



**MAKING FRIENDS  
AFTER SCHOOL PROGRAM  
GUIDELINES**

Policies, Practices, and General Information

**August 22, 2011 -  
June 8, 2012**



**After School Student File Check List  
August 22, 2011 — June 8, 2012**

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**Student Last Name, Student First Name, Middle**

- \_\_\_\_\_ Child Information Form
- \_\_\_\_\_ Student's Social Security Number
- \_\_\_\_\_ School Grade Level (approximate if not in specific grade)
- \_\_\_\_\_ Current Photo (no larger than 5 x 7)
- \_\_\_\_\_ Tuition Contract Form
- \_\_\_\_\_ \$100 Registration Fee
- \_\_\_\_\_ Pre-payment for First Month of After School Care
- \_\_\_\_\_ Medical Form
- \_\_\_\_\_ Sick Student Policy
- \_\_\_\_\_ Hospitalization Policy
- \_\_\_\_\_ Emergency Medical Authorization Form
- \_\_\_\_\_ Child Pick-Up Authorization Form
- \_\_\_\_\_ Confidentiality Agreement
- \_\_\_\_\_ Authorization for Photography/Video Form
- \_\_\_\_\_ Behavior Management Plan
- \_\_\_\_\_ JCC Parking Permit
- \_\_\_\_\_ Signed After School Parent Manual

Parent/Guardian needs to provide the following to The Victory Center Administration office:

- \_\_\_\_\_ Copy of Student's IEP or equivalent
- \_\_\_\_\_ Copy of Student's Insurance Card/Proof of Insurance Coverage (if applicable)
- \_\_\_\_\_ Health Immunization Forms (Blue & Yellow)

## **INTRODUCTION:**

This program is offered as a community service by The Victory Center for Children with Autism and Behavioral Challenges. The After School Program is intended to be a high quality program that provides instruction in a 2:1 student-to-teacher ratio for children with disabilities, with Teacher/Counselors trained in the methodologies and best practices of Applied Behavior Analysis. The curriculum will be based on a modified version of The ABLLS-R and/or VB-MAPP and subjects will include Literacy, Fitness Skills (ABLLS-based therapy), and Social Skills.

## **AFTER SCHOOL PROGRAM HOURS:**

The After School Program operates Monday through Friday from 2:30 pm to 5:30 pm. You may refer to the enclosed School Calendar for days of operation. Please note, on days that The Victory Center is closed, or is marked as early release, there will be no After School Program.

## **CLOSING POLICY:**

**Holidays:** The Victory Center's After School Program will be open Monday through Friday from August 22, 2011 through June 8, 2012. Please refer to the enclosed School Calendar for days of operation. The program will be closed on all days that school is not in session.

**Hurricane Policy:** When Miami-Dade County Public Schools are closed because of weather, the After School Program will also be cancelled. You may call the school, or refer to the Miami-Dade County Public School website, for school closure due to hurricane activity.

## ENROLLMENT REQUIREMENTS:

1. The program is available to children between the ages 3 to 22, diagnosed with autism spectrum disorder(s). Only children whose parents/guardians have completed the registration process may be considered for acceptance into the After School Program:
  - The Child Information Form
  - After School Tuition Contract
  - \$100 Registration Fee
  - Pre-payment for First Month of After School Care
  - Medical Update Form
  - Sick Student Policy
  - Hospitalization Policy
  - Emergency Medical Authorization Form
  - Child Pick-Up Authorization Form
  - Confidentiality Agreement
  - Authorization for Photography/Video Form
  - Behavior Management Plan
  - JCC Parking Permit
2. When the After School Program is at maximum capacity, parents may place their child(ren) on a waiting list and be notified on first come, first served basis.
3. All children in the After School Program must have proof of full coverage insurance.

## FEES:

- **Program Fees** are \$300 per month, which will be invoiced on a monthly basis. The first payment is due the first week of After School no later than Monday, August 22, 2011 by 5:00pm.
- There is a **Registration Fee** of \$100 per child per school year and it is required at time of registration. This fee is non-refundable.
- **Please make checks payable to:** The Victory Center.

## Past Due Accounts and Returned Checks:

Program participants agree to pay any cost incurred by The Victory Center for the collection of past due balances, including without limitation, attorney fees and costs charged by the collection agency. If After School Program services will be paid by check, the check writing portion of the Tuition Contract must be completed. Parents will be **notified in writing** when an account is overdue. If payment is not made in full within five (5) days or other arrangements made, the child will be ineligible to attend.

## Late Payment Penalty:

Payment is required in advance of services being rendered on a monthly basis. A **\$25.00** late fee will be added to your balance on the last day of the week being Friday of that same week.

## **CHILD DROP-OFF/PICK-UP POLICY:**

You must sign your child in and out when dropping off and picking up your child. If your child is a Victory Center student, his/her teacher will sign in the child. If you are picking up a child before 4 pm, please come into the front office and inform the school secretary. Your child will be brought to the front office by their teacher. If you are picking up your child early but it is after 4 pm, please contact the After School Care Program coordinator at the number provided to you and your child will be walked out to car pool. After School Care requires you to sign your child out each day. A child may only be picked up by individuals who have been designated on the "**Emergency Information Form**" by the parent or legal guardian. Please call or send a note to let staff members know that someone other than the parent will pick up the child. Please be sure that the person who will pick up your child knows that he/she will be expected to have an ID, so that we can be sure who is picking up your child. These conditions are made for the protection of your child.

### **Late Pick-Up Penalty:**

If a student is picked up more than 5 minutes late, a \$30 charge will be applied, and an additional \$30 charge for every 15 minutes thereafter. **If you are chronically late picking up your child/children, after the third offense, they may be dropped from the program.**

## **HEALTH AND MEDICAL INFORMATION:**

For the protection of all the children, no child will be admitted to the After School Program while he/she has a temperature. We need your help in keeping contagious diseases such as colds, flu, and stomach viruses out of the center. When your child is sick, you will be called to pick up your child as soon as possible. Children should not be sent back to the After School Program for at least 24 hours after they are clear of fever symptoms (please see the attached sick policy). Children in attendance should be well enough to participate in all activities. Parents must furnish medicine and adhere to the procedures listed below in order for the teachers to administer medications. The parent/guardian must complete a form, which is available in the After School Program Packet. Teachers cannot fill out medicine forms or labels for you.

### **For prescription medication/lotions and foods supplements:**

Parents must fill out and sign the appropriate portion of the Request for Administration of Medication form. Medication and food supplements must be brought in the original container that has a prescription label with the child's name, dosage amount/frequency, duration of medical treatment, and prescribing doctor's contact information clearly marked on it. If for any reason the medication does not have a prescription label, such as in the case of samples given by the doctor's office, the child's doctor must fill out and sign the appropriate portion of the Request for Administration of Medication form. Parents must inform their child's teacher and the Director in writing about the medication and what it is being used for, and demonstrate any special procedures required to administer, if necessary. At the end to the treatment period, the medication container (and any remaining medication, if applicable) will be returned to the parent, or safely discarded by the Center.

**For non-prescription (over the counter) medication and lotions, not including sunscreen:**

Medication must be brought in the original container, clearly marked with their child's name. If the dosage to be given to the child is in any way different from the standard directions on the medication (such as a smaller dosage because the child is smaller in height/weight than other children of his/her age), the child's doctor must fill out and sign the appropriate portion of the Request for Administration of Medication form. Parents must inform their child's teacher and the Director about the medication and what it is being used for, and demonstrate any special procedure required to administer, if necessary. Non-prescription medication can be administered for a maximum of three days, topical lotion for skin ailments for a maximum of 14 days. If a longer treatment period is necessary, procedures for Prescription Medication administration will be in effect (including requiring permission/signature of the child's doctor). At the end of the treatment period, the medication container (and any remaining medication, if applicable) will be returned to the parent, or safely discarded by the Center.

**In the event of a minor accident/injury (bumps, scrapes, bruises, etc.):**

Staff will administer First Aid as necessary, and comfort the child. Staff will make sure all other children are properly supervised, in no danger of harming themselves, and are not interfering with the care for the injured child. A staff member who witnessed it, signed by the reporting staff member and the Director, will fill out an Incident/Injury Report Form detailing the incident. The injured child will be monitored through the rest of the day to make sure there are no additional concerns/complaints as a result of the injury. If another concern arises, teachers and the Director will determine if additional treatment is necessary or if the child's parent should be contacted. Parents must review and sign the Incident/Injury Report Form when they arrive to pick up their child at the end of the day, and a copy of the form will be given to them.

## Child Information Form

**Child's\*:** Last Name \_\_\_\_\_, First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

**Mother's:** Last Name \_\_\_\_\_, First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

**Father's:** Last Name \_\_\_\_\_, First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Does child live with a legal guardian other than mother or father?  Yes  No

If yes, **Guardian's:** Last Name \_\_\_\_\_, First Name \_\_\_\_\_, Middle Initial \_\_\_\_\_

**Street Address\*** \_\_\_\_\_ **City\*** \_\_\_\_\_ **ZIP Code\*** \_\_\_\_\_

**Parent/Guardian Phone** \_\_\_\_\_ **Work Phone** \_\_\_\_\_ **Email** \_\_\_\_\_

**Child's Gender\***  Male  Female **Child's Date of Birth (mo/day/yr)\*** \_\_\_\_\_

**Child's Race\*:**  American Indian or Alaskan  Asian  Black or African American  
 Pacific Islander  White  Other, please specify \_\_\_\_\_

**Child's Ethnicity\*:**  Hispanic  Haitian  Other, please specify \_\_\_\_\_

**Child's Country of Origin:** \_\_\_\_\_

**Is Child Proficient in English?\***  Yes  No

**Additional/Other language(s) spoken in the home\*:**  Spanish  Haitian-Creole  Other \_\_\_\_\_  
 None

**Child's Social Security number\*:** \_\_\_\_\_  No SSN;  Prefer not to give SSN

**MDCPS ID Number\*:** \_\_\_\_\_  No MDCPS ID;  Prefer not to give MDCPS ID

**Child's Current Grade\*:** \_\_\_\_\_ **Child's Current School\*:** \_\_\_\_\_

**Does child have health insurance (ex., private insurance, KidCare, Medicaid)?\***  Yes  No

**Does child have a documented disability?\***  Yes  No

- If yes, do you have (check all that apply):*
- an Individualized Family Service Plan (IFSP; if under 3 years old)
  - an Individualized Education Plan (IEP) from the school system
  - a Section 504 Plan
  - a medical diagnosis from a doctor
  - a diagnosis by a state certified/licensed professional (ex., psychologist)
  - disclosure by the parent or guardian describing the child's specific condition and/or need for accommodations

*If yes, how would you best classify the disability type(s)? (check all that apply):*

- Autism Spectrum Disorders
- Learning Disability
- Chronic Medical Condition
- Physical Disability
- Developmental Delay (under 5 only)
- Speech/Language Impairment
- Emotional and/or Behavioral Disorder
- Visual Impairment (or blind)
- Hearing Impairment (or deaf)
- Other Disability \_\_\_\_\_
- Intellectual Disability (or mental retardation)

**PARENT/GUARDIAN SIGNATURE\*:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

### For Staff Use Only (MUST BE COMPLETED)

ORGANIZATION: \_\_\_\_\_ SITE LOCATION: \_\_\_\_\_

**The Making Friends After School Program  
Tuition Contract**

This agreement is made on \_\_\_\_\_ (Date) between The Victory Center's After School Program and the Parent/Guardian, \_\_\_\_\_, with custody of \_\_\_\_\_ who reside at the following address:

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

(H) Phone: \_\_\_\_\_ (W) Phone: \_\_\_\_\_ (C) Phone: \_\_\_\_\_

1. I enroll my child(ren) for the The Victory Center's After School Program
2. I agree to pay \$300 for this service in advance by check each month..
3. I agree to pay a \$25 late fee if my payment is not received on time.
4. I agree to pay a registration fee of \$100 per each child enrolled in the program. I understand that the registration fee is due each school year at the time of registration and my child is not considered enrolled until the fee is received.
5. I do not expect the After School Program to provide medical insurance for my child(ren) nor will I hold the After School Program, Director or staff liable for injuries which may occur in the normal provision of child care. I will provide my own medical insurance.
6. I have read the attached policies and rules. Until these policies are changed, I accept them as they are and agree to abide by them.

Child(ren) enrolled:

\_\_\_\_\_ Name & Age

\_\_\_\_\_ Name & Age

\_\_\_\_\_ Name & Age

\_\_\_\_\_ Name & Age

Please complete information for anyone who may pay the After School Program Fees by check (payable to The Victory Center).

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Driver's License # \_\_\_\_\_ State \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Driver's License # \_\_\_\_\_ State \_\_\_\_\_

Parent/Guarding Signature : \_\_\_\_\_ Date: \_\_\_\_\_

The Victory Center  
Medical Update Form

Child's name: \_\_\_\_\_

List of Medications: Note specific dosages

_____	_____
_____	_____

Child's most recent diagnosis:

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

Any changes to child's medical history:

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

**Allergies**

Foods: \_\_\_\_\_

Reaction: \_\_\_\_\_

Counteract: \_\_\_\_\_

**Medication:** \_\_\_\_\_

Reaction: \_\_\_\_\_

Counteract: \_\_\_\_\_

**Animals/Insects:** \_\_\_\_\_

Reaction: \_\_\_\_\_

Counteract: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **Sick Student Policy** (Revised January 2011)

Occasionally, your child may become ill and unable to attend school. Please phone the Administration Department at 305-466-1142 ext. 201 or the Educational Director at ext. 203 to notify The Victory Center that your child will be out for the day. This allows the Educational Director to more efficiently schedule teacher staffing and modify class schedules for that particular day.

We understand that it is difficult for working parents to stay at home with a sick child. In an effort to control illness amongst other children, teachers, and possible pregnant or nursing staff members/teachers, in conjunction with the State of Florida Department of Children and Family Services, as well as the Center for Disease Control (CDC), **please do not send your child to school with the following symptoms:**

- Communicable diseases, such as measles, mumps, chicken pox, scarlet fever, whooping cough, etc...
- Head Lice (Child must be free of lice and nits before returning to school.)
- Symptoms of pink eye (watery eyes, discharge, pink/redness) or any type of skin rash
- Swollen glands with runny nose, runny nose with green or yellow mucus discharge, deep coughs (especially when spitting up phlegm), redness around ears (possible ear infection), unexplained rash, vomiting, fever of 100 degrees Fahrenheit or more.
- Bloody nose or any open skin lesions.
- Diarrhea. If your child has more than one loose stool, he or she will be sent home.
- Seizures. If your child shows symptoms or has a seizure at school, he or she must be sent home. The policy for Seizures is due to not having a nurse or medical staff on the premises.

If your child becomes ill during the day and is found to have any of the above mentioned symptoms which may result in infecting another child or staff member, we will separate your child from the others the best we can until you, the parents, are notified and your child is picked up. We do not have a room in which sick children can rest or a school nurse so you are expected to pick up your child within **ONE** hour after being notified.

### **Returning to School**

If you can present a doctor's note stating the specific symptoms your child was sent home with are not contagious, except if the symptoms were diarrhea and/or a fever, your child may return the same day **BEFORE NOON**. Otherwise, due to our classroom schedules, afternoon activities, and staff assignments the remainder of the day, the child may return **the following day**. **Please Note: Children without a doctor's clearance are to remain out of school the following school day and are only to return when symptoms are no longer present. The child must remain out for at least one full day, not including the day they were sent home.** A physician's note may be required for your child to return at the discretion of administration even if they were out of school the following day, depending on the seriousness of the illness and any symptoms present when they are dropped off at car pool.

### **Doctor's Note**

For your assistance, we have created a form to be filled out by the physician to ensure the clearance clearly states the symptoms being assessed and whether they are or are not contagious. We cannot accept notes from a doctor simply stating "May return to school". Please note that if the child is returned the following day with a doctor's note, it is up to the discretion of the school to determine if the child appears well enough to be present as per the CDC recommendations outlined below.

### **Emergency Contacts**

If a parent cannot be reached, the Educational Director will contact those persons on your child's emergency list. Please be prepared for such situations and make arrangements ahead of time. Please keep all emergency and work numbers current. We would greatly appreciate your cooperation in keeping all of our students and teachers healthy and safe. This will enable our teachers to be more productive with the children.

## Sick Student Policy Continued

**CDC recommends that people with influenza-like illness remain at home until at least 24 hours after they are free of fever (100° F [37.8°C]), or signs of a fever without the use of fever-reducing medications.**

Sick individuals should avoid contact with others. Keeping those with a fever at home may reduce the number of people who get infected, since elevated temperature is associated with increased shedding of influenza virus. **CDC recommends this exclusion period of 24 hours regardless of whether or not antiviral medications are used.** People on antiviral treatment may shed influenza viruses that are resistant to antiviral medications.

Many people with influenza illness will continue shedding influenza virus 24 hours after their fevers go away, but at lower levels than during their fever. Shedding of influenza virus, as detected by RT-PCR, can be detected for 10 days or more in some cases. Therefore, when people who have had influenza-like illness return to work, school, or other community settings they should **continue to practice good respiratory etiquette and hand hygiene and avoid close contact with people they know to be at increased risk of influenza-related complications.**

Because some people may shed influenza virus before they feel ill, and because some people with influenza will not have a fever, it is important to take all safety precautions. To lessen the chance of spreading influenza viruses that are resistant to antiviral medications, adhering to the exclusion period is very important for the health and safety of others.

If you receive, a call from the school to retrieve your child you must come **within the hour** or send an authorized individual. If we cannot reach you, we will call your emergency contact person. Failure to comply with these procedures will be considered a violation of school policy.

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

Time Called: \_\_\_\_\_

Time Picked Up: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Classroom: \_\_\_\_\_

Reason for Pick-Up: \_\_\_\_\_

Date When Student May Return:  With note: Today before noon or tomorrow  \_\_\_\_\_

\_\_\_\_\_  
**Educational Director**

\_\_\_\_\_  
Date

\_\_\_\_\_  
**Lead Teacher**

Date

\_\_\_\_\_  
Witness

Date

By signing below, I acknowledge my receipt of the above Sick Student Policy and agree to adhere to the terms and conditions stated herein.

\_\_\_\_\_  
**Parent Signature**

\_\_\_\_\_  
**Parent Name Printed**

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

## **HOSPITALIZATION POLICY**

1. If a student is absent due to a hospitalization or placement as noted below, the following procedures must be followed PRIOR to the student being allowed to return to school.  
Such hospitalizations may include:
  - a. Hospitalization in a psychiatric facility,
  - b. Commitment to a substance-abuse facility
  - c. Court commitment to a residential/hospital facility,
  - d. Residential commitment by state agencies such as the Department of Children and Family (DCF)
  - e. Long-term hospitalization for serious illnesses or injury, and
  - f. Other long-term placements.
2. Prior to a student returning to school, the guardian (s) of the student must notify The Victory Center 48 hours in advance to ensure proper planning and a smooth transition back to school.
3. The guardian (s) of the student must meet with the Educational Director and/or the Assistant Educational Director within 24 hours prior to planned return of the student in order to discuss treatment planning, educational goals, and any other pertinent information necessary to ensure a smooth and successful transition.
4. A treatment summary from the treating facility/physician must be provided 24 hours prior to the student returning to ensure recommendations and special accommodations can be accommodated and implemented.
5. If 2, 3, and 4 are not completed, the student cannot return to school until all requirements are fulfilled.

By signing below, I acknowledge my receipt of the above Hospitalization Policy and agree to adhere to the terms and conditions stated herein.

\_\_\_\_\_

**Parent Signature**

\_\_\_\_\_

**Parent Name Printed**

\_\_\_\_\_

**Date**

## EMERGENCY MEDICAL AUTHORIZATION FORM

**Student Name:** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Telephone:** \_\_\_\_\_

**PURPOSE:** To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached. Information provided on this form will be shared with school personnel who interact with your child to ensure his/her safety at school unless you note otherwise.

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**Residential (lives with) Parent or Guardian: (Designate - work or home)**

Mother's Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_  
Father's Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_  
Guardian's Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_

**Name of Relative or Childcare Provider (circle one):**

\_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_

### PART I OR II MUST BE COMPLETED

**PART I - TO GRANT CONSENT**

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor \_\_\_\_\_ Phone \_\_\_\_\_  
Dentist \_\_\_\_\_ Phone \_\_\_\_\_  
Preferred Local Hospital \_\_\_\_\_ Phone \_\_\_\_\_

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by the above-named doctor, or, in the event the designated practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

#### IMPORTANT

Please list any facts concerning the child's medical history including allergies, medications being taken, current medical conditions, and any physical impairments to which the school and a physician should be alerted.

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

**PART II - REFUSAL TO CONSENT**

I do not give consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

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

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

\_\_\_\_\_  
**Signature of Parent/Guardian**

**The Making Friends After School Program  
Emergency Information**

Child's Name: \_\_\_\_\_ Name Called: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Present Age: \_\_\_\_\_ Sex: \_\_\_\_\_ (H) Phone: \_\_\_\_\_

Approximate time child will be picked up: \_\_\_\_\_

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

Mother Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Hours: \_\_\_\_\_

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

Father Name: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Hours: \_\_\_\_\_

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

Doctor's name & phone number: \_\_\_\_\_

**Nearest Relative or neighbor to contact in emergency if parents cannot be reached:**

Name: \_\_\_\_\_ (H) Phone: \_\_\_\_\_ (W) Phone: \_\_\_\_\_

Name: \_\_\_\_\_ (H) Phone: \_\_\_\_\_ (W) Phone: \_\_\_\_\_

Person authorized to pick up child. (Child can only be picked up by persons on this list)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Additional person living or working in home: (include siblings)

_____	_____	_____
Name & Age	Name & Age	Name & Age

**Allergies** \_\_\_\_\_ **Fears** \_\_\_\_\_

Any health problems? \_\_\_\_\_ Medication required? [ ] Yes [ ] No

Medication taken regularly \_\_\_\_\_

Relate any information which you think would be of help to the staff. \_\_\_\_\_

\_\_\_\_\_

**Child Pick-Up Authorization Form**

I give permission for my child, \_\_\_\_\_, to be  
(Print Child Name)

Picked up from The Making Friends Afterschool Program by the following person(s)

Please List

<b>Print Name</b>	<b>Driver's License #/State Issued</b>	<b>Phone</b>

**Please attach a photo copy of photo ID/Driver's License for all individuals that are authorized to pick up your child.**

Print Parent Name: \_\_\_\_\_

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

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

**Confidentiality Agreement**

Updated June 2010

Confidentiality - It is important for your family to feel secure that your child's information is kept confidential. All oral and written reports are kept in the strictest confidence. Each child's progress is documented and maintained in a file kept on school property. These files are open to each parent to be reviewed and discussed as needed. It is also important that you be aware of and respectful of, other families and children you may observe when you come to view your child's progress. We will not discuss your child with any other parent and we will not discuss any other child with you. We ask that you also refrain from discussing your observations of children other than your own with other parents, as a simple courtesy.

I have read and understand **Confidentiality Agreement**

**Parent's signature serves as acknowledgment of receipt of The Victory Center's Confidentiality Policy.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Executive Director Signature



### AUTHORIZATION FOR PHOTOGRAPHY/VIDEO

From time to time during the school year staff photographs, school videos and our own public relations efforts are utilized to visually explain the many varied types of programs and events that we offer at The Victory Center, Inc. The photographs or videos may be used in seminars, classes, newspapers, brochures, school catalogs, internet, television or any other public or media form.

By signing this form, I consent to my child being included in school media as indicated above.

By signing this form, I, \_\_\_\_\_, the parent or guardian of \_\_\_\_\_ hereby authorize and give consent to the staff of The Victory Center to include my child in school media and marketing materials.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

Any and all Photos and Recordings taken of you, your children or wards shall be the sole property of The Victory Center.

## **Behavior Management Plan**

ABA methods are used to support persons with autism in at least six ways:

1. to increase behaviors (eg reinforcement procedures increase on-task behavior, or social interactions);
2. to teach new skills (eg, systematic instruction and reinforcement procedures teach functional life skills, communication skills, or social skills);
3. to maintain behaviors (eg, teaching self control and self-monitoring procedures to maintain and generalize job-related social skills);
4. to generalize or to transfer behavior from one situation or response to another (eg, from completing assignments in the resource room to performing as well in the mainstream classroom);
5. to restrict or narrow conditions under which interfering behaviors occur (eg, modifying the learning environment); and
6. to reduce interfering behaviors (eg, self injury or stereotypy).

The Behavior Analyst will conduct a Functional Behavioral Assessment for each student identified to be in need of ABA services. This is a process that includes the following components:

- a. selection of interfering behavior or behavioral skill deficit
- b. identification of goals and objectives
- c. establishment of a method of measuring target behaviors
- d. evaluation of the current levels of performance
- e. design and implementation of the interventions that teach new skills and/or reduce interfering behaviors
- f. continuous measurement of target behaviors to determine the effectiveness of the intervention, and
- g. ongoing evaluation of the effectiveness of the intervention, with modifications made as necessary to maintain and/or increase both the effectiveness and the efficiency of the intervention.

The interventions will be individualized based on the need of the student and function of the behaviors. Staff will collect and analyze data based on careful observation of student behavior and necessary changes in the student's environment to promote change in behavior will be made. Antecedent stimuli and consequences influence acquisition and continuation of behaviors and need to be determined individually for each student. Staff and parents will be trained on any intervention(s) deemed to be appropriate by the Behavior Analyst. If data collection is necessary, data sheets will be provided and trained thoroughly to assist with treatment recommendations.

Some examples of interventions for specified behaviors (to be individualized and revised based on the need of the student):

- Physical aggression: refers to any or all of the following acts: physical assaults on peers, staff or family members; verbal threats and hostile statements; threatening gestures; tantrums; and property destruction.

1. A student's motivation for aggression will be determined.
    - a. This information is then used to develop an individually tailored intervention.
    - b. Such an intervention can identify and strengthen adaptive behaviors that serve the same function as the target behavior.
  2. Interventions
    - a. For example, if aggression is motivated by attention, the student will be taught appropriate social skills, such as hand shaking, raising an arm, or learning to say 'hey, come here', to gain attention in an acceptable manner.
    - b. Interventions based upon a functional assessment can also include removing those events that trigger aggression. For example, if attention-maintained aggression is more likely to occur after the person has been ignored for an extensive period of time, one such intervention to reduce attention-maintained aggression would be to give frequent periods of attention.
- Self Injurious Behaviors: is deliberate infliction of tissue damage or alteration to oneself, taking one's anger out on one's self by biting, hitting cutting or banging one's head
1. *Initially, a functional analysis will be conducted in order to obtain a detailed description of the person's self-injurious behavior and to determine possible relationships between the behavior and his/her physical and social environment*
  2. Interventions
    - a. Communication Skill Building
      - i. Encourage student to use communication to express emotions
      - ii. Use journals to express emotions through writing
      - iii. Trigger Log – student tracks each time he or she engages in SI and the events leading up to it
    - b. Behavioral Interventions
      - i. Stress Management and Tension Release
      - ii. Diaphragmatic and Controlled breathing
      - iii. Meditation and Visualization
      - iv. Exercise, specifically aerobic

If all ABA interventions fail to keep the student, peers, and/or staff safe, appropriate PCM techniques will be utilized.

I have read The Behavior Management Plan and understand and agree to the information contained therein.

By signing below I also understand that the intensity and severity of my child's behaviors may result in suspension from the Aftercare program if these behaviors are not manageable in a 2:1 setting and are a risk to the safety of my child and/or others.

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Print name

Date \_\_\_\_\_

Dear Parents & Guardians:

In an effort to increase security on our campus, we will be issuing parking permits. This will enable us to identify who is on our campus.

Please fill out the form below and either mail it back to us or bring it to the Administration Office. Once we receive this form, we will issue you the parking permits.

Thank you,  
Dr. Anja Kroell



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### MAR-JCC PARKING PERMIT INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Car 1: Make: \_\_\_\_\_ Model: \_\_\_\_\_ Year: \_\_\_\_\_

Color: \_\_\_\_\_ License Plate: \_\_\_\_\_ State: \_\_\_\_\_

Car 2: Make: \_\_\_\_\_ Model: \_\_\_\_\_ Year: \_\_\_\_\_

Color: \_\_\_\_\_ License Plate: \_\_\_\_\_ State: \_\_\_\_\_

I agree to return the parking pass that is given to me upon my child's exit from the Victory Center for Autism.

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