**Beyond the Spectrum**

**Returning Student Information**

**Please return the completed packet by Friday August 4th**



**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Student Name**

**Parent/Guardian Name (1)**

**Parent/Guardian Name (2)**

***Please complete each form in its entirety.* Keep for your records the pages indicated. Return the packet prior to the start of the new academic year. Any section which does not apply, please mark with N/A or a line through the section. Completing this packet helps Beyond the Spectrum assure we provide your child the best care. Thank you!**

 **Revised 07-25-2023**

**Beyond the Spectrum Returning Student Information**

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Grade \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street City Zip

Enrolling Parent Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Parent(s)/ Guardian(s) Residing with Child**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sibling Name and age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sibling Name and age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sibling Name and age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sibling Name and age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Name(s) of Parent(s)** **Residing at a different address (**if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street City State Zip

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sibling Name and age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sibling Name and age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sibling Name and age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sibling Name and age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Beyond the Spectrum Returning Student Information**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pediatrician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the child have seizures? Yes No If yes, be sure to complete a seizure protocol form.

Does the child have an EpiPen that will be kept at school? Yes No If yes, complete a medication form.

Will the child be taking any medications *during the school day*? Yes No If yes, complete a medication form.

Please list any and all medical, neurological or developmental diagnoses that your child has received from a doctor.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any allergies, including food and medication

|  |  |  |
| --- | --- | --- |
| **Allergen** | **How the reaction presents** | **Treatment** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Please list all medications that your child takes regularly, including both prescription and over-the-counter.

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication Name** | **Rx or OTC?** | **Dosage/ Frequency** | **Reason for Medication** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**\_\_\_\_\_ (initial) I understand that medications may impact my child’s behavior throughout the school day and I agree to inform BTS of any medication differences or changes for my child.**

**Beyond the Spectrum Student Preference Assessment Form 2023-2024**

**Student Name (Please Print):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Completed By:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To assist your child’s teacher(s) in the pairing process, it is important to identify your child’s preferences, reinforcers, and dislikes. Students have very specific enforcers and may engage with them in particular ways. Please provide as much detail as possible, such as brand names or circumstances. Please circle any “favorites” or strongly disliked items.

**GENERAL INTERESTS**

|  |  |  |
| --- | --- | --- |
| **Category and Examples** | **Child’s Likes** | **Child’s Dislikes** |
| **School Subjects** |  |  |
| **Animals** |  |  |
| **Electronics** |  |  |
| **People** |  |  |
| **Sports** |  |  |
| **Physical Activity** |  |  |
| **Art** |  |  |
| **Public Places** |  |  |

**SENSORY PREFERENCES**

|  |  |  |
| --- | --- | --- |
| **Category and Examples** | **Child’s Likes** | **Child’s Dislikes** |
| **Auditory (sound)** |  |  |
| **Visual (color, light)** |  |  |
| **Tactile (physical touch)** |  |  |
| **Kinesthetic**  |  |  |
| **Olfactory (smell)** |  |  |
| **Gustatory (taste)** |  |  |

**TOY PREFERENCES**

|  |  |  |
| --- | --- | --- |
| **Category and Examples** | **Child’s Likes** | **Child’s Dislikes** |
| **Building Blocks** |  |  |
| **Dolls/Stuffed Animals** |  |  |
| **Vehicles** |  |  |
| **Sensory Toys** |  |  |

**ENTERTAINMENT PREFERENCES**

|  |  |  |
| --- | --- | --- |
| **Category and Examples** | **Child’s Likes** | **Child’s Dislikes** |
| **Board Games** |  |  |
| **Group Games** |  |  |
| **Movies** |  |  |
| **TV Shows** |  |  |
| **Music** |  |  |
| **Video Games** |  |  |
| **Pretend Play** |  |  |
| **Characters/Celebrities** |  |  |
| **Books/Magazines** |  |  |

**FOOD PREFERENCES**

|  |  |  |
| --- | --- | --- |
| **Category and Examples** | **Child’s Likes** | **Child’s Dislikes** |
| **Restaurants** |  |  |
| **Fruits and Vegetables** |  |  |
| **Breakfast** |  |  |
| **Lunch** |  |  |
| **Dinner** |  |  |
| **Snacks/Drinks** |  |  |

**REWARD PREFERENCES – Besides verbal praise, what motivates your child?**

|  |  |  |
| --- | --- | --- |
| **Category and Examples** | **Child’s Likes** | **Child’s Dislikes** |
| **Note Home** |  |  |
| **Money/Coins** |  |  |
| **Tokens/Points** |  |  |
| **Special Food/Treat** |  |  |
| **Treasure Box** |  |  |
| **Title** |  |  |

**Beyond the Spectrum Parent Goal Setting Form Academic Year 2023-2024**

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent(s) Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate the goals you would like to see your child work towards during the school year. We provided 5 goals categories. Please note any specific skills you would like Beyond the Spectrum to address with your child. Please rank these goals in order of priority; 1 being most important. The school collaborates with therapists to determine appropriate therapy and needs.

**Academics:** This area involves the child’s ability to attend to, retain and use information. Example goals include improving handwriting, increasing reading level, telling time.

Goal 1:

Goal2:

**Communication:** This includes the child’s ability to request items or activities, communicate emotions thoughts or information such as participating in in conversation, using PEC’s or a device to meet communication needs

Goal 1:

Goal 2:

**Body and Sensory Function:** This category refers to fine motor skills, gross motor skills and sensory integration. Example goals may include decrease sensitivity to sounds, improve balance and coordination and increase physical flexibility.

Goal 1:

Goal 2:

**Life Skills:** This includes daily living tasks such as dressing, toileting, preparing food, folding clothes and knowing personal identifying information.

Goal 1:

Goal 2:

**Social Skills and Participation:** This includes the child’s ability to engage in social situations sharing toys, expressing emotions appropriately and conversation skills.

Goal 1:

Goal 2:

**Beyond the Spectrum**

**Credit Card Authorization Form for Before care and After care**

Mastercard \_\_\_\_\_\_\_\_ Visa \_\_\_\_\_\_\_\_ American Express \_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name on Card: (Please Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Exp. Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3 Digit Security Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Payment for: (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Recurring Payment Plan**

I authorize Beyond the Spectrum to charge my credit card every Monday for the previous week of before care and/or after care charges.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Registration Paid Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Beyond the Spectrum Authorized Pick-Up and Student Release Form**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student's Name (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Beyond the Spectrum uses the following criteria to assure each child is picked up or removed from the facility by authorized persons only:

1. No child will be released to any person whose name does not appear on this Authorized Pick-Up List or has been approved and added by using the authorized addition form.
2. Before any person can remove a child, proper I.D., such as a current Driver's License, must be shown.
3. If there is ever any question as to the identification of any person attempting to remove a child from BTS, the legal parent or guardian will be notified immediately.
4. The legal parent or guardian must give advanced written authorization before any person not appearing on our Authorized Pick-Up List will be allowed to remove a child from Beyond the Spectrum.
5. In the event of an emergency, the legal parent or guardian may give above stated permission verbally, but only if given directly to the Administrator or authorized office personnel. **This new pick-up person will not be added to the permanent list unless you specifically request us to do so.**
6. All authorized pick-up persons MUST complete the Authorization Affidavit, to enter the facility.

**For your child's protection, THEY WILL NOT be released to an unauthorized person.** Approved picture identification (driver's license) will be required. A list of these persons will be placed in each classroom.

List below those who have permission to pick up your child

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Beyond the Spectrum defines a legal parent or legal guardian to be person(s) who enrolled the child and whose signature is found on the enrollment form. In the case where a divorce or legal separation has occurred or is in process, legal court documentation must be presented as proof that he/she has been awarded temporary or permanent custody of the child in question. We will not hesitate to call 911 immediately if any disruptions or disputes develop on school property. The safety of the minor child in our custody will always take top priority in any situation. This also applies to those allowed to pick up the child from BTS. ONLY official court documents, whose authenticity has been verified, will supersede any other documents received or placed on file.

I hereby authorize all above listed names as active and approved people to pick up my child from BTS facility.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother or Legal Guardian’s Name Mother or Legal Guardian’s Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father or Legal Guardian’s Name Father or Legal Guardian’s Signature

## **Beyond the Spectrum Confidential information Consent and Release**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby give my full consent and authorize my child, for academic assessment results, progress, and other information to be released, discussed and/or obtained from the specified individual(s) selected below.

All information will be held strictly confidential

Student Name (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_Beyond the Spectrum teachers and teacher’s assistants

\_\_\_\_\_Beyond the Spectrum Administration

\_\_\_\_\_ABA therapists contracted with Beyond the Spectrum

\_\_\_\_\_Occupational, physical and speech therapists contracted with Beyond the Spectrum

\_\_\_\_\_Music therapists contracted with Beyond the Spectrum

Parent/Legal Guardian Name (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian Name (Signature): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## **Beyond the Spectrum Parental Authorization and Agreement**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child’s Name (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ENROLLMENT AGREEMENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian Initials**

I understand that my child is being enrolled at Beyond the Spectrum Education Center and will be attending programs for the upcoming school year.

**FINANCIAL AGREEMENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian Initials**

I understand that if any out-of-pocket payments are due, they will be invoiced by prior arrangement with Administration on a monthly/quarterly/annual basis and due as follows

* Balances paid in full are due by September 1st
* Quarterly payments are due in 4 separate payments with a ($5.00/per quarter invoicing fee) due on the 1st of September, November, February and April
* Monthly payments are due by the 15th of every month with a ($5.00/month invoicing fee)
* All out-of-pocket payment plans must be pre-arranged with administration

**\_\_\_\_\_\_\_\_\_\_ Non-Refundable Registration Fee of $600.00**

We offer Visa, Master Card, Discover and debit payments. Credit card payments incur a (3% processing fee).

Past due tuition payments incur a $15.00 late fee

A $35.00 NSF fee is charged for all returned checks. After two (2) returned checks all payments must be made by cash or credit card.

**AUTHORIZATION FOR OBSERVATION AND SCREENING:** I give my permission for my child to be observed and receive developmental screening which may include vision, hearing, speech, language, motor and development skills. I understand these screenings help teachers plan appropriate activities for my child. I understand following these screenings the results will be shared with me confidentially.

**PARENTAL PLEDGE AND SUPPORT:** I have read, consent to and support all the above authorizations, pledges and agreements as stated above and as required by Beyond the Spectrum policies and procedures.

**Parent/Legal Guardian Name (Please print):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Legal Guardian Name Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*It is the responsibility of the parent(s) and/or legal guardian(s) to provide court ordered documentation regarding custody and/or revocation of parental rights.**

## **Beyond the Spectrum Liability Waiver**

Child’s Name (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Allergy/Medical Concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Release and Waiver**

 parent(s) and/or legal guardian(s) of

(child) in consideration of the services provided by Beyond the Spectrum, a nonprofit organization existing under the laws of the State of Florida, do hereby release and forever discharge and hold harmless Beyond the Spectrum and their successors and assigns from any and all liability, claims, demands of whatsoever kind or nature, either in law or in equity, which arise or may hereafter arise with respect to my child's enrollment, participation and attendance at Beyond the Spectrum and the services they provide.

l/ We understand and acknowledge that this Release discharges Beyond the Spectrum from any liability or claim l/We or our child may have against Beyond the Spectrum with respect to any bodily injury, personal injury, illness, death, or property damage, that may result from my child i s attendance and/or participation with Beyond the Spectrum, whether caused by the negligence of Beyond the Spectrum, its agents, employees, volunteers, representatives, officers, directors and or otherwise. l/We also understand that Beyond the Spectrum does not assume any responsibility for or obligation to provide financial assistance or other assistance, including but not limited to, medical, health or disability insurance in the event of injury, illness, death or property damage. l/We hereby release and forever discharge Beyond the Spectrum from any claim which arises or may arise on account of any decision by any representative or agent of Beyond the Spectrum, regarding the exercise of power of consent to first aid, medical or dental treatment on behalf of my/our child.

**Governing Law**

This Agreement shall be governed by the laws of the State of Florida.

**Severability**

If any clause or provision of this Release and Waiver shall be held to be invalid by any court of competent jurisdiction, the invalidity of such clause or provision shall not otherwise affect the remaining clauses or provisions of this Release, which shall continue to be enforceable

**Alternative Dispute Resolution**

The Parties agree that any legal action relating to or arising out of this Release and Waiver shall be brought exclusively in binding arbitration in Bradenton, Florida and subject to the Rules of the American Arbitration Association.

Each party shall be responsible for its share of the arbitration fees in accordance with the applicable Rules of Arbitration. In the event a party fails to proceed with arbitration, unsuccessfully challenges the arbitrator's award, or fails to comply with the arbitrator's award, the other party is entitled to costs of suit, including a reasonable attorney's fee for having to compel arbitration or defend or enforce the award.

(THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION WHICH AFFECTS YOUR LEGAL RIGHTS AND MAY BE ENFORCED BY THE PARTIES.)

IN WITNESS WHERE OF, the undersigned further covenants and represents that I (we) have read this document; and that I (we) voluntarily signed this Release and Waiver of Liability.

Parent/Legal Guardian Name (Please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## **Beyond the Spectrum Photography Permission Release Form**

**FULL PHOTO RELEASE – Please initial**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I understand and give my permission my child’s photograph/video may be used in classrooms or other appropriate area within Beyond the Spectrum as well as being used in Beyond the Spectrum craft/gift projects.

**OR SELECT INDIVIDUAL PREFERENCES – Please initial all that apply**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I understand and give my permission my child’s photograph/video may be used in classrooms or other appropriate area within Beyond the Spectrum as well as being used in Beyond the Spectrum craft/gift projects.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I understand and give my permission my child’s photograph/video may be used for on-campus fundraising projects

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I understand and give my permission my child’s photograph may be used for the yearbook

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I understand and give my permission my child’s photograph may be used for the school newsletter

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I understand and give my permission my child’s photograph/video may be used for off-campus fundraising and marketing projects

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I understand and give my permission my child’s photograph/video to be used on the following social media to promote activities, celebrate student work or achievements, etc.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Beyond the Spectrum Facebook, Instagram, Twitter and Tick-Tock.

The main purpose is to improve communication between our school, our parents and the community. There may be instances we would like to upload pictures with your child or share class work your child has done.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Beyond the Spectrum web page, www.beyondthespectrum.org

**OR NO PHOTOS – Please initial**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I **do not** give Beyond the Spectrum permission for my child to be photographed or videotaped for any reason.

Child’s Name (Please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Beyond the Spectrum Seclusion and Restraint Policy**

Beyond the Spectrum, Inc. ***prohibits*** the use of seclusion – a procedure that isolates and confines a student in a separate, locked area until he or she is no longer an immediate danger to self or others.

As allowed by the Board of Directors at Beyond the Spectrum, seclusion **does not include**:

* A staff member, trained in the use of de-escalation techniques or restraint, is physically present in the same unlocked room as the student
* Student requested breaks in a separate location in the room or in a separate room but within the line of sight of the teacher or supervising adult
* Time-out procedures as defined below

Time-Out — a behavioral intervention in which the student is temporarily removed from an activity. Time-out is appropriately used when:

* The setting used for a time-out is non-locking, appropriately lighted, ventilated, and temperature controlled
* The duration of the time-out is reasonable in consideration of the purpose of the time-out as well as the age of the student
* The student is reasonably monitored by an attending adult who is in reasonable physical proximity of the student and has sight of the students while in time-out
* The time-out space is free of objects that expose harm to the student or others

Chemical Restraint: The Board of Directors at Beyond the Spectrum prohibits the use of chemical restraint — any medication that is used to control violent physical behavior or restrict the students' freedom of movement that is not prescribed treatment for the students' medical or psychiatric condition.

Mechanical Restraint: The Board of Directors at Beyond the Spectrum prohibits the use of mechanical restraint — the use of any device or material attached to or adjacent to a students' body that is intended to restrict the normal freedom of movement and which cannot be easily removed by the student.

Physical Restraint: The Board of Directors at Beyond the Spectrum prohibits the use of physical restraint — direct physical contact from an adult that prevents or significantly restricts a student's movement, except in those situations in which the student is an immediate danger to self or others, and the student is not responsive to less intensive behavioral interventions, including verbal directives or other de-escalation techniques. Physical restraint as a form of discipline or punishment is strictly prohibited.

The Board of Directors at Beyond the Spectrum prohibits the use of any physical restraint that restricts the flow of air to a student's lungs. Any method of physical restraint in which pressure is applied to the student's body that restricts the flow of air into the student's lungs, including face-down, face-up, or on the side, is prohibited.

Physical restraint ***does not include***, as the Board of Directors at Beyond the Spectrum allows, limited physical contact and/or redirection to promote student safety or to prevent self-injurious behavior, providing physical guidance or promoting when teaching a skills, redirecting attention, positioning during skill acquisition, providing guidance to a location, providing comfort, or providing limited physical contact as reasonably needed to prevent imminent destruction to school or another person's property.

Beyond the Spectrum, Inc. utilizes the following physical restraint procedures:

* All physical restraint must be immediately terminated when the student is no longer in immediate danger to self or others or if the student is observed to be in severe distress
* Parents shall be provided, at least annually, with information regarding the policy for use of physical restraint
* Annual training for select faculty and staff on the use of physical restraint as well as the Beyond the Spectrum Seclusion and Restraint Policy. Only trained staff can engage in reactive protocols including
	+ Use of physical restraint
	+ Techniques to prevent the need to use physical restraint
	+ De-escalation techniques
	+ Maintain written or electronic documentation on training provided, and a list of participants present for each training session
* Written parental notification when atypical restraint is used with their child within one school day of the incident
* The use of physical restraint shall be in the presence of a minimum of two adults and must be documented by the staff or faculty participating in or supervising the restraint.
* Annual report to the Board of Directors at Beyond the Spectrum on the use and documentation of physical restraint as well as any prohibited use of seclusion, chemical, mechanical or physical restraint.

Policy Construction

Nothing in this policy shall be constructed to prohibit an employee of Beyond the Spectrum, Inc. or any of its employees from any of the following:

* Use of any other classroom management techniques or approaches including a student’s removal from the classroom, that is not specifically addressed in this policy
* The right of school personnel to use reasonable force as permitted under the Code of Florida or Department of Education statute 1003.573 or modifies the rules and procedures governing discipline under the Code of Florida
* Reasonable actions to diffuse or break up a student altercation or fight
* Reasonable action to obtain possession of a weapon or other dangerous objects on, in possession of, or in control of a student
* Discretion in the use of physical restraint to protect students or others from imminent hard or bodily injury. Nothing in this policy shall be constructed to create a criminal offense or private cause of action against Beyond the Spectrum, Inc., its programs, agents or employees
* In instances in which a student is an immediate danger to self or others, the school or program must determine when it becomes necessary to seek assistance from law enforcement and/or emergency medical personnel. Parents must be promptly informed when their child is removed from the school or program setting by emergency medical or law enforcement personnel

By my signature I acknowledge the Seclusion and Restraint policy.

Student Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Beyond the Spectrum Financial Management**

**Please retain this page for your records**

**For all finance, scholarship and payment questions please contact:**

**Peggy Caruso, Finance Director**

**941-447-8400**

**peggy.caruso@beyondthespectrum.org**

**Monday to Friday, 9:00am to 2:00pm**

**Beyond the Spectrum Medication Authorization Over the Counter Medications**

Please complete and return this form to the front desk

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex: \_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_

Grade: \_\_\_\_\_\_\_\_\_\_\_ Student Year: 20\_\_\_\_\_\_\_\_\_\_ to 20\_\_\_\_\_\_\_\_\_\_

School Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I grant permission to Beyond the Spectrum to administer over-the-counter medication to my child while in school. I will supply the named medication(s) in an unopened, original store container. I understand it is my responsibility to personally deliver medication(s) to Beyond the Spectrum. **Do not send medication(s) with your child.** I understand this agreement is valid until I terminate permission or until the end of the school year. I understand the law provides there shall be no liability for civil damages as a result of administering such medication(s) where the person administering such medication(s) acts as an ordinarily reasonably prudent person would under the same or similar circumstances.

**NO OTHER MEDICATION(S) ARE APPROVED**

|  |  |
| --- | --- |
| Desitin | For use on diaper area **(circle)**Rapid Relief Cream, Maximum Strength Original Paste, Multi-Purpose Ointment |
| Balmex | For use on diaper area **(circle)**Diaper Rash Cream, Multi-Purpose Ointment |
| A and D | For use on diaper area **(circle)**Original Ointment, Zinc Oxide Cream |
| Vaseline | Apply to unbroken skin areas as directed by parent |
| Insect Spray | Apply per package directions |

Parent/Legal Guardian Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication Order Reviewed by Administration (Name Print/Signature) Date

**Beyond the Spectrum Medication Authorization Over the Counter Medications Middle and High School Students Only**

Please complete and return this form to the front desk

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex: \_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_

Grade: \_\_\_\_\_\_\_\_\_\_\_ Student Year: 20\_\_\_\_\_\_\_\_\_\_ to 20\_\_\_\_\_\_\_\_\_\_

School Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I grant permission to Beyond the Spectrum to administer over-the-counter medication to my child while in school or while participating in field trips. I will supply the named medication(s) in an unopened, original store container. I understand it is my responsibility to personally deliver medication(s) to Beyond the Spectrum. **Do not send medication(s) with your child.** I understand this agreement is valid until I terminate permission or until the end of the school year. I understand the law provides there shall be no liability for civil damages as a result of administering such medication(s) where the person administering such medication(s) acts as an ordinarily reasonably prudent person would under the same or similar circumstances.

Mark only one box below. No other medication is approved

|  |  |
| --- | --- |
| **Please circle one**Tylenol or Acetaminophen | One (1) 325mg (regular strength tablet or 325mg chewable equivalent every four (4) hours as needed. (NO LIQUID) |

Children must be 12 years of age or older for the medication(s) listed below

|  |  |
| --- | --- |
| **Please circle one**Tylenol or Acetaminophen | Two (2) 325mg (regular strength tablets or 650mg chewable equivalent every four (4) hours as needed. (NO LIQUID) |
| **Please circle one**Tylenol or Acetaminophen | One (1) 500mg (extra strength tablet every four (4) hours as needed.  |
| **Please circle one**Advil/Motrin or Ibuprofen | One (1) 200mg (regular strength tablet or 200mg chewable equivalent every six 6) hours as needed. (NO LIQUID) |
| **Please circle one**Advil/Motrin or Ibuprofen | Two (2) 200mg (regular strength tablets or 400mg chewable equivalent every six (6) hours as needed. (NO LIQUID) |

Parent/Legal Guardian Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication Order Reviewed by Administration (Name Print/Signature) Date

**Beyond the Spectrum Student Seizure Protocol**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student Name (Please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Legal Guardian Name (Please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please answer as fully as possible the following questions.**

**Is the child diagnosed with epilepsy or another seizure disorder?**

**What does the seizure look like?**

**When do seizures generally occur?**

**Are there any known triggers for the seizure?**

**Does the student keep seizure medication at school?**

**If yes, does the medication stay at school or go home with the student in the student’s backpack?**

**What is the protocol for a seizure lasting one minute or less?**

**What is the protocol for a seizure lasting more than one minute?**

**What is the protocol for a seizure lasting more than five minutes?**

**When should we contact the parent/guardian?**

**When do we call 9-1-1?**

**Any other special instructions?**

**Beyond the Spectrum Before Care and After Care Registration**

**Please check services needed: Before care \_\_\_\_\_ After care\_\_\_\_\_\_**

**\*\*\* PLEASE NOTE: Aftercare is not available on scheduled half days\*\*\***

**Please schedule before care or after care one week in advance so we can provide adequate staff. Thank you**

**Before care program hours: 7:30 am - 8:30 am, Monday to Friday**

**Only on certain days (Check all that apply): M\_\_\_ T\_\_\_ W \_\_\_ TH \_\_\_ F \_\_\_**

**After care program hours: 2:30 pm - 5:30 pm, Monday to Friday**

**Only on certain days (Check all that apply): M\_\_\_ T\_\_\_ W \_\_\_ TH \_\_\_ F \_\_\_ After care pick up time \_\_\_\_\_\_\_\_\_\_\_**

**PROGRAM FEES: Registration Fee: $50.00, Before Care per day: $13 per hour, Before Care per week: $50**

**After Care per hour: $13, After care per week: $150. Please see the attached *“Credit Card Authorization Form for Before care and After care”* which is required to be on file for billing purposes. Thank you!**

**POLICY AND PROCEDURE**

* **Students are required to have a snack packed each day. During this time, they will do homework, work on social skills, and go to recess.**
* **Credit card on file is billed on the Monday following services of the prior week.**
* **Aftercare staff is limited for behavior support. Any student that requires behavior support beyond our staffing will not be able to attend.**
* **Students must be signed out by a person that is on their authorized pick-up list form.**
* **Late pick-up fees will be enforced at $10 a day. After 3 late pick-ups, your child will be dismissed from the program.**
* **If before care or after care payments are delinquent by 2 weeks, the student will not be allowed to attend until payments are current**
* **If any school out-of-pocket payments are not current, the student will be unable to attend until payments are current**

**Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Before/After Care Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Child’s Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Who does the child live with: \_\_\_\_\_\_Both Parents \_\_\_\_\_\_Mom \_\_\_\_\_\_Dad \_\_\_\_\_\_Other**

**Name of Primary Parent/Legal Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Other Parent/Legal Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Any medical concerns we should be aware of (conditions? allergies?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**By signing below, I agree to abide by the terms and conditions of the program.**

**Parent/Legal Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**



**Before Care and After Care Guidelines**

I am aware I can stay in after care if I demonstrate expected and appropriate behaviors and listen to adults.

I understand I will receive only one warning for my behaviors

If I continue to make unsafe or inappropriate choices, I will leave aftercare immediately

My parent/guardian will be contacted to immediately pick me up

|  |  |
| --- | --- |
| **STAY IN BEFORE CARE / AFTERCARE** | **LEAVE BEFORE CARE / AFTERCARE** |
| **Appropriate talking voice****Hands and feet to myself****Respecting personal property****Respecting other’s property****Calm body****Appropriate language****Listening to adults** | **Yelling****Touching others****Throwing or breaking items****Uncontrolled body****Inappropriate language****Arguing****Not listening to adults** |

**MEDICATION TREATMENT AUTHORIZATION**

FOR MEDICAL/ TREATMENT ADMINISTRATION DURING SCHOOL HOURS

If your child needs to have medication(s)/treatment during the school day, state regulations and school board policy require you and your doctor provide written permission for administration of both prescribed and over-the-counter medication(s) or treatment(s).

Medication refers only to those products approved by the Food and Drug Administration (FDA) for use as a drug.

The parent, legal guardian or authorized adult must hand carry medication(s) to school administration. DO NOT put medication(s) in your child’s lunch bag or backpack. Staff will not accept medication during drop off or pick up.

**Prescribed Medication(s)** must arrive in the original container with the original and unaltered prescription label attached. The label must clearly display all legal information required for a pharmacist to dispense a prescription medication (patient’s name, doctor’s name, issue and expiration dates, medication name and dosage instructions). The label must match the physician’s order.

**Over-the-counter medication(s)** must arrive in the original and unopened store-issued container. Thake time to label the container with your child’s full name, birthdate, date you brought the medication to the school and physician’s dosage instructions.

**Albuterol Inhalers and Epinephrine Auto Injectors** must be delivered in the original box with the original and unaltered pharmacy label attached.

The Medication/Treatment Authorization Form must be completed and accompany all prescribed and over-the-counter medication(s) to be given to your child during the school day.

* Staff will not administer medication(s) without written consent
* By law, staff cannot administer liquid medication
* If the prescribed dosage is ½ tablet, it is the responsibility of the pharmacist, parent or legal guardian to divide the medication
* It is the parent(s) or legal guardian(s) responsibility to notify the school of any medication changes
* It is the parent(s) or legal guardian(s) responsibility to assure the school has an adequate supply of medication for the student
* It is the parent(s) or legal guardian(s) responsibility to pick up all medication(s) if the medication is changed, discontinued or at the end of the school year.
* Medication(s) not picked up will be discarded

Beyond the Spectrum administration reserves the right to amend the contents of this document with or without prior notice