STUDENT REGISTRATION FORM

Student's LEGAL Name: Last: _____ First: _____ Middle: _____

Nickname: _____ Birth Date: _____ Student Cell: _____

Gender: _____ Ethnicity/Ethnicities: _____ Grade in School: _____

Parent/Guardian **1** Full Name: _____ Home Phone: _____ Cell: _____

Address: _____ Work Phone: _____

City: _____ Zip: _____

Parent/Guardian **2** Full Name: _____ Home Phone: _____ Cell: _____

Address: _____ Work Phone: _____

City: _____ Zip: _____

Parent/Guardian **1** E-Mail: _____ Parent/Guardian **2** E-Mail: _____

Child resides with: ☐ Both Parents ☐ Mother Only ☐ Father Only ☐ Other, Name/Relationship: _____

Legal Guardian: ☐ Both Parents ☐ Mother Only ☐ Father Only ☐ Other, Name/Relationship: _____

Emergency contact (other than Parent/Guardian): _____ Relationship: _____ Phone: _____

Emergency contact (other than Parent/Guardian): _____ Relationship: _____ Phone: _____

Physician's Name: _____ Phone: _____ Dentist's Name: _____ Phone: _____ List

any medical concerns: _____ List

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

Medications @ Home (Name/Time/Amount) _____

Medications @ School (Name/Time/Amount) _____

Physical Restrictions: _____ Dietary Concerns: _____

Language spoken in home if other than English: _____

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

_____ _____ Signature of Parent or Guardian Date

Over

STUDENT REGISTRATION FORM

Student's LEGAL Name: Last: _____ First: _____ Middle: _____

OUTSIDE AGENCIES INFORMATION:

Is the student currently seeing a **therapist** (outside of school)? ☐ YES ☐ NO If "yes" please specify the following: Name of therapist: _____ Address: _____ City: _____ Zip Code: _____ Phone Number: _____ Do we have permission to contact this therapist? ☐ YES ☐ NO

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

Is the student currently seeing a **psychiatrist** (outside of school)? ☐ YES ☐ NO If "yes" please specify the following: Name of psychiatrist: _____ Address: _____ City: _____ Zip Code: _____ Phone Number: _____ Do we have permission to contact this psychiatrist? ☐ YES ☐ NO

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

Is the student currently involved in the courts? ☐ YES ☐ NO

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

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

Phone number: _____

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

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

INSURANCE INFORMATION:

Name of Insurance Company: _____ Phone Number: _____

Address of Company: _____

Policy Holder's Name: _____ Birth Date: _____

Group/Policy Number: _____ Employer: _____

AUTHORIZATION FOR ALTERNATIVE TRANSPORTATION

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

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

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

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

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

Adult's Name	*Phone Number*	*Relationship to the Student*

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

Parent/Guardian's Signature _____ *Date* _____

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

_____ _____

Name **Date of Birth**

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

□ Educational Reports & Information (e.g., Individualized Education Plans (IEP); Social/Developmental Histories; Progress Reports & Information; Disciplinary Reports; IWAS/SIS Data)

□ Mental Health Information (e.g., therapeutic summaries; psychological evaluations; psychiatric reports; monthly progress reports to physicians, substance abuse evaluations and progress notes)

□ Medical Reports & Information (e.g., medical/physical forms/reports; laboratory results)

□ Re-release of records from physicians, mental health professionals, hospitals, partial hospitalization programs, and outpatient treatment programs which were obtained during the time the student was enrolled at our school

TO THE FOLLOWING:

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

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

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

_____ _____

Signature of Parent/Guardian **Date**

_____ _____

Signature of Student (if 12 years or older) **Date**

_____ _____

Witness **Date**

Consent to Release

Educational, Mental/Physical Health and Legal Information

Name _____ Date of Birth _____

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

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

TO/FROM:
Name: _____

Address: _____

City, State, Zip: _____

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

AND Your Child's Home School District and its agents

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

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

_____ _____
Signature of Parent/Guardian **Date**

_____ _____
Signature of Student (if 12 years or older) **Date**

_____ _____
Witness **Date**

Authorization for the Administration of Medication at School

Student Name _____ Date of Birth _____

Address _____

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

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

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

Condition(s) Requiring Medication(s) _____

Possible Side Effects _____

Physician's Signature _____ Date _____

Phone # _____ Fax # _____

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

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

_____

_____

_____

_____

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

Parent's/Guardian's Signature _____ Date _____

Home Phone # _____ Work or Mobile Phone # _____

* See "Medication Policies and Procedures" on back*

Virtual Connections Academy Medication Policies and Procedures

(Revised 6.15.2020)

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

1. Medication(s) are defined as all prescription and non-prescription (over the counter) pharmaceuticals and preparations. This includes but is not limited to; pain relievers, fever reducers, cough drops, eye drops, contact lens solutions, inhalers, allergy medications, skin ointments/lotions.

2. Medication will not be administered at school without a written physician's order and written parent/guardian permission on our school Authorization for the Administration of Medication form.

3. Prescription medication must be provided in the original pharmacy or physician labeled container clearly marked with the student's name and directions for use. Over the counter (OTC) medications must be in the original manufacturer's packaging and clearly marked with the student's name.

4. It is the parent/guardian's responsibility to provide the school with any and all medications/preparations that have been authorized to administer.

5. All student medications (prescription and over-the-counter) must be **delivered to school by the parent, guardian, or other responsible adult approved by the school administration. The student may not bring in medications, and medication is not to be brought in by the drive of transportation.** You may deliver medications to the school Monday through Friday, 8 am to 4 pm (Mon. – Thur. during summer session).

6. All medications, which are taken during school hours, will be locked in the nurse's office. An exception may be considered for bronchial inhalers with physician orders and parent permission.

7. The parent/guardian must assume responsibility for informing the school of any change in the student's health, or medications. Written Physician Orders and Parent Permission must accompany changes in medication given at school.

8. The school will act based on the health and medication information provided by the parent/guardian and health care provider(s). It is expected that the information provided is accurate, complete, and up-to-date and that any changes will be communicated to the school in an expedited manner.

9. Medication is administered by VCA administrators. When dispensing medication, the medication administrator checks the Authorization for the Administration of Medication form, the student photo, and the log sheet to ensure the correct medication and dosage are provided to the correct student. Upon dispensing medications, the medication administration is logged with the time, date, and initials of the medication administrator in the Medication Log. The Medication Log includes student name, photo, medication name with dosages, and the Authorization for the Administration of Medication form.

- SPECIAL NOTE: This policy will be modified upon updated guidance from ISBE (6.15.2020)

VCA SPECIAL TREATMENT TECHNIQUES

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

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

At times, students may require a high level of intervention and support. When this occurs, students are given the opportunity to temporarily leave the activity in order to manage their high level of stress before returning. Students who struggle to advocate for their needs may require guidance, prompting, or directives by staff members to take this restorative break.

If the behavior continues to disrupt the group, the student may receive a more intensive level of support from the Therapist, Case Manager, Clinical Director, or Principal. Our staff are trained in crisis intervention, conflict resolution, and teaching students the skills to better manage their impulses; more effectively get their needs met; and practice pro-social, appropriate ways to cope with and express their thoughts and feelings.

If a student is acting in a manner that indicates the possibility of physical harm to him/herself or others, it may be appropriate for the staff to engage in a "therapeutic hold" of the student in order to prevent this outcome. The safety and dignity of the child, as well as the safety of peers and staff, is of paramount importance in this process; and it is always as unobtrusive and brief as possible. VCA follows the Crisis Prevention Institute (CPI) guidelines in regard to the use of therapeutic holds and adheres to Section 1.285 of the IL school code. All staff has been trained in supine therapeutic holds and may be used based on individualized student needs. Administration reviews all student medical records along with IEP documentation and psychologist reports to determine if there are no medical contraindications to its use. Consistent staff training in crisis prevention and non-violent physical intervention techniques is provided by VCA and is required of all Staff Members. If a therapeutic hold is necessary to maintain care, welfare, safety, and security of students and staff, the following will occur:

1. A senior staff member will be present during the intervention. If a physical restraint exceeds 15 minutes or if repeated episodes occur during any 3-hour time period, a senior staff member will evaluate the situation.
2. The school nurse and the student's therapist will be notified
3. The school nurse or designee will conduct a wellness check

4. Parents will be notified on the same school day
5. NCI paperwork will be completed and maintained by the principal to ensure dissemination of information to the parent and to ISBE including:
   a. Restorative Intervention Referral Form (precipitating classroom events, antecedents, interventions used)
   b. School Incident Report (narrative by all staff involved in the hold, including therapist, nurse, and senior staff member evaluating the child immediately after the hold)
   c. Student Intervention Form (behavior intervention form completed by student)
6. Completion of ISBE Restraint paperwork completed and sent to:
   a. Parent within 1 school day
   b. District (via email) and ISBE (via SIS system in IWAS) within 2 school days
7. On a school level, therapeutic hold data is reviewed on a monthly and annual basis by the administrative team to assess for increases or decreases in incidents. Based on the monthly data, the team determines the needs for therapeutic holds for individual students, a review of Functional Behavioral Analyses, and the effectiveness of the current Behavior Intervention Plans.

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

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

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

Revised 4.14.2021

SPECIAL TREATMENT TECHNIQUES

Signature page

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

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

Signature of Parent/Guardian Date

Revised 4.14.2021

Electronic and Telecommunication Policy

The Connections Organization Schools may use approved interactive videoconferencing, school e-mail, and school phones for text (VCA only), for both educational and psychoeducational services. Telecommunications/video conferencing offers the opportunity to increase student/ family access to psychological and educational services. Telecommunications also allows for staff to interact with each other regarding students and their needs. All school staff will be provided relevant professional training to ensure their competence in both the technologies used and the potential impact of the technologies on students/families.

There are risks to using e-mail, text, and video conferencing in regard to confidentiality. While we take precautions to protect information, such as having information password protected, and using video-conferencing that is consistent with HIPAA regulations, we recognize there are risks to confidentiality using telecommunications.

We also store information electronically. The electronically stored information may include case notes, communication notes, and progress on Individualized Educational Plan (IEP) goals. The data stored will be password protected. If there is a breach of electronically communicated or maintained data, school personnel will notify the families and district representatives as soon as possible. By signing the student handbook, I acknowledge and accept the use of this policy, and understand the risks to confidentiality of using electronic communication.

_____ _____

Print & Sign (Parent/Guardian) Date

_____ _____

Print & Sign (Student - if 12 or over) Date

RECEIPT & ACKNOWLEDGMENT

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

I understand the provisions of this handbook, and have discussed all questions, comments and concerns with the Senior Staff Members at Connections Organization , **Dr. Tanya Guild** (Principal), **Dr. Bernadette Santiago** (Senior Clinical Psychologist). Administrative staff can be reached at **(224) 801-8821** or through email. Please call the front desk, or see the school website for specific phone extensions and email addresses.

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

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

Parent/Guardian Printed Name	**Parent/Guardian Signature**
Student Printed Name	**Student Signature**
Date	

Student Name: _____

SCHOOL INFORMATION,
PARENTAL WAIVERS & CONSENT FORMS

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

Thank you.

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

FOOD

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

LATE ARRIVALS & ABSENCES

Please call the Front Desk (224-801-8821) to inform school staff, **prior to 8:30am** on the day of your child's absence or late arrival, and *indicate whether you would like your child's absence to be **excused or unexcused***. Office hours are from 8:00am – 4:00pm, but messages can be left for the Front Desk Staff at any time.

Student Name: _____

LATE ARRIVAL & EARLY PICK-UP

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

CABS/BUSES

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

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

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

MEDICATION

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

INSURANCE

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

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

_____

Signature of Parent/Guardian Date

Student Name: _____

EDUCATIONAL SERVICE COLLABORATIONS

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

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

_____

Signature of Guardian Date

THERAPY & ASSESSMENT PROGRAMS

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

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

_____

Signature of Parent/Guardian Date

DEPARTURE FROM SCHOOL WITHOUT PERMISSION

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

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

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

_____

Signature of Parent/Guardian **Date**

Student Name: _____

MULTIMEDIA

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

□ I **DO** give permission for my child to be photographed/videotaped.

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

_____

Signature of Parent/Guardian Date

FIELD TRIPS

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

□ I **DO** give permission for my child to travel within the 10-mile radius.

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

_____

Signature of Parent/Guardian Date

PERMISSION FOR USE OF SUNSCREEN & INSECT REPELLANT

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

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

Sunscreen

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

Insect Repellant

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

Signature of Parent/Guardian Date