[SCHOOL NAME]

School-Parent-Student Compact
20___-20___

The [School] ("District") and the parents of students participating in activities, services, and programs funded by Title I have jointly developed this Compact which outlines how the parents, school staff, and students will share the responsibility for improved student academic achievement and the means by which the school and parents will build and develop a partnership to help children achieve the State's high standards.

School Responsibilities:

The faculty and staff of the District, will:

- Provide high quality curriculum and instruction in a supportive and effective learning environment to enable children to meet the challenging State academic standards.
- Consider the promises made in the Compact at parent-teacher conferences.
- Provide parents with frequent progress reports pursuant to district policy.
- Communicate and work with families to support students' learning.

Parent Responsibilities:

The parent(s) will support their child's learning in the following ways:

- Communicate and work with teachers and school staff on an ongoing basis to be involved and support my child's learning.
- Value and support my child's attendance at school.
- Ensure that homework is completed.
- Promote positive use of my child's extracurricular time.
- Participate in parent groups that support the district's students.
- Endeavor to stay informed about my student's progress and request updates as needed.

Student Responsibilities:

The student will share the responsibility to improve his or her academic achievement in the following ways:

- Cooperate with my teachers in school and be responsible for my behavior.
- Complete all of my homework assignments on time.
- Participate to the best of my ability in all of my classes.
- Participate in extracurricular activities which will help me become a better student and stay active in my school and community.
- Let my teachers and family know when I need help.

EMERGENCY RESPONSE TO LIFETHREATENING ASTHMA OR SYSTEMIC ALLERGIC REACTIONS (ANAPHYLAXIS)

DEFINITION: Life-threatening asthma consists of an acute episode of worsening airflow obstruction. Immediate action and monitoring are necessary.

A systemic allergic reaction (anaphylaxis) is a severe response resulting in cardiovascular collapse (shock) after the injection of an antigen (e.g. bee or other insect sting), ingestion of a food or medication, or exposure to other allergens, such as animal fur, chemical irritants, pollens or molds, among others. The blood pressure falls, the pulse becomes weak **AND DEATH CAN OCCUR.** Immediate allergic reactions may require emergency treatment and medications.

LIFETHREATENING ASTHMA SYMPTOMS: Any of these symptoms may occur:

- Chest tightness
- Wheezing
- Severe shortness of breath
- Retractions (chest or neck "sucked in")
- Cyanosis (lips and nail beds exhibit a grayish or bluish color)
- Change in mental status, such as agitation, anxiety, or lethargy
- A hunchedover position
- Breathlessness causing speech in onetotwo word phrases or complete inability to speak

ANAPHYLACTIC SYMPTOMS OF BODY SYSTEM: Any of the symptoms may occur within seconds. The more immediate the reactions, the more severe the reaction may become. Any of the symptoms present requires several hours of monitoring.

- Skin: warmth, itching, and/or tingling of underarms/groin, flushing, hives
- Abdominal: pain, nausea and vomiting, diarrhea
- Oral/Respiratory: sneezing, swelling of face (lips, mouth, tongue, throat), lump or tightness in the throat, hoarseness, difficulty inhaling, shortness of breath, decrease in peak flow meter reading, wheezing reaction
- Cardiovascular: headache, low blood pressure (shock), lightheadedness, fainting, loss of consciousness, rapid heart rate, ventricular fibrillation (no pulse)
- Mental status: apprehension, anxiety, restlessness, irritability

EMERGENCY PROTOCOL:

1. CALL 911
2. Summon school nurse if available. If not, summon designated trained, nonmedical staff to implement emergency protocol
3. Check airway patency, breathing, respiratory rate, and pulse
4. Administer medications (EpiPen and albuterol) per standing order
5. Determine cause as quickly as possible
6. Monitor vital signs (pulse, respiration, etc.)
7. Contact parents immediately and physician as soon as possible
8. Any individual treated for symptoms with epinephrine at school will be transferred to medical facility

STANDING ORDERS FOR RESPONSE TO LIFETHREATENING ASTHMA OR ANAPHYLAXIS:

- Administer an IM EpiPenJr. for a child less than 50 pounds or an adult EpiPen for any individual over 50 pounds
- Follow with nebulized albuterol (premixed) while awaiting EMS. If not better, may repeat times two, backtoback
- Administer CPR, if indicated

_____ _____

(PHYSICIAN) Date

Student Fee Waiver Application

The school district will waive certain fees for students who qualify for free and reduced lunches under the income guidelines of the United States Department of Agriculture. If you would like the school district to waive specific student fees for your student, you must fill this form out in its entirety and submit it, along with any required documentation, to the office of the Superintendent of Schools.

Part 1: Name of the student on behalf of whom you are requesting a fee waiver: _____

Part 2: Specific fee(s) for which you are requesting a waiver:

_____

_____

Part 3: Eligibility. Select ONE of the following:

- Check here if your student is eligible for fee waivers because he or she is a foster child. Please attach official documentation from the agency sponsoring the child.
- Check here if your student is eligible for fee waivers because you receive Food Stamps, FDPIR or TANF for the child. Please attach a copy of one of the following:
    - A Food Stamp, FDPIR or TANF Certification Notice that shows dates of certification
    - A letter from Food Stamp or Welfare Office confirming your receipt of Food Stamps, FDPIR or TANF
    - An ATP (Authorization to Participate) card with an expiration date. Do not send your EBT card
- Check here if your student is eligible because your household income is less than 180% of poverty level.

1. Name 2. (list everyone in your household)	Last month's income and how often it was received Example: $100/monthly $100/twice a month $100/every other week				Check if no income
	_____/ _____	____/ _____	____/ _____	____/ _____	
	_____/ _____	____/ _____	____/ _____	____/ _____	G
	_____/ _____	____/ _____	____/ _____	____/ _____	G
	_____/ _____	____/ _____	____/ _____	____/ _____	G
	_____/ _____	____/ _____	____/ _____	____/ _____	G
	$_____/ _____	$_____/ _____	$_____/ _____	$____/ _____	G

Please attach documents verifying the amount of money your household received last month from each source. The documents you provide must show the name of the person who received the income, the date it was received, how much was received and how often it was received.

Acceptable documentation includes:

Jobs: current paycheck stub or pay envelope that shows how often pay is received; letter from employer stating gross wages and how often they are paid; or business or farming papers, such as a ledger or tax books.

Social Security, Pensions, or Retirement: A notice of eligibility from state employment security office, check stub, or letter from Workers= Compensation Court.

Welfare Payments: A benefit letter from a welfare agency.

Child Support or Alimony: A court decree, agreement, or copies of checks received.

Other income (such as rental income): Information that shows the amount of income received, how often it is received, and the date received.

No income: A brief note explaining how you provide food, clothing and housing for your household and when you expect an income.

Part 4. Signature and Verification
An adult household member must sign this application.

PLEASE READ THIS CERTIFICATION BEFORE SIGNING:

I certify that all information on this application is true and that all income is reported. By my signature on this document, I give school authorities permission to disclose my student's eligibility for fee waivers to school personnel as necessary to effect the fee waiver. I understand that any clothing, equipment, or other materials used by my student during his or her participation in the activity for which student fees have been waived are and will remain the property of the school district.

Sign: _____
Date: _____

NOTICE OF POLICY ON OPTING OUT OF ASSESSMENTS

The Board of Education has adopted a policy on approval and denial of state and federal assessment opt-out requests, which is based on requirements in law. The policy can be requested by contacting the Superintendent of Schools at [or can be viewed online by visiting: {hyperlink}].

NOTE: Provide this notice at the beginning of the school year to parents of students attending schools receiving Title I funds. It can be included in handbooks or sent as a stand-alone document.

PARENTAL AUTHORIZATION AND RELEASE FORM
ADMINISTRATION OF NON- PRESCRIPTION DRUGS TO STUDENTS

While the administration of medications to students should be scheduled outside of school hours whenever possible, occasionally it may be necessary for school personnel to administer nonprescription drugs to a student as authorized by the student's parents, guardians, or medical professionals and state law. School personnel will only dispense those nonprescription drugs which have been approved by state and federal law for use as a drug and meet the definition of nonprescription drugs in Nebraska's Medication Aide law which states:

> Nonprescription drugs means nonnarcotic medicines or drugs which may be sold without a medical order and which are prepackaged for use by the consumer and labeled in accordance with the requirements of the laws and regulations of this state and the federal government.

In order for students to be administered nonprescription medication by school personnel, a parent or guardian must:

- Complete and return this authorization form.
- Provide the district with any nonprescription drugs you wish to be administered in its original container from the manufacturer, which must include legible, unadulterated manufacturer instructions. The container must be labeled with the student's name.
- Provide the district with specific written instructions regarding the requested nonprescription drug's administration, including the date(s) the student is to be administered the drug, the dosage to be administered, the frequency of administration, and any other details or conditions relevant to administration.

School personnel will not administer nonprescription drugs in a manner inconsistent with the manufacturer instructions or state law. School personnel will not administer non-prescription drugs that is expired.

The undersigned are the parent(s), guardian(s), or person(s) in charge of

_____.
(name of the student)

I authorize and request school personnel to administer nonprescription drugs to my student. I release the school district, its officials, and employees from any and all liability concerning the administration of nonprescription drugs to my student.

DATED this _____ day of_____, 20__.

_____
Parent/Guardian

PARENTAL AUTHORIZATION AND RELEASE FORM
ADMINISTRATION OF PRESCRIPTION DRUGS TO STUDENTS

The undersigned are the parent(s), guardian(s), or person(s) in charge of

_____.
(name of the student)

It is necessary that the student receive (name of drug) _____, a physician-prescribed drug, during school intervals beginning on (date) _____ and continuing through_____. (date)

I hereby request that the School District, or its authorized representative, administer the drug named above to my child named above, in accordance with the prescribing physician's instructions, and agree to:

1. Submit this request to the teacher.
2. Make certain the Physician's Request for the Administration of Prescription Medication by School Personnel is submitted to the teacher.
3. Make sure personally that the drug is received by the teacher and/or county nursing service administering it, in the container in which it was dispensed by the prescribing physician or licensed pharmacist.
4. Make sure personally that the container in which the drug is dispensed is marked with the drug name, dosage, interval dosage, and date after which no administration should be given.
5. Submit a REVISED STATEMENT signed by the physician prescribing the drug to the teacher IF ANY OF THE INFORMATION PROVIDED BY THE PHYSICIAN CHANGES.
6. Release the School District and the Board of Education of the School District and all employees, agents, and the representatives of the School District from any liability concerning the giving or non-giving of the drug to the student.

DATED this _____ day of_____, 20__.

_____
Parent/Guardian

ADMINISTRATION OF MEDICATION TO STUDENTS
PHYSICIAN'S REQUEST FOR ADMINISTRATION OF PRESCRIPTION MEDICATIONS BY SCHOOL PERSONNEL

DATE _____

CHILD'S FULL NAME _____ is under my care and must take medication which I have prescribed during the school day.

Name of medication (as it appears on container in which the drug is stored)

_____

Dosage and time_____

Date administration of drug is to begin _____

Possible adverse reactions to be reported to physician _____

_____

Special instructions for the administration and storage of the drug _____

_____

I or my designee(s) have trained school personnel or approved alternative training as adequate to administer the medication, have evaluated the situation, the general administration plan and if applicable, the self administration plan or emergency care plan, and deemed each to be safe and appropriate, and if applicable authorize the use of hypodermic syringes and needles or similar medical terms.

Name of Physician and Designee

_____

Print or Type

_____

Primary Phone Number

_____

Secondary Phone Number

_____

Signature of Physician

One Copy to Employee
One Copy to Nebraska Department of Labor
One Copy to Issuing Officer

Federal Hour Restrictions
Not more than 3 Hours on a School Day
Not more than 18 Hours in a School Week
Not More than 8 Hours on a Nonschool Day
Not more than 40 Hours in a Nonschool Week
Not Before 7 a.m. nor After 7 p.m.
(9 p.m. from June 1st through Labor Day)

Nebraska Hour Restrictions
Not More than 8 hours in One Day
Not More than 48 Hours in One Week
Not Before 6 a.m. nor After 10 p.m.

NEBRASKA WORKFORCE DEVELOPMENT
DEPARTMENT OF LABOR

5723 "F" Street * Omaha, Nebraska 68117-1898 * (402) 595-3095

Employment Certificate
(For Minors 14 and 15 Years of Age)

☐ Employment During School Year
☐ Employment During School Vacations

Date of Issue _____, 20____

This certificate authorizes the employment of _____ (NAME OF MINOR)

_____ (ADDRESS OF MINOR) by _____ (NAME OF EMPLOYER)

_____ (ADDRESS OF EMPLOYER) _____ (NATURE OF BUSINESS)

_____ (EMPLOYER'S TELEPHONE NUMBER) _____ (WORK TO BE DONE BY MINOR)

_____ Days per week; _____ Hours per week; _____ Hours per day $ _____ Hourly wage

Day's work to start at _____ ☐A.M. ☐P.M. Minor's Sex: ☐Female ☐Male

Day's work to end at _____ ☐A.M. ☐P.M. Minor's Age _____ Date of Birth _____

Certificate valid from _____, 20 _____ to _____, 20 _____

Evidence of age accepted _____ (Specify) Grade Completed _____

Place of Birth _____ (City) (State)

Color of Hair _____ Color of Eyes _____ Height ___ feet ___ inches Weight _____ pounds

Distinguishing facial marks

_____

Name of Parent(s) _____ Telephone Number _____

Certificate is valid for one year. **Sign here** _____ (SIGNATURE OF MINOR)

* * * * * * *

This is to certify that I have examined, approved and filed the papers required, and that the minor has been examined and has signed this certificate in my presence.

NOTE: State and Federal Child Labor Laws are different. It is the responsibility of the employer to be aware of which law applies and to be governed by the more restrictive. Information regarding Federal Child Labor Laws may be obtained from the U.S. Department of Labor, Wage and Hour Division, Omaha, NE, (402) 221-4682.

_____ (Issuing Officer's Signature)

_____ (Title) (Telephone No.)

_____ (Name of School) (County)

_____ (Address of School)

_____ (City) (Zip)

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