INNOVATIONS ACADEMY THERAPEUTIC DAY SCHOOL PROGRAMS

3rd through 8th grade School Education Program
Student Data Packet
2020-2021

Innovations Academy
Home of the Phoenix

APPROVED BY
THE ILLINOIS STATE BOARD OF EDUCATION

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

"We inspire hope and resilience by putting our students first"

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: **1)**_____
(Even if taken at home) (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 PLACEMENT:** _____

BUS COMPANY: _____ **PHONE:** _____

TEACHER: _____ **THERAPIST:** _____

INNOVATIONS ACADEMY –3rd through 8th Grade School

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 our consent to the records designated above, or to specific portions of such records.

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

INNOVATIONS ACADEMY – 3rd through 8th grade School
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 – 3rd through 8th Grade School

INNOVATIONS ACADEMY

Parental/Guardian Authorization for Medication Administration

STUDENT: _____ **BIRTHDATE:** _____

I herewith acknowledge that I am primarily responsible for administering medication to _____ (student). However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize Innovations Academy and its employees and agents, on my behalf and stead, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of Innovations Academy), lawfully prescribed medication in the manner described below. I acknowledge that is may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse, and specifically consent to such practices. I further acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I have against Innovations Academy, its employees and agents arising out of the administration of said medication. In addition I agree to hold harmless and indemnify Innovations Academy, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of actions or injuries incurred or resulting from the administration or attempts at administration of said medication.

Parent's Signature:_____ Date:_____ Home phone:_____

Address: _____ Business phone:_____

Physician Authorization
(TO BE COMPLETED BY LICENSED PRESCRIBER)

Relevant Diagnosis:_____ Medication: _____ Dosage: _____

Route: _____ Time(s):_____

To be given: Everyday at school or Episodic/Emergencies Only (circle one.)

Intended effect of this medication: _____

Expected side effects, if any: _____

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

Relevant Diagnosis:_____ Medication: _____ Dosage: _____

Route: _____ Time(s):_____

To be given: Everyday at school or Episodic/Emergencies Only (circle one.)

Intended effect of this medication: _____

Expected side effects, if any: _____

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

_____ _____
Prescriber's Signature **Date Signed**

_____ _____
Prescriber's Printed Name **Prescriber's Emergency Phone #**

_____
Prescriber's Address

INNOVATIONS ACADEMY – 3rd through 8th Grade School
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 #

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

INNOVATIONS ACADEMY – 3rd through 8th Grade School
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 – 3rd through 8th Grade School
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.

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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

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

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)

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

INNOVATIONS ACADEMY

Community/Fieldtrip RELEASE

Please Fill Out This Section Completely.

STUDENT: _____ **BIRTHDATE:** _____

Innovations Academy students may be permitted to attend educational related student community/fieldtrips

I, _____
PARENT / LEGAL GUARDIAN

Please Check One:

- Do
- Do Not

THIS CONSENT IS OPTIONAL FOR ENROLLMENT AT **INNOVATIONS ACADEMY**. IF YOU CHOOSE TO REFUSE THIS RELEASE OR CHECK "Do not," YOUR CHILD WILL NOT attend or participate in the Community/Fieldtrip events.

_____ _____
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

Mask/Face Covering Policies

Please Fill Out This Section Completely.

STUDENT: _____ **BIRTHDATE:** _____

In accordance with ISBE standards, all Innovations Academy students are required to wear masks/face covering **at all times** in school buildings even when social distancing is maintained. Face coverings do not have to be worn outside **if social distancing is maintained.** (https://www.isbe.net/Documents/Part-3-Transition-Planning-Phase-4.pdf)

A physician's note is required for a student who is not able to wear a face covering due to trouble breathing.

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

Social Distancing Policies

Please Fill Out This Section Completely.

In accordance with ISBE standards, students are to maintain a 6-foot physical distance from all other persons as much as possible. Students are to follow the directional visual reminders throughout the school building. (https://www.isbe.net/Documents/Part-3-Transition-Planning-Phase-4.pdf)

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_____ _____

STUDENT SIGNATURE **DATE**

_____ _____

PARENT / LEGAL GUARDIAN SIGNATURE **DATE**

RECEIVED BY INNOVATIONS ACADEMY:

_____ _____

INNOVATIONS PRINCIPAL SIGNATURE **DATE**

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INNOVATIONS ACADEMY
Symptom Screenings

Please Fill Out This Section Completely

In accordance with IBSE standards, all students will enter the building through the screening tent on a daily basis. In the tent they will be asked screening questions and have their temperature taken. Any student who has a temperature greater than 100.4 degrees Fahrenheit/38 degrees Celsius or currently known symptoms of **COVID-19**; such as, but not limited to, fever, cough, shortness of breath or difficulty breathing, chills fatigue, muscle and body aches, headache, sore throat, new loss of taste or smell, congestion or runny nose, nausea, vomiting or diarrhea may **NOT** enter the building. (https://www.isbe.net/Documents/Part-3-Transition-Planning-Phase-4.pdf)

Parents/guardians of individuals who exhibit symptoms will be required to see a medical provider for evaluation, treatment and information about when their children are able to return to school.

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_____ _____

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

Lunch/Outside Food Policies

Please Fill Out This Section Completely

In accordance with ISBE standards, individual packaged meals will be provided for students by Innovations Academy. Areas where students consume meals will be thoroughly cleaned and disinfected before and after meals. Students will not be allowed to share food/food products. (https://www.isbe.net/Documents/Part-3-Transition-Planning-Phase-4.pdf)

Outside food /food products are not to be brought from home without prior administrative approval.

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 – 3rd through 8th Grade School
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.

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_____ _____

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.