Benhaven

125 North Plains Industrial Road
Wallingford, CT 06492
(203) 793-1905
Fax (203) 793-1909

Dear Parent or Guardian:

Enclosed is a General Information Sheet and School Administration application, which we need for our files and for the admittance of your child to Benhaven School. There are a number of general consent forms that need your signature. You will also receive an Emergency Individual fact sheet that needs to be filled out completely as part of the application process and updated annually to keep the information current. If you have any questions please feel free to contact me.

Important Medical forms that need to be filled out completely:

Form	Completed by
Authorization for Emergency-Medical Treatment and/or Surgical Treatment	Parent/Guardian
Health Assessment Form	Parent/Guardian
Authorization for Administration of Medicine	Parent/Guardian
Authorization for Nursing/Medical Services	Parent/Guardian
Authorization for the Administration of Aspirin or Aspirin like Substances & over the counter medicines	Parent/Guardian (must provide medicine)
Insurance Information	Parent/Guardian
Medical Evaluation	Physician
Immunization Record	Physician
Authorization for the Administration of Medicines by School Personnel	Physician/Dentist Parent/Guardian

If you have questions or are confused please do not hesitate to call for assistance. Please note your child cannot attend Benhaven until we have all medical forms completed and on file.

Thank you for your anticipated cooperation.

Regards,
Sarah Cyr
School Program Specialist
Benhaven School

Parent/Guardian Guidelines

When your child comes to Benhaven School our goal is to create a supportive-collaborative relationship between the family and Benhaven school staff. Our experience has taught us that students, families and staff all benefit when we have successfully created such relationships. To assist in creating that climate the following are guidelines for a good foundation on which to establish expectations:

Communication

- Establish an agreement with your child's teacher on the frequency and means with which to communicate the general progress of your child, accomplishments, concerns, behavior etc... Some options are; daily notebook, weekly phone calls, email, an individualized communication form.
- Parents/guardians are a critical member of your child's team. It is important that you participate in more formal meetings regarding your child's progress these include: PPT meetings, regular team meetings, behavioral overviews, futures plans.
- Speak directly to your child's teacher regarding important matters. The teacher is the primary person responsible for your child's program and will likely be the one to best assist you.
- If you have concern, please address it to the teacher and/or an administrator. Critical feedback is certainly welcome when it comes to creating a positive change for your child. However, a relationship based solely on critical feedback creates stress and is not productive. It may be best to send that feedback in a sealed envelope or communicate via phone to maintain privacy.

Visiting

- We welcome visits and observations in the classroom however scheduled visits work best. Visits that have a specific purpose that you and the teacher have agreed can be helpful. We also recognize that visits can be disruptive to your child and other students unless planned ahead.
- You may be asked to participate in events that are happening in your child's classroom or in the school building. Some of these include holiday events, cookouts and music activities. That may mean coming to school and/or sending a food or other necessary items in with your child. Your participation is important for the success of the event and your child's enjoyment.

Health and Medical

- **Benhaven is approved by the State Department of Education and is required to abide by its regulations.**

Upon admission this includes:

- documentation of updated physical, and immunization records.

Ongoing this includes:

- updated medication orders and written consent for PRN medications (Tylenol, Motrin Benadryl, Epipen etc…)
- Updated emergency information forms. These are required annually and updated as changes occur. **In an emergency it is critical we are able to reach you.**
- Updated documented physicals at ages 11,14,and 18.
- Communicating any medication changes to nurse/child's teacher
- Adhering to the guidelines established for illness. (see attached)

Resources available:

- Scheduled in-services on specific topics of interest in the field of autism.
- A library of information on autism research and treatment
- Guidance for guardianship
- Guidance on transitioning to adult services/post 21
- Regular team meetings with a focus on improving your child's quality of life
- Participation in Functional Behavior Assessments
- Participation in Futures Planning

Benhaven Admission Questionnaire

Student's Name______________________________ DOB____________________________

Address____

Telephone #

Home__________________________

Mother's name_________________________________

Occupation/Place of work_______________________________

Work #____

Cell #_______________________________________

Email address________________________________

Father's Name____________________________________

Occupation/place of work_______________________________

Address (if different than above)____

Work #___________________________

Cell #_____________________________

Email _________________________________

Siblings

Name______________________ age____________________

Name______________________ age____________________

Name______________________ age____________________

Name______________________ age____________________

Parents are: Married Divorced Separated

Language spoken in the Home_____________________________

Legal Guardian if not parents______________________________

In the event of an emergency list 2 people we may contact

Name______________________ Phone#___________________ relationship___________________

Name______________________ Phone#___________________ relationship___________________

Describe student's morning routine:

Describe student's evening routine:

Describe student's weekend routine:

Skill Assessment

Please indicate whether your son/daughter can perform the following activities

Skill	Does independently	Does with help	Cannot do	Comments
Uses the toilet				
Washes hands				
Brushes teeth				
Shower/bath				
Dresses self				
Undresses self				
Makes a snack				
Feeds self				
Watches TV				
Uses computer/iPad				
Listens to music				
Understands yes				
understands no				
speaks				
Uses pictures to communicate				
Uses sign language				
Communicates he/she is sick or hurt				
Makes request known				
Rides safely in vehicles				
Is able to wait for short periods of time				
Can occupy free time safely				
Can swim				

Does your child sleep through the night?____

Does your child have any fears?____

Are there any religious
restrictions?____

Is your child aggressive? Describe effective response and situations that it is likely to occur.

Is your child self-injurious? Describe effective responses and situations that it is likely to occur.

Is your child destructive? Describe effective responses and situations that it is likely to occur.

What are the safety concern you have with your child (e.g. street crossing, wanders/runs away, hot stoves, water safety)?

Does your child have particular eating habits (e.g. special diet, picky eater, favorite foods, fast pace eating, needs food cut)? Please describe:

Does your child have of Pica (eating non edibles)? Does he/she ingest non edibles or mouth them? What kinds of things does he/she put in their mouth?

Does your child have behaviors that are of special concern? For example unusual sexual behavior (disrobing, public masturbation, touching others, internet safety. Please describe:

List your child's likes/preferences	List your child's dislikes/things that don't work

What do you hope your child will achieve at Benhaven?

Medical information

Physician____________________________ phone #____________________

Neurologist____________________________ phone #____________________

Psychiatrist ____________________________phone #____________________

Dentist____________________________ phone #____________________

Insurance provider____________________________

Insurance identification #________________________

Does your child have any allergies?____

Does your child have seizures? ____

What type of seizure, describe?____

How often and how long do the typically last?____________________________________

List any chronic medical conditions; e.g. asthma, heart issues, GI problems etc

____

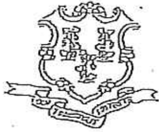
____

Medication

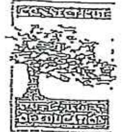
List any medications your child takes regularly

Name of medication	Why is it prescribed	dosage	Time of day given

21 A



State of Connecticut Department of Education
Health Assessment Record



To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part II).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, a physician assistant or the school medical advisor prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

Please print

Student Name (Last, First, Middle)	Birth Date	☐ Male ☐ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity ☐ American Indian/ Alaskan Native ☐ Hispanic/Latino	☐ Black, not of Hispanic origin ☐ White, not of Hispanic origin ☐ Asian/Pacific Islander ☐ Other
Primary Care Provider		
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance? Y N
Does your child have dental insurance? Y N

If your child does not have health insurance, call 1-877-CT-HUSKY

* If applicable

Part I — To be completed by parent/guardian.
Please answer these health history questions about your child before the physical examination.

Please circle Y if "yes" or N if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Hospitalization or Emergency Room visit	Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocations	Y	N	Fainting or blacking out	Y	N
Allergies to medication	Y	N	Any muscle or joint injuries	Y	N	Chest pain	Y	N
Any other allergies	Y	N	Any neck or back injuries	Y	N	Heart problems	Y	N
Any daily medications	Y	N	Problems running	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	N	Bleeding more than expected	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	N	Problems breathing or coughing	Y	N
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	N
Any problems with speech	Y	N	Dental braces, caps, or bridges	Y	N	Asthma treatment (past 3 years)	Y	N
Family History						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)				Y	N	Diabetes	Y	N
Any immediate family members have high cholesterol				Y	N	ADHD/ADD	Y	N

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any **medications** your child will need to take **in** school:

All medications taken in school require a separate Medication Authorization Form signed by a health care provider and parent/guardian.

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian Date

To be maintained in the student's Cumulative School Health Record

HAR-3 REV 4/2010

Part II — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name ______________________ Birth Date ____________ Date of Exam ____________

☐ I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider under Connecticut State Law

***Height** _____ in. / _____% ***Weight** _____ lbs. / _____% **BMI** _____ / _____% **Pulse** _____ ***Blood Pressure** _____ / _____

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
*Gross Dental			Arms/Hands		
Lymphatic			Hips		
Heart			Knees		
Lungs			Feet/Ankles		
Abdomen			***Postural** ☐ No spinal abnormality	☐ Spine abnormality: ☐ Mild ☐ Moderate ☐ Marked ☐ Referral made	
Genitalia/ hernia					
Skin					

Screenings

***Vision Screening**

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

☐ Referral made

***Auditory Screening**

Type:	Right	Left
	☐ Pass ☐ Fail	☐ Pass ☐ Fail

☐ Referral made

	Date
Lead:	
*HCT/HGB:	
Other:	

TB: High-risk group? ☐ No ☐ Yes PPD date read: Results: Treatment:

*IMMUNIZATIONS

☐ Up to Date or ☐ Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

Asthma ☐ No ☐ Yes: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent ☐ Exercise induced
If yes, please provide a copy of the Asthma Action Plan to School

Anaphylaxis Allergies ☐ No ☐ Yes: ☐ Food ☐ Insects ☐ Latex ☐ Unknown source
If yes, please provide a copy of the Emergency Allergy Plan to School
History of Anaphylaxis ☐ No ☐ Yes Epi Pen required ☐ No ☐ Yes

Diabetes ☐ No ☐ Yes: ☐ Type I ☐ Type II **Other Chronic Disease:**

Seizures ☐ No ☐ Yes, type:

☐ This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.
Explain: ______________________________

Daily Medications (*specify*): ______________________________

This student may: ☐ **participate fully in the school program**
☐ participate in the school program with the following restriction/adaptation: ____________

This student may: ☐ **participate fully in athletic activities and competitive sports**
☐ participate in athletic activities and competitive sports with the following restriction/adaptation: ____________

☐ Yes ☐ No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.
Is this the student's medical home? ☐ Yes ☐ No ☐ I would like to discuss information in this report with the school nurse.

Signature of health care provider MD / DO / APRN / PA   Date Signed   Printed/Stamped *Provider* Name and Phone Number

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) Note: *Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP	*	*	*	*		
DT/Td						
Tdap						
IPV/OPV	*	*	*			
MMR						
Measles	*	*				
Mumps	*					
Rubella	*					
HIB	*				Students under age 5	
Hep A						
Hep B	*	*	*			
Varicella	*					
PCV					Pneumococcal conjugate vaccine	
Meningococcal						
HPV						
Flu						
Other						

Disease Hx of above ______________ (Specify) ______________ (Date) ______________ (Confirmed by)

Exemption

Religious _____ **Medical: Permanent** _____ **Temporary** _____ **Date** _____

Recertify Date _________ Recertify Date _________ Recertify Date _________

Immunization Requirements for Newly Enrolled Students at Connecticut Schools

KINDERGARTEN
DTaP: At least 4 doses. The last dose must be given on or after 4th birthday
Polio: At least 3 doses. The last dose must be given on or after 4th birthday
MMR: 1 dose on or after the 1st birthday
Measles: Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose
Hib: Children less than 5 yrs of age need 1 dose at 12 months or older Children 5 and older do not need proof of Hib vaccination
Hep B: 3 doses
Varicella: 1 dose on or after the 1st birthday or verification of disease

GRADES 1-6
DTaP /Td/Tdap: At least 4 doses. The last dose must be given on or after 4th birthday
Students who start the series at age 7 or older only need a total of 3 doses
Polio: At least 3 doses. The last dose must be given on or after 4th birthday
MMR: 1 dose on or after the 1st birthday
Measles: Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose
Hep B: 3 doses
Varicella: 1 dose on or after the 1st birthday or verification of disease

GRADES 7-12
Td/Tdap: At least 3 doses. The last dose must be given on or after 4th birthday. Students who start the series at age 7 or older only need a total of 3 doses
Polio: At least 3 doses. The last dose must be given on or after 4th birthday
MMR: 1 dose on or after the 1st birthday
Measles: Second dose of measles vaccine (or MMR), given at least 4 weeks after the first dose
Hep B: 3 doses
Varicella: 1 dose on or after first birthday or verification of disease:
VARICELLA VACCINE: For students <13 years of age, 1 dose given on or after the 1st birthday. For students 13 years of age or older, 2 doses given at least 4 weeks apart
VERIFICATION OF DISEASE: Confirmation in writing by a MD, PA, or APRN that the child has a previous history of disease, based on family or medical history

Initial/Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped *Provider* Name and Phone Number

Benhaven Guidelines for Keeping Students Home from School

When Not to Send Your Child to School

1. Runny nose with -green or yellow discharge.
2. Severe or worsening cough.
3. Headache that is debilitating.
4. Abdominal Pain
5. Vomiting has occurred within the last 24 hours
6. Conjunctivitis-child must be on antibiotics 24 hrs before returning to school.
7. Temperature of 100 degrees or more. Must stay home until at least 24 hours after they no longer have a fever or signs of a fever without the use of fever reducing medicine.
8. Impetigo-severely contagious skin malady.
9. Any childhood diseases-chicken pox, etc
10. Your child wants to sleep and is hard to keep him/her awake.
11. More than one loose bowel movement/diarrhea has occurred within the last 24 hours.
12. Strep Throat-child must be on antibiotics for 24 hours before returning to school
13. Labored Breathing.
14. Fungal Rash

When Your Child Will be Sent Home from School

1. Temperature of 100 degrees or more. Must stay home until at least 24 hours after they no longer have a fever or signs of a fever without the use of fever reducing medicine.
2. Conjunctivitis must be on antibiotics 24 hours before returning to school.
3. Nausea or vomiting.
4. Severe headache.
5. Aches or pains due to accidents or behaviors.
6. Severe cuts or abrasions due to accidents or behaviors.
7. If student cannot be kept awake.
8. More than one loose bowel movement or diarrhea.
9. Shortness of breath.
10. Severe Cough.

INSURANCE INFORMATION

Student: ______________________

Insurance Company: ______________________

Policy #: ______________________
____
____
____

Doctor's Name: ______________________
Address: ______________________
____
____

Telephone #: ______________________

Psych. Name: ______________________
Address: ______________________
Telephone #: ______________________

Dentist Name: ______________________
Address: ______________________
Telephone #: ______________________

Dental Ins.: ______________________
____
____
____

Parent's/Guardian Name: ______________________
Address: ______________________
____
____
Telephone #: ______________________

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Person: ______________________________
Last name First

Date of Birth: ____________

Allergies: ______________ Date of Last Tetanus Shot: ________

AUTHORIZATION FOR EMERGENCY-MEDICAL AND/OR SURGICAL TREATMENT

This form will be used only in an emergency situation only when a parent of guardian cannot be readily contacted.

IN CASE OF EMERGENCY, I HEREBY AUTHORIZE DOCTORS AT EITHER

______________________ (Medical Facility or Personal Physician)

(and whomever they may designate as their assistants) TO PERFORM ANY EMERGENCY PROCEDURE; OR TO ADMINISTER ANESTHESIA AND/OR TO ADMIT, IF NECESSARY, MY DAUGHTER/SON.

Medical Insurance Co.: ______________________

Policy #: ______________________

Policy Holder: ______________________

Signed: ______________________
Legal Guardian

Relationship: ______________________

Address: ______________________

____

____

____

Phone: ______________________

AUTHORIZATION FOR THE ADMINISTRATION OF ASPIRIN OR ASPIRIN LIKE SUBSTITUTES & OVER THE COUNTER MEDICATIONS

TO BE USED FOR PARENTAL/GUARDIAN REQUESTS FOR ASPIRIN AND ASPIRIN LIKE SUBSTITUTES (ACETOMINOPHEN, IBUPROFEN) AND COLD OR ALLERGY MEDICATION WITHOUT A PHYSICIAN /DENTIST ORDER.

The state laws and regulations permit boards of education and schools to accept requests from parents/guardians to give aspirin or an aspirin like substitutes (acetaminophen or ibuprofen) and over the counter medications including cold or allergy medication to a student. In such cases the order of a licensed physician or dentist is not required.

Information provided by parent/guardian:

Name of student: ______________________ Date of request: __________

Address: ________________________________ Date of birth: ______

Town: ______________________

Reason Medication is to be given: ______________________________

Name of Medication: ______________________________________

Amount and frequency: ____________________________________

Time of Administration: ______________________

Medication to be administered from ______________ To ______________
(Date) (Date) (Up to one year)

I hereby request that the medication listed above be administered to my child by the appropriate school personnel in accordance with state regulations. I understand that I must supply the school with the medication in the original container, properly labeled, and will provide no more than the supply of said medication requested by the school. I understand this medication must be picked up within one week following termination of the request.

Name: ____________________________ Relationship to child: ______________

Signature: __________________________ Date: __________

Address: ___________________________ Telephone: ______________

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES BY SCHOOL PERSONNEL

The Connecticut State Law requires a physician's written order and the parent or guardian's authorization for a nurse, or in the absence of a nurse, the principal or teacher to administer medical preparations, exclusive of hallucinogens or narcotics, to any student.

Physician's Name: ______________________ Telephone No. ______________

Address: ____

Physician's Order

Name of child: ______________________________ Date: ____________

Address: ______________________________________ DOB: ____________

Condition for which drug is being administered: ______________________

____

Name of drug: ____

Amount of drug: ____

Time of Administration: ____

Medication shall be administered from ______________ to ______________
(date) (date)

Relevant side effects to be observed, if any: ______________________

____

If there are side effects, plan for management: ______________________

____

Physician's signature: ______________________

Authorization Of A Parent or Guardian Concerning The Adminisration of Above Medicines by School Personnel

To: ______________________ Date: ______________________

I hereby request that school personnel give my child ______________________
(name of child)

The medicine ordered above by the physician: ______________________
(parent signature)

____
(address)

____

____
(telephone)

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Name of Person: ____

Address: ____

I hereby authorize Benhaven School and the nursing and medical personnel to take those actions necessary for administration of medications in accordance with treatment and/or services provided.

Parents and guardians will be kept informed of medical needs and will be contacted as the need arises.

________________________________ ________________

Signature of Parent Date

Guardianship: complete if Benhaven resident/student is 18 years or older.

Parent is guardian. Check one: Yes__ No__

If "no", list name of guardian: ________________________

Address: ________________________________

Telephone Number:

2IA

Benhaven, Inc . Revised 9/94

AUTHORIZATION FOR NURSING/MEDICAL SERVICES

Name of student or resident ______________ ______________
last first

Date of birth: ____________________

I hereby authorize Benhaven, Inc., and the nursing and medical personnel to take those actions that its professional staff deem appropriate for nursing and medical services (routine or of a monitoring nature).

Guardians will be kept informed of nursing and medical needs and will be contacted as the need arises.

________________________________ ________________
Signature of Legal Guardian Date

Benhaven Policy for Sunscreen and Insect Repellant Application

It is the policy of Benhaven School to apply sunscreen and/or insect repellant for students during the spring/summer months prior to community outings.

Please note we only use repellant that is deet free. The sunscreen application is especially important for our students who are taking medication which makes them more susceptible to sunburns.

Benhaven

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Fax (203) 793-1909

1/29/2020

Consent Form for My Child's Photo to be used on the Benhaven School Website

Benhaven would like to be able to use your child's photo on our website. Please indicate below by checking the appropriate line if you will grant us permission to do so. I understand that I can change this preference at any time by written notice. Please sign and date as indicated.

____ I give Benhaven School permission to use my child's photo on their website.

____ I do not give Benhaven School permission to use my child's photo on their website.

Signature of Parent or Guardian: ______________________________

Date: ______________

Thank you for your attention to this matter:

Greg Spector
Operations Coordinator

21A

125 North Plains Industrial Road
Wallingford, CT 06492
(203) 793-1905
Fax (203) 793-1909

Benhaven Photo/Video Release Authorization

I hereby give permission for my child________________________ to be photographed or videotaped used solely for developing, monitoring and improving programing for my child. I authorize the following uses:

Please indicate yes or no to the following use:

In the classroom__________
In the school building_______________
Assessment of behavior to be shared with team members___________
Assessment of other programs to be shared with team members____________
Information to share with child's physician______________

Please indicate any other specific criteria when you would or would not agree to have your child photographed or video taped

____
____
____
____
____
____
____
____

Parent/guardian signature

____

Date

____

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Permission Slip

I give my permission for official visitors of Benhaven to observe my child ___________ with the understanding that the visitors will not reveal my child's identity to individuals not employed by Benhaven.

______________________________ ________________

Parent/Guardian Signature Date

PARENT NOTIFICATION OF EMERGENCY MANAGEMENT PROCEDURES

I, ______________________________, parent/guardian of ____________________ have been notified of the laws related to the use of seclusion and restraint at Benhaven.

I know that I can speak with my child's teacher and/or the school director at any time about this.

__________________________ Signature

______________ Date

21A

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EARLY DISMISSAL

Please complete Part A or Part B.

Part A: *For Students Living At Home*

In case no one is home when you try to reach me to tell me you are sending my child home early, I have made arrangements with the person listed below. That person has agreed, in writing, to wait for and accept responsibility for my child until I pick up my child.

Signed (Parent): ______________________

Alternate Name: ______________________
Person's Address: ______________________
____
____

Phone Number: ______________________ Alternate Number: ____________

I agree to wait for and accept responsibility for ____________ at such time when the parents cannot be reached. I will keep the child until the parent comes for him, provided ~~the school has contacted me before sending the child to me.~~

Signed: ____________________ Date: ________________

Part B: *For Students Living In A Group Home*

In the event of an early dismissal, I agree to have staff present to receive ____________.
Contact information for an early closing:

Name: ______________________
Phone Number: ______________________

Alternate Contact: ________________
Phone Number: ______________________

Signed ________________ Date: ______________

Role: ________________

EMERGENCY CONTACT PERSONS

Name: ____

Telephone #: ______________________

Name: ____

Telephone #: ______________________

Name: ____

Telephone #: ______________________