House or apartment shared with friends or family members ☐ Friends/Family member (other than parent/guardian)
*If applicable, please complete a Residency Questionnaire (704 KAR 7:090)

Student Mailing Address: (If different) _____ (Street or PO Box and Apt #) (City) _____ (State) _____ (Zip) _____

☐ There are no changes to student's address or phone number. Parents/Guardians, please initial here_____
Ethnicity: Is your child Hispanic/Latino: ☐ Yes ☐ No
Student Race: (Check all that apply) ☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ American Indian or Alaskan Native
U.S. Citizen: ☐ Yes ☐ No If no, country of residence: _____ ☐ Migrant ☐ Immigrant ☐ Refugee; (Country) _____

Last School Attended: _____ Kentucky School: ☐ Yes ☐ No
Last Date Attended: _____ School Telephone #: (___)_____
School Address: (City) _____ (County) _____ (State) _____

Race/Ethnic Group Categories
- White (not Hispanic)-A person having origins in any of the original peoples of Europe, North Africa, or the Middle East
- Black/African American (not Hispanic)-A person having origins in any of the black racial groups of Africa
- Hispanic/Latino-A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture of origin regardless of race
- Asian-A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent.
- Pacific Islander-A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- American Indian or Alaskan Native-A person having origins in any of the original peoples of North & South America and who maintains culture identification through tribal affiliation or community attachment.

Parents/Guardians Living in Same Household as Student

Legal Name: _____ (Last) _____ (First) _____ (M. I.) DOB: _____
Relationship to Student: _____
Phone: Home (__)_____ Work: (__)_____
Cell Phone: (__)_____
E-Mail: _____

Legal Name: _____ (Last) _____ (First) _____ (M. I.) DOB: _____
Relationship to Student: _____
Phone: Home (__)_____ Work: (__)_____
Cell Phone: (__)_____
E-Mail: _____

Siblings Living in Same Household as Student

Legal Name: _____ Suffix: _____
Birth Date _____ Sex: _____ Grade: _____
Name of Boone County School: _____

Legal Name: _____ Suffix: _____
Birth Date _____ Sex: _____ Grade: _____
Name of Boone County School: _____

Legal Name: _____ Suffix: _____
Birth Date _____ Sex: _____ Grade: _____
Name of Boone County School: _____

Legal Name: _____ Suffix: _____
Birth Date _____ Sex: _____ Grade: _____
Name of Boone County School: _____

Parents/Guardians Living at an Address Different from Student

Does this parent/guardian have joint custody? _____
Should this parent/guardian receive school information? ____
Is this person legally restricted access to this student? _____
(A copy of the court order MUST be provided to the school.)
Legal Name: _____ DOB: _____
Relationship to Student: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: Home (__)_____ Work: (__)_____
Cell Phone: (__)_____ E-Mail: _____

Does this parent/guardian have joint custody? _____
Should this parent/guardian receive school information? ____
Is this person legally restricted access to this student? _____
(A copy of the court order MUST be provided to the school.)
Legal Name: _____ DOB: _____
Relationship to Student: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: Home (__)_____ Work: (__)_____
Cell Phone: (__)_____ E-Mail: _____

Special Services

Does this student have special needs, or receive special education services? ☐Yes ☐No
Does this student have a 504 plan? ☐Yes ☐No Does this student receive Title I services? ☐Yes ☐No
Does this student receive services for speech? ☐Yes ☐No
Has this student been formally identified as Gifted/Talented? ☐Yes ☐No

Transportation

Primary Transportation to School (check all that applies): ☐ Car Rider ☐Walker ☐School Bus Bus #: _____ (assigned by school district staff)

Transportation by BCS: ☐A.M. ☐P.M. ☐Both A.M & P.M. ☐More Than 1 Mile ☐Less Than 1 Mile ☐None Daycare: _____

Language

Is English **most frequently** spoken in the home? ___Yes ___No, what language?_____
Did your child learn English when he/she **first** began to talk? ___Yes ___No, what language?_____
Does your child **most frequently** speak English at home? ___Yes ___No, what language?_____
Is English **most frequently** spoken to the child at home? ___Yes ___No, what language?_____

(If any answers above are other than English, please complete the "Home Language Survey")

Medical Information

List and identify health conditions (such as severe allergies, chronic medical conditions, and/or allergies to medications): _____

_____

*Per state regulation, any student with a health condition (such as asthma, allergies, diabetes, seizures, etc.) must have a health care plan on file. For more information, please contact the school Nurse or Health Clerk.

Regular Medication: _____ Dosage: _____
An "Authorization to Give Medication" form must be on file for any medication to be given to a student during the school day.

Physician Name: _____ Telephone: _____

I give school officials permission to contact the named Health Care Provider: _____
(Parent/Guardian Signature)

Emergency Information

If needed, what hospital should this student be taken to? _____

IN AN EMERGENCY, if parent/guardian cannot be contacted, please call and/or release my child to one of the following:

Name: _____ Relationship to student _____ Telephone No: (___)_____

Name: _____ Relationship to student _____ Telephone No: (___)_____

If there is anyone NOT ALLOWED access to this student, list their name and relationship: (Legal documentation MUST be provided to the school.)

Name: _____ Relationship to student _____

The school is not responsible for students authorized by parent to leave school during school hours or for students in elementary and middle school authorized by parent to privately return to their homes after school.

If there are changes made during the year, please contact the school office IMMEDIATELY.

Parent/Guardian Signature _____ Date: _____

Office Use Only	
New Enrollment	____
Revised Enrollment	____
Office Personnel	____
Date	____

Revised 01/2017

BOONE COUNTY SCHOOLS

PARENTAL CONSENT FOR RECORD RELEASE

To Principal of: _____
(Name of Previous School)

_____
(Address)

_____
(City, State, Zip)

I am the parent/legal guardian of _____ (DOB)
(Name of Student)

You are authorized to:

☐ **Release the checked information**

☐ **Release all information**

☐ 1. Cumulative Records

☐ 2. General identifying data (Name, Address, DOB, Grade Level Completed, Grades, Class Standing, Attendance Record)

☐ 3. Standardized Achievement and Aptitude Test Scores

☐ 4. Medical/Health Records

☐ 5. Special Education Due Process File

☐ 6. Gifted File

☐ 7. Title I File

☐ 8. ESS File

☐ 9. Limited English Proficiency/English as Second Language File

☐ 10. Record of Extra-Curricular Activities

☐ 11. Other (Specify) _____

_____

To: _____

_____

_____

The reason for this request is:

☐ Transfer to school due to change in residence

☐ Other – Specify _____

_____
Signature of Parent or Legal Guardian

_____
Address City

_____
Date Phone Number

Boone County Schools

ACKNOWLEDGEMENT OF REVIEW OF THE CODE OF CONDUCT AND ACCEPTABLE TECHNOLOGY USE PROCEDURES

Student's Name:_____

Teacher:_____

Please review the *Code of Conduct* with your child. His/her teacher has discussed it in class. The policies and regulations it references are an integral part of the daily student life, supporting a safe, responsible, respectful, and secure learning environment. For each student to be successful in school, it is important to note that there will be periodic review of important sections of the *Code of Conduct* during the school year, in particular sections related to:

- *Student Expectations (page 13)*
- *Student Rights (page 22)*
- *Acceptable Technology Use (page 27)*

It is essential that the school and home work together to assure that all students meet the high expectations for behavior established in the *Code of Conduct*. This enables students to succeed in school and the community. Your support is vital to this process.

After you have read the *Code of Conduct* with your child, please sign and return the signed form to school within one month of enrollment.

As the parent(s) or guardians(s) of:_____(Student name), we have read and discussed the ***Code of Conduct and the Acceptable Technology Use procedures*** with our child. We understand that the policies and regulations referenced in these documents apply to all students at all times on all Board of Education property, including in school buildings and on school grounds; in all school vehicles; and at all schools, school-related, or Board-sponsored activities, including but not limited to, school field trips and sporting events, whether such activities are held on school property or at locations off school property, including private business or commercial establishments.

We understand the expectations, rights, responsibilities, and guidelines outlined within and understand that it is our responsibility to convey to our child the importance of meeting them and using the technology resources responsibly. We also agree to abide and support these rules including our use of the Infinite Campus Parent/Guardian Portal.

Boone County Schools' network communications are not private, and may be viewed by Boone County School personnel, or by someone appointed by them, to ensure that all guidelines are followed.

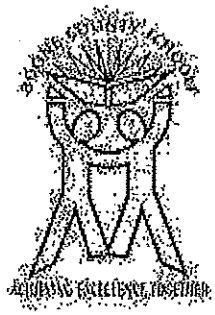
Parent/Guardian Signature_____Date_____

Parent/Guardian Signature_____Date_____

Student Signature_____Date_____

The Code of Conduct can be found on the district website at: www.boone.kyschools.us

PLEASE DETACH THIS FORM AND RETURN TO YOUR CHILD'S TEACHER.



Boone County Schools
Permission to Videotape/Photograph/Publish

PLEASE COMPLETE THIS FORM AND SUBMIT IT TO THE SCHOOL.

Dear Parent/Guardian:

At some time during the school year, school/District personnel or other District-authorized persons may videotape or photograph classroom activities or special projects in which your child participates during or after the school day for staff/student evaluative, educational, or public awareness or fund raising purposes. Such videotapes or photographs may be viewed by peers, faculty, or administrators. On special occasions such as a videotape or photograph of a class or school play or of an academic or athletic event, the film or photograph may be viewed by a general audience including, but not limited to, publication on the school or District Web site, event programs and newsletter and in school yearbooks,

Please review this form carefully, sign and date the form, and submit the form to the school. Although we will make efforts to comply with your request, bear in mind that we cannot monitor all adults at all times, especially during the special occasions when other parents may take pictures or may tape the event.

Once signed and dated, this form shall remain in effect for your child's enrollment in the District schools. However, at any time during the school year, **you may amend this form only for future uses/preferences by notifying the Principal in writing of your request.**

As the parent(s)/guardians(s) of _____, *I/we give the*
Student's Name

Boone County School District permission to release my/our child's name, photograph, and/or audio/video reproduction for publication concerning school functions and activities, including academic and athletic activities.

Name of Parent(s)/Guardian(s) (***Please print.***) _____

_____

_____ _____
Parent/Guardian's Signature ***Date***

_____ _____
Parent/Guardian's Signature ***Date***

_____ _____
Principal/Designee's Signature ***Date***

Boone County Schools
School Health Services Department
8330 US 42
Florence, KY 41042

School Permission Slip

For completion of immunization records

Kentucky has a statewide immunization registry (KYIR) that medical practices use to help keep track of their patient's immunizations. They use this system to record vaccines given to patients and to access information about their patients' immunization histories, including vaccines given at other medical offices. KYIR makes it easy to keep track of a patient's immunization status, even if the patient visits more than one medical practice. It also helps ensure doctors and nurses give the right vaccines at the right time, and allows them to remind their patients when vaccines are due or overdue.

The information in KYIR is CONFIDENTIAL-only authorized users may access the system. Authorized users include health departments, medical practices, schools, childcare facilities, WIC Programs, and health care plans.

Some records in KYIR may be incomplete or missing because an immunization was given in another state, or because the medical practice did not enter it into the system. Your child's school wishes to help improve our community's records by providing missing immunization information to KYIR, but requires your permission to do so, in accordance with the Family Educational Rights and Privacy Act (FERPA).

By signing below, you can make your child's immunization history more complete, helping to ensure appropriate and timely future immunization.

Please sign this form if you agree to grant permission for your child's school to provide your child's immunization history to KYIR. This may include creating a new record, or updating an existing record. Please use a separate form for each additional child.

My Name: _____

My Child's Name: _____

My Child's Date of Birth: _____

Signature: _____

My Telephone Number: _____ Date Signed: _____

Please submit this form to your school administrator/nurse- thank you!

Office Use Only

Name of school: _____ Form Rec'd by *(school staff)*: _____

Immunization history attached to form? Y or N

Date Rec'd by KYIR: _____ Date Entered into KYIR: _____

Medication Administration Procedures
Boone County Schools
Student Services/Health Services

(Revised Jan. 26, 2015)

4-page document

Introduction

The goal for the use of medication in school is to assist all students to participate at their fullest independent capacity. Policies and procedures developed to implement the handling, monitoring and assisting with medication will comply with each school's effort to ensure a safe, secure and orderly school environment and with Boone County Board of Education policies. Some families have chosen natural and homeopathic remedies, including herbal and dietary supplements, over traditional FDA-approved medications. The use of these prescribed remedies must follow all school policies and procedures for use at school.

Procedures

1. Parents/guardians and health care providers shall complete a Medication Administration Consent Form and/or Prescription Form for Self-Medication of Prescribed Medication before any person administers prescribed medication to a student or before a student self-medicates. Notes and phone calls will not be accepted. Consent Forms are to be kept in the binder with the Medication Assistance Records (MAR). The first dose of any new medication should be given at home and not at school.

2. Any change in prescribed medication, dosage, route or frequency requires a new authorization/consent form signed by the doctor and parent and a new prescription bottle/label from the pharmacy indicating the change. The health care provider may fax the requested medication change on letterhead or a prescription pad to the school office and this written change may be attached to the original medication administration consent form until a new authorization/consent form is completed by the doctor/parent. We are unable to accept verbal dosage changes for prescription medicines and prescribed dietary supplements from parents/guardian.

3. Medicines will be stored in a locked cabinet or drawer. Students will not have access to this area. Emergency medicines and medications approved for students to carry may be exempted from this requirement based on the individual student's needs as assessed by a school nurse. School staff will accept no more than a one week supply of prescribed medicine unless otherwise approved by the Principal or designee. In accordance with board policy #09.2241 a student may be permitted to carry a medication for individual use only if ordered, in writing, to do so by his or her health care provider. Medication requiring refrigeration shall be kept in a locked container that can be stored with food in a supervised area or a separate refrigerator.

4. Aspirin, narcotic pain relievers, (i.e. Percocet, Vicodin, Codeine, Demerol, Morphine, etc.) and benzodiazepine tranquilizers (i.e. Valium, Dia*Stat*, Xanax, Ativan, etc.) will not be routinely accepted by school personnel. Parents/guardians requesting that these medicines be given to their child at school must be referred to the nursing staff for individual evaluation of the student's health condition. Additional documentation from the child's health care provider may be requested. Because of health safety concerns due to the correlation between aspirin administration and Reyes Syndrome in children and teenagers recovering from chickenpox or flu-like symptoms, if an aspirin-containing medication such as Excedrin, Pepto-Bismol, Alka-Seltzer, Kaopectate, Pamprin, etc. (or their generic forms) is requested to be administered at school, a doctor's order/signature is required in addition to the parent's signature on the Medication Administration Consent form. Additionally the student's temperature is to be taken and documented prior to administering. Do not administer the medication and notify the parent/guardian if the student has a temp greater than 99 degrees or has any of the health conditions noted above.

5. Parents are to make every effort to give doses of prescribed medication at home if ordered to be given once, twice or three times a day. If a mid-day dose is required this is to be noted on the Medication Administration Consent Form that is completed and signed by the parent/guardian and physician. Medication that must be given at school should be brought to school by the parent/guardian whenever possible. Medication that is sent to school with the student should be transported in the original container placed in a sealed envelope and given to designated school personnel immediately upon arrival. Prescribed oral medications in pill/tablet/capsule form shall be counted and the number recorded on the Medication Administration Record.

6. Field Trip Medication Administration: Prescribed medications (prescription, herbal and dietary supplements alike) ordered by a physician and non-prescription over-the-counter medications which are essential for the student to take during and/or after school hours while attending a school-sponsored event/field trip shall be given according to the instructions noted on the Medication Administration Consent Form. Medicines administered on field trips are to be documented immediately on the student's MAR by the person administering that medication.

7. Prescription medication must have a pharmacy label affixed that includes the child's name, date dispensed, name of the medication, dosage, strength, expiration date, and directions for use including frequency, route of administration, time interval of the dose, prescriber's name, and pharmacy name, address and phone number.

8. Prescribed herbal/dietary supplements and non-prescription over the counter medication must be in the original container and marked with the student's name. In addition to the completed 'Consent' form, the prescribing physician for a herbal/dietary supplement is requested to prepare a letter which includes the following:
   - confirmation that the herbal/dietary supplement is safe for the child to take;
   - documentation that the herbal/dietary supplement must be administered during the school day; and
   - instructions on how and when the herbal/dietary supplement must be administered at school.

9. A student's medicine (with the exception of topical preparations for emergency First Aid use) must be provided by the parent/guardian. No stock medications such as Tylenol, Mylanta, cough drops etc. will be kept at school for the purpose of administering to students.

10. If a child refuses to take medication or is uncooperative during medication administration, documentation shall be made, the parent/guardian and school nurse (if appropriate) will be contacted and the medication administration may be omitted. If necessary, a conference may be scheduled with the parent/guardian to resolve the conflict.

11. School personnel authorized to give medications must be trained in accordance with KRS 158.838, KRS 156.502 and 702 KAR 1:160. Guidelines for diabetic medication administration under 702 KAR 1:160 no longer apply to training of non-licensed school personnel. These trainings are good for the current school year and must be completed annually. Medication administration to students cannot be delegated to parent or community volunteers (exception: a parent administering medicine to his or her own child).

12. Non-prescription (over the counter) medications may be accepted on an individual basis as provided by the parent/guardian when a completed Medication Administration Consent Form is submitted. The medication should be in the original container, dated upon receipt, and given no more than 3 consecutive days without an order from the physician/health care provider. Medications shall not be administered beyond its expiration date.

13. Medication is not to be released to students to take home on the bus. The parent/guardian will be notified of any unused medication remaining at school and is responsible for retrieving this. Medication not picked up by the end of the school year is to be discarded by mixing with glue (for pills) and kitty

litter (for liquids) and placed in a trash receptacle or destroyed in accordance with current health standards. Prescription medication not retrieved is to be counted, with a witness present, and discarded as above. Document this on the student's MAR, including the witness' signatures.

14. 911 and the student's parent/guardian are to be called after the administration of any emergency medications (injectable epinephrine such as an Epi-Pen or Auvi-Q, Glucagon, Dia*stat,* Versed and Clonazepam for prolonged seizures). The student may be taken home, at the parent/guardian's discretion, if they communicate this to EMS and arrive at school to accept responsibility for the student prior to EMS decision to transport to the hospital.

15. Except for medications approved for self-administration, the administration of any medication to a student must be supervised by an authorized individual and documented on the medication log. Documentation of all medicines is to be in the following format:
    a. Medication administration at or during school hours is to be immediately documented on the Boone County Medication Administration Record (MAR) in black or blue ink only: *no pencil,* No white-out or other means of covering data entered is to be used; draw a single line through the error, note 'Void" and initial.
    b. Each entry must be complete with the student's first and last name, grade, sex, classroom teacher when medication is due, health care provider and emergency contact information and the name of the medication with the dosage and time it is to be given. The dosage must be specified (i.e. 5 mg. not 1 pill).
    c. Each record is an annual (whole school year) log with separate pages for daily and 'as needed' (PRN) medicines.
    d. The original medication administration log is to be placed in the student's file as a permanent part of the student's file.
    e. *Daily medications* are to be given within 30 minutes before or after the stated dose time. Document immediately that the dose has been given with the time the medication was administered and the initials of the person administering the medication; initial and sign the MAR in the bottom left corner
    f. *PRN medications* are given 'as needed'. Examples include rescue inhalers for students with asthma, Tylenol, Epi-pens, Glucagon and Dia*Stat*. After administering, document the time given and initial.
    g. Utilize the 'Key' to document medicine that is missed due to student absence or not given due to school not being in session.
    h. If a medicine is discontinued, write D/C and draw a line horizontally through the remaining weeks.
    i. If a medicine is started after the first of the month, draw a line horizontally through the spaces prior to the first dose.
    j. If a medicine dose is changed, discontinue the medicine as in 'H' above and make a new MAR with the new dose starting on the appropriate date as in 'I' above.

16. Medication errors: If an error in the administration of medication is recognized, initiate the following steps:
    1. Keep the student in the First Aid Room. If the student has already returned to class when the error is recognized, have the student accompanied to the First Aid Room.
    2. Complete a Medication Administration Incident Report form.
        a. Assess and document the student's status
        b. Identify the incorrect dose/type of medication taken by the student.
        c. Immediately notify the school administrator and school nurse of the error, who will notify the parent/guardian.
        d. Notify the student's physician/health care provider as appropriate.
        e. If unable to contact the physician/health care provider, contact the Poison Control Center for instructions.

f. Record in detail all circumstances and actions taken, including instructions from the Poison Control Center or physician/health care provider, along with the student's status.

17. To safely accommodate physician-ordered titrating doses that are different than the dose written on the prescription bottle, the following conditions would need to be met prior to making that accommodation:
    - A Medication Consent Form would be completed and signed by both parent and healthcare provider for each specific dose adjustment. (For example, if the dose request was for one pill at noon for one week, increasing to two pills at noon for the following week to reach the desired dose of 3 pills at noon daily thereafter, we would need a new consent for completed and signed for each of those dose adjustments);
    - A new MAR would be completed for each dose change; this way the dose on the current MAR will match the current Medication Administration Consent form;
    - A small tab (like a small post-it note) with the current dose (as noted on the Consent Form and MAR) would be completed by the nurse noting current dose due to titration. This would be affixed to the bottle in such a way that all other info on the pharmacy label would still be visible.
    - When the dosage has been titrated, the prescription bottle label would be updated to reflect the current dose, matching with the consent form.

Please contact a member of the nursing staff if you have any questions regarding administering medications at school, the procedures outlined above, if you need clarification on an order or if you are unfamiliar with a medicine.

All forms pertaining to assisting with medication at school as well as these guidelines will be reviewed as needed by the nursing staff. All suggestions regarding revisions should be directed to the school district health coordinator. Any revisions to the above will be in accordance with current education and nursing laws and will reflect safe school nursing practice.

REFERENCES:

- American Academy of Pediatrics. School Health Policy and Practice. 5th Ed. 1993.
- Boone County Board of Education. Policy #09.2241, Dispensing Medication. 07/08/2010
- National Association of School Nurses. Position Statement, Administration of Medication in the School Setting.
- Medication Administration Training Manual for Non-licensed School Personnel; Kentucky Department of Education, March 2011

RELATED POLICY:
09.2241

RELATED PROCEDURES:
09.2241 AP.21
09.2241 AP.22

Boone County Schools
School Health Services Department

Medication Administration Consent Form

Prescribed medications (including herbal and dietary supplements) and over the counter medications shall be given according to the instructions below. All prescription medication MUST be in the original pharmacy container, labeled with student name, prescribing healthcare provider, strength and dose of medication and directions for use, including a time(s) for dosing. Over the counter medications MUST be in their original containers. No more than one week's supply of prescription medication may be received at school; for a field trip, only the amount of medication required for the event will be accepted. Please refer to Boone County Schools medication policy and procedures for more detailed information. This consent is only valid for the current school year.

Student's Name: _____ **Date of Birth:** _____ **Grade:** _____

Allergies: _____

****Please advise the school nurse immediately of any changes in medication or dosing.****

Medication 1: _____ Diagnosis/ Condition: _____

Dose (mg/ml): _____ Route: _____ Administration time(s): _____

Possible side effects: _____

*For Epinephrine, Diastat, Glucagon or an inhaler; student has received training, is capable and:

Physician's initial in appropriate box	
☐ may SELF-CARRY	☐ may SELF-ADMINISTER

Medication 2: _____ Diagnosis/ Condition: _____

Dose (mg/ml): _____ Route: _____ Administration time(s): _____

Possible side effects: _____

*For Epinephrine, Diastat, Glucagon or an inhaler; student has received training, is capable and:

Physician's initial in appropriate box	
☐ may SELF-CARRY	☐ may SELF-ADMINISTER

Specific to field trips: In the case of field trips or school-related functions, slight adaptations to medication administration times may be necessary. Unless otherwise indicated, student may self-administer medication with school-trained personnel while on a field trip.

I request trained Boone County School employees to administer or supervise the administration of this medication in accordance with Boone County Schools' Medication Administration Guidelines and the above instructions. I release Boone County School District and any of its employees (hereinafter the "District") from any liability or harm which is suffered by the student (named above) as a result of this request. I further agree to indemnify and hold the District harmless from any legal action or other attempts to acquire compensation, including damages and legal and medical fees, from the District whenever the District has acted in accordance with the information provided by my child's physician.

Trained Unlicensed School Personnel: The Boone County Board of Education has adopted a procedure in which a staff member, from the school the child is attending, will administer either an injection, prescribed medication or other emergency procedure in the event of a crisis. The undersigned understands that the staff member administrating the above care may not be a licensed healthcare professional, but that this staff member will undertake to do his or her best to comply with the procedure as developed by the student's physician in the case of a life threatening emergency where in immediate intervention is required.

Parent/ Guardian signature: _____ **Date:** _____

Physician signature: _____ **Date:** _____

Physician name: _____ **Phone number:** _____

Staff administering medication are trained annually by a registered nurse.

Revised: Nov. 2018,SLW

RISE ACADEMY

Joseph Hibbett, School Principal • Melissa Lameier, Vice Principal
Tammy Dorgan, School Counselor

Dear Parents/Guardians:

We have an exciting program called Circle Strength. The purpose of this program is to increase student self-confidence. The program does this by focusing on student socio-emotional intelligence (i.e. self-awareness, emotional strength, and self-responsibility). Additionally, the program will focus on academic achievement which will be measured by reading achievement and CERT assessment scores. Lastly, the program will focus on physical fitness. The physical fitness portion will focus on strength training and cardiovascular endurance.

Due to the physical fitness portion of this program, parent consent is required. By signing this consent form you are giving permission for your child's physical participation in the program and, therefore, releasing Rise Academy from any liabilities.

Parent Name (Printed):_____

Parent Signature:_____Date:_____

Student Name (Printed):_____

Student Signature:_____Date:_____

Return to K. Brantheupt

ACE Parent Survey

How can we help?

We offer a unique blend of programs and services to serve your family and child. The goal is to meet the needs of the students and families in school and at home as a means to help them do well in school.

What grade is your child in?

☐ Middle School ☐ 9 ☐ 10 ☐ 11 ☐ 12

Are you raising children other than your own?

☐ Yes ☐ No

In the past 12 months have you had difficulty...

Providing food for your family? ☐ Yes | ☐ No

Finding housing for your family? ☐ Yes | ☐ No

Needed help paying rent or mortgage? ☐ Yes | ☐ No

Getting your child with school supplies? ☐ Yes | ☐ No

In the past 12 months have you or your child...

Needed assistance with medical care? ☐ Yes | ☐ No

Needed assistance with dental care? ☐ Yes | ☐ No

Needed assistance with vision care? ☐ Yes | ☐ No

Needed assistance with hearing care? ☐ Yes | ☐ No

Does your child have a primary care provider?

☐ Yes ☐ No

Do you or your child have vision or hearing insurance?

☐ Yes ☐ No

Would you like information on teen substance abuse treatment?

☐ Yes ☐ No

Would you like information on....

☐ gangs ☐ drug/ alcohol abuse

☐ drug/alcohol prevention ☐ Self Esteem

☐ teen pregnancy prevention ☐ teen pregnancy

☐ Self-harm (like cutting) ☐ Other:

ACE Parent Survey

Continued

Do you need information on obtaining your GED?

☐ Yes | ☐ No

Do you or your child need information on job searching or career guidance?

☐ Yes | ☐ No

Would you like information about a support group for grandparents or people raising children other than their own?

☐ Yes | ☐ No

What would you like to learn about?

Please share any additional comments or suggestions.

ACE Parent Survey