STUDENT REGISTRATION FORM | CONNECTIONS DAY SCHOOL

20____ - 20____ School Year

(Please fill out completely)

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 continued

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: _____

THANK YOU FOR COMPLETING THIS FORM!

Connections Day School
1610 South US Highway 45 | Libertyville, IL 60048
Phone: 847.680.8349 | **Fax:** 847.680.8583 | **Web:** www.connectionsdayschool.net

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 ☐ CO-OP: _____ ☐ Other: _____

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

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** _____

Rev 5/12/16

SPECIAL TREATMENT TECHNIQUES

Signature page

We thank you for taking the time to read and review the Special Treatment Techniques of our school. 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

Connections Organization

**(Connections Day School, South Campus,
New Connections Academy, Connections Academy East)**

SCHOOL INFORMATION,
PARENTAL WAIVERS & CONSENT FORMS

Please fill out this 7-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.

SCHOOL HOURS

August – May:	Mondays, Tuesdays, Wednesdays & Fridays:	9:00 – 3:00
	Thursdays:	9:00 – 2:00
Summer Term:	Mondays, Tuesdays, Wednesdays & Thursdays:	9:00 - 3:00

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 to inform school staff, **prior to 9:00 am** 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.

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

Your Connections Organization School 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

EDUCATIONAL SERVICE COLLABORATIONS

In order to provide educational services for all students, The Connections Organization Schools 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

The Connections Organization Schools 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. The Connections Organization Schools are well-regarded clinical training sites for therapists in Illinois and beyond.

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

_____ _____

Signature of Parent/Guardian Date

SPECIAL TREATMENT TECHNIQUES

The Staff at the Connections Organization Schools (Connections Day School, South Campus, New Connections Academy, and Connections Academy East) 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 utilize a variety of strategies to help the students learn the academic, social and emotional management skills necessary for success within the school environment.

Throughout the school day, the staff utilize 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, the student may persist with disruptive or inappropriate behaviors. When this occurs, the student will be asked to leave the activity, but remain within the proximity of the group while taking a "break" in the hallway.

If the behavior continues to disrupt the group, the student may be referred to the Restorative Interventions and Supports RIS) office for a more intensive level of support. Our Behavioral Intervention Specialists 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. Consistent staff training in crisis prevention and non-violent physical intervention techniques is provided by the Connections Organization 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
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 the same school day
5. NCI paperwork will be completed 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. The student's team engages in a discussion of current behavioral concerns and an analysis of the effectiveness of the current Behavior Intervention Plan at the next Functional Behavioral Assessment meeting

The Connections Organization (Connections Day School, South Campus, New Connections Academy, and Connections Academy East) 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 Connections Day School.

We do not endorse the use of time-out/padded rooms, mechanical restraint or harsh/punitive interventions. The Connections Organization does not engage in 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.

Your signature below acknowledges that you have read and understand the Special Treatment Techniques outlined 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**

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. CDS may use an outside agency for Picture Day and Yearbook production. This requires a release of parent contact as well as student name (first name, last initial) to be associated with the photo. The student's name would also appear in the Yearbook as such. 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 your Connections Organization School (Connections Day School, South Campus, New Connections Academy, or Connections Academy East). 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 repellent unless this authorization is provided.

Sunscreen

☐ **YES**, my child may use sunscreen at school at school

☐ **NO**, my child may not use sunscreen

Insect Repellent

☐ **YES**, my child may use insect repellent with DEET at school (6-7% DEET)

☐ **YES**, my child may use insect repellent applied **without** DEET at school

☐ **NO**, my child may not use insect repellent at school

_____ _____

Signature of Parent/Guardian Date

Student Authorization For Acceptable Use Of Electronic Networks Form

I agree that I will follow Connections Day School's *Acceptable Use of Electronic Networks* when I use Connections Day School electronic network. I understand that if I violate these rules I can be disciplined, which may include loss of computer network use and privileges, detention, suspension, expulsion, or other consequences.

I understand that:

- Information or files which I create, place, transmit, or receive through Connections Day School's electronic network may be opened, reviewed, copied, and used by school officials and/or their designees at any time they deem appropriate in connection with the protection of the network, the application or enforcement of any school policy or suspected violations of the law. There are no expectations of privacy with respect to any such information or documents, except as may be provided by applicable law governing the privacy of student records and information.
- Information or documents placed on Connections Day School's system may be lost or damaged.
- If, in violation of Connections Day School *Acceptable Use of Electronic Networks* policies, I misuse the computer network or cause harm to the network or anyone else or their information or documents, such that it disrupts the operation of Connections Day School; threatens the integrity and operation of the computer network; violates the rights of others; violates federal, State or local law; or is contrary to the behavior expectations of Connections Day School; I will be responsible for paying for such misuse or damage as will my parents or guardian to the extent provided by applicable law.
- Once this completed authorization form is submitted, I will be held responsible to the terms of this *Acceptable Use of Electronic Networks Agreement* throughout my enrollment at Connections Day School or any other Connections Organization school. If my computer network privileges are suspended or revoked, a new authorization must be submitted.

Students: By signing below, I agree to abide by the *Acceptable Use of Electronic Networks Agreement* and the related policies in the Student-Parent Handbook.

Parent/Guardian: By signing below, I certify that I have reviewed with my child the rules regarding use of Connections Day School's electronic network.

Student Name	Student Signature	Date
Parent / Guardian Name	Parent / Guardian Signature	Date

Connections Day School

Handbook Acknowledgement

I, the undersigned, acknowledge that I have read and understood the Connections Day School **2025-2026 Student & Parent Handbook.**

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

Parent/Guardian Printed Name _____ **Parent/Guardian Signature** _____

Student Printed Name _____ **Student Signature** _____

Date _____

*This form must be signed and returned to the school office by August 14th, 2025. It will be maintained in the student's file.

CONNECTIONS ORGANIZATION

(CONNECTIONS DAY SCHOOL, SOUTH CAMPUS, NEW CONNECTIONS ACADEMY,
CONNECTIONS ACADEMY EAST, VIRTUAL CONNECTIONS ACADEMY)

FUNCTIONAL BEHAVIORAL ASSESSMENT CONSENT FORM

Dear Parent/Guardian,

As part of your child's placement, a Functional Behavior Assessment (FBA) will be conducted by the School Team. An FBA is the process of:

- ✓ Identifying behavior(s) that interfere with learning
- ✓ Identifying environmental factors which impact behavior(s) that interfere with learning
- ✓ Determining the cause/function of the behavior(s) that interfere with learning
- ✓ Developing a hypothesis of the function of behavior s) that are interfering with learning

The purpose of the FBA is to gather relevant data to plan for and determine the needs regarding a possible Behavior Intervention Plan, which must be developed anytime a student exhibits behaviors that interfere with learning (his or her learning or the learning of others).

A FBA may include, but is not limited to, the following indirect as well as direct methods:

Indirect:
Review of student cumulative records- health, medical, and educational

Direct:
Structured interview with school personnel and/or student
Observations and data collections regarding student behavior

☐ I give consent for an FBA to be completed for my child. I further understand that my consent is voluntary and can be revoked.

☐ I *do not* give consent for an FBA to be completed for my child.
Reasons (Optional):_____

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Signature Date

Connections Organization

AUTHORIZATION FOR ALTERNATIVE TRANSPORTATION

It is the policy and expectation of the Connections Organization Schools (Connections Day School, South Campus, New Connections Academy, and Connections Academy East) 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*
Adult's Name	*Phone Number*	*Relationship to the Student*
Adult's Name	*Phone Number*	*Relationship to the Student*
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 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***

Connections Day School
1610 South US Highway 45
Libertyville, IL 60048
Phone: 847-680-8349 Fax: 847-680-8583

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 _____

* See "Medication Policies and Procedures" on back*

Connections Organization Medication Policies and Procedures

(Revised 6.25.23)

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 medication, and medication is not to be brought in by the driver of transportation.** You may deliver medications:
    a) To the school Monday thru Friday, 8:00am to 4:00 pm (Mon. – Thur. during summer session).
    b) Once per month at Parent Night.

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.

Connections Day School
1610 South US Highway 45 | Libertyville, IL 60048
Phone: 847.680.8349 | **Fax:** 847.680.8583 | **Web:** www.connectionsdayschool.net

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 and/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 to Connections Day School.

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**

Rev 5/26/16