2400 E Wassall St
Wichita, KS 67216

Phone: 973-1600
Fax: 973-1610

2019 - 2020 School Year

**RE: Clinical Services at Sowers High School**

**U.S.D. 259** is pleased to be able to provide a therapeutic educational setting for qualified students. Students attending Sowers are evaluated for appropriate therapeutic services and are provided with those services that are indicated for their success in the school setting.

**These school-based services** are provided by clinicians employed by the school district and there is no additional charge to parents. Therapeutic services may include classroom consultation, evaluation (which may be clinical or program evaluation), individual and group therapy, parent consultation, family therapy, and community provider collaboration and consultation as the need is indicated for each student.

**Students** who are receiving services from private clinicians or community agencies may receive adjunct services as needed to enhance school success.

USD 259 Clinical personnel are further able to assist parents in obtaining needed services from Community Mental Health Center Providers and private providers.

**Records of therapy sessions are kept confidential and secure**. Access to information is limited to professional staff and is shared only when information will directly assist that professional in working with the child. Information is shared with outside agencies or individuals only when a release of information is signed, or according to existing legal requirements. Parents are notified of any issues that arise during the provision of clinical services which represent a clear and imminent danger to the child.

**As with the development of their child's Individualized Education Plan (IEP)**, parents are asked to be involved in the development and implementation of these therapeutic services through the development of a Clinical Treatment Plan. Related IEP services will be reviewed and integrated with the appropriate Clinical Treatment strategies and services, Crisis plans, or other relevant plans.

The **staff members** below are those involved in Clinical Services at Sowers and are available to answer questions or to speak further with you about these services.

**Jackie Hultman, Principal 973-1600; Jim Sommer, Clinical Therapist 973-1636**
**Phillip Newman, Clinical Social Worker 973-1635**

## CONSENT TO PARTICIPATE IN THERAPEUTIC SERVICES:

I understand that my child is enrolled in a therapeutic educational setting.
I have read the above information and I hereby give my consent for the clinical services described to be provided to my child, _____.
***(student's name)***

By signing below, I further certify that I am the legal guardian for this student.

_____ _____
Parent/Guardian Signature Date

_____ _____
Student Signature Date

WICHITA
PUBLIC SCHOOLS

Dear Parent/Legal Guardian:

In an effort to include Sowers Alternative High School student's accomplishments and participation in a variety of activities; we request your permission to include pictures and name of your child in the sources listed below.

Signing this form will not allow media personnel to interview students.

Our public relations efforts will be directed toward the inclusion of students in District publications, building publications, the Wichita Eagle and occasional radio and/or television reports.

Your permission will help us to better inform the public as to our mission and the many positive accomplishments of our students. Please contact me if you require additional information.

Sincerely,

Jacqueline Hultman, Principal
Sowers Alternative High School

I grant permission for _____ pictures/photographs along with identifying information to be included in the following:

Please Circle:

Yes No USD 259 District publications and other media

Yes No Local newspapers/print media

Yes No Television and radio reports (no interviews)

Parent/Legal Guardian Signature _____ Date_____

Wichita Public Schools
Sowers Alternative High School
2400 Wassall
Wichita, KS 67216
316.973.1600

RE: FIELD TRIPS/SCHOOL RELATED ACTIVITIES

The pupils who will participate in the described activity will be transported as indicated. The vehicle will be properly insured as required by Kansas Law (KSA 40-3107e)

Date(s) and Purpose of Activity: Career Employment Searches
Business Tours
Recreational Activities

DATES AND TIMES ARE SUBJECT TO CHANGE BUT WILL BE ANNOUNCED

Types of transportation to be used: Licensed Public Conveyance_____
School Bus ____
Leased Van ____
Private Passenger Vehicle _____
Walk outside for photo class _____

Reasonable precautions will be taken to provide for the pupils safety. We request that _____ be transported as stated above.

**Student's Name**

We relieve and absolve the Wichita Public Schools of any responsibility other than that stated above. In addition, I hereby give consent for participation in Field Trip Activities and Transportation to and from school, or other programs not listed above.

_____ _____

Date Parent/Legal Guardian Signature

## Wichita Public Schools

*Division of Student Support Services*

## Department of Health Services

Date - _____ Student Legal Name - _____

Birthdate - _____ Grade - _____

Health Care Provider/Doctor - _____ Phone Number - _____

**If your child has significant health issues, it is your responsibility to notify the school nurse. Directly notifying the school nurse helps to ensure your child receives appropriate care.**

**Circle "Yes" or "No". If "Yes", please comment – use back of form if needed.**

**Any Health Concerns** **Yes** **No** _____ _____

| **Medical History** | | | **Age at Diagnosis** | **Comments** |
|---|---|---|---|---|
| Allergies | Yes | No | _____ | List Allergies_____ |
| Asthma | Yes | No | _____ | _____ |
| Bladder Problem | Yes | No | _____ | _____ |
| Bowel Problem | Yes | No | _____ | _____ |
| Braces | Yes | No | _____ | _____ |
| Dental Appliance | Yes | No | _____ | _____ |
| Eye Problems | Yes | No | _____ | _____ |
| If "Yes" - Date of last vision exam _____ | | | | |
| Glasses | Yes | No | _____ | _____ |
| Contacts | Yes | No | _____ | _____ |
| Head Injury | Yes | No | _____ | _____ |
| Hearing Problems | Yes | No | _____ | _____ |
| Ear Tubes | Yes | No | _____ | _____ |
| Hearing Aids | Yes | No | _____ | _____ |
| Genetic Disorder | Yes | No | _____ | _____ |
| Headaches | Yes | No | _____ | _____ |
| Heart Problem | Yes | No | _____ | _____ |
| Kidney Problem | Yes | No | _____ | _____ |
| Seizure Disorder | Yes | No | _____ | _____ |
| Stomach Problem | Yes | No | _____ | _____ |
| Other | Yes | No | _____ | _____ |
| Accidents | Yes | No | _____ | Date/Details_____ |
| Injuries | Yes | No | _____ | Date/Details_____ |
| Surgeries | Yes | No | _____ | Date/Procedure_____ |
| Medication(s) | Yes | No | _____ | _____ |

Name of medication _____ Dosage _____

Time medication is taken_____ Will this medication be taken at school? Yes No

Name of medication _____ Dosage _____

Time medication is taken_____ Will this medication be taken at school? Yes No

_____ _____

Signature of person completing this form Relationship to student

# Unattended Drop Off (UDO)
# TRANSPORTATION FORM

Student Name: _____ DOB: _____

ID #: _____ Grade: _____ School: _____

Parent/Guardian: _____

Address: _____ Zip Code: _____

I/We parent/guardian of _____ request that the IEP Team review the need and approval of a UDO. I understand that I am entrusting my child with a significant responsibility. I believe that my child is able to care for him/herself without adult supervision for extended periods of time.

Parent/Guardian: _____ Date: _____

Parent/Guardian: _____ Date: _____

The IEP Team has met and is requesting the following:

☐ No UDO
Justification:

☐ Regular Education bus with a stop within ____ block(s) of the transportation address
☐ Special Education bus with a stop at nearest corner from the transportation address
☐ Curb to curb
Justification:

☐ Revoked
Justification:

IEP Team Representative _____ Date: _____
Principal _____ Date: _____
Coordinator _____ Date: _____
Transportation _____ Date: _____