Dear Parents and Guardians,

We are looking forward to a wonderful school year. Our teachers are well prepared to provide your children with the best education possible. The expectations have been set high for students to learn in a safe and orderly environment.

The Autauga County School System's **Code of Conduct** has been designed with these goals in mind. As in previous years, this document is available on-line at *www.acboe.net*. You should notify your school if you do not have Internet access, and a hard copy of the **Code of Conduct** will be provided. Please read the manual in its entirety. Understanding all guidelines provided will ensure a successful school year.

Sincerely,

R S Agee

Spence Agee
Superintendent

ACKNOWLEDGEMENT OF RECEIPT OF ACCESS TO THE CODE OF CONDUCT

I, _____, am enrolled at _____. My parent(s)/guardian(s) and I hereby acknowledge by our signatures that we have received the above notice and understand that we can access, read, and review the **Code of Conduct** at *www.acboe.net*. We further acknowledge and agree to be bound by the provisions in the **Code of Conduct**.

_____ _____
Signature of Student Date

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Parent/Guardian Date

Note: The student is to sign the above statement. If the student lives with both parents/guardians, both are to sign the statement with the student. If the student lives with only one parent/guardian, only one is to sign the statement with the student.

INTERNET USE, BRING YOUR OWN DEVICE (BYOD), AND SAFETY POLICY
STUDENT AGREEMENT

Every student, regardless of age, must read and sign below.

I have read, understand, and agree to abide by the terms of the foregoing Internet Use, Bring Your Own Device (BYOD), and Safety Policy. Should I commit any violation or in any way misuse my access to the Autauga County School District's computer network and the Internet, I understand and agree that my access privilege may be revoked and disciplinary action may be taken against me.

Student Name _____
(PRINT CLEARLY)

Home Phone _____

Home Address _____

Student Signature _____

Date _____

Place an "X" in the correct blank:
I am 18 or older _____.
I am under 18 _____.

If I am signing this Policy when I am under 18, I understand that when I turn 18, this Policy will continue to be in full force and effect and agree to abide by this Policy.

INTERNET USE, BRING YOUR OWN DEVICE (BYOD), AND SAFETY POLICY
PARENT(S)/GUARDIAN(S) AGREEMENT

To be read and signed by parent(s) or guardian(s) of students who are under the age of eighteen.

Student Name_____
(PRINT CLEARLY)

As the parent or legal guardian of the above student, I have read, understand, and agree that my child or ward shall comply with the terms of the Autauga County School District's Internet Use, Bring Your Own Device (BYOD), and Safety Policy for the student's access to the District's computer network and the Internet. I understand that access is being provided to the students for educational purposes only. However, I also understand that it is impossible for the School to restrict access to all offensive and controversial materials and understand my child or ward's responsibility for abiding by the Policy. I am therefore signing this Policy and agree to indemnify and hold harmless the school, the District, teachers, and other staff against all claims, damages, losses and costs, of whatever kind, that may result from my child's or ward's use of his/her access to such networks or his/her violation of the foregoing Policy. Further, I accept full responsibility for supervision of my child's or ward's use of his/her access account if and when such access is not in the School setting. I hereby give permission for my child or ward to use the building approved account to access the Autauga County School District's network and the Internet. Parent(s)/Guardian(s) Name _____
(PRINT CLEARLY)

Home Phone _____

Home Address _____

Parent/Guardian Signature _____Date_____

Parent/Guardian Signature _____Date_____

PARENT/GUARDIAN PERMISSION
FOR PUBLICATION OF STUDENT PHOTO/VIDEO

Dear Parents and Guardians,

Autauga County School System is including on our website photographs and/or video recordings of students and teachers in classroom settings. These photographs/recordings will be utilized for professional development activities and for publications related to **Autauga County School System**. It is our practice to seek parent permission before including a student's photograph or video clip. We must have your signed permission in order to include your student in the media publications.

Please review, sign, and return the consent form below.

_ _

The Autauga County School System has my permission to take photographs and/or video recordings of my child, ___________________________________ (please print child's name). These photographs and/or video recordings may be used on the district website and in district publications for the 2018-2019 school term.

School: ___________________________________

Student's Grade: ________

Student's Homeroom Teacher: __________________________________

Parent/Guardian Signature: ____

Print Name of Parent/Guardian: _______________________________________

Date: ____________

TEXTBOOK FORM

TO: Parent or Guardian

FROM: Autauga County Board of Education

SUBJECT: Pupil/Parent Responsibilities for Care of Textbooks in Accordance with Section of the Free Textbook Law, Act 221, Special Session 1965

All textbooks issued are the property of the Autauga County Board of Education and shall be retained for normal use only during the period pupils are engaged in the course of study for which the textbooks are selected.

Textbooks issued to pupils may be used in the same manner and to the same extent as though such books were owned by the pupil; except that the pupils must recognize their responsibility for the proper care of books checked out to them by observing the following practices:

A) Keeping the book clean outside and inside.
B) Refraining from marking the book with pen or pencil.
C) Keeping the pages free of finger prints.
D) Avoiding turning down, tearing, or otherwise damaging pages.
E) Refraining from placing the book where it may become soiled or damaged by the weather.
F) Keeping the book protected with a book cover (optional)

The parent, guardian, or other person having custody of a child to whom textbooks are issued shall be held liable for any loss, abuse, or damage in excess of that which would result from the normal use of the textbooks. If the parent, guardian, or person having custody of the child to whom the textbook was issued fails to pay the assessed damages within 30 days after notification, the student shall not be entitled to further use of the textbooks until remittance of the amount of loss or damage has been made. (House Bill 230)

A) For such loss or damage, the pupil will be assessed a variable of:
    1) Full price if new when issued.
    2) Seventy-five percent of full price for books two years old.
    3) Fifty percent for books three years old or older.
B) No textbook will be issued to any pupil until all charges for lost or damaged textbooks have been paid.

All textbooks must be returned to the issuing school by the pupil when he is promoted or transferred and when he terminates his attendance for any other reason.

The textbook form issued to students must be **signed** by student and parent/guardian and **returned** to the school prior to issuance of books.

I certify that I have read and understand the above regulations and agree to comply with them.

______________________________ ________________
Signature of Student Date

______________________________ ________________
Signature of Parent/Guardian Date

________________________ ________________________
Teacher's Name School

ID PROGRAM INFORMATION AND CONSENT FORM

Program Background:

The Independent Decision (ID) Program, approved by the Autauga County School Board and administered by PASS: The Noble Idea, Inc. (PASS), aims to reinforce a positive drug free lifestyle by providing incentives to students in 7th through 12th grades who refrain from using drugs. Students who test negative for drugs receive an ID card that entitles them to discounts at participating local businesses and to program sponsored social events. Students participating in the program agree to undergo initial drug screening and periodic random follow-up drug testing. The ID program is voluntary. Once in the program, students remain until they complete their 12th grade year. **Students may discontinue the program at any time, with parental consent**. Students who withdraw from the program must relinquish their ID cards. Students under the age of 18 are permitted to participate in the ID Program **only** with written consent from the student **and** parent or legal guardian.

Drug Testing Procedure

All drug testing will be performed under the direction of Drug Testing Services, Inc. of Montgomery, Alabama. Students participating in the ID Program will be notified when to report to a designated place at his/her school site to provide a urine or saliva sample for the initial screening. The screening will be conducted in a confidential manner. If preliminary screening is negative, the student will receive the ID card within a few days of the screening. Students' ID Program files are locked and maintained at the PASS Office to protect confidentiality. To maintain the integrity of the program, random follow-up testing will occur periodically

In the event of a positive test, samples are sent to a lab for analysis and review by a Medical Review Officer (MRO). The MRO then contacts the parent to determine if the positive screen is due to prescribed medication or illegal use. In the event of a positive test, either when initial screening takes place or hen re-testing occurs, the school coordinator will notify the student and parent privately and the student will be asked to surrender the ID card until a negative sample is collected. A parent may challenge a confirmed positive result at his/her expense. The challenge test will be sent to a different laboratory.

It is important to emphasize that the purpose of the program is to reward positive, healthy behaviors. Students who are taking prescribed medications are encouraged to participate. Testing of drugs in the ID program is in no way an investigative tool of a law enforcement agency. Positive results will not result in criminal prosecution.

The Autauga County School System and PASS cannot guarantee that students participating in the ID Program will not share information with other students whether within or outside of the ID Program.

I have read the above information and have received a copy of this form. I may withdraw at any time.

I understand that by signing this form, I agree to participate in the ID Program Date _____

Student Participant's Name (print)

_____

Student Participant's Signature

_____

Student's School _____ Grade _____

Student's Date of Birth _____

Parent or Legal Guardian's Name (print) _____

Parent or Legal Guardian's Signature _____

Parent or Legal Guardian's Address _____

_____

Parent or Legal Guardian's Phone Number(s) _____ (home) _____ (cell)

_____ (work) _____ (other)

ALABAMA STATE DEPARTMENT OF EDUCATION

HEALTH ASSESSMENT RECORD

School Year: 2018-2019

To Parent or Guardian:
The purpose of this form is to provide the school nurse with additional information regarding your child's health needs. The school nurse may contact you for further information. The information requested is essential for the school nurse to meet the health needs of your child.

This information will be kept confidential.

PLEASE complete both sides of this form (Return to the School Nurse)

Name of Student (Last, First, Middle)	Birth Date	Sex	School

Address (Street)

Home Telephone Number:	Cell Phone Number:	Additional Phone Number:	Grade	Teacher/Homeroom

Name of Parent/Guardian (Last, First Middle) — Work Phone Number:

Transportation

☐ Bus Rider Bus Number: ☐ Car Rider ☐ Special Needs Bus ☐ After School

Part I – Health Information

Place your child receives health care:

Physician's Name: _____

Address: _____

Phone:_____

☐ **Community Health Center**

☐ **Health Department**

☐ **Hospital Clinic**

☐ **No Regular Place**

☐ **Private Doctor /HMO**

Your child's Insurance Information:

☐ **ALL KIDS**

☐ **Medicaid**

☐ **No Insurance**

☐ **Other** _____

☐ **Private Insurance**

Place your child receives dental care:

Dentist's Name: _____

Address: _____

Phone:_____

☐ **Community Health Center**

☐ **Health Department**

☐ **Hospital Clinic**

☐ **No Regular Place**

☐ **Private Dentist /HMO**

Preferred Hospital: _____

Part II – Medical History Medical Equipment /Procedures Required at School

☐ Catheter ☐ Gastric Tube ☐ Nebulizer Treatments ☐ Oxygen Supplement ☐ Tracheostomy

☐ Vagal Nerve Stimulator (VNS) ☐ Ventilator ☐ Wheelchair ☐ Walker

☐ Other *Please explain:*

Medications and Procedures at School require a Prescriber/Parent Authorization Form (one for each medication or procedure) Please see your school nurse.

Please Complete Back of Form (Signature Required)

ALABAMA STATE DEPARTMENT OF EDUCATION

HEALTH ASSESSMENT RECORD

School Year: 2018-2019

Part III – Medical History

□ YES □ NO	**KNOWN HEALTH PROBLEMS** If **NO**, go directly to the bottom of the page and provide parent/guardian signature If **YES**, and diagnosed by a physician, answer each question below.
□ YES □ NO □ YES □ NO	**Attention Deficit Disorder (ADD)** **Attention Deficit Hyperactivity Disorder (ADHD)** Requires medication □ At school □ At Home
□ YES □ NO	**Allergies:** □ Hives/rash □ Medications □ **Food** _____ □ **Insects** _____ □ Breathing difficulty □ Epi-pen □ **Environmental** _____ □ **Medications** _____ □ Other:
□ YES □ NO	**Asthma** □ Uses an inhaler at school □ Uses an inhaler at home
□ YES □ NO	**Blood/Bleeding Problems:** □**Hemophilia,** □**Von Willebrand's,** □**Other** □ **Requires medication** ***Please explain:***
□ YES □ NO	**Frequent Nose Bleeds:** *Please explain*
□ YES □ NO	**Cancer/Leukemia:** *Please explain*
□ YES □ NO	**Cerebral Palsy:** *Please explain*
□ YES □ NO	**Cystic Fibrosis:** *Please explain*
□ YES □ NO	**Dental Problems:** *Please explain:*
□ YES □ NO	**Diabetes** □ **Type 1 Diabetes** □ Monitors Blood Sugars at school □ Requires Insulin at school □ Insulin pump □ Glucagon order □ **Type 2 Diabetes** □ Managed with diet □ Oral medication
□ YES □ NO	**Emotional/Behavioral/Psychological:** *Please explain:*
□ YES □ NO	**Gastrointestinal/Stomach Problems:** *Please explain:*
□ YES □ NO	**Genetic / Rare Disorders:** *Please explain:*
□ YES □ NO	**Headaches:** *Please explain:*
□ YES □ NO	**Hearing Problems:** □ Right Ear □ Left Ear □ Both ears □ Hearing loss □ Hearing aid □ Tubes □ Cochlear Implant
□ YES □ NO	**Heart Condition:** □ ***Activity restrictions**:* □ **Medications taken at home***:* *Please explain:*
□ YES □ NO	**Hypertension (High Blood Pressure):** *Please explain:*
□ YES □ NO	**Juvenile Arthritis/Bone-Joint Problems:** *Please explain:*
□ YES □ NO	**Kidney/ Bladder/ Urinary Problems:** *Please explain:*
□ YES □ NO	**Scoliosis:** □ No Treatment □ Wears Brace □ Surgery □ Family History
□ YES □ NO	**Seizures/Convulsions:** Type of seizure: _____ *Medications:* □ Diastat □ Klonopin □ Versed □ Medication taken at home □ Other _____ *Please explain:*
□ YES □ NO	**Sickle Cell:** □ Anemia □ **Trait**
□ YES □ NO	**Shunt:** □ VP shunt *Please explain:*
□ YES □ NO	**Spina Bifida:**
□ YES □ NO	**Special Diet:** *Please explain:*
□ YES □ NO	**Vision Problems:** □ Wears glasses □ Wears contacts □ Other
□ YES □ NO	**Other Medical Conditions:** *Please include **any** medications taken at home only.*

Required Signatures

Signature of parent(s) or guardian:_____ **Date:**_____

Signature of school nurse: _____ **Date:**_____

HEALTH HERO
You Keep Them Smart
We Keep Them Healthy

2018 Vaccine Consent Form
Flu Shot Clinic Date August 30, 2018
FORM MUST BE RETURNED TO THE SCHOOL NURSE BY August 20th
School Name:

PLEASE COMPLETE ALL OF THE INFORMATION BELOW - **Please print using ink** (Incomplete forms will not be accepted)

FIRST NAME of Student:	**LAST NAME of Student:**
Gender: Male Female **Birthdate: (mo,day,yr)**	**Age** **Homeroom Teacher / Grade**
Address	**Home Phone # ( ) -** **Cell Phone # ( ) -**
City **Zip Code** **State**	**Student Race:** (Circle one) African American / Black White Alaskan/ Native American Asian Hispanic Non-Hispanic Hawaiian / Pacific Islander Other :
Email address:	

The current health care laws require us to bill your insurance company for the vaccine. The service is offered at no cost to you. Answers are always confidential.

Please fill out the following questions pertaining to your child's Health Insurance:

Medicaid ☐ **My child does NOT have health insurance** ☐	**Insurance Company:**
Policy Holder's First Name:	**Policy Holder's Last Name:**
Member ID:	**Policy Holder's Date of Birth: (mo,day,yr)**

CHECK YES OR NO FOR **EACH** QUESTION

YES	NO	
☐	☐	1. Has your child ever had a life threatening reaction(s) to the flu vaccine in the past?
☐	☐	2. Has your child ever had Guillain-Barre' syndrome?
☐	☐	3. Does your child have an allergy to eggs?
☐	☐	4. Does your child have a blood disorder such as hemophilia?
☐	☐	5. Will this be the first time your child has ever received a flu vaccination?

IF YOU HAVE ANY HEALTH QUESTIONS, PLEASE CONTACT YOUR CHILD'S PEDIATRICIAN OR CALL US AT 334-738-4840 TO SPEAK TO A REPRESENTATIVE.

I have read the information about the vaccine and special precautions on the Vaccine Information Sheet. I am aware that I can locate the most current Vaccine Information Statement and other information at www.immunize.org or www.cdc.gov. I have had an opportunity to ask questions regarding the vaccine and understand the risks and benefits. I request and voluntarily consent for the vaccine to be given to the person listed above of whom I am the parent or legal guardian and having legal authority to make medical decisions on their behalf. I acknowledge no guarantees have been made concerning the vaccine's success. I hereby release the school system, HNH Immunizations, Inc. & subsidiaries, affiliated schools of nursing, their directors and employees from any and all liability arising from any accident or act of omission which arises during vaccination. I understand this consent is valid for 6 months and that I will make the school aware of any health changes prior to the vaccination clinic date. Clinic dates can be obtained from the school. I understand that the health related information on this form will be used for insurance billing purposes and your privacy will be protected.

Printed Name of Parent/Guardian _____ Signature of Parent/Guardian _____ Date _____

VIS CDC IIV 08/07/2015 FLUCELVAX
LOT Number: **EXP Date:**
RN #_____ Date:_____
AREA FOR OFFICIAL ADMINSTRATION USE ONLY

HNH Immunizations Inc.
326 Prairie St. North
Union Springs, AL 36089
AL@healthherousa.com
(334) 738-4840

VACCINE INFORMATION STATEMENT

Influenza (Flu) Vaccine (Inactivated or Recombinant): *What you need to know*

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1 Why get vaccinated?

Influenza ("flu") is a contagious disease that spreads around the United States every year, usually between October and May.

Flu is caused by influenza viruses, and is spread mainly by coughing, sneezing, and close contact.

Anyone can get flu. Flu strikes suddenly and can last several days. Symptoms vary by age, but can include:

- fever/chills
- sore throat
- muscle aches
- fatigue
- cough
- headache
- runny or stuffy nose

Flu can also lead to pneumonia and blood infections, and cause diarrhea and seizures in children. If you have a medical condition, such as heart or lung disease, flu can make it worse.

Flu is more dangerous for some people. Infants and young children, people 65 years of age and older, pregnant women, and people with certain health conditions or a weakened immune system are at greatest risk.

Each year **thousands of people in the United States die from flu**, and many more are hospitalized.

Flu vaccine can:

- keep you from getting flu,
- make flu less severe if you do get it, and
- keep you from spreading flu to your family and other people.

2 Inactivated and recombinant flu vaccines

A dose of flu vaccine is recommended every flu season. Children 6 months through 8 years of age may need two doses during the same flu season. Everyone else needs only one dose each flu season.

Some inactivated flu vaccines contain a very small amount of a mercury-based preservative called thimerosal. Studies have not shown thimerosal in vaccines to be harmful, but flu vaccines that do not contain thimerosal are available.

There is no live flu virus in flu shots. **They cannot cause the flu.**

There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against three or four viruses that are likely to cause disease in the upcoming flu season. But even when the vaccine doesn't exactly match these viruses, it may still provide some protection.

Flu vaccine cannot prevent:

- flu that is caused by a virus not covered by the vaccine, or
- illnesses that look like flu but are not.

It takes about 2 weeks for protection to develop after vaccination, and protection lasts through the flu season.

3 Some people should not get this vaccine

Tell the person who is giving you the vaccine:

- **If you have any severe, life-threatening allergies.** If you ever had a life-threatening allergic reaction after a dose of flu vaccine, or have a severe allergy to any part of this vaccine, you may be advised not to get vaccinated. Most, but not all, types of flu vaccine contain a small amount of egg protein.
- **If you ever had Guillain-Barré Syndrome (also called GBS).** Some people with a history of GBS should not get this vaccine. This should be discussed with your doctor.
- **If you are not feeling well.** It is usually okay to get flu vaccine when you have a mild illness, but you might be asked to come back when you feel better.

CDC U.S. Department of Health and Human Services Centers for Disease Control and Prevention

4 Risks of a vaccine reaction

With any medicine, including vaccines, there is a chance of reactions. These are usually mild and go away on their own, but serious reactions are also possible.

Most people who get a flu shot do not have any problems with it.

Minor problems following a flu shot include:

- soreness, redness, or swelling where the shot was given
- hoarseness
- sore, red or itchy eyes
- cough
- fever
- aches
- headache
- itching
- fatigue

If these problems occur, they usually begin soon after the shot and last 1 or 2 days.

More serious problems following a flu shot can include the following:

- There may be a small increased risk of Guillain-Barré Syndrome (GBS) after inactivated flu vaccine. This risk has been estimated at 1 or 2 additional cases per million people vaccinated. This is much lower than the risk of severe complications from flu, which can be prevented by flu vaccine.
- Young children who get the flu shot along with pneumococcal vaccine (PCV13) and/or DTaP vaccine at the same time might be slightly more likely to have a seizure caused by fever. Ask your doctor for more information. Tell your doctor if a child who is getting flu vaccine has ever had a seizure.

Problems that could happen after any injected vaccine:

- People sometimes faint after a medical procedure, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting, and injuries caused by a fall. Tell your doctor if you feel dizzy, or have vision changes or ringing in the ears.
- Some people get severe pain in the shoulder and have difficulty moving the arm where a shot was given. This happens very rarely.
- Any medication can cause a severe allergic reaction. Such reactions from a vaccine are very rare, estimated at about 1 in a million doses, and would happen within a few minutes to a few hours after the vaccination.

As with any medicine, there is a very remote chance of a vaccine causing a serious injury or death.

The safety of vaccines is always being monitored. For more information, visit: **www.cdc.gov/vaccinesafety/**

5 What if there is a serious reaction?

What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or unusual behavior.

  Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.

What should I do?

- If you think it is a severe allergic reaction or other emergency that can't wait, call 9-1-1 and get the person to the nearest hospital. Otherwise, call your doctor.
- Reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor should file this report, or you can do it yourself through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**.

VAERS does not give medical advice.

6 The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.

Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling **1-800-338-2382** or visiting the VICP website at **www.hrsa.gov/vaccinecompensation**. There is a time limit to file a claim for compensation.

7 How can I learn more?

- Ask your healthcare provider. He or she can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636 (1-800-CDC-INFO)** or
  - Visit CDC's website at **www.cdc.gov/flu**

Vaccine Information Statement
Inactivated Influenza Vaccine

08/07/2015

Office Use Only

42 U.S.C. § 300aa-26