

CATHOLIC SCHOOL POLICY HANDBOOK

FORMS / EXHIBITS

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STUDENT ACCIDENT REPORT

SCHOOL _____ MCC UNIT NO. _____ PHONE: (____) _____ - _____

ADDRESS: _____ CITY: _____ ZIP: _____

NAME OF INJURED STUDENT: _____ DATE OF BIRTH: _____ GRADE: _____

PARENT'S NAME: _____ PHONE: (____) _____ - _____

PARENT'S ADDRESS: _____
(NUMBER & STREET) (CITY) (ZIP)

DATE OF ACCIDENT: _____ TIME: _____ AM _____ PM _____

SPECIFIC LOCATION OF ACCIDENT: _____

PERSON SUPERVISING: _____ TITLE: _____

DESCRIBE HOW ACCIDENT OCCURRED: _____

DESCRIBE ACCIDENT LOCATION, SURFACE AND CONDITION: _____

DESCRIBE INJURY, EXTENT, AND PART OF BODY: _____

NAME OF PERSON PROVIDING FIRST AID: _____

DESCRIBE FIRST AID ADMINISTERED: _____

WERE PARENTS NOTIFIED? YES ___ NO ___ HOW? _____

BY WHOM? _____ AT WHAT TIME? _____

LIST WITNESSES, ADDRESSES, AND PHONE NUMBERS:

PERSON MAKING REPORT: _____ PHONE (____) _____ - _____

TITLE: _____ DATE OF REPORT: _____

ALL ACCIDENTS SHOULD BE REPORTED TO THE PRINCIPAL'S OFFICE ON THIS FORM ON THE DAY THEY OCCUR.

STUDENT ACCIDENT SUPPLEMENTAL INSURANCE IS PROVIDED BY A SEPARATE PROGRAM THROUGH MICHIGAN CATHOLIC CONFERENCE. HOWEVER, TO PROTECT THE DIOCESE FROM POTENTIAL LIABILITY, THIS REPORT MUST BE COMPLETED FOR ALL INJURIES OTHER THAN MINOR CUTS AND BRUISES..

PLEASE REPORT ALL INJURIES IMMEDIATELY TO GALLAGHER BASSETT SERVICES, INC.:

IF UNIT LOCATED IN ARCHDIOCESE:
PO BOX 687, SOUTHFIELD MI 48037
(248) 352-1062 FAX (248) 350-1710

IF UNIT LOCATED OUTSIDE ARCHDIOCESE:
PO BOX 1448, EAST LANSING MI 48826-1448
(517) 351-3100 (800) 926-1819 FAX (517) 351-552

**AUTHORIZATION FOR RELEASE OF STUDENT RECORDS TO AN
INSTITUTE OF HIGHER LEARNING OR PROSPECTIVE EMPLOYER**

TO: _____
(Name of High School)

FROM: _____
(Name of Student)

I hereby authorize the above school to forward any information from my official record which may be requested by an institution of higher learning or a prospective employer.

This request is to remain in force until rescinded in writing by my parents/guardian, or by me.

Signed: _____
(Student)

Signed: _____
(Parent/Guardian if student is under 18)

Date: _____

BOMB THREAT RESPONSE REPORT

(Sample)

Phoned in Threat:

Questions to Ask:

Exact Wording of the Answer:

1. When is bomb going to explode?
2. Where is it right now?
3. What does it look like?
4. What kind of bomb is it?
5. What will cause it to explode?
6. Did you place the bomb?
7. Why?
8. What is your address?
9. What is your name?

DETAILS OF THE WORDING OF THE THREAT:

Caller's Voice: male female adult juvenile soft loud slow rapid distinct
 calm laughing angry crying deliberate excited normal deep
 raspy accent lisp disguised slurred nasal stutter ragged
 cracking voice clearing throat deep breathing familiar

If the voice is familiar, who did it sound like? _____

Background Sounds: street noises house noises factory machinery motor office booth
 animal noises voices long distance clear other

Threat Language: well spoken rational irrational foul incoherent taped
 message read by threat maker

Written Threat

Describe _____

Where found? _____

Face-to-Face Threat

Who made the threat? _____

Exact Words: _____

To who is the threat directed? _____

Suspicious Package

Describe: _____

Where was package found? _____

Person who received threat: _____ Date/Time: _____

ELECTRONIC INFORMATION ACCESS AND USE CONTRACT FOR STUDENTS

The Diocese of Gaylord encourages and strongly promotes the use of technology in the Catholic schools and Parish Educational Programs of the Diocese. To ensure that students can make full use of the technologies available, all use of technology must have proper authorization and follow the Diocese's and school's terms, conditions, and regulations for the use of Internet and other technologies. These procedures apply to all computers/technologies whether located at school, parish center, or office.

1. I will follow the Diocese of Gaylord and the school's and parish's code of ethics for Internet and technologies. (Diocesan Policy 5132 and Administrative Regulations 5132.1).
2. I will use only authorized computer disks. I will not use a disk from outside the school or parish until it has been virus checked by the school and authorized for use in the school or parish.
3. I will not use another's computer or computer disks without permission. I will not use another's password or identity code.
4. I will respect my safety and that of others. I will not reveal my personal address or phone number through the use of technology. I will not allow another person to reveal my personal address or phone number through the use of technology. I will not reveal the name, address, or phone number of others through the use of technology. I will not transmit or use photographs of others without proper authorization.
5. I will respect the laws of the United States, its individual states, and foreign countries in regard to copyrighted material, threatening, violent, or harassing material, obscene material, and material protected by trade secret.
6. I will not submit, publish, or display any defamatory, inaccurate, abusive, obscene, profane, sexually oriented, threatening, racially offensive, or illegal materials, nor encourage the use of any controlled substance.
7. I will use technology in a way which preserves it and which is an acceptable use of it. I will not vandalize the school's or parish's or anyone's data, software, hardware, or technological equipment.
8. I will attend and participate in one training session on acceptable use of the Internet and local area networks before I am granted the privilege of use.

Access and use of the Internet, local area networks, computers, and other technologies are a privilege for the user. I have read and understand the contract for use of this privilege. I accept the terms, conditions, and regulations of this contract.

Student User Signature

Date

Parent/Guardian Signature (**I have read and support this student contract**)

Date

School or Parish Designee

Date

EMERGENCY DRILLS
Documentation Form

Type of Drill

- Fire Drill (6 required)
- Tornado Drill (2 required)
- Lock Down/Shelter in Place Drill
(2 required)

Type of Drill

- Standard
- Class Change
- Recess
- Other Events

Name of Reporting School: _____

Date of Drill: _____ Time drill was held: _____ (am/pm)

Exact Time required to evacuate/shelter/secure: _____

Total Participants: _____

Remarks: _____

This report is for emergency drill # _____ for school year _____.

Name of person conducting drill: _____

Title of person conducting drill: _____

Signature of person conducting drill: _____

Lock Down/Shelter in Drill Place drill was COORDINATED with:

- Emergency Management Coordinator

Name and Title _____

AND

- Law Enforcement (county sheriff or chief of police or designee of MSP)

Name and Title _____

OR

- Fire (fire chief or designee)

Name and Title _____

LOG OF ACCESS TO STUDENT RECORDS

(Non-school personnel/third party access)

School _____ Student's Name _____

Date Written request for access was received	Date Access was completed	Individual/Agency who is to receive data	Reason for Access	Signature of person releasing data	Official Position of person releasing data
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PROOF OF RECEIPT OF RECORDS _____

MEDIA RELEASE

SAMPLE:

Photo Permission:

I understand that during the course of school and school sponsored events, students will occasionally be photographed and/or videotaped for various school publications, website, newspaper articles, fundraisers etc. I hereby authorize such activities to take place.

Child's Name (Please print) _____

Parent Signature _____ Date _____

MEDICAL TREATMENT RELEASE FORM

To Whom it May Concern:

As a parent/guardian I do hereby authorize the treatment by a qualified and licensed Medical Doctor in an emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

Name of Minor: _____ Relationship to you: _____

Reason for which release is intended: _____

Address of Minor: _____ Phone: _____

Emergency Phone: _____ Cell phone: _____

Family Physician: _____ Phone: _____

Address: _____ City: _____

List allergies, medication, contacts, or other pertinent comments:

Health Insurance Data:

Company: _____ Policy: _____

Group: _____ Contract: _____

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

Date: _____

Signed: _____
(Parent or Guardian)

MEDICATION/TREATMENT AUTHORIZATION FORM

Name of Student _____ Birth Date _____

School _____ Grade _____

SECTION I

To be completed by the physician or licensed health care provider on all medications
(REQUIRED)

Diagnosis / Purpose of medication / treatment (optional) _____

Name of medication / treatment _____

Dosage _____ Frequency _____ Time _____ Route _____

Start date _____ Stop date _____ Indefinite _____

Instructions, adverse reactions, storage requirements, etc. _____

Physician's signature _____ Date _____

Physician's Name (print) _____

Physician's Address _____

SECTION II

To be completed by Parent/Guardian (REQUIRED)

Medications and treatment supplies will be brought to school by the parent/guardian unless other safe arrangements are necessary and possible. All medication should be kept in a labeled container as prepared by a pharmacy, physician or pharmaceutical company and labeled with the student's name, route, dosage and frequency. The prescription renewal and medication/treatment supply shall be the responsibility of the parent/guardian.

The student is responsible for presenting himself/herself on time and for taking the medication as prescribed. The undersigned parent/guardian shall notify the school district in writing in the event the prescription shall be discontinued.

I request that the medication/treatment be administered in conformance with the physician/licensed health care provider directions and according to the School District's policy. I give permission for the physician/healthcare provider/staff and school district staff to share information needed to assist my child with medication needs.

Parent/Guardian Signature _____ Date _____

PARENT PERMISSION FORM FOR FIELD TRIP PARTICIPATION

Dear Parent or Legal Guardian:

Your son/daughter is eligible to participate in a school-sponsored activity requiring transportation to a location away from the school premises. This activity will take place under the guidance and supervision of employees from _____ School. A brief description of the activity follows:

Name of Event: _____
Destination: _____
Designated Supervisor of Activity: _____
Date and Time of Departure: _____
Date and Anticipated Time of Return: _____
Method of Transportation: _____
Student Cost: _____

If you would like your child to participate in this event, please complete, sign, and return the following statement of consent and release of liability. As parent or legal guardian, you remain fully responsible for the actions and conduct of your child.

******* STATEMENT OF CONSENT *******

I hereby consent to participation by my child, _____, in the event described above. I understand that this event will take place away from the school grounds and that my child will be under the supervision of the designated school employee and/or adult on the stated dates. I further consent to the conditions stated above on participation in this event, including the method of transportation.

In consideration of my child being allowed to participate in this field trip, I agree to indemnify and hold harmless _____ School/ Parish, any and all affiliated organizations, their employees, agents and representatives, including volunteer and other drivers, from any and all claims, including negligence, arising from or relating to my child's participation in this field trip. This indemnification and hold harmless agreement does not apply to claims for intentional misconduct or gross negligence.

(Print Parent's Name) (Date)

(Parent's Signature)

Please return this entire form by: _____ to _____
(Date) (Person)

REQUEST FOR STUDENT'S TRANSCRIPT AND RECORDS

Date: _____

Principal:

I certify that, as of the above date, the following students have enrolled at:

Name of School

Address

City, State, ZIP

Name: _____	Grade: _____
_____	Grade: _____
_____	Grade: _____
_____	Grade: _____
_____	Grade: _____

Please send the records on the students listed above including all Remedial, Special Education, and 504 files to the school named above.

Principal's Signature: _____

STUDENT DATA FORM

(Date) _____ (School) _____

Child's Name _____ Grade Entering _____
(Last) (First) (Middle)

Home Address _____
(Number & Street Name) (City) (Zip)

Home Telephone Number _____ Place of Birth _____
Sex: M F Birth date _____ (City & State)

Emergency Data

In case of an accident or serious illness the school will first contact a parent.

1. PERSONS OTHER THAN PARENT TO BE NOTIFIED IN EMERGENCY SITUATION WHEN PARENT IS NOT AVAILABLE:

(Name) (Address) (Phone)

(Name) (Address) (Phone)

2. PHYSICIAN PREFERRED FOR EMERGENCY TREATMENT:

(Doctor's name) (Address) (Phone)

3. Hospital: _____

Health Information

4. Does the child have medical problems or physical disabilities, etc.?

(please specify)

5. Does student take any medication regularly? _____ Yes _____ No

6. Does student need to wear eye glasses during the school day? _____ Yes _____ No

For survey purposes ONLY.

Race: _____ American Indian _____ Black _____ Caucasian
_____ Hispanic _____ Oriental _____ Other

Religion: _____

Family Data

	Father	Mother (Maiden)
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1. Name _____
2. Country or State of Birth _____
3. Language spoken in the Home _____
4. Place of work & occupation _____
5. Business phone _____
6. Religion _____
7. Marital Status
Married _____ Separated _____
Divorced _____ Remarried _____
Deceased _____ Deceased _____
9. Name of Step Parent and/or legal guardian _____
10. With whom does the child reside? _____

Children in the Family (Youngest to Oldest)			
Name	Birth date	School	Grade/Level
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Parish/Church Data

We are registered members of _____ Parish/Church

We attend _____ Parish/Church

We live within the boundaries of this parish: _____ Yes _____ No

Sacrament(s) this child has received (if applicable):

	Church	City	Date
Baptism	_____	_____	_____
Confirmation	_____	_____	_____
1st Communion	_____	_____	_____
1st Confession	_____	_____	_____

Signature

VOLUNTEER/EMPLOYEE DRIVER INFORMATION SHEET

I. Driver:

Name: _____ Date of Birth: _____

Address: _____ City: _____

II. Vehicle that will be used:

Name of Owner: _____ Year and Make: _____

Address of Owner: _____ Model: _____

_____ License Plate: _____

Registration Expires: _____ Inspection Expires: _____

If more than one vehicle is to be used requested information must be provided for each vehicle.

III. Insurance Information: The insurance coverage for a privately owned vehicle is the limit of the insurance policy covering that specific vehicle.

Insurance Company: _____

Policy Number: _____

Expiration Date: _____

Liability Limits of Policy*: _____

***Please Note:** The minimal, acceptable liability limit for privately owned vehicles is \$500,000 CSL (Combined Single Limit). Due to some insurers limitations, limits of \$250,000 per person/\$500,000 per occurrence are acceptable.

IV. Certification:

I certify that the information given on this form is true and correct to the best of my knowledge. I understand that as a volunteer/employee driver, I hold a valid driver's license and have the required insurance coverage in effect on any vehicle used to transport students, co-employees, service recipients and/or act on behalf of the church or related entities.

(Signature)

(Date)

V. Recommendation:

Only experienced drivers, i.e. 21 or over, should transport students.