INNOVATIONS ACADEMY THERAPEUTIC DAY SCHOOL PROGRAMS

৩ STREAMWOOD, ILLINOIS ৩

High School and Vocational Education Program
Student Data Packet
2016-2017

APPROVED BY
THE ILLINOIS STATE BOARD OF EDUCATION

1360 Irving park rd.
Streamwood, Illinois 60107
Phone: (630) 540-3900 Facsimile: (630) 540-3908

PERSONAL DATA SHEET

Please Fill Out This Section Completely.

DATE: ________________________

STUDENT: ______________________________________ **BIRTHDATE:** _____________________________________

LEGAL GUARDIAN(S): ____

ADDRESS: ___________________________________ **CITY:** _______________________ **ZIP:** ___________

PHONE: _______________________

MOTHER: ____________________________________ **CELL PHONE:** _______________________________

EMAIL: ____ **WORK PHONE:** _____________________________

FATHER: ____________________________________ **CELL PHONE:** _______________________________

EMAIL: ____ **WORK PHONE:** _____________________________

EMERGENCY CONTACT PERSON: ____

RELATIONSHIP TO STUDENT: _____________________________ **PHONE:** _____________________________

CURRENT MEDICATIONS:
(Even if taken at home)

1)____
(name) (time) (dosage)

2)____
(name) (time) (dosage)

3)____
(name) (time) (dosage)

PHYSICIAN: ____ **PHONE:** ____________________________

ADDRESS: ____

MEDICAL INSURANCE CO: ____

ALLERGIES: ____

ALLERGIC REACTION: _________________________ **EPI PEN REQUIRED?:** YES NO

SCHOOL DISTRICT: ___________________________ **CONTACT PERSON:** _______________________________

HOME SCHOOL: ______________________________ **LAST GRADE COMPLETED:** ________________________

LAST SCHOOL ATTENDED: _____________________ **CURRENT GRADE:** _________________________________

FOR OFFICE USE ONLY **DATE OF 14-7.02 PLACEMENT:** ____________________________________

BUS COMPANY: ________________________________ **PHONE:** ____

TEACHER: ___________________________________ **THERAPIST:** _______________________________________

INNOVATIONS ACADEMY – HS/Vocational Education Program

CONSENT FOR EMERGENCY MEDICAL TREATMENT

Please Fill Out This Section Completely.

STUDENT: ______________________________________ **BIRTHDATE:** __________________

I give my consent for **Innovations Academy** personnel to authorize, on my behalf, any necessary

evaluation and emergency medical treatment for my son / daughter (***circle one***)

_______________________________, should such evaluation or treatment be deemed necessary.

I understand that **Innovations Academy** will neither be held liable for medical outcomes nor financially responsible for the costs of any medical evaluation or treatment.

THIS CONSENT IS MANDATORY FOR ENROLLMENT AT **INNOVATIONS ACADEMY**. FAILURE TO SIGN THIS CONSENT WILL PREVENT YOUR CHILD FROM BEING ENROLLED AT INNOVATIONS ACADEMY.

____

PARENT/LEGAL GUARDIAN (PLEASE TYPE OR PRINT)

______________________________________ ___________________________

PARENT/LEGAL GUARDIAN SIGNATURE **DATE**

______________________________________ ___________________________

NAME OF INSURANCE COMPANY **POLICY NUMBER**

______________________________________ ___________________________

INNOVATIONS PRINCIPAL SIGNATURE **DATE**

This Consent Is Valid Until One (1) Year After Above Date.

INNOVATIONS ACADEMY – HS/Vocational Education Program

PHYSICAL MANAGEMENT POLICY

Please Fill Out This Section Completely.

STUDENT: ______________________________________ **BIRTHDATE:** __________________

At times, it becomes necessary to use physical management with students who are behaving in an unsafe manner. It is the philosophy of **Innovations Academy** that physical restraint is always used as a last resort and used only in the following situations:

1.) The student is a danger to himself or herself.
2.) The student is a danger to others (staff, students, etc.)

All staff members at **Innovations Academy** are trained to address a student's inappropriate behavior through a non-violent behavior management program (CPI®). However, when a student engages in the behaviors listed above, he or she may require the use of a physical management procedure. The parent or guardian will be notified if a physical restraint occurs. If a student is unable to gain control of his or her behavior through physical management, a parent or legal guardian may be called to remove the student for the remainder of the day.

I have read and understand the above policy. I understand that physical management will only be used as a last resort for the safety of my child, as well as other students and staff.

THIS CONSENT IS MANDATORY FOR ENROLLMENT AT **INNOVATIONS ACADEMY**. FAILURE TO SIGN THIS CONSENT WILL PREVENT YOUR CHILD FROM BEING ENROLLED AT INNOVATIONS ACADEMY.

_______________________________________ ______________________________

STUDENT SIGNATURE **DATE**

_______________________________________ ______________________________

PARENT / LEGAL GUARDIAN SIGNATURE **DATE**

_______________________________________ ______________________________

INNOVATIONS PRINCIPAL SIGNATURE **DATE**

This Consent Is Valid Until One (1) Year After Above Date.

INNOVATIONS ACADEMY – HS/Vocational Education Program

ELECTRONIC DEVICE POLICY

Please Fill Out This Section Completely.

STUDENT: ______________________________________ **BIRTHDATE:** __________________

Electronic devices, such as cell phones, iPods, mp3 players, portable CD/DVD players, and both hand-held and console video games, are a disruption to the educational and therapeutic process at **Innovations Academy**. As a result, students must relinquish all electronic devices to school staff upon entering the school building. Such devices are labeled and stored in the front office and under constant supervision before being returned to the student at the end of the school day.

THIS CONSENT IS MANDATORY FOR ENROLLMENT AT **INNOVATIONS ACADEMY**. FAILURE TO SIGN THIS CONSENT WILL PREVENT YOUR CHILD FROM BEING ENROLLED AT INNOVATIONS ACADEMY.

INNOVATIONS ACADEMY IS **NOT** RESPONSIBLE FOR THE LOSS, THEFT OR DAMAGE OF ANY ELECTRONIC DEVICES.

AS A RESULT, **INNOVATIONS ACADEMY STRONGLY ENCOURAGES** STUDENTS TO LEAVE ELECTRONIC DEVICES AT HOME.

____ _______________________________

STUDENT SIGNATURE **DATE**

____ _______________________________

PARENT / LEGAL GUARDIAN SIGNATURE **DATE**

____ _______________________________

INNOVATIONS PRINCIPAL SIGNATURE **DATE**

This Consent Is Valid Until One (1) Year After Above Date.

INNOVATIONS ACADEMY – HS/Vocational Education Program

ACCEPTANCE OF INNOVATIONS ACADEMY POLICY & EDUCATIONAL PLACEMENT

Please Fill Out This Section Completely.

STUDENT: ______________________________________ **BIRTHDATE:** __________________

Please support **Innovations Academy** in being fully involved in your child's educational performance.

We have read the full content of **Innovations Academy Student Data Packet** and the **Student Handbook**. We understand that **Innovations Academy** is a ***full-year school program***, and that attendance year-round is ***mandatory*** for placement. Failure to attend in excess of five (5) consecutive days will result in notification of the student's home school district.

We understand the information and fully accept the responsibility to follow all of the rules and guidelines of the program contained in this Packet and the Student Handbook.

THIS CONSENT IS MANDATORY FOR ENROLLMENT AT **INNOVATIONS ACADEMY**. FAILURE TO SIGN THIS CONSENT WILL PREVENT YOUR CHILD FROM BEING ENROLLED AT **INNOVATIONS ACADEMY**.

____ ________________________________

STUDENT SIGNATURE **DATE**

____ ________________________________

PARENT / LEGAL GUARDIAN SIGNATURE **DATE**

RECEIVED BY INNOVATIONS ACADEMY

____ ________________________________

INNOVATIONS PRINCIPAL SIGNATURE **DATE**

This Consent Is Valid Until One (1) Year After Above Date.

INNOVATIONS ACADEMY – HS/Vocational Education Program

Student Information Release

Please Fill Out This Section Completely.

STUDENT: ____ **BIRTHDATE:** ____________________

STUDENT ADDRESS: ______________________________

____

Permission is granted to the Innovations Academy Therapeutic Day School programs and to the agencies or persons listed below to exchange permanent, confidential and temporary educational records as listed regarding the above named student for a period not to exceed one year from date of signature. This authorization grants permission for verbal and written communication, for use in making decisions regarding the student's educational and treatment program.

- A transcript of courses taken, grades and credits earned, and attendance information in order to facilitate enrollment and develop educational plan;
- Medical and immunization records in order to verify the student's health status; doctor's orders for medications at school;
- Results of standardized achievement, intelligence, personality, and vocational tests;
- Educational records and/or diagnostic reports such as psychological or psychiatric evaluations, social history, progress notes, multidisciplinary staffing reports, IEPs, state data reported by the student's home district to ISBE data systems, and other pertinent specialists' reports;
- Discipline Records;
- Teacher and/or counselor reports and observations;
- Other ____.

Please indicate the following agencies (or individuals) with which Innovations Academy can exchange information:

School District: ____________________________ Phone/Contact information: ______________________________

Other: __________________________________ Phone/Contact information: ______________________________

Other: __________________________________ Phone/Contact information: ______________________________

Other: __________________________________ Phone/Contact information: ______________________________

Parent/Guardian/Student Permissions

____

(Parent or Guardian)

____

(Student)

____

(Date)

Note: As the parent or guardian of the above named student, you are entitled to inspect, copy, or challenge the contents of the records, and to limit your consent to the records designated above, or to specific portions of such records.

INNOVATIONS ACADEMY – HS/Vocational Education Program

PHOTO RELEASE

Please Fill Out This Section Completely.

STUDENT: ____ **BIRTHDATE:** ____________________

Innovations Academy students may be illustrated in internal education related student presentations or class projects.

I, ____

PARENT / LEGAL GUARDIAN

Please Check One:

- o Do
- o Do Not

consent to have my child's image appear in such internal photographic displays, student presentations or projects.

THIS CONSENT IS OPTIONAL FOR ENROLLMENT AT **INNOVATIONS ACADEMY**. IF YOU CHOOSE TO REFUSE THIS RELEASE OR CHECK "Do Not," YOUR CHILD WILL NOT BE PHOTOGRAPHED FOR DISPLAYS, STUDENT PRESENTATIONS OR CLASS PROJECTS.

____ ________________________________

STUDENT SIGNATURE **DATE**

____ ________________________________

PARENT / LEGAL GUARDIAN SIGNATURE **DATE**

RECEIVED BY INNOVATIONS ACADEMY

____ ________________________________

INNOVATIONS PRINCIPAL SIGNATURE **DATE**

This Consent Is Valid Until One (1) Year After Above Date.

INNOVATIONS ACADEMY – HS/Vocational Education Program

Release of Student Artwork and Supporting Materials

Please Fill Out This Section Completely.

I authorize Innovations Academy to access and utilize artwork created by my child, ____, during art class
(student name)
and/or art therapy sessions (or photographic reproductions of this work), and relevant information from his/her case.

I understand that the artwork may be used for research, publication, consultation with mental health professionals, presentations at professional conferences, educational purposes, and display at Innovations Academy art shows, subject to the following restrictions:

(Restriction. If no restrictions are imposed, write "None.")

I understand that my child's confidentiality will be maintained and the release of any identifying information will be prohibited.

____
(Parent/guardian signature) (date)

____
(Printed parent/guardian name)

____
(Art Therapist/Art Teacher signature) (date)

INNOVATIONS ACADEMY – HS/Vocational Education Program

Authorization and Permission for Administration of Medication

Please Fill Out This Section Completely if Innovations Academy will provide medication to your child during the school day.

STUDENT: ______________________________ **BIRTHDATE:** ________________ **DATE:**____________

School medications and health care services are administered following these guidelines:

- *Physician/Prescriber signed dated authorization to administer the medication.*
- *Parent signed, dated authorization to administer the medication.*
- *The medication is in the original labeled container as dispensed or the manufacturer's labeled container*
- *The medication label contains the student name, name of the medication, directions for use and date.*
- *Annual renewal of authorization and immediate notification, in writing, or changes.*

Physician Authorization:

__________________________ ____________ ____________________________

Medication/Health Care Treatment **Dosage** **Time to be administered**

__________________________ ____

Intended effect of this medication **Expected side effects, if any**

____

Other medications student is taking

____

May student self-administer medication under supervision of Health Service personnel or designate?
(A student self-administration form must be completed) (Please circle) YES / NO

Administration Instructions

____

____

____

Discontinue/Re-Evaluate/Follow-up Date (circle one)

________________________________ ________________________________

Prescriber's Signature Date Signed

________________________________ ________________________________

Prescriber's Emergency Phone # Prescriber's Address