COVID Policies

Student's Name: _____ DOB: _____

In response to COVID-19, NLA has adjusted protocols and procedures to ensure the safety of our students and team members. Please read and initial the following statements. By initialing, you acknowledge that you have read, understand, and will comply with stated policy and/or procedure.

COVID-19 Contact

If a student, family member, or caregiver has come into contact with someone with COVID-19 or has experienced any symptoms associated with COVID-19, they must self-isolate for 14 days. Students are encouraged to participate in virtual learning. _____ Initial

If a student, family member, or caregiver has traveled to any hot zones or outside the country, they must self-isolate for 14 days. Students are encouraged to participate in virtual learning. _____ Initial

If a student, family member, or caregiver tests positive for COVID-19, NLA will assist with contact tracing and notify anyone that they have come into contact with to prevent further spreading. The student must receive two negative COVID-19 test results prior to returning onsite. _____ Initial

Parent and/or guardian will contact NLA administration should any of these events occur to minimize spreading of COVID-19. _____ Initial

Attendance

In person or virtual learning will continue to be tracked and recorded for scholarship compliance. Students must be in attendance on site or virtually to be counted as present by the teacher or designated party. _____ Initial

Face Mask Policy

Parents, guardians, and nurses are required to wear a face mask while onsite. If a student is able to wear a face mask, please provide and encourage its use. Should the face mask be soiled during the school day, it will be placed in a plastic bag within their school bag. _____ Initial

Limited Contact Policy

Students, parents, guardians, nurses, and team members are required to maintain limited physical contact when possible. Hugging, high fives, and other forms of physical contact are strongly discouraged. _____ Initial

Drop Off Policy

Students within the Discovery and Explorers classrooms may use the Discovery Door. Students within the Voyagers classroom may use the Voyagers door. Students within the Launch Pad, Orbiters and Navigators classrooms may use the Orbiters door. (*DOORS WILL BE LABELED*) Students may enter the building no earlier than **7:45am**. When more than one student is entering the building at the same time, the student and parent will wait outside the door and maintain social distance from other families until a staff member has cleared each student/parent to enter the building. Students will be met at the No Limits Academy entrances by a member of the NLA team. A temperature of 99 degrees or higher will not be granted entrance within the school. COVID-19 symptom monitoring will be performed daily. Visible symptoms including but are not limited to fever, cough, mucus, runny nose, nasal congestion, and/or other respiratory symptoms will also not be granted entrance within the school. The student will be requested to self-isolate for 14 days and be tested for COVID-19 if symptoms persist.

Students who are late (after 9:00 am), may only enter through the Ability Plus Therapy entrance. You will be met at the entrance by a member of the APT team for temperature testing and COVID symptom monitoring. Parents/Guardians will sign-in their student at the front desk for attendance compliance. Should the student not be granted entry, the front desk administrators will notify NLA administration. The student will be requested to self-isolate for 14 days and be tested for COVID-19 if symptoms persist. _____ Initial

Pick Up Policy

Students within the Discovery and Explorers classrooms may use the Discovery Door. Students within the Voyagers classroom may use the Voyagers door. Students within the Launch Pad, Orbiters, or Navigators classrooms may use the Orbiters door. Navigators may also exit through APT. Parents and/or transportation may enter through these doors no earlier than **2:30pm.** For pick up prior to 2:30pm, entrance will be granted through Ability Plus Therapy's entrance. Parents will be met at the No Limits Academy entrances by a member of the NLA team. Temperatures will be taken by a point and shoot thermometer. A temperature of 99 degrees or higher will not be granted entrance within the school. Your child will be escorted to you by a member of the NLA team. At that time, the student will be requested to self-isolate for 14 days and encouraged to participate in virtual learning. _____ Initial

Teacher Communication

To limit classroom exposure, we request that parents and/or guardians who pick up or drop off remain within the classroom for a short period of time only. Communication with the teacher or teacher assistants may be brief but further discussion required may be carried out via phone or email. _____ Initial

Virtual Learning Schedule

Virtual learning will be available to all students daily. Should a classroom require quarantine closure, all students in that classroom will be instructed virtually. Notification will be made by NLA administration via text. Parents will be notified by text message of classroom closure as soon as that determination is made. Classroom closure may occur on short notice.

Should a student be transported by a transportation company, the child will be quarantined within their classroom until the parent is available for pick up. We request that this be completed within a timely manner as to not expose other team members.

The Virtual Learning schedule is as follows:

8:30am - 9:00am	Virtual Worship (Zoom)
9:00am - 3:00pm	Parents and students utilize Google Classroom lesson plans, resources and videos.
3:00pm - 4:00pm	Teacher/Teacher Assistant Contact

Google classroom links will be emailed at the start of school. _____ Initial

Lunch Procedure

All lunches must come prepared including but not limited to; puree, portion size, etc. Lunches will no longer be able to be stored within a refrigerator. Student lunches will remain within their classroom throughout the day. Due to this, cold lunches must have an appropriate cold pack. Microwaves will be available within the classroom for warming. Food containers will no longer be washed but sent back within the student's lunch bag. _____ Initial

On Site School Supplies

Individual students must be provided with their own supplies purchased by their parents. Please review the attached list. These supplies will be labeled within each student's school supply box provided by No Limits Academy. These boxes will be regularly disinfected daily or upon use. _____ Initial

Aftercare

No Limits Academy will not be providing aftercare thus we request pickup be no later than **3:05pm.** _____ Initial

As the parent of a student attending No Limits Academy, I understand and agree to abide by the terms of this agreement, as evidenced by my initials above and signature below.

Parent Name: _____

Parent Signature: _____ Date: _____

No Limits Academy: _____ Date: _____

Cell phone number(s) for emergency COVID text messages _____

General Policies - Parent Agreement

Student's Name: _____ DOB: _____

No Limits Academy is a private Christian school for children with complex and physical disabilities. We at No Limits Academy promise our best effort in creating a comprehensive learning environment for your child. To accomplish this goal, we need the cooperation of all our parents. Therefore, we wish to enter into the following agreement with you, the parent:

**NOTE: All Policies are available on our website at https://wwww.nolimitsacademy.com/schoolpolicy-documents.

No Limits Academy Philosophy

By initialing below, you acknowledge that you have read and understand No Limits Academy's philosophy (available online). _____ Initial

Statement of Faith

By initialing below, you acknowledge that you have read and understand our Statement of Faith (available online). _____ Initial

No Limits Academy Core Values

By initialing below, you acknowledge that you have read and understand our core values (available online). _____ Initial

Admissions Policy

By initialing below, you acknowledge that you have read and understand the Admissions Policy (available online). _____ Initial

Curriculum Policy

No Limits Academy will educate your child from a Christian worldview and provide an environment that is spiritually edifying, with curriculum and instruction designed to achieve the explicit goal of helping its students develop a Christian worldview and apply this worldview in all of life, inside and outside the classroom. Our school is committed to Christ-centered education and the teaching of God's truth, whether it is scientific, historical, philosophical, or spiritual. Our students are challenged individually to excel in every facet of learning. It is our desire that we clearly honor God in all our pursuits. It is our hope that our students follow Christ, forthrightly proclaim Him, and recognize and use their gifts as members of the body of Christ. ____ Initial

Attendance Policy

Regular and prompt attendance is vital to your child's success in school. We value your support and request your help in improving your child's attendance records.

- All students must be in attendance a minimum of four (4) hours of instructional time to be considered present each day. School hours are from 8:30am to 3:00pm.

- Absences must be reported to the school or Ability Plus Therapy.
- A student who has fifteen (15) days of unexcused absences within a quarter risks the chance of jeopardizing their McKay or Gardiner scholarship. Days not included in this count are: (1) court dates, (2) religious holidays, (3) illness with or without (medically related circumstances) medical documentation, (4) chronic and extended illness, (5) family vacations, (6) intensive therapy treatments, or (7) other events at discretion of Administration. If a student has met the maximum number of unexcused absences, a meeting may be held and the administration has the authority to dismiss the student from school.
- Fifteen (15) unexcused absences within a quarter could result in an attendance meeting which may include parents and administration. At this meeting, the child could be placed on a 30 day probationary period with significant improvement in attendance. If attendance has not improved, the administration has the right to dismiss the student. _____ Initial

Student Pick-Up Policy

Students remaining at the school after 3:00 p.m. will be signed-in to the NLA After-Care Program (available online) and charged accordingly. If you have an emergency and are going to be late, it is your responsibility to notify the school office. ____ Initial

Student Progress Policy

No Limits Academy requires parents to be an active part of their child's education team. Parents are required to attend all progress meetings that are scheduled for their child throughout the school year (Life-Plan Meeting, Therapy Re-Evaluations, etc.). No Limits Academy and Ability Plus Therapy will make every effort possible to work with your schedule. By initialing below, you hereby agree to attend all requested meetings arranged by No Limits Academy and Ability Plus Therapy. _____ Initial

Internet Access Policy

By initialing below, I hereby attest that my child understands and will follow the Internet Access Policy (available online) and authorize use of internet for educational purposes. I understand that suitable guidance and supervision will be provided during access to the Internet. _____ Initial

Wellness Policy

No Limits Academy requires all students who are present in school to be free from any contagious sickness and fever for a full 24-hour period. By initialing below, you are agreeing to abide by No Limits Academy's Sickness Policy (available online). ____ Initial

Seizure Policy

No Limits Academy requires that the Physician Prescribed Emergency Seizure Treatment Order form is completed by the student's neurologist, if applicable. This form is mandatory and students may not attend school until this form is completed. This policy is in place to ensure student safety by providing specific information to staff on how to respond when a student has a seizure. By initialing below, you agree to assist No Limits Academy in obtaining this form from the physician and acknowledge that you have received and read the Seizure Policy (available online). ____ Initial

Media Release Policy

By signing below, you hereby authorize No Limits Academy permission to photograph, take motion pictures or video footage, and/or make electronic sound recordings of your child for any purpose, including, but not limited to educational, promotional, and other public media, including social media, as

may be deemed appropriate by No Limits Academy, without payment or any other consideration. Such photographic or electronic reproductions will become the property of No Limits Academy and will not be returned to you. You irrevocably authorize No Limits Academy to edit, alter, copy, exhibit, publish or distribute photographic or electronic reproductions for purposes of creating a curriculum, and/or publicizing its programs or for any other lawful purpose, and may be used in newspapers, magazines, websites, social media, marketing materials, television and other media outlets.

☐ I consent photo/video release of my child ☐ I decline photo/video release of my child

Parent Signature: _____ Date: _____

Surveillance Release Policy

By initialing below, you hereby acknowledge that No Limits Academy has surveillance video of classrooms and hallways and give full consent to be recorded for the purpose of monitoring student safety. ____ Initial

Consent For Assistive Care Of Minor Students

Florida law requires consent of parent/legal guardian for assistive care of Activities of Daily Living (ADL) for minor students, if your son or daughter is under the age of 18 years and is enrolled in No Limits Academy.

By signing below, you hereby authorize No Limits Academy to provide assistive care such as feeding, hygiene, transfers, positioning, and equipment use as recommended by Physical, Occupational, and Speech Therapists.

I further understand that, once my child reaches the age of majority, my consent is no longer required.

I acknowledge that I have read and that I understand this consent, and that any questions I had prior to signing could be answered by calling No Limits Academy.

Parent Signature: _____ Date: _____

School Responsibilities

- Provide a safe, stimulating, and appropriate learning environment.
- Create individual learning plans that best satisfy the learning style and social-psychological needs of each student that receives ESE services.
- Collaborate with parents to provide a positive learning environment for the students.
- Work with the parents to resolve disputes in a fashion that is satisfactory to all parties.
- Whenever necessary, a committee of parents and teachers will act together as arbitrators to resolve disputes.
- Report accurately and in a timely fashion on student progress.
- Serve as a resource for information and assistance to students and parents.

Parent Responsibilities

- Be active members of the Parent/School Organization: That is, to make an effort to participate at all meetings and projects initiated by the school.
- Communicate your child's special educational or psychological needs.
- Donate a minimum of twenty (20) hours per year in support of school functions, in addition to attendance at school meetings.
- Ensure your student arrives at school on time (see Tardiness Policy).
- Be prompt in picking up your student (see Student Pick-up Policy).

- Be mindful of school rules and policies and help enforce them.
- Contribute supplies as requested by the Director of Education.

No Limits Academy reserves the right to dismiss a student/family for the following reasons (but not limited to):

- Failure to maintain regular attendance
- Failure to complete required forms
- Lack of parental cooperation
- Physical or verbal abuse of any person or property
- Our inability to meet the child's needs
- Lack of compliance with handbook regulations

**The decision to dismiss a student is at the sole discretion of the administration of No Limits Academy.*

As the parent of a student attending No Limits Academy, I understand and agree to abide by the terms of this agreement, as evidenced by my initials above and signature below.

Parent Name: _____

Parent Signature: _____ Date: _____

No Limits Academy: _____ Date: _____

Student Information Update

Students Name: _____

Current Home Address: _____

Current Phone Numbers:

Mom/Guardian Cell:_____ Dad/Guardian Cell:_____

Home Phone:_____

Mom/Guardian Work:_____ Dad/Guardian Work:_____

Current Email Address:

Mom/Guardian:_____

Dad/Guardian:_____

Emergency Contact Information:

	First Name	Last Name	Relationship	Contact Number
Emergency Contact #1:				
Emergency Contact #2:				
Emergency Contact #3:				
Emergency Contact #4:				
Emergency Contact #5:				

Authorized Pick-up Persons

(NOTE: if a person who is not listed attempts to pick up your child, we will not release the child to this person until we have received your authorization. It is your responsibility to keep this list up to date.)

	First Name	Last Name	Relationship
1			
2			
3			
4			
5			

Transportation Release (please choose one):

☐ My child will not be using a transportation company.

☐ I authorize _____ (transportation company name) to drop off and pick up my child daily. I will notify No Limits Academy and Ability Plus Therapy if this changes.

**No Limits Academy or Ability Plus Therapy will call you when your child does not show up for school to confirm their absence. We will not take the transportation companies word. Thank you for helping us ensure your child's safety and wellbeing.*

_____	_____	_____
Parent/Legal Guardian Name (Please print)	**Parent/Legal Guardian Signature**	**Date**

Coordination of Care & Authorization for Use and Disclosure of Protected Health and Personally Identifiable Information

Student's Full Name: _____ DOB: _____

I give full consent to No Limits Academy to coordinate care with all of my child's providers (therapists, nursing companies, doctors, etc.) I understand that this is important for my child to receive the best education and care possible and for his/her safety. _____ (Initial to authorize or X to decline)

Records Requests/Release:

I authorize **Ability Plus Therapy** to release all therapy and medical reports to **No Limits Academy** that are deemed appropriate for the education and safety of my child as needed. _____ (Initial to authorize or X to decline)

I authorize **No Limits Academy** to release the completed seizure form and other pertinent medical information to **Ability Plus Therapy** that is deemed appropriate for the safety of my child as needed. _____ (Initial to authorize or X to decline)

I authorize **No Limits Academy** and _____(name of nursing agency) to reciprocally disclose information that is deemed appropriate for the education and safety of my child as needed. _____ (Initial to authorize, X to decline or N/A if not applicable)

Please ***do not disclose*** the following: _____

Expiration Date: This authorization is in effect on the date it is signed and will automatically expire when the student is dis-enrolled from No Limits Academy.

By initialing and signing this authorization form I understand:

1. Information used or disclosed will not be re-disclosed by No Limits Academy or Ability Plus Therapy.
2. I have the right to refuse to sign this authorization or decline any of the statements above by placing an X after the statement. If I do not initial the statements or sign this form, my child may not be able to enroll as a student at or may be dismissed from No Limits Academy.
3. I have the right to revoke this authorization partially or in full at any time by making the request in writing to No Limits Academy. However, my child may be dismissed from No Limits Academy.
4. I understand I have the right to inspect and obtain a copy of any information disclosed.
5. I hereby release Ability Plus Therapy, No Limits Academy and their employees from any and all liability that may arise from the release of information authorized by me.

Signature of patient over 18 years:_____ Date: _____

Signature of legal guardian / parent: _____ Date: _____

**Empowered Representative: _____ Date: _____
****Must provide POA or supporting documentation as personal representative or healthcare surrogate.**

No Limits ACADEMY

Creating an educational environment for the body, mind, and Spirit

Gardiner Scholarship Tuition Agreement

Student Name: _____ School Year: _____

Parents/guardians who register their child at No Limits Academy must comply with the financial terms outlined herein. It is understood that the obligation to pay tuition and fees each quarter is unconditional. It is the parent's responsibility to maintain scholarship eligibility and monitor funds.

Payment Policy

1. No Limits Academy tuition is $35,000 for the 2020-2021 school year.
2. No Limits Academy obtains tuition payments quarterly (Sept. 1, Nov. 1, Feb. 1, Apr. 1.)
3. Gardiner invoices must be approved within **7 days** of submission.
4. It is the parent's responsibility to make sure scholarship funds are available each quarter.
5. Parents will be responsible for any outstanding balance for tuition at the end of the year.
6. Outstanding tuition will disqualify them for re-enrollment for the following year.

In registering my child, I agree to meet the financial commitments to No Limits Academy. I have read and agree to comply with the terms in this agreement.

Financial Waivers are available for students whose scholarship does not cover the total tuition of No Limits Academy. These waivers are dependent on yearly donations and sponsors.

In registering my child, I agree to meet the financial commitments to No Limits Academy. I have read and agree to comply with the terms in this agreement.

Individual Responsible for Payment of Tuition:

_____

Name Relationship Telephone

_____

Street Address City State Zip

Parent/Legal Guardian Signature: _____ **Date:** _____

Signature of Individual Responsible for Tuition: _____ **Date:** _____

(if not Parent or Legal Guardian)

No Limits ACADEMY

Creating an educational environment for the body, mind, and Spirit

McKay Scholarship Tuition Agreement

Student Name: _____ School Year: _____

Parents/guardians who register their child at No Limits Academy must comply with the financial terms outlined herein. It is understood that the obligation to pay tuition and fees each quarter is unconditional. It is the parent's responsibility to maintain scholarship eligibility and monitor funds.

Payment Policy

1. No Limits Academy tuition is $35,000 for the 2020-2021 school year.
2. No Limits Academy obtains tuition payments quarterly (Sept. 1, Nov. 1, Feb. 1, Apr. 1.)
3. McKay checks must be signed within **14 days** of receipt.
4. It is the parent's responsibility to make sure your student stays eligible for the McKay scholarship.
5. Parents are responsible for submitting doctor notes to justify their child's absences.
6. Delayed check signing and/or unexcused absences will disqualify students from McKay and for re-enrollment for the following year.

Financial Waivers are available for students whose scholarship does not cover the total tuition of No Limits Academy. These waivers are dependent on yearly donations and sponsors.

In registering my child, I agree to meet the financial commitments to No Limits Academy. I have read and agree to comply with the terms in this agreement.

Individual Responsible for Payment of Tuition:

_____

Name Relationship Telephone

_____

Street Address City State Zip

Parent/Legal Guardian Signature: _____ **Date:** _____

Signature of Individual Responsible for Tuition: _____ **Date:** _____
(if not Parent or Legal Guardian)

Authorization for Use and Disclosure of Protected Health Information

Patient's Full Name: _____ DOB: _____/_____/_____

Phone: (Hm) ( )_____ (Wk) ( )_____ (Cell) ( )_____

Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Records Request: To be released _____ To be inspected _____ To be obtained from person/organization below____

Occupational Therapy Reports____ Physical Therapy Reports ___ Speech Therapy Reports ___ Billing ___

All Records ____ Other Records or Specific Info from Records Selected: _____

_____

Please ***do not disclose*** the following: _____

Disclose records from _____ thru _____

NOTE: *We do not disclose records we received from other organizations/providers. You will need to request those records from the original provider.*

Any information released pursuant to this request may include information related to AIDS/HIV, mental health, and drug and alcohol abuse. If you do not wish to have this information disclosed, initial here _____

Purpose for Disclosure: Personal____ Insurance____ Legal____ HealthCare____ Other: _____

Release To: Ability Plus Therapy _____ Patient/Parent or Guardian_____ Facility/Office/Person Stated Below _____

_____ All health care providers involved in this patient's care *****Please note that by selecting this option, we may release records to or request records from any and all providers at any given time until the expiration date specified below.***
(please initial)

Person/Organization/ Physician _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: ( )_____ Fax: ( ) _____ Email: _____

Method of Delivery: US Mail _____ E-mail _____ Fax _____ Pick up _____

Person/Organization/ Physician _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: ( )_____ Fax: ( ) _____ Email: _____

Method of Delivery: US Mail _____ E-mail _____ Fax _____ Pick up _____

Expiration Date: This authorization will automatically expire in 12 months unless otherwise revoked or indicated to expire

on _____ or upon occurrence of the following event: _____

By signing this authorization form I understand:

1. There may be a fee for obtaining copies of records, except for copies mailed directly to a healthcare facility or physician, and I agree to pay such charges.
2. The information will be provided within 30 days after receipt of the request. Ability Plus Therapy may request a 30-day extension only one time, and if so, they will provide me with a written statement of the reasons for the delay and the date by which the access request will be processed.
3. Information used or disclosed may be subject to re-disclosure by the recipient and would no longer be protected by Federal Privacy Regulations.
4. I have the right to refuse to sign this authorization. If I do not sign this form, my health care or payment for health care will not be affected.
5. I have the right to revoke this authorization at any time by making the request in writing to Ability Plus Therapy. However, I understand that my revocation any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
6. I understand I have the right to inspect and obtain a copy of any information disclosed.
7. I hereby release Ability Plus Therapy and its employees from any and all liability that may arise from the release of information authorized by me.

Signature of patient over 18 yrs:_____ Date: _____
***A photo ID must be provided for proof of identity.**

Signature of legal guardian** / parent*: _____ Date: _____
***A photo ID must be provided for proof of identity.**

**Empowered Representative: _____ Date: _____
****Must provide POA or supporting documentation as personal representative or healthcare surrogate.**

Staff Use Only

ID Verified: __Yes __No Date Request Received: _____ Request Received by: _____
(Name, Title)

Extension Requested: __ No __Yes, Reason_____

Extension Notification - Date Sent: _____

Request Processed by: _____ Date Processed: _____
(Name, Title)

Records Released: _____

Updated 04/16

No Limits ACADEMY

MEDICATION FORM

(Parental Request for Administering Medication at School)

Student's Name:_____

I request that school personnel give my child the following prescribed medication:

Name of Medication	Dose	Time(s) to be Given	Prescribing MD	Illness or Condition Prescribed for	Start and End Dates to be Given

Prescription medicine must have original prescription label on the bottle, which must include the child's name, medication and dosage, frequency of administration, doctor's name, pharmacy's name and phone number.

I agree to furnish the school with medication in the bottles as described above. I further understand that the school's designated person will administer this medicine to my child in good faith at my request.

Non-Prescribed Medication Permitted at School (please write dose if space provided):

☐ Aspirin (dose): _____ ☐ Tylenol (dose):_____ ☐ Advil (dose): _____

☐ Aleve (dose): _____ ☐ Benadryl (dose): _____ ☐ Allergy Relief

☐ Neosporin ☐ Anti-itch ☐ Cough Drops ☐ Tums ☐ Pepto Bismol ☐ Midol

Other:_____

NOTE: Non-prescription medicine must be in its original (store label) container, marked with the student's name.

I agree to furnish the Academy with medication in the bottles as described above. I further understand that the Academy's designated person will administer this medicine to my child in good faith at my request.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____