

STARKVILLE ACADEMY

STUDENT HANDBOOK ACKNOWLEDGEMENT PAGE

Student's Name _____
(PLEASE PRINT – LAST NAME, FIRST NAME)

Student's Grade: _____

Parents'/Guardians' Names: _____
(PLEASE PRINT)

This is the Starkville Academy Student Handbook for the 2019-2020 school year. We hope you find it informative regarding our school's philosophy and policies. Should you have questions regarding school policies after reading the handbook, please contact the school office.

It is very important that each Parent/Guardian and Student(s) read the handbook.

IMPORTANT: PLEASE READ CAREFULLY

Starkville Academy may disclose "directory" information such as a student's name, address, telephone number, date, and place of birth, honors and awards, and dates of attendance.

Additionally, Starkville Academy will use pictures and works of its students on its website and/or in advertising.

Parents, guardians, or other persons signing below must notify Starkville Academy and request that said information not be disclosed about their child/children or their child's/children's photo or works not be displayed on the school website/advertising. Email Noa Katherine Hardin at nhardin@starkvilleacademy.org to make this request.

Please complete this page and return it to the school. Each student in your family attending Starkville Academy should return a form.

I, _____ (PLEASE PRINT PARENT/GUARDIAN NAME), accept parental responsibility regarding all rules as described in the Starkville Academy Student Handbook.

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____

I, _____ (PLEASE PRINT STUDENT NAME), have read and will follow all rules, policies, and procedures as described in the Starkville Academy Student Handbook.

STUDENT SIGNATURE: _____

DATE: _____

EMERGENCY TELEPHONE NUMBERS

This form must be completed and on file prior to the student's first day of school.

STUDENT'S NAME _____ HOME PHONE # _____

STUDENT'S GRADE _____ STUDENT CELL PHONE # (grades 7-12) _____

HOME ADDRESS _____

MOTHER'S NAME _____

EMAIL _____

EMPLOYED BY _____ PHONE # _____

CELL # _____

FATHER'S NAME _____

EMAIL _____

EMPLOYED BY _____ PHONE # _____

CELL # _____

OTHER SIBLINGS at SA: Name and Grade

PERSONS TO NOTIFY IF PARENTS CANNOT BE REACHED:

NAME _____ PHONE # _____
CELL # _____

RELATIONSHIP _____

NAME _____ PHONE # _____
CELL # _____

RELATIONSHIP _____

NAME _____ PHONE # _____
CELL # _____

RELATIONSHIP _____

NAME OF PHYSICIAN _____ PHONE # _____

ALLERGIES _____

OTHER SPECIAL PRECAUTIONS _____

VISION DEFECT? _____ HEARING DEFECT? _____

DATE

PARENT'S SIGNATURE

**STARKVILLE ACADEMY
STUDENT CHECK-OUT AUTHORIZATION**

I understand that in order for my child to be able to leave campus for any reason other than a school sponsored activity, I must come to the office and sign her/him out of school. If I am unable to do so, the following people are authorized to sign my child out of school.

Name, Phone Number, and Relationship to Student

Name, Phone Number, and Relationship to Student

Parent Signature

Date

Student Name

Grade

STARKVILLE ACADEMY AUTHORIZATION TO ADMINISTER MEDICATION

Whenever possible, medication schedules should be arranged so medication is given at home. If medication is to be administered at school, please complete the following information where applicable:

Student's Name _____ Grade _____ Date _____

Over the Counter Medications

The school is prepared to provide over-the-counter medications to your child upon request (i.e. Tylenol, aspirin, Benadryl, etc.) Does the school have your permission to administer such medications?

Yes or No _____ (parent/guardian signature)

Limitations on types of over-the-counter medications: _____

Any known allergies: _____

Existing medical conditions: _____

Prescribed Medications

Prescription medication can be administered at school provided these guidelines are followed:

1. Medication must be delivered to the school office by a parent or guardian.
2. Medication should be in the container in which it was purchased (dispensed). Pharmacists will give an extra labeled bottle.
3. Medication label must indicate the student's name, name of medication, physician's name, dosage, frequency, and date.
4. Any sample medications must be accompanied by orders from the physician.
5. A separate supply of medication must be kept at school. Medication will not be transported between home and school on a daily basis.
6. If a dropper, spoon, cup, etc., is required for administration of medication, it should be provided to the school labeled with the student's name.
7. This form should be updated if changes are made to medication type and/or dosage.
8. Any medication not taken home by parent at the end of the school year will be destroyed.

As the parent/guardian of the student named above, I request the principal/principal's designee to administer the prescription medication described below to my child.

Name of Medication _____ Dosage _____

Time to be given _____ Date to Start _____ Date to End _____

Health condition requiring medication: _____

Possible side effects/special instructions: _____

Name of physician prescribing medication: _____ Phone _____

I understand that school personnel cannot be held liable for reactions to or effects from the administration of the medication. I also grant permission for school personnel to contact the physician if there are urgent questions or concerns about the medication. I have read the guidelines and agree to abide by them.

Parent/Guardian signature _____ Date: _____ Phone: _____
Home _____ Work _____ Cell _____

STARKVILLE ACADEMY ACTIVITY PERMISSION

It is my desire to allow _____, a student at Starkville Academy, to participate in school sponsored sports, band, or other activities for the current school year. I understand that occasionally injuries occur in these activities and that Starkville Academy assumes no risk or responsibility for these injuries.

While Starkville Academy is not an agency for any company selling student accident policies, the school will make available a low-cost insurance policy for its students .I release Starkville Academy, the Board of Directors, the Head of School, Coaches, and Teachers from all responsibility in case of injury.

_____ Date _____

Parent or Guardian

Student's Grade _____ Parent's Phone Cell _____ Home _____

Work _____

Please complete fully: THIS IS VERY IMPORTANT!

Medical Information: The above named participant is covered for hospitalization under
Policy# _____ Name of Insurance
Company _____ Address of Insurance Company

_____ If Group Policy Policy, give employer _____ Group # _____

_____ The above named participant is not covered by hospitalization insurance. In the case of athletics, student must present current physical form to the coach prior to first practice. This form will remain on file in Athletic Director's office.