

**School Board Organization****DECLARATION AS A CANDIDATE FOR DIRECTOR  
OF THE C-6 SCHOOL DISTRICT OF JEFFERSON COUNTY, MISSOURI**TO: Board Secretary

I, the undersigned, a resident of the Fox C-6 School District, declare myself a candidate for the office of a director of said school district for a **term of \_\_\_years**, to be voted on at the municipal (school) election to be held on the \_\_\_day of **April 20\_\_**.

**I declare that I:**

1. Am a citizen of the United States of America.
2. Am a resident taxpayer of the district.
3. Will have resided in Missouri for a minimum of one (1) year preceding my election, if elected.
4. Am at least 24 years of age.
5. Am eligible to hold office in accordance with Missouri law, including §§115.348, and 561.021, RSMo. I am not serving a sentence or period of probation for a felony or a crime that if committed in Missouri would be a felony. I have never pled guilty or *nolo contendere* nor been convicted under Missouri law or the law of another jurisdiction of a felony connected with the exercise of the right of suffrage.
6. Am not registered or required to be registered as a sex offender under Missouri Law, §§ 589.400-.425, RSMo.
7. Have filed all required campaign disclosure reports for all previous election in which I was a candidate and have paid all fees assessed against me by the Missouri Ethics Commission, if applicable.

I understand that I am required to file a financial interest statement with the State of Missouri, Missouri Ethics Commission as stated by the Regulation of Conflict of Interest and Lobbying, Missouri Ethics Law, and the Missouri Campaign Finance Disclosure Laws.

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**Name of Person Accepting Declaration**

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**Candidate Signature**

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**Title of Person Accepting Declaration**

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**Address**

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**City, State, Zip**

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**Date/Time Received      Number Drawn, if Applicable**

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**Phone**

Revised: 11/00, 05/02, 10/06, 11/06, 11/07, 02/09, 12/11  
Re-approved: 05/02, 06/03, 08/05, 08/06, 07/07, 07/08, 07/09, 6/10, 6/11, 6/12

Effective: 11/00, 05/02, 10/06, 11/06, 11/07, 02/09, 12/11  
Effective: 05/02, 06/03, 08/05, 08/06, 07/07, 07/08, 7/09, 06/10, 06/11, 6/12

**School Board Organization****Code of Ethics/Nepotism**

Board members shall not debate or vote upon the employment of any person to whom they are related to within the fourth degree (Form #0342.1). The Board may employ a person related in the fourth degree to Board members in the capacity of a non-supervisory position. Non-supervisory positions include:

- Teacher
- Nurse
- Custodian
- Food Service
- Aide
- Teacher assistant
- Maintenance
- Secretarial or clerical
- Coach

However, the Board may not, under any circumstances, employ a person related in the fourth degree to one of its Board members in the capacity of a supervisory position. Supervisory positions include:

- Administrative interns
- Assistant principals
- Principals
- Assistant superintendents
- Superintendent
- Coordinators
- Assistant directors
- Directors
- Supervisors

This policy is not retroactive. It applies to events/actions/hiring/promotions/transfers subsequent to the date of approval of this policy.

No administrator or other supervisor shall be in the direct line of supervision and/or evaluation for a person who is related within the third (3rd) degree of consanguinity or affinity to the administrator or supervisor, either by consanguinity or affinity. Administrators or supervisors who, on the date this policy is first adopted, are in the direct line of supervision and/or evaluation for a person who is related within the third (3rd) degree to the administrator or supervisor may continue in that position until such time as the Board of Education and/or administration may determine, pursuant to their authority to assign persons in accordance with the best interests of the District, that the administrator, supervisor, or related person should be re-assigned.

Any Board of Education member shall not be eligible for employment within the district for a period of one (1) year after said member has completed his or her term of office.

In the event that a Board member's, assistant superintendent's, or superintendent's relative is applying for a supervisory position in the school district, a special hiring committee will be comprised. The special hiring committee will consist of at least 4 members and no more than 8, of which 2 will be current Board members. No member of the special hiring committee can be related within the fourth (4<sup>th</sup>) degree of consanguinity or affinity to the individual applying for a supervisor position.

Once the candidate is selected by the committee, the applicant will be recommended to the Superintendent.

The Superintendent will meet with the candidate before recommending for hiring.

The Board of Education will approve the hiring only when five of the seven members vote yes. No Board member related to the candidate within the fourth (4<sup>th</sup>) degree of consanguinity or affinity shall debate or vote upon the approval of the candidate for employment.

It is the policy of the Fox C-6 School District, that a board member will resign immediately if a relative is hired in a supervisory capacity, or promoted to supervisory capacity, or promoted to a higher supervisory position from a lower supervisory position.

#### **CHART OF RELATIONS**

0 SELF or SPOUSE	1 CHILD	2 GRAND CHILD	3 GREAT GRAND CHILD	4 GREAT GREAT GRAND CHILD
1 PARENTS	2 BROTHER or SISTER	3 NIECE or NEPHEW	4 GRAND NIECE or NEPHEW	
2 GRAND PARENTS	3 AUNT or UNCLE	4 FIRST COUSIN		
3 GREAT GRAND PARENTS	4 GREAT AUNT or UNCLE			
4 GREAT GREAT GRAND PARENTS				

A husband is related by marriage (affinity) to his wife's relatives in the same way that she is related to them by blood (consanguinity), and she to his in the same manner, but the kindred of spouses are not related to one another. (A brother of the husband is not related to a brother of the wife, etc.)

The “first degree of consanguinity or affinity” includes father, mother, spouse, son or daughter by virtue of blood relationship or marriage.

Half relationship is the same as a whole relationship.

Step relationship is the same as a blood relationship.

A relationship by marriage (affinity) terminates if death or divorce occurs.

Adopted: 11/97  
Revised: 06/03, 6/13, 2/14

Effective: 06/03, 6/13, 2/14

**Meetings**

**Meetings - Participation by Public**

**GUIDELINES FOR PUBLIC COMMENTS**  
**AT BOARD MEETINGS**

1. Problems involving particular/identifiable employee and/or students are reserved for executive session.
2. The speaker will be solely responsible for his/her statements. The Board does not accept any obligation or liability for the words or actions of any speaker. Any Board member shall interrupt or stop the speaker at any time if it is deemed the matter should be heard in executive session.
3. **The speaker must be a resident or employee of the school district.** Proof of residency may be required at the Board's discretion. A non-resident may address the Board by contacting the Superintendent or Board President and asking to be placed on the agenda.
4. Any resident who wishes to speak shall submit a specific outline of their remarks to the **Board President by 6:45p.m. on the evening of the meeting.** The Board shall determine whether the speaker will be heard during public comments or in executive session. This section does not preclude any individual from contacting the Board President and asking to be placed on the formal agenda or requesting an executive session.
5. **A maximum of 30 minutes** at the beginning of each meeting will be allocated for public comments (**Per Policy # 0412**).
6. **A three-minute time period will be allowed per speaker.** A warning will be given after two and one-half minutes. The Vice-President of the Board will be the time keeper.
7. The Board may discuss an item and ask question for **clarification**. However, it will not ordinarily act on an item presented during public comments at that meeting.

## **PUBLIC COMMENTS INFORMATION**

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

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

**Does this topic deal with particular/identifiable personnel or students?**

**Please check one: Yes \_\_\_\_\_ No \_\_\_\_\_**

**Specific outline of the Topic I Wish to Present:**

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**I HAVE READ AND UNDERSTAND the Public Comments Guidelines.**

**Signature:** \_\_\_\_\_

**Religion****Assurance of Religious Expression**

To comply with the No Child Left Behind Act of 2001 (NCLB), the District must certify in writing to the Missouri Department of Elementary and Secondary Education by October 1 annually that the District has no policies that prevent or otherwise deny participation in constitutionally protected prayer by students or employees.

**ASSURANCE STATEMENT**

As a condition of receiving funds under the No Child Left Behind Act, the local educational agency certifies that no policy of the local educational agency prevents or otherwise denies participation in constitutionally protected prayer by students or employees, as detailed in the guidance provided by the U.S. Department of Education.

The \_\_\_\_\_ School District hereby certifies that it has no policies or practices that prevent or deny participation in constitutionally protected prayer.

\_\_\_\_\_  
Superintendent

\_\_\_\_\_  
Date

**Equal Opportunity**

**Civil Rights, Title IX, Section 504 Notice**

**NOTICE OF NONDISCRIMINATION**

Students, parents of elementary and secondary school students, employees, applicants for admission and employment and sources of referral of applicants for admission and employment with the Fox C-6 School District are hereby notified that this institution does not discriminate on the basis of race, color, national origin, ethnicity, sex, religion, disability, age, sexual orientation or perceived sexual orientation in admission, access to, treatment, or employment in its programs and activities.

Any person having inquiries concerning the Fox C-6 School District's compliance with the regulations implementing these Prohibitions is directed to contact the District's Assistant Superintendent of Human Resources who is the Title II, Title VI, Title IX, and Age Act Coordinator for the District or persons can contact the District's Assistant Superintendent of Secondary Education who has been designated to coordinate the District's compliance with the regulations implementing Section 504. The Assistant Superintendent of Human Resources and the Assistant Superintendent of Secondary Education can be reached at 636-296-8000 and are located at the District's Central Office - 745 Jeffco Blvd. Arnold, MO 63010-1432.

Any person may also contact the Assistant Secretary for Civil Rights, U.S. Department of Education, regarding Fox C-6 School District's compliance with the regulations implementing Title IX or Section 504.

Dr. Critchlow  
Superintendent of the Fox C-6 School District



**Equal Opportunity**

**Civil Rights, Title IX, Section 504 Grievance Form**

**TITLE IX/SECTION 504  
GRIEVANCE FORM**

Date \_\_\_\_\_

Your name \_\_\_\_\_

Your school and/or position \_\_\_\_\_

Place where you may be reached \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Nature of your grievance. (Please describe the policy or action you believe may be in violation of Title IX/Section 504 or other civil rights statute: please identify any person(s) you believe may be responsible.)

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

If others are affected by the possible violation, please give their names and/or positions:

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

Please describe any corrective action you wish to see taken with regard to the possible violation. You may also provide other information relevant to this grievance.

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

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Signature of Grievant

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Date

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Location

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Signature of Person Receiving Grievance

**Note:** This form should be filed with the District's:

Title II, Title IV, Title IX and Age Act Coordinator  
Assistant Supt-Human Resources  
Central Office  
745 Jeffco Blvd.  
Arnold, MO 63010-1432  
Telephone: 636-296-8000

Or

Section 504 Coordinator  
Assistant Supt-Secondary Education  
Central Office  
745 Jeffco Blvd.  
Arnold, MO 63010-1432  
Telephone: 636-296-8000

**Equal Opportunity**

**Civil Rights, Title IX, Section 504 Documentation Form**

**DOCUMENTATION FORM  
(Title IX and Section 504)**

Name of individual alleging noncompliance with Regulations outlined in Title IX and Section 504.

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

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

State the nature of the complaint and the remedy requested.

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Indicate Principal's or Supervisor's response or action to above complaint.

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\_\_\_\_\_  
Principal's Signature

**School-Community Relations**

**School Volunteers**



**VOLUNTEER FORM**

**(THERE IS NO CHARGE REQUIRED FOR THIS FORM)**

**VOLUNTEER'S NAME:** \_\_\_\_\_  
*(The District requires that only one form per Volunteer be completed)*

**NAMES OF YOUR CHILDREN AND SCHOOL THEY ATTEND:**

\_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**TELEPHONE NO.:** \_\_\_\_\_

**STUDENT(S) ASSISTING:** \_\_\_\_\_

**SCHOOL ATTENDING:** \_\_\_\_\_

**GRADE LEVEL:** \_\_\_\_\_

**Have you ever been convicted, charged, or plead guilty to a felony or a misdemeanor related to sexual misconduct? YES \_\_\_\_\_ NO \_\_\_\_\_**

**If yes, please provide details:** \_\_\_\_\_

\_\_\_\_\_

**Has a finding of probable cause of child abuse or neglect by any state agency been entered against you? YES \_\_\_\_\_ NO \_\_\_\_\_**

**If yes, please provide details:** \_\_\_\_\_

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Signature

Date

**Falsification of this document is a misdemeanor**

<b>Office Use only:</b>	<input type="checkbox"/> <b>Volunteer/Chaperone</b>	<input type="checkbox"/> <b>Screened Volunteer</b>
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Adopted: 10/07, 11/07

Effective: 10/07, 11/07

Revised: 02/09

Effective: 02/09

Consolidated School District No. 6 (Fox)

**School/Community Relations**

**School Employee**

**Employee Confidentiality Agreement**

I understand that in the course of my employment with the Fox C-6 School District, I may become aware of or have access to confidential information about specific students. This information may include but is not limited to: student records pertaining to grades, academic performance, behavior, disabilities, medical records involving health issues, and other related records.

I understand and agree that I will not disclose, discuss, copy or otherwise transmit, either verbally or in writing, or by electronic communication any information which I obtain during the course of my employment, unless said disclosure or transfer is required as part of my performance of my duties and responsibilities.

I further agree and understand that the information I obtain during employment is to remain confidential and my failure to keep all information confidential will result in disciplinary action up to and including termination.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

Adopted: 8/11

Effective: 8/11

**School/Community Relations**

**School Substitute**

**School Substitute Confidentiality Agreement**

I understand that in the course of my substitute time with the Fox C-6 School District, I may become aware of confidential information about specific students and staff. This information may include but not be limited to such information as grades, academic performance, behavior, disabilities, health issues, and related matters. I understand and agree that I will not disclose such confidential information except to school employees that have a need to know.

\_\_\_\_\_  
Substitute Signature

\_\_\_\_\_  
Date

Adopted: 8/11

Effective: 8/11

**School/Community Relations**

**School Volunteer**

**School Volunteer Confidentiality Agreement**

I understand that in the course of my volunteer time with the Fox C-6 School District, I may become aware of confidential information about specific students and staff. This information may include but not be limited to such information as grades, academic performance, behavior, disabilities, health issues, and related matters. I understand and agree that I will not disclose such confidential information except to school employees that have a need to know.

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Volunteer Signature

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Date

Adopted: 8/11

Effective: 8/11

Consolidate School District No. 6 (Fox)



**GENERAL ADMINISTRATION**

**Form 1425.4**

**School/Community Relations**

**School Visitation/Observation**

**School Visitation/Observation Confidentiality Agreement**

I understand that in the course of my school visitation/observation with the Fox C-6 School District, I may become aware of confidential information about specific students and staff. This information may include but not be limited to such information as grades, academic performance, behavior, disabilities, health issues, and related matters. I understand and agree that I will not disclose such confidential information except to school employees that have a need to know.

\_\_\_\_\_  
Visitor/Observer Signature

\_\_\_\_\_  
Name of School for Visitation/Observation

\_\_\_\_\_  
Visitor/Observer Printed Name

\_\_\_\_\_  
Telephone Number of Visitor/Observer

\_\_\_\_\_  
Date

Adopted: 8/11

Effective: 8/11

Consolidate School District No. 6 (Fox)

**School/Community Relations**

**Research Requests Review**

**RESEARCH REQUEST REVIEW**

Has the investigator observed the following agreements?

\_\_\_\_\_ Submitted a letter of introduction providing evidence of sponsorship by a faculty member of an institution of higher education or professional organization.

\_\_\_\_\_ Obtained the Superintendent's approval of the District's participation.

\_\_\_\_\_ Submitted a copy of the research design, (three (3) pages or less) sample tests, questionnaires, interview guides and descriptions of materials, techniques and procedures to be used in the study.

\_\_\_\_\_ Provided written approval of the principal(s) whose school(s) are to be involved which assures that data collecting will not in any way disrupt existing school programs.

\_\_\_\_\_ Provided evidence that parents' permission has been secured for students directly involved as subjects.

\_\_\_\_\_ Assured that all information regarding individuals will be held in strict confidence.

\_\_\_\_\_ Submitted a definite date, not later than one month after conclusion of data gathering, for a preliminary report to the Superintendent on progress and findings to date, and a subsequent deadline for the final report.

\_\_\_\_\_ Assured that, at the conclusion of the study, a report of findings and interpretation will be provided to the Superintendent and copies sent to the principal of each participating school and the Office of Curriculum and Instruction.

\_\_\_\_\_  
Superintendent of Schools

\_\_\_\_\_  
Investigator

\_\_\_\_\_  
Principal

\_\_\_\_\_  
Institution

The investigator should obtain appropriate signatures, keep one copy, and return a copy of this agreement with one copy of the proposal to the Superintendent of Schools.

**School/Community Relations**

**Research Requests Agreement**

**AGREEMENT FOR RESEARCH STUDY**

To be completed by the Investigator and submitted in duplicate.

Topic \_\_\_\_\_ Date \_\_\_\_\_

Name of Investigator \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Investigator's University or Institution \_\_\_\_\_

Purpose of the Study (describe briefly): \_\_\_\_\_

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

Procedure: \_\_\_\_\_

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

Students to be involved: How many \_\_\_\_\_ Age, grade, or class \_\_\_\_\_

Schools \_\_\_\_\_

Total time required: During school time \_\_\_\_\_ Out of school time \_\_\_\_\_

Beginning date \_\_\_\_\_ Ending date \_\_\_\_\_

Teachers involved \_\_\_\_\_

\_\_\_\_\_

How will this study contribute to professional knowledge that can lead to educational improvement? \_\_\_\_\_

\_\_\_\_\_

List and attach the instruments to be used \_\_\_\_\_

\_\_\_\_\_

**School/Community Relations**

**Public Record Search and Duplication Cost Certification**

**CERTIFICATION OF COST  
FOR PUBLIC RECORD DUPLICATION**

I, \_\_\_\_\_, certify that the fee charged for this public record search and duplication is fair, reasonable and does not exceed the actual cost incurred by the District in the following respects:

1. The fee charged for the public record search and duplication was \_\_\_\_\_.
2. The public documents searched and duplicated consisted of \_\_\_\_\_  
(brief description) and totaled \_\_\_\_\_ pages.

By: \_\_\_\_\_  
Custodian of Records/Designee

\_\_\_\_\_ Date

**School/Community Relations**

**Denial of Access to Requested Records**

**RATIONALE FOR DENIAL OF  
ACCESS TO PUBLIC RECORDS**

1. On (date) a request was made for the following documents: (description of documents requested) by (name of person requesting access).
2. On (date) (name of custodian of records/designee) provided notice that the records requested would not be provided.
3. The reason for denial of access to requested records is as follows:  
  
(Brief rationale, i.e.,
  - a. No such document exists.
  - b. The record requested is a closed record relating to the performance of a specific employee §610.021(3).
  - c. The record requested is an internal memorandum prepared on behalf of a member or members of the Board consisting of recommendations, advice, or opinion for use by the Board in the Board's decision-making process §610.010(6). )
4. A completed copy of this form was provided to (name of person requesting record) on (date) by means of (describe how provided, i.e., certified mail, hand delivery, etc.) by (name of person delivering completed form).

By: \_\_\_\_\_  
Custodian of Records/Designee

\_\_\_\_\_ Date

A copy of this document is to be provided within three business days of denial of request.

**Private, State and Federal Programs Administration**

**Title I Parent Notification of Teacher Qualifications**

**NOTIFICATION OF TEACHER QUALIFICATIONS**

Dear Parent or Guardian:

Our district is required to inform you of certain information that you, according to the No Child Left Behind Act of 2001 (Public Law 107-110), have the right to know.

Upon your request, our district is required to provide to you, in a timely manner, the following information:

- Whether the teacher has met state qualification and licensing criteria for the grade levels and subject areas in which the teacher provides instruction.
- Whether the teacher is teaching under emergency or other provisional status through which state qualification or licensing criteria have been waived.
- Whether your child is provided services by paraprofessionals and, if so, their qualifications.
- What baccalaureate degree major the teacher has and any other graduate certification or degree held by the teacher, and the field of discipline of the certification.

In addition to the information that you may request, the District will provide to you individually:

- Information on the achievement level of your child in each of the state academic assessments as required under this part; and
- Timely notice that your child has been assigned, or has been taught for four or more consecutive weeks by, a teacher who is not highly qualified.

Fox C-6 School District

**STUDENTS**

**Form 2110**

**Nondiscrimination and Student Rights**

**Notice of Appeal/Request for an Impartial Due Process Hearing  
Under Section 504**

Student's Name: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

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

Phone Number: E-Mail: \_\_\_\_\_

I am in disagreement with the following decisions made by the District pertaining to my child's identification/evaluation/educational placement under Section 504:

Please describe the facts and circumstances giving rise to the disagreement:  
(Please state the background leading to the disagreement and why you disagree with the multidisciplinary team's decision(s):

Please state the specific issues to be decided at the due process hearing:

Please describe the relief you are requesting through the due process hearing (what result you would like the hearing officer to provide if the hearing officer decides in your favor):

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Date of Signature

**STUDENTS**

Student Handbook and Employee Handbook

**Form 2130****Nondiscrimination and Student Rights****Harassment/Discrimination Grievance Form****HARASSMENT/DISCRIMINATION GRIEVANCE FORM**

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

Department: \_\_\_\_\_ Job Title: \_\_\_\_\_

Immediate Supervisor: \_\_\_\_\_

Home Address and Phone: \_\_\_\_\_  
\_\_\_\_\_Work Address and Phone: \_\_\_\_\_  
\_\_\_\_\_

Date of Alleged Incident(s): \_\_\_\_\_

Did the incidents involve: sexual harassment/discrimination, racial harassment/discrimination, harassment/discrimination because of age, harassment/discrimination because of color, national origin or ethnicity, harassment/discrimination because of disability, harassment/discrimination because of sexual orientation or perceived sexual orientation (*circle all that apply*).

Name of person you believe harassed or discriminated against you or another person:  
\_\_\_\_\_

Were there other employees involved with the harassment? \_\_\_\_\_

If the alleged harassment/discrimination was toward another person, identify that other person:  
\_\_\_\_\_

Describe the incident as clearly as possible, including such things as what force, if any, was used, any verbal statements (i.e. threats, requests, demands, etc.), what, if any physical contact was involved. Attach additional pages as necessary.

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



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Effective: 12/96  
Consolidated School District No. 6 (Fox)

**HARASSMENT  
ADMINISTRATIVE FOLLOW-UP FORM**

Date of Investigation: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What action was taken: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of follow-up conference: \_\_\_\_\_

Results of the conference: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of follow-up conference: \_\_\_\_\_

Results of the conference: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of final report: \_\_\_\_\_

Date copy sent to employee: \_\_\_\_\_

\_\_\_\_\_  
Signature of Administrator

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Effective: 12/96  
Consolidated School District No. 6 (Fox)

**Nondiscrimination and Student Rights****Sexual Harassment Prohibited Notice**

**SEXUAL HARASSMENT PROHIBITED  
NOTICE  
TO ALL EMPLOYEES AND STUDENTS  
REGARDING SEXUAL HARASSMENT**

The Fox C-6 School District is committed to an academic and work environment in which all students and employees are treated with dignity and respect. Sexual harassment of students and employees whether committed by supervisors, employees or students and regardless of whether the victim is an employee or student will not be tolerated.

Sexual harassment includes but is not limited to:

1. sexual slurs, threats, verbal abuse and sexually degrading descriptions
2. graphic verbal comments about an individual's body
3. sexual jokes, notes, stories, drawing, pictures or gesture
4. spreading sexual rumors
5. touching an individual's body or clothes in a sexual way
6. displaying sexually suggestive objects
7. covering or blocking of normal movements
8. unwelcomed sexual flirtation or propositions
9. acts of retaliation against a person who reports sexual harassment.

Inquiries, complaints or grievances from students and their parents and employees regarding sexual harassment or compliance with Title IX may be directed to the Superintendent of Schools, to the District's Title IX Coordinator or the Director of the Office of Civil Rights, Department of Education, Washington, D.C.

The District's Title IX Coordinator is:

Assistant Supt-Human Resources  
Central Office  
745 Jeffco Blvd.  
Arnold, MO 63010-1432  
Telephone: 636-296-8000

**Nondiscrimination and Student Rights****Discrimination and Harassment Prohibited Notice****Notice of Non-Discrimination**

The Fox C-6 School District does not discriminate on the basis of race, color, national origin, ethnicity, sex, religion, disability, age, sexual orientation or perceived sexual orientation in its programs, activities or employment practices. The following persons have been designated to handle inquiries regarding the non-discrimination policies:

Section 504 Coordinator Assistant Supt-Secondary Ed. Central Office 745 Jeffco Blvd. Arnold, MO 63010-1432 Telephone: 636-296-8000	Title VI Coordinator Assistant Supt-Human Resources Central Office 745 Jeffco Blvd. Arnold, MO 63010-1432 Telephone: 636-296-8000	Title IX Coordinator Assistant Supt-Human Resources Central Office 745 Jeffco Blvd. Arnold, MO 63010-1432 Telephone: 636-296-8000
Title II Coordinator Assistant Supt-Human Resources Central Office 745 Jeffco Blvd. Arnold, MO 63010-1432 Telephone: 636-296-8000	Age Act Coordinator Assistant Supt-Human Resources Central Office 745 Jeffco Blvd. Arnold, MO 63010-1432 Telephone: 636-296-8000	

Any person may also contact the Kansas City Office for Civil Rights, U.S. Department of Education, regarding the District's compliance with Section 504, Title II, Title VI, Title IX, and the Age Discrimination Act.

Office for Civil Rights  
U.S. Department of Education  
8930 Ward Parkway, Suite 2037  
Kansas City, MO 64114-3302  
Telephone: 816-268-0550

Any person may also contact the Equal Employment Opportunity Commission for concerns relating to the Age Discrimination in Employment Act, or Title VII.

Robert A. Young Federal Building  
1222 Spruce Street  
Room 8.100  
St. Louis, MO 63103  
Telephone: 800-669-4000

Other agencies dealing with non-discrimination issues include:

Missouri Commission for Human Rights  
Department of Labor and Industrial Relations  
P.O. Box 1129  
3315 W. Truman Blvd.  
Telephone: 573-751-3325

U.S. Department of Justice  
950 Pennsylvania Ave., NW  
Washington, DC 20530-0001  
Telephone: 202-353-1555

**STUDENTS**

Student Handbook and Employee Handbook

**Form 2130.3**

**Nondiscrimination and Student Rights**

**Discrimination/Harassment Administrative Follow-Up Form**

**DISCRIMINATION/HARASSMENT  
ADMINISTRATIVE FOLLOW-UP FORM**

Date of Investigation: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What action was taken: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of follow-up conference: \_\_\_\_\_

Results of the conference: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of follow-up conference: \_\_\_\_\_

Results of the conference: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of final report: \_\_\_\_\_

Date copy sent to employee: \_\_\_\_\_

\_\_\_\_\_  
Signature of Administrator

\*\*\*\*\*

Effective: 12/96

Consolidated School District No. 6 (Fox)



**Non-Discrimination and Student Rights**

**Searches by School Personnel: Student Lockers**

**ACKNOWLEDGEMENT CONCERNING  
USE OF STUDENT LOCKERS**

I acknowledge and understand that:

1. Student lockers are the property of the School District
2. Student lockers remain at all times under the control of the School District
3. I am expected to assume full responsibility for my school locker.
4. The School District retains the right to inspect student lockers for any reason at any time without notice, without student consent, and without a search warrant.

---

Student

---

Date

---

Locker Number

**Non-Discrimination and Student Rights**

**Searches by School Personnel: Parking Lots**

**ACKNOWLEDGEMENT CONCERNING  
USE OF STUDENT PARKING LOTS**

I acknowledge and understand that:

1. Students are permitted to park on school premises as a matter of privilege, not of right.
2. The School District retains authority to conduct routine patrols of student parking lots and inspections of the exteriors of student automobiles on school property.
3. The School District may inspect the interiors of student automobiles whenever a school authority has reasonable suspicion to believe illegal or unauthorized materials are contained inside the automobiles.
4. Such patrols and inspections may be conducted without notice, without student consent, and without a search warrant.
5. If I fail to provide access to the interior of my car upon request by a school official, I will be subject to school disciplinary action.

---

Student

---

Date

**STUDENTS**

**Form 2230**

**Admission and Withdrawal**

**Residency Enrollment Checklist**

**RESIDENCY ENROLLMENT CHECKLIST**

Name of Parent/Guardian\_\_\_\_\_

Address\_\_\_\_\_

City/State\_\_\_\_\_ Zip\_\_\_\_\_

Telephone Number: Home\_\_\_\_\_ Work\_\_\_\_\_

Name of Student\_\_\_\_\_

Address\_\_\_\_\_

City/State\_\_\_\_\_ Zip\_\_\_\_\_

Telephone Number: Home\_\_\_\_\_ Work\_\_\_\_\_

**Address Verification** (Parent/Legal Guardian) (Attach copy of document)

\_\_\_\_ Rental contract

\_\_\_\_ Real Estate Contract signed by all parties

\_\_\_\_ Utilities Bill/Deposit Receipt

\_\_\_\_ Other, such as payroll check, driver's license, W-4, employment documents

**BASIS FOR ADMISSION OF STUDENT** (Section 167.020 RSMo)

\_\_\_\_ Resides with parent in the School District

\_\_\_\_ Resides with legal guardian in the School District (Copy of court ordered guardianship must be attached. A guardian may be appointed for the sole and specific purpose of school registration (SB944).)

\_\_\_\_ Resides with a military guardian in the School District (SB944).

\_\_\_\_ Homeless child (person less than 21 years of age who lacks a fixed, regular and adequate nighttime residence), including a child who is:

- a. \_\_\_\_ living on the street, in a car, abandoned building or other form of shelter not designated as a permanent home
- b. \_\_\_\_ living in a community shelter facility
- c. \_\_\_\_ living in transitional housing for less than one year

Give address or directions \_\_\_\_\_

\_\_\_\_ Special circumstances (Section 167.151, RSMo)

- a. \_\_\_\_ an orphan
- b. \_\_\_\_ one parent living
- c. \_\_\_\_ parents do not contribute to the student's support
- d. \_\_\_\_ agriculture (all four of the following conditions must be met: owns real estate of which 80 acres or more are used for agricultural purposes, parent's residence is on the real estate, at least 35% of the real estate is in the District, parent notified District on or before June 30 that student would be attending)

\_\_\_\_ Parent is a teacher under contract with the District (Board policy required-Section 167.151 168.151, RSMo)

\_\_\_\_ Parent is a regular employee with the District (Board policy required-Section 163.011, RSMo)

**Other exemptions to the residency requirements (Section 167.020.6, RSMo)**

\_\_\_\_ Attending school not in the pupil's district of residence as a participant in an interdistrict transfer program established under a court-ordered desegregation program

\_\_\_\_ A ward of the state and has been placed in a residential care facility by state officials\*

\_\_\_\_ Has been placed in a residential care facility due to a mental illness or developmental disability\*

\_\_\_\_ Has been placed in a residential facility by a juvenile court\*

\_\_\_\_ Has a disability identified under state eligibility criteria if the student is in the District for reason other than accessing the District's educational program

\_\_\_\_ Has transferred from an unaccredited school

\*The district of residence will be billed for the local tax effort for the student(s) attending under these circumstances.

**Date of Student Admission** \_\_\_\_\_

\_\_\_\_ Student denied admission. Date of denial \_\_\_\_\_

\_\_\_\_ Waiver requested. Date of request \_\_\_\_\_

**WAIVER INFORMATION**

Waiver requested by:

\_\_\_\_ Parent

\_\_\_\_ Legal guardian

\_\_\_\_ Student (at least 18 years old)

\_\_\_\_ Other (complete information below)

a. Name of person/relative student resides with \_\_\_\_\_

b. Relationship \_\_\_\_\_

c. Address \_\_\_\_\_

d. City/State \_\_\_\_\_ Zip \_\_\_\_\_

e. Address Verification \_\_\_\_\_

f. Reason why student is living with person/relative \_\_\_\_\_

\_\_\_\_\_

Other reasons showing hardship or good cause \_\_\_\_\_

\_\_\_\_\_

**Hearing Date** (must be within 45 days of request) \_\_\_\_\_

\_\_\_\_ Student admitted pending decision on waiver request

**Date student admitted** \_\_\_\_\_

\_\_\_\_ Waiver granted. Date \_\_\_\_\_

\_\_\_\_ Waiver denied. Date \_\_\_\_\_

**Students attending school pursuant to the above information may be counted for state aid purposes.**

**Nonresident students who may enroll and are not counted by the District for state aid:**

\_\_\_\_ Tuition

\_\_\_\_ Tax credit tuition – Any person who pays a school tax in any other district than that in which he resides may send his children to any public school in the district in which the tax is paid and receive as a credit on the amount charged for tuition the amount of the school tax paid to the district (Section 167.151(3), RSMo)

\_\_\_\_ Transportation hardship as assigned by the Commissioner of Education (Section 167.121, RSMo)

\_\_\_\_ Attending a regional or cooperative alternative education program or an alternative education program on a contractual basis (Section 167.020.6, RSMo)

## STUDENTS

**Form 2230.1**

**Page 1 of 2**

### Admission and Withdrawal

### Request for Waiver of Residency Requirement

For Office Use Only

Date received \_\_\_\_\_

By \_\_\_\_\_

Decision \_\_\_\_\_

Copy to Superintendent \_\_\_\_\_

## **FOX C-6 SCHOOL DISTRICT**

### **REQUEST FOR WAIVER OF RESIDENCY REQUIREMENT**

The Safe Schools Act of 1996 (H.B. 1301 & 1298) requires that minor students (age 17 and younger) must be domiciled with and physically living with a parent or court-appointed legal guardian within the Fox School District to be eligible to enroll in the Fox School District.

An adult who is not a parent or court-appointed legal guardian may request a waiver of the residency requirement on behalf of a minor student living with that adult within the Fox School District. You may present your "good cause" or "hardship" circumstances on this form for consideration by the District.

The District has up to 45 days after receipt of the request to respond. The student may attend classes pending a decision of the waiver request. If the waiver is not granted, the student will no longer be allowed to attend a Fox school. Generally speaking, "good cause" or "hardship" circumstances are temporary. Therefore, any waiver that might be granted will be in effect for a maximum of 45 days.

Submit your request for waiver of residency requirement to the building principal as part of the enrollment process. The principal may act on the request or defer the decision to a hearing by a superintendent's office. If the decision is deferred, you will be contacted about the hearing within five days.

Student's name \_\_\_\_\_

Name and address of adult requesting waiver of residency requirement:

Current address \_\_\_\_\_

\_\_\_\_\_

Birth \_\_\_\_\_

\_\_\_\_\_ Phone # \_\_\_\_\_

List name and address of all schools this student has attended in the past 12 months.

\_\_\_\_\_

Do you have children attending Fox Schools? YES NO

Which schools? \_\_\_\_\_

Please describe the "good cause" or "hardship" reasons that you

Has this student ever been suspended or expelled from a Missouri school? YES NO

If yes, explain the circumstances and reasons.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Parent's name and address:

\_\_\_\_\_

\_\_\_\_\_  
Parent's phone # \_\_\_\_\_

Effective:  
Consolidated School District No. 6 (Fox)

12/96



**STUDENTS**

**Form 2230.2**

**Admission and Withdrawal**

**Affidavit Regarding Prior Discipline**

**OATH OR AFFIRMATION REGARDING PRIOR DISCIPLINE  
TO BE COMPLETED PRIOR TO ENROLLMENT OF STUDENT**

I, \_\_\_\_\_ having been duly sworn upon my oath,  
Parent/Guardian

or having affirmed that I will tell the truth, do hereby state and depose as follows:

I am the parent/guardian, or other person having custody or charge of

\_\_\_\_\_, a student seeking to enroll in  
Student

\_\_\_\_\_, and am legally authorized to make  
School District

educational decisions for the Student.

I hereby certify as follows: (Check one, and provide all additional information requested.

WARNING: Under Missouri law, the failure to provide true, accurate, and complete information to each and every question and subpart thereto may result in your being charged with and convicted of a Class B misdemeanor.)

\_\_\_\_\_ The Student **has never been suspended or expelled** from any school in this state or any other state for any offense relating to weapons, alcohol or drugs, or for the willful infliction of injury to another student.

\_\_\_\_\_ The Student **has been suspended and/or expelled** from school in this state or another state for one or more offenses relating to weapons, alcohol or drugs, or for the willful infliction of injury to another student.

**For each and every suspension and/or expulsion**, provide the following information (request additional information sheets, if necessary):

1. Name and Address of School District.
2. Name of School.
3. Nature of Offense.
4. Date of Offense.
5. Date Suspension/Expulsion Began.
6. Date Suspension/Expulsion Ended/Is Scheduled to End.

I hereby certify that I have provided true, complete, and accurate information for each and every suspension and/or expulsion imposed upon the Student for each and every offense relating to weapons, alcohol or drugs, or for the willful infliction of injury to another student.

I hereby swear or affirm that all information I have provided in this document is true, accurate, and complete to the best of my knowledge.

I understand that if I have provided any false information in this document that I may be charged with and convicted of a Class B misdemeanor.

I also understand that this registration document will be maintained as part of the Student's permanent scholastic record.

---

Signature of Parent/Guardian

---

Date

STATE OF MISSOURI )  
 ) SS  
COUNTY OF \_\_\_\_\_ )

On this \_\_\_\_th day of 20\_\_\_\_, before me appeared \_\_\_\_\_  
to me personally known, who, being by me duly sworn, did say that he/she executed the  
foregoing instrument and acknowledged said instrument to be his/her free act and deed.

IN TESTIMONY WHEREOF, I have hereunto set my hand and affixed my official seal in the County and State aforesaid, the day and year first above written.

Notary Public

My commission expires: \_\_\_\_\_

**Admission and Withdrawal****Transfer Students - Elementary/High School Student Transfer*****FOX C-6 SCHOOL DISTRICT*****Elementary School Transfer Request**

Date of Request: \_\_\_\_\_ New \_\_\_\_\_ Renewal \_\_\_\_\_  
(Check One Only)

Names of Student (s)

**Grade and Building Placement**

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

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

Name of Parent/Guardian \_\_\_\_\_

Address \_\_\_\_\_  
(Street) (City, State) (Zip)

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

Current School Attendance Area \_\_\_\_\_ Request Transfer To \_\_\_\_\_

**State Reason for Request:** (If additional space is needed, use back of form. Please attach documentation to form.)

**1. Transfers, when approved, will be contingent upon the following: 1. space within the grade level requested; 2. good attendance including no excessive tardiness or late pickups; and, 3. the student does not regularly disrupt the educational process of the classroom, grade level, and/or building.**

**If an elementary transfer request is approved, that does not mean a secondary transfer (middle/high school) will be approved. Secondary transfers are much more restrictive than elementary transfers. Babysitting/Daycare is not a reason for transfer approval at the secondary level.**

**No special bus transportation is furnished for a student who transfers out of his/her own attendance area. TRANSPORTATION IS THE RESPONSIBILITY OF THE PARENT. PUNCTUAL AND REGULAR ATTENDANCE IS EXPECTED.**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**Return to:**       **Fox C-6 School District**  
Assistant Superintendent for Elementary Education  
745 Jeffco Blvd.  
Arnold, MO 63010

(You may also return this form to the Principal's office, and it will be forwarded to the Assistant Superintendent.)

<b>Office Use Only</b>	<b>Approved</b> ____
<b>Approval:</b>	<b>Denied</b> _____

# FOX C-6 SCHOOL DISTRICT

## Secondary School Transfer Request

Date of Request: \_\_\_\_\_ New \_\_\_\_\_ Renewal \_\_\_\_\_  
(Check One Only)

Names of Student (s)

Grade and Building Placement

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

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

Name of Parent/Guardian \_\_\_\_\_

Address \_\_\_\_\_  
(Street) (City, State) (Zip)

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

Current School Attendance Area \_\_\_\_\_ Request Transfer To \_\_\_\_\_

State Reason for Request: (If additional space is needed, use back of form. Please attach documentation to form.)

Students who have been approved for voluntary transfer of enrollment shall be permitted to participate in interscholastic activities only in accordance with the regulations of the Missouri State High School Activities Association (MSHSAA). In general, a voluntary transfer student is ineligible 365 days if a change in school is made after entering secondary school without an accompanying move on the part of the student's parents/guardians. Parents/guardians and/or students should check with their building principals to obtain information relating to MSHSAA guidelines.

If an elementary transfer request is approved, that does not mean a secondary transfer (middle/high school) will be approved. Secondary transfers are much more restrictive than elementary transfers. Babysitting/Daycare is not a reason for transfer approval at the secondary level.

No special bus transportation is furnished for a student who transfers out of his/her own attendance area. **TRANSPORTATION IS THE RESPONSIBILITY OF THE PARENT. PUNCTUAL AND REGULAR ATTENDANCE IS EXPECTED.**

Parent/Guardian Signature

Date

Return to: Fox C-6 School District  
Assistant Superintendent for Secondary Education  
745 Jeffco Blvd.  
Arnold, MO 63010

Office Use Only	Approved ____
Approval:	Denied ____

(You may also return this form to the Principal's office, and it will be forwarded to the Assistant Superintendent.)

Effective: 12/96

Revised: 8/10, 5/13

Consolidated School District No. 6 (Fox)

Effective: 8/13

**Admission of Homeless Students**

**Admission Procedures for Homeless Students**

**FOX C-6 SCHOOL DISTRICT**

**AWARENESS NOTICE REGARDING HOMELESS STUDENTS**

**POLICY 2260 - ENSURES THAT HOMELESS STUDENTS WILL HAVE  
EQUAL ACCESS TO A FREE, APPROPRIATE PUBLIC EDUCATION.**

Homeless students are those identified in the Stewart B. McKinney Homeless Assistance Act and include a student who:

1. Is living on the street, in a car, tent, abandoned building, or some other form of shelter not designed as a permanent home;
2. Is living in a community shelter facility; or
3. Is living in a transitional home for less than one full year.

Please contact your building principal or counselor in order to complete procedures related to admission and/or continued enrollment of homeless students.

Additional information may be obtained by contacting the Homeless Coordinator, at the Administration Building, 745 Jeffco Blvd., Arnold, MO, 636-296-8000.

### **HOMELESS STUDENT CHECKLIST**

In keeping with Policy 2260, Admission of Homeless Students, please complete this form if a student enrolls in the District who is homeless, or becomes homeless, during the course of the school year.

A copy of this form should be retained in the student's permanent file, with the original submitted to the Homeless Coordinator for the District, along with the Student Information/Enrollment Form.

Please respond by placing a check mark next to those statements which apply to the student:

\_\_\_\_\_ Student/family is currently living on the street -

\_\_\_\_\_ in a car

\_\_\_\_\_ in a tent

\_\_\_\_\_ in an abandoned building

\_\_\_\_\_ in a community homeless shelter

\_\_\_\_\_ temporary residence, such as a motel

\_\_\_\_\_ Student/family is currently living in a transitional home for less than one year

\_\_\_\_\_ with relative, or other family member

\_\_\_\_\_ with friend(s)

\_\_\_\_\_ other

Homeless students will have access to a free, appropriate public education.

\*\*\*\*\*



**STUDENTS****Form 2340****Attendance****Truancy Referral**

OFFICE USE ONLY	
Reason	Phase
C	I
Q	II
Y	III
O	P

**TRUANCY REFERRAL**

Student's Name: \_\_\_\_\_ Date of Referral: \_\_\_\_\_

School: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Student lives with \_\_\_\_\_ Relationship \_\_\_\_\_

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

Place of Employment: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Referring Person: \_\_\_\_\_

Student has been absent \_\_\_\_\_ days out of \_\_\_\_\_ during the quarter/year

Number of days excused absences \_\_\_\_\_ Number of days unexcused absences (truancy) \_\_\_\_\_

Was a parental conference requested? \_\_\_\_\_ Did parents appear for conference? \_\_\_\_\_

Date of Conference: \_\_\_\_\_ Results: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other Pertinent Information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signed: \_\_\_\_\_ Title: \_\_\_\_\_

\*\*\*\*\*

Effective: 12/96

Consolidated School District No. 6 (Fox)

**Student Educational Records****FERPA Notice of Designation of Directory Information****NOTICE OF DESIGNATION OF DIRECTORY INFORMATION**

Dear Parents and Guardians:

The Family Educational Rights and Privacy Act (FERPA), a Federal law, requires that Fox C-6 School District, with certain exceptions, obtains your written consent prior to the disclosure of personally identifiable information from your child's education records. However, Fox C-6 School District may disclose appropriately designated "directory information" without written consent, unless you have advised the District to the contrary in accordance with District procedures. The primary purpose of directory information is to allow the Fox C-6 School District to include this type of information from your child's educational records in certain school publications. Examples include:

- A playbill, showing your student's role in a drama production;
- The annual yearbook;
- Honor roll or other recognition lists;
- Graduation programs; and
- Sports activity sheets, such as for wrestling, showing weight and height of team members.

Directory information, which is information that is generally not considered harmful or an invasion of privacy if released, can also be disclosed to outside organizations without a parent's prior written consent. Outside organizations include, but are not limited to, companies that manufacture class rings or publish yearbooks. In addition, two federal laws require local educational agencies (LEAs) receiving assistance under the Elementary and Secondary Education Act of 1965 to provide military recruiters, upon request, with three directory information categories - names, addresses and telephone listings - unless parents have advised the LEA that they do not want their student's information disclosed without their prior written consent.

If you do not want Fox C-6 School District to disclose directory information from your child's educational records without your prior written consent, you must notify the District in writing by \_\_\_\_\_ (date). Fox C-6 School District has designated the following information as directory information:

***[THE FOLLOWING ARE SUGGESTED INCLUSIONS. IF A DISTRICT WISHES TO ADD OR DELETE, IT SHOULD CONSULT WITH ITS LEGAL COUNSEL.]***

- |                           |  |
|---------------------------|--|
| ▪ Student's name          | ▪ Grade Level  |
| ▪ Address                 | ▪ Participation in officially recognized activities and sports |
| ▪ Telephone listing       | ▪ Weight and height of members of athletic teams               |
| ▪ Photograph              | ▪ Degrees, honors and awards received                          |
| ▪ Date and place of birth |  |
| ▪ Dates of attendance     |  |

Adopted:  
Consolidated School District No. 6 (Fox)  
November, 2010

**Student Educational Records****FERPA Educational Rights Annual Notification**

Each year the Fox C-6 School District is required to give notice of the various rights accorded to parents or students pursuant to the Family Educational Rights and Privacy Act (FERPA). Parents and students have a right to be notified and informed. In accordance with FERPA, you are notified of the following:

**RIGHT TO INSPECT:** You have the right to review and inspect substantially all of your education records maintained by or at this institution.

**RIGHT TO PREVENT DISCLOSURES:** You have the right to prevent disclosure of education records to third parties with certain limited exceptions. It is the intent of this institution to limit the disclosure of information contained in your education records to those instances when prior written consent has been given to the disclosure, as an item of directory information of which you have not refused to permit disclosure, or under the provisions of FERPA which allow disclosure without prior written consent.

One exception which permits disclosure without consent is disclosure to school officials with legitimate education interests. A school official is a person employed by the school district as an administrator, supervisor, instructor, or support staff member (including health or medical staff and law enforcement unit personnel); a person serving on the school board; a person or company with whom the school district has contracted to perform a special task (such as an attorney, auditor, consultant, or therapist); or a parent, student or volunteer serving on an official committee, such as a disciplinary or grievance committee. A school official has a legitimate educational interest if the official needs to review an education record in order to fulfill his or her professional responsibility.

**RIGHT TO REQUEST AMENDMENT:** You have the right to seek to have corrected any parts of an education record which you believe to be inaccurate, misleading or otherwise in violation of your rights. This right includes the right to a hearing to present evidence that the record should be changed if this institution decides not to alter the education records according to your request.

**RIGHT TO COMPLAIN TO FERPA OFFICE:** You have the right to file a complaint with the Family Policy Compliance Office, U.S. Department of Education, Washington, D.C., 20202-4605, concerning the Fox C-6 School District's failure to comply with FERPA.

**RIGHT TO OBTAIN POLICY:** You have the right to obtain a copy of the written policy adopted by the Board of Education of the Fox C-6 School District in compliance with FERPA. A copy may be obtained in person or by mail from:

(Name and address of the District's Custodian of Records).

**Discipline**

**Student Vehicle Use: Parking Lots and Searches**

**ACKNOWLEDGEMENT CONCERNING  
USE OF STUDENT PARKING LOTS**

I acknowledge and understand that:

1. Students are permitted to park on school premises as a matter of privilege, not of right.
2. The School District retains authority to conduct routine patrols of student parking lots and inspections of the exteriors of student automobiles on school property.
3. The School District may inspect the interiors of student automobiles whenever a school authority has reasonable suspicion to believe illegal or unauthorized materials are contained inside the automobiles.
4. Such patrols and inspections may be conducted without notice, without student consent, and without a search warrant.
5. If I fail to provide access to the interior of my car upon request by a school official, I will be subject to school disciplinary action.

---

Student

---

Date

**Discipline**

**Short Term Suspension Notice**

**NOTICE OF SUSPENSION FOR UNDER TEN DAYS**

May 3, 2008

Mrs. John D. Caprio  
25 Bluebird Lane  
St. Louis, MO 63000

Dear Mrs. Caprio:

Your son, Bryan, has been suspended from Best Junior High School for five (5) school days for the following misconduct and/or violation of District or school rules or regulations:

---

---

---

Your son has had the charges of misconduct explained to him and has been given the opportunity to disagree with the charges and the suspension. It has been determined that your son committed the act(s) in question and should be suspended.

Your son may return to school on May 11, 2008. Make-up work (will) or (will not) be given for this time. While suspended, your son may not come on any school campus except with you for the purpose of discussing conduct. If you have any questions, please call.

Sincerely,

Principal

cc: Superintendent

**NOTE:**

**This form may not be appropriate with respect to a disabled student under the Individuals with Disabilities Education Act or Section 504 of the Rehabilitation Act, or a student who may be suspected of disability. Please consult legal counsel under these circumstances.**

**Discipline**

**Short Term Suspension Notice**

**NOTICE OF SUSPENSION FOR TEN DAYS WITH  
RECOMMENDATION TO SUPERINTENDENT FOR ADDITIONAL DAYS**

May 3, 2008

Mrs. John D. Caprio  
25 Bluebird Lane  
St. Louis, MO 63000

Dear Mrs. Caprio:

Your son, Bryan, has been suspended from Best Junior High School for ten (10) school days for the following misconduct and/or violation of District or school rules or regulations:

---

---

---

Your son has had the charges of misconduct explained to him and has been given the opportunity to disagree with the charges and the suspension. It has been determined that your son committed the act(s) in question and should be suspended. Given the severity of the misconduct, I will also be referring this matter to the Superintendent for possible further disciplinary action.

While suspended, your son may not come on any school campus except with you for the purpose of discussing his conduct. If you have any questions, please call.

Sincerely,

Principal

cc: Superintendent

**NOTE:**

**This form may not be appropriate with respect to a disabled student under the Individuals with Disabilities Act or Section 504 of the Rehabilitation Act, or a student who may be suspected of disability. Please consult legal counsel under these circumstances.**



**Discipline**

**Long Term Suspension Notice**

**NOTICE OF PROPOSED SUSPENSION BETWEEN 11 AND 180 DAYS**

*Hand delivered or Certified Mail Return Receipt Request*

May 10, 2008

Mr. & Mrs. John D. Caprio  
25 Bluebird Lane  
St. Louis, MO 63000

Dear Mr. & Mrs. Caprio:

I understand that Mr. Bob Smith, Middle School Principal, has suspended your child, Bryan Caprio, for ten (10) school days. Mr. Smith has also made a referral to my office for possible future disciplinary action for Bryan's following acts of misconduct:

---

This misconduct is in violation of Board Policy *[insert policy number]* and Regulation *[insert regulation number]*. Accordingly, I have decided to suspend Bryan for an additional 45 school days, for a total of 55 school days. Bryan is entitled to a hearing before the Board of Education to determine if he violated the rules in the manner stated above and whether he should be suspended for the amount of time stated above. For such a hearing to take place, you must request it within five school days of your receipt of this letter. You may send written notice of appeal to the Board directly at the District Central Office or call me at 314-555-1212.

If you request a hearing, it will be scheduled as soon as practicable at a mutually convenient time. At a hearing, you and your child may present any witnesses or documentary evidence in an effort to refute the charges of misconduct and on the issue of a proper punishment, if it is determined that the misconduct occurred.

If you request a hearing, the School's Administration will provide you with a list of the witnesses who will testify on behalf of the Administration, together with a short description of their testimony. The Administration may also use documents at the hearing. If documents are to be used, they will be provided to you prior to the hearing.

A COPY OF THE SCHOOL DISTRICT POLICIES REGARDING DISCIPLINE PROCEDURES IS ATTACHED TO THIS LETTER. PLEASE REVIEW THESE POLICIES. I have determined that Bryan's presence poses a continuing danger to persons or property or an ongoing threat of disrupting the academic process. Therefore, Bryan will remain on suspension until the hearing is held.

If you have any questions regarding the reasons for the proposed suspension or anything connected with the hearing, please feel free to call me. If you do not request a hearing, my suspension as stated above will stand.

Sincerely,

Superintendent

Enclosures

**NOTE:**

**This form may not be appropriate with respect to a disabled student under the Individuals with Disabilities Education Act or Section 504 of the Rehabilitation Act, or a student who may be suspected of disability. Please consult legal counsel under these circumstances.**

**Discipline**

**Notice of Expulsion Hearing**

**NOTICE OF PROPOSED SUSPENSION OF 180 SCHOOL DAYS WITH  
RECOMMENDATION FOR EXPULSION**

*Hand delivered or Certified Mail Return Receipt Request*

May 10, 2008

Mr. & Mrs. John D. Caprio  
25 Bluebird Lane  
St. Louis, MO 63000

Dear Mr. & Mrs. Caprio:

I understand that Mr. Bob Smith, Middle School Principal, has suspended your child, Bryan Caprio for ten (10) school days. Mr. Smith has also made a referral to my office by for possible future disciplinary action for Bryan's following acts of misconduct:

---

This misconduct is in violation of Board Policy *[insert policy number]* and Regulation *[insert regulation number]*. Accordingly, I have decided to suspend Bryan for an additional 170 school days, for a total of 180 school days. Please be advised that I will also recommend to the Board of Education that Bryan be permanently expelled from the District.

Unless you waive your right to a hearing in writing, the expulsion hearing will be held at the Board of Education Office, 0000 School Road, St. Louis, MO, 63000 at approximately 6:00 p.m., June 1, 2008. Bryan, you and your attorney or representative are invited to be present to confront and cross-examine witnesses and to present evidence on Bryan's behalf. Please contact my office, in writing, no later than 4:00 p.m., May 25, 2008 to inform us of your intentions. If you do not contact us by that time, it will be assumed that you do not plan to attend; however, the Board of Education will proceed and will make a decision concerning the expulsion recommendation.

If you inform us that your intention is to participate in the hearing, the School's Administration will provide you with a list of the witnesses who will testify on behalf of the Administration, together with a short description of their testimony. The Administration may also use documents at the hearing. If documents are to be used, they will be provided to you prior to the hearing.

I am sorry that it has become necessary to recommend to the Board of Education that Bryan be expelled from further attendance at any District School, but I am sure you agree, it is important that the other students have the opportunity to learn in a secure and safe environment.

Sincerely,

Superintendent

**NOTE:**

**This form may not be appropriate with respect to a disabled student under the Individuals with Disabilities Act or Section 504 of the Rehabilitation Act, or a student who may be suspected of disability. Please consult legal counsel under these circumstances.**

**STUDENTS**

**Form 2664**

**Discipline**

**Minor Offense Report – “Safe Schools Act”**

**JEFFERSON COUNTY SHERIFF’S DEPARTMENT  
Minor Offense Report  
“Safe Schools Act”**

Case Number: \_\_\_\_\_ Date of Incident: \_\_\_\_\_ Incident: \_\_\_\_\_  
Location of Occurrence: \_\_\_\_\_

Involved: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Race: \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

Involved: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Race: \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

Description of  
Event: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Witness: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Race: \_\_\_\_\_  
Parent/Guardian: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

Witness:\_\_\_\_\_

Date of Birth:\_\_\_\_\_ Sex:\_\_\_\_\_ Race:\_\_\_\_\_

Parent/Guardian:\_\_\_\_\_

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

Phone:\_\_\_\_\_

Reported by:\_\_\_\_\_

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

Phone: \_\_\_\_\_

Further Action Requested: \_\_\_\_\_

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

Effective: 12/96

Consolidated School District No. 6 (Fox)

**Discipline****Juvenile Incident Report****JUVENILE INCIDENT REPORT**

Date of Referral\_\_\_\_\_

Student's Name\_\_\_\_\_Date of Birth\_\_\_\_\_  
Last First

School\_\_\_\_\_Grade\_\_\_\_\_

Student lives with\_\_\_\_\_Relationship\_\_\_\_\_  
Last First

Address\_\_\_\_\_Phone\_\_\_\_\_

Parent's Name\_\_\_\_\_Date of Birth\_\_\_\_\_  
Last First

Address\_\_\_\_\_Phone\_\_\_\_\_

Place of Employment\_\_\_\_\_Phone\_\_\_\_\_

Name of referring person\_\_\_\_\_

Was a parental conference requested?\_\_\_\_\_

Did Parents appear for conference?\_\_\_\_\_Date of Parental conference\_\_\_\_\_

Results of conference\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_**Report of Incident:**

Important: For law violations include nature of offense, time and place of occurrence, names of witnesses and details of the offense.  
For home-related or school-related problems include the nature of the complaint and specific details of any related incident.

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Signed:\_\_\_\_\_

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Effective: 12/96  
Consolidated School District No. 6 (Fox)



**Discipline****Student Discipline Hearing Introduction****HEARING INTRODUCTION**

The hearing in the case of (student) is convened pursuant to Board of Education policy and pursuant to Section 167.161 of the Missouri Revised Statutes.

Section 167.161, RSMo., provides as follows: Suspension or expulsion of pupil - notice - hearing.

The School Board of any District, after notice to parents/guardians and a hearing upon charges preferred, may suspend or expel a pupil for conduct which is prejudicial to good order and discipline in the schools or which tends to impair the morale or good conduct of the pupils.

At the hearing, the Board shall consider the evidence and statements that the parties present, and may provide by general rule not inconsistent with this section for the procedure and conduct thereof.

These proceedings are being recorded by a licensed court reporter. A transcript will be prepared and made available at cost.

During the course of the hearing, both parties will be permitted to call witnesses, to cross-examine witnesses called by the other party, and to submit exhibits.

At the conclusion, counsel for both parties will be permitted, at their option, to make closing oral argument and/or submit a written brief. If either party chooses to submit a post-hearing brief, the decision in this case will not be rendered until the Board has had sufficient time to read the briefs.

**Discipline**

**Student Hearing Agenda**

**STUDENT HEARING AGENDA**

**1. HEARING INTRODUCTION (Form 2671)**

**2. ENTRY OF APPEARANCE**

"Will counsel for the Administration and counsel for ( Student ) (or student's parent/guardian if no attorney is present) enter their appearances for the record please."

**3. PRELIMINARY MATTERS**

"Are there any preliminary matters before we begin the hearing?"

a. Stipulations

b. Motions to dismiss

"Your objection or motion will be noted and it will be taken under submission."

**4. ADMINISTRATION'S CASE**

a. "\_\_\_\_\_, are you ready to proceed?"

b. Call and swear witnesses.

c. If any objections are made during testimony of witnesses, they should be resolved as follows: "Your objection has been noted for the record and will be taken under submission."

d. At the end of the questioning of each witness, the Board Attorney will state that he/she has no further questions for the witness. The student's attorney or parent/guardian should then be asked if they have any cross-examination of the witness.

e. If the student's attorney or parent/guardian cross-examine the witness, opportunities should be offered for any redirect (additional questioning by the Board Attorney) and then any re-cross (additional questioning by the student's attorney or parent/guardian).

**5. STUDENT'S CASE**

- a. At the conclusion of the Administration's case, the Board Attorney will state that the Administration rests its case.
- b. The student's attorney or parent/guardian should then be asked, "Are you ready to proceed?" They will answer that they are and should be directed to call their first witness.
- c. The questioning should proceed in the same manner as in the Administration's case (#4).

**6. REBUTTAL**

At the conclusion of the student's case, the Board Attorney should be asked if he/she has any rebuttal. In all likelihood, there will be none.

**7. CLOSING**

- a. At the conclusion of the hearing, a statement should be made that: "Counsel and parent/guardian will have the opportunity to present a closing oral argument and submit briefs if they so desire." "What is your preference?" Most likely, closing arguments will be presented to the Board.
- b. Upon conclusion of the arguments, the attorney(s) and parent/guardian should be briefed concerning the timing of the Board's decision.
  - i. If the attorney(s) and parent/guardian do not wish to submit briefs, the Board will adjourn to reach a decision. The Board will prepare written findings of fact and conclusions of law which should be available within three (3) days.
  - ii. If the attorney(s) and parent/guardian wish to submit briefs, a date when the briefs will be due should be set: ten (10) days from receipt of transcript. The Board should review the briefs and then reach its decision. Again, the Board's decision will be accompanied by written findings of fact and conclusion of law.

**STUDENTS**

**Form 2671.2**

**Discipline**

**Student Hearing Decision**

Before the School Board of Education

\_\_\_\_\_, Superintendent )

Best School District\_\_\_\_\_, District )

and )

Bryan D. Caprio\_\_\_\_\_, Student )

**BOARD OF EDUCATION'S FINDINGS OF FACT,  
CONCLUSION OF LAW, AND DECISION.**

On May 10, 2003, (Superintendent name) served written notice on Mr. and Mrs. John Caprio stating that their son, Bryan, had been suspended from Best Junior High School for a period of 180 days. The written notice of June 1, 2003, further advised Mr. and Mrs. Caprio that Bryan had been recommended to the Board of Education for expulsion because of his involvement in (i.e., possession of drugs, etc) at Best Junior High School on (date), 2003.

A hearing was held on June 28, 2003, in the boardroom in the Administration Offices of Best School District. Bryan and his mother were present during the hearing. A court reporter was employed by the District and a record made of the proceedings.

At the conclusion of the hearing, the Board of Education deliberated in executive session, after which and after having given full consideration to the testimony presented at hearing, decided as follows:

**FINDINGS OF FACT**

1. That at all times relevant hereto, Bryan Caprio has been a student at Best Junior High School in the Best School District.
2. (Simple statements of conduct - sentence by sentence.)
3. (Additional statements of conduct.)
4. (Additional statements of conduct.)
5. That on ( date ), 2003, Bryan Caprio was questioned about the incident by Assistant Principals Robert Rob and Neil Neal.
6. That during the ( date ) conference with School Administrators, Bryan Caprio admitted his involvement in the (incident, i.e., possession of drugs, sale of drugs, assault of teacher, etc).
7. That the admissions of Bryan Caprio on ( date ), 2003, were voluntary and were made without threat or duress.
8. That Best School Board of Education Policy\_\_\_\_\_ prohibits any person from (incident, i.e., possession of drugs, sale of drugs, assault of teacher, etc.) on school premises. Under Board policy, students who violate Policy\_\_\_\_\_ are subject to suspension and/or expulsion from school.
9. That on ( date ), 2003, after a full investigation by Mr. Rob, Bryan Caprio was suspended for ten (10) days and was recommended to the Superintendent for further disciplinary action.
10. That on ( date ), 2003, Bryan Caprio's mother was advised of her son's involvement in the \_\_\_\_\_ incident; his suspension for ten (10) days; and Bryan's referral to the Superintendent and the Board of Education for further disciplinary action.
11. That on ( date ), 2003, the Caprio family received written confirmation of Bryan's suspension.
12. That on ( date ), 2003, Superintendent suspended Bryan Caprio for a period of ninety (90) days and recommended that Bryan be permanently expelled from the schools of the Best School District because of his involvement in the (incident).

13. That by correspondence dated ( date ), 2003, Mr. and Mrs. Caprio were informed by the Superintendent that Bryan had been suspended from school for violation of School Board policy. Attached to the correspondence of ( date ), 2003, was a copy of Board Policy \_\_\_\_\_, which was alleged to have been violated.
14. That by correspondence of ( date ), 2003 hearing, the Caprios were advised of the date, time, and place of the Board hearing.
15. That prior to the ( date ), 2003 hearing, the Caprio family and/or their attorney were provided with the following information:
  - a. List of documents entered into the record at hearing.
  - b. Additional documents entered into the record at hearing.
  - c. Copy of the Board of Education "Student Disciplinary Hearing Policy."
  - d. Names of the witnesses to be called by the Administration.
  - e. Summary of the nature of the testimony offered by the Administration.
  - f. Statement of the charge.

### **CONCLUSION OF LAW**

1. (In special cases, identification of specific items as unlawful will be needed, i.e., "the pipe bomb, knife, etc., possessed by Bryan Caprio was a deadly weapon within the meaning of the Board of Education Policy 2620," or "The capsules sold by Bryan Caprio were physical or mind-altering drugs within the meaning of the Board of Education Policy 2610.")
2. The facts set out in paragraphs \_\_\_\_\_ through \_\_\_\_\_ of the Findings of Fact set out above constitute conduct which violated Board of Education Policy \_\_\_\_\_, which prohibits students from \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ on or about School District grounds.
3. The facts set out in paragraphs \_\_\_\_\_ through \_\_\_\_\_ of the Findings of Fact set out above constitute conduct which, pursuant to Section 167.161 of the Missouri Revised Statutes, is prejudicial to the good order and discipline in the schools and which tends to impair the morale and good conduct of the students of Best Junior High School.
4. The facts set out in paragraphs \_\_\_\_\_ through \_\_\_\_\_ of the Findings of Fact set out above constitute fulfillment of the process procedures required by Federal Law and required under Section 167.171 of the Missouri Revised Statutes.

5. The facts set out in paragraphs \_\_\_\_\_ through \_\_\_\_\_ of the Findings of Fact set out above satisfy the notice requirements set out in Sections 167.161 and 536.067 of the Missouri Revised Statutes and set out in Board Policy.

### **DECISION**

On the basis of the foregoing Findings of Fact and Conclusions of Law, the Board of Education has determined that Bryan Caprio (state offense, i.e., possession of a deadly weapon on May 23, 2003, or sold mind-altering drugs on May 23, 2003). Such conduct, as engaged in by Bryan Caprio, is in violation of Board of Education Policy \_\_\_\_\_, is prejudicial to the good order and discipline of the District's schools and does undermine the morale and good order of the District's students. Based upon this determination, the Board of Education has voted unanimously to (state penalty, i.e., suspend Bryan Caprio for a period of sixty (60) days or expel Bryan Caprio) from the schools of the Best School District.

Best School District Board of Education

By: \_\_\_\_\_  
President

DATED:(Month, Day, and Year)

A copy of the foregoing Findings of Fact, Conclusions of Law and Decision have been mailed to Mr. and Mrs. John Caprio, on this \_\_\_\_\_ day of \_\_\_\_\_, 2003.

**Discipline****Agreement for Reporting Third Degree Assault****AGREEMENT FOR REPORTING THIRD DEGREE ASSAULT  
TO LAW ENFORCEMENT AGENCY**

This Agreement for Reporting Third Degree Assault to Law Enforcement Agency (hereinafter "Agreement") is entered into this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, by and between \_\_\_\_\_, Superintendent of the \_\_\_\_\_, and \_\_\_\_\_, Superintendent \_\_\_\_\_ School District \_\_\_\_\_, (hereinafter "Law Enforcement Agency"), Law Enforcement Agency/(ies)

pursuant to Mo. Rev. Stat. § 167.117, for the purpose of establishing guidelines for school district principals in reporting incidents that may constitute third degree assault under Missouri law when such incidents occur on school property or on school buses or when such incidents occur during school activities.

**Definition of Third Degree Assault**

For purposes of this Agreement, a person commits assault in the third degree if that person:

1. Attempts to cause or recklessly causes physical injury to another person; or
2. With gross negligence, causes physical injury to another person by means of a deadly weapon; or
3. Purposely places another person in apprehension of immediate physical injury; or
4. Recklessly engages in conduct which creates a grave risk of death, serious disfigurement or protracted impairment of the function of any part of the body of another person; or
5. Knowingly causes physical contact with another person with knowledge that the other person regards the contact as offensive or provocative.

**Factors to Be Considered by Principals**

When a principal in this School District believes that an incident of third degree assault has occurred on school property, on a school bus, or during a school activity (regardless of



whether that activity occurs on or off of school property), the principal may consider the following guidelines in determining whether to report the particular incident.

1. The age and maturity of the student involved.
2. Whether the incident involved the use of or threatened use of a weapon or involved sexual misconduct or allegations of sexual misconduct.
3. The nature and severity of the conduct.
4. The nature and severity of injury, if any, inflicted on the other person involved.

In addition to these factors, the principal may consider any other factors which the principal, in the exercise of professional judgment, determines to be appropriate under the circumstances. The guidelines listed above shall in no way inhibit a principal from reporting to law enforcement any conduct which the principal believes may constitute a violation of state or federal law, regardless of whether such conduct actually constitutes such a violation.

### **Procedure for Making Report to Law Enforcement**

If a principal determines, in his/her professional judgment, that an incident shall be reported to law enforcement under this Agreement, the principal should contact the Law Enforcement Agency by telephone or in writing as soon as reasonably practicable after the principal receives a report of the incident and after the principal has, if necessary, investigated the incident to determine whether the incident necessitates a report.

The principal subsequently shall provide the Law Enforcement Agency with any additional documentation that the principal or School District deems necessary. Such information will be provided in accordance with applicable federal and state law.

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Superintendent

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Authorized Law Enforcement  
Official/Agency

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School District

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Date

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Date

**STUDENTS**

**Form 2740**

**Crisis Management Plan**

**Student Safety**

# **EMERGENCY & SAFETY/SECURITY PROCEDURES MANUAL**

Effective: 12/96  
Revised: 06/03, 08/08

Consolidated School District No. 6 (Fox)

**STUDENTS****Form 2920****Activities and Athletics****Acknowledgement of Activity Rules and Guidelines**

School \_\_\_\_\_

Activity \_\_\_\_\_

Coach/Sponsor \_\_\_\_\_

**School Rules and Guidelines Associated with This Activity**

(Rules and guidelines to be established by the coach/sponsor and school administration)

**District Guidelines for Student Activities**

Participation in District-sponsored activities and on District athletic teams is a privilege and not a legally protected right. Although students do not possess a legally protected right to participate in extracurricular activities, the District provides students suspended from participation with an informal opportunity to discuss the basis for their suspension.

**Hazing Prohibited**

I agree that I will refrain from participating in any student hazing activities as a participant or as an observer. I further understand that violation of the District's hazing policy may result in suspension or expulsion from school and suspension or expulsion from participation in all activities.

**Student and Parent Acknowledgement of the Above Rules and Guidelines**

I acknowledge that violation of any of the above rules and guidelines for this activity may result in suspension or permanent removal from this activity or all extracurricular activities depending upon the nature of the violation. I further agree that subject to an opportunity to present the student's version of the alleged violation, the decision of the Superintendent/designee concerning suspension and duration of suspension is final.

\_\_\_\_\_  
Student Signature\_\_\_\_\_  
Parent/Guardian Signature\_\_\_\_\_  
Date\_\_\_\_\_  
Date

**STUDENTS**

**Form 2930**

**Activities and Athletics**

**MSHSAA Concussion Return to Play Form**

The MSHSAA Concussion Return to Play Form is attached hereto. Copies may be made of the attached, or additional copies may be obtained from Missouri State High School Activities Association.

**STUDENTS****Form 2930.1****Activities and Athletics****MSHSAA Return to Play (RTP) Procedures After a Concussion**

The MSHSAA Return to Play (RTP) Procedures After a Concussion Form is attached hereto. Copies may be made of the attached, or additional copies may be obtained from Missouri State High School Activities Association.

**STUDENTS****Form 2930.2****Activities and Athletics****MSHSAA Handout: A Fact Sheet for Parents and Athletes**

The MSHSAA Handout: A Fact Sheet for Parents and Athletes is attached hereto. Copies may be made of the attached, or additional copies may be obtained from Missouri State High School Activities Association.

**Activities and Athletics****Interscholastic Athletics****STUDENT AND PARENT AGREEMENT TO COMPLY WITH  
EXTRACURRICULAR CODE OF CONDUCT**

The Fox C-6 School District's ("District" or "Fox") has established its Extracurricular Code of Conduct so that students and their parents/legal guardians will be aware of the behavioral expectations of those students who participate in extracurricular activities at Fox. Fox students who participate in MSHAA-regulated extracurricular activities, or other extracurricular activities in which competitions/performances occur, will be required to comply with the standards and rules contained in the Extracurricular Code of Conduct. Moreover, the effective cooperation of parents/legal guardians and their participation in the enforcement of this Code of Conduct are vital to ensuring that students follow the rules and avoid behaviors that are damaging to the students themselves and the community.

***By signing this Student and Parent Agreement to Comply with Extracurricular Code of Conduct, the student and parent/legal guardian certify as follows:***

- We have received a complete copy of the Extracurricular Code of Conduct;
- We have read the Extracurricular Code of Conduct in its entirety;
- We understand and agree with the terms of the Extracurricular Code of Conduct;
- We agree that the Extracurricular Code of Conduct is reasonable and fair;
- We pledge to comply with the terms of the Extracurricular Code of Conduct
- We recognize that compliance with the Extracurricular Code of Conduct is a prerequisite to participation in extracurricular activities at Fox;
- We recognize that participation in extracurricular activities at Fox is a privilege and *not* a right or entitlement;
- We recognize that if a student fails to comply with the Extracurricular Code of Conduct, the student will be subjected to the consequences stated in the Code of Conduct; As parents/legal guardians of the child referenced below, we commit ourselves to ensuring that our child complies with the Extracurricular Code of Conduct, and we agree that we will set an example for our child through our own conduct.
- We understand that participation in extracurricular activities in Fox C-6 School District is contingent upon our signature upon, and return of, the Agreement.

\_\_\_\_\_  
*Student Signature*

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

\_\_\_\_\_  
*Please Print Name of Student Here*

\_\_\_\_\_  
*Parent/Legal Guardian Signature*

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

\_\_\_\_\_  
*Please Print Name of Parent/Legal Guardian Here*

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Adopted: 11/98  
Revised: 02/02, 09/04

Effective: 02/02, 08/05

Consolidated School District No. 6 (Fox)



**Employment****Coaching Code of Ethics****COACHING CODE OF ETHICS****Guiding Principals**

Coaches at public schools are first and foremost educators. Coaches have a duty to supplement student-athletes' academic endeavors by imparting valuable life skills and emphasizing the positive attributes of athletic competition. Recognizing that coaches mold the minds of formative youths, this Code requires coaches to instill in their athletes the values of respect, honor, discipline, duty, leadership, fairness, and sportsmanship. These basic tenets of a coach's responsibility are embodied in the following coaching guidelines.

**Obligation to the School**

- The coach will never place the goal of winning on a pedestal, such that winning is valued more than the need to develop the student-athlete's academic abilities and personal character. The coach will have the responsibility to harmonize the interests of developing athletic skills with the promotion of academic achievements.
- The coach, as a representative of the school and a role model for student-athletes, will be held to the highest possible ethical and moral standard and will conduct all of his or her affairs with dignity and honor.
- As part of this high ethical and moral standard, the coach will refrain from using profanity, making obscene gestures, or verbally abusing any individual at practices, competitions, during transportation to or from any practice or competition, or at any other setting where the coach is acting in an official capacity as a representative of the school. Activities barred by the Code include, but are not limited to: threats, humiliation, insults, and ridicule.
- The coach will control his or her emotions and ego when representing the school and will avoid displays of anger, intimidation, or frustration.
- The coach will never seek to assert influence over any school faculty for the purpose of according student-athletes privileges not ordinarily accorded other students.

- The coach will be familiar with the requirements of this Code. The coach will honor the spirit and purpose of this Code and require all others associated with the sport to abide by the Code as well.
- The coach will follow all federal, state, and local laws and regulations pertaining to school athletics and demand the same from all others associated with the sport.

### **Obligation to Students**

- The coach will at all times place the safety, health, and well-being of the student-athlete above any desire or pressure to win.
- The coach will maintain a professional relationship with student-athletes and must not, under any circumstances, develop a romantic or sexual relationship with any student-athlete.
- The coach will instill in the student-athletes the belief that participation in sports is a privilege and not a right. To obtain this privilege, the coach will instruct student-athletes on how to represent the school with honor, dignity, and respect.
- The coach will not permit or condone hazing of any student-athletes on the team or any other school students.
- The coach will not use or consume any alcohol or tobacco products in the presence of student-athletes and will not permit or condone any student-athlete's use of alcohol or tobacco products.
- The coach will stress to student-athletes the importance of natural and healthy physical development. The coach must never recommend, encourage, permit, or condone the use of any illegal or banned performance enhancing substance.

### **Obligation to Officials, Parents, and Fans**

- The coach will demonstrate proper sportsmanship when in contact with all officials, parents, and fans. The coach will be humble in victory and gracious in defeat.
- The coach will proactively seek the cooperation of parents and fans in maintaining the appropriate emphasis on sportsmanship.
- The coach will treat others equitably and require all student-athletes to do the same.

- The coach will communicate with parents in a respectful manner and provide parents with an opportunity to express any concerns in a cooperative environment, free of any hostility.
- The coach will not engage in any taunting of opponents, fans, or officials, and will ensure that student-athletes refrain from taunting as well.
- The coach will treat all officials with courtesy and respect. The coach will refrain from public criticism of officials.

### **Acknowledgment**

Many of the ideas for this Code of Ethics were drawn from numerous other codes. The most significant of these were developed by the National Federation of State High School Associations, National Coaching Foundation, and the British Institute of Sports Coaches.

**I have read and understand the requirements of this Coaching Code of Ethics. I will act in accordance with this Code. I understand that school (and district) officials will expect that I will follow this Code. I understand that my failure to follow this Code will be sufficient grounds for discipline by the school, up to and including, termination of my position with the school.**

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**Coach Signature**

---

**Date**

**Personnel Assignment and Transfer**

**Compensatory Time Off Agreement**

**COMPENSATORY TIME OFF AGREEMENT**

In accordance with the Fair Labor Standards Act, the School District has a policy of granting nonexempt employees compensatory time off in lieu of compensation for hours worked in excess of forty (40) hours per workweek. I understand and agree that the School District may elect to give me compensatory time at the rate of one and one-half (1 1/2) hours for all hours worked in excess of forty (40) hours per workweek. I also understand that the compensatory time may be limited, used or paid out consistent with the provisions of the School District's policy, applicable law and regulations of the U.S. Department of Labor. I also understand that I have the right to use the accumulated compensatory time within a reasonable time provided that I submit a written request for the same to my immediate supervisor no later than two (2) weeks in advance of the requested period, and further provided that the use of compensatory time during the requested period will not unduly disrupt academic instruction and/or the provision of academic services in the School District.

\_\_\_\_\_  
Name of Employee

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date

## **PERSONNEL SERVICES**

**Form 4321**

### **Absences, Leaves and Vacation**

#### **Family Medical Leave Act Forms**

The following FMLA forms are attached. Copies may be made of the enclosed notice, or additional copies may be obtained from the U.S. Department of Labor, Wage and Hour Division.

Certification of Health Care Provider for Employee's Serious Health Condition/Form WH-380-E Revised January 2009	4321.1
Certification of Health Care Provider for Family Member's Serious Health Condition/Form WH-380-F Revised January 2009	4321.2
Employee Rights and Responsibilities under the Family and Medical Leave Act/WHD Publication 1420 Revised February 2013	4321.3
Notice of Eligibility and Rights & Responsibilities/Form WH-381 Revised February 2013	4321.4
Designation Notice/Form WH-382 January 2009	4321.5
Certification of Qualifying Exigency for Military Family Leave/Form WH-384 Revised February 2013	4321.6
Certification for Serious Injury or Illness of Current Servicemember - - for Military Family Leave/Form WH-385 Revised February 2013	4321.7
Certification for Serious Injury or Illness of a Veteran for Military Caregiver Leave/Form WH-385-V Revised February 2013	4321.8

**PERSONNEL SERVICES**

**Form 4321.1**

**Absences, Leaves and Vacation**

**FMLA: Certification of Health Care Provider for Employee's Serious Health Condition**

The FMLA Certification of Health Care Provider for Employee's Serious Health Condition Form WH-380-E Revised January 2009 is attached hereto. Copies may be made of the attached, or additional copies may be obtained from the U.S. Department of Labor, Wage and Hour Division.

Certification of Health Care Provider for  
Employee's Serious Health Condition  
(Family and Medical Leave Act)

U.S. Department of Labor  
Wage and Hour Division



OMB Control Number: 1235-0003  
Expires: 2/28/2015

**SECTION I: For Completion by the EMPLOYER**

**INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave due to a serious health condition to submit a medical certification issued by the employee's health care provider. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact: \_\_\_\_\_

Employee's job title: \_\_\_\_\_ Regular work schedule: \_\_\_\_\_

Employee's essential job functions: \_\_\_\_\_

Check if job description is attached: \_\_\_\_\_

**SECTION II: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 20 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b).

Your name: \_\_\_\_\_  
First Middle Last

**SECTION III: For Completion by the HEALTH CARE PROVIDER**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

Provider's name and business address: \_\_\_\_\_

Type of practice / Medical specialty: \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

**PART A: MEDICAL FACTS**

1. Approximate date condition commenced: \_\_\_\_\_

Probable duration of condition: \_\_\_\_\_

**Mark below as applicable:**

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

\_\_\_ No \_\_\_ Yes. If so, dates of admission:

\_\_\_\_\_

Date(s) you treated the patient for condition:

\_\_\_\_\_

Will the patient need to have treatment visits at least twice per year due to the condition? \_\_\_ No \_\_\_ Yes.

Was medication, other than over-the-counter medication, prescribed? \_\_\_ No \_\_\_ Yes.

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

\_\_\_ No \_\_\_ Yes. If so, state the nature of such treatments and expected duration of treatment:

\_\_\_\_\_

2. Is the medical condition pregnancy? \_\_\_ No \_\_\_ Yes. If so, expected delivery date: \_\_\_\_\_

3. Use the information provided by the employer in Section I to answer this question. If the employer fails to provide a list of the employee's essential functions or a job description, answer these questions based upon the employee's own description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: \_\_\_ No \_\_\_ Yes.

If so, identify the job functions the employee is unable to perform:

\_\_\_\_\_

4. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**PART B: AMOUNT OF LEAVE NEEDED**

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery? \_\_\_ No \_\_\_ Yes.

If so, estimate the beginning and ending dates for the period of incapacity: \_\_\_\_\_

6. Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition? \_\_\_ No \_\_\_ Yes.

If so, are the treatments or the reduced number of hours of work medically necessary?  
\_\_\_ No \_\_\_ Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

\_\_\_\_\_

Estimate the part-time or reduced work schedule the employee needs, if any:

\_\_\_\_\_ hour(s) per day; \_\_\_\_\_ days per week from \_\_\_\_\_ through \_\_\_\_\_

7. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? \_\_\_ No \_\_\_ Yes.

Is it medically necessary for the employee to be absent from work during the flare-ups?  
\_\_\_ No \_\_\_ Yes. If so, explain:

\_\_\_\_\_

\_\_\_\_\_

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency : \_\_\_\_\_ times per \_\_\_\_\_ week(s) \_\_\_\_\_ month(s)

Duration: \_\_\_\_\_ hours or \_\_\_\_\_ day(s) per episode

**ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
**Signature of Health Care Provider** **Date**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

**PERSONNEL SERVICES**

**Form 4321.2**

**Absences, Leaves and Vacation**

**FMLA: Certification of Health Care Provider for Family Member's Serious Health Condition**

The FMLA Certification of Health Care Provider for Family Member's Serious Health Condition Form WH-380-F Revised January 2009 is attached hereto. Copies may be made of the attached, or additional copies may be obtained from the U.S. Department of Labor, Wage and Hour Division.

Certification of Health Care Provider for  
Family Member's Serious Health Condition  
(Family and Medical Leave Act)

U.S. Department of Labor  
Wage and Hour Division



OMB Control Number: 1235-0003  
Expires: 2/28/2015

**SECTION I: For Completion by the EMPLOYER**

**INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA protections because of a need for leave to care for a covered family member with a serious health condition to submit a medical certification issued by the health care provider of the covered family member. Please complete Section I before giving this form to your employee. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. §§ 825.306-825.308. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 C.F.R. § 1630.14(c)(1), if the Americans with Disabilities Act applies.

Employer name and contact: \_\_\_\_\_

**SECTION II: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II before giving this form to your family member or his/her medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave to care for a covered family member with a serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form to your employer. 29 C.F.R. § 825.305.

Your name: \_\_\_\_\_  
First Middle Last

Name of family member for whom you will provide care: \_\_\_\_\_  
First Middle Last

Relationship of family member to you: \_\_\_\_\_

If family member is your son or daughter, date of birth: \_\_\_\_\_

Describe care you will provide to your family member and estimate leave needed to provide care:

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

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**SECTION III: For Completion by the HEALTH CARE PROVIDER**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the patient needs leave. Page 3 provides space for additional information, should you need it. Please be sure to sign the form on the last page.

Provider's name and business address: \_\_\_\_\_

Type of practice / Medical specialty: \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

**PART A: MEDICAL FACTS**

1. Approximate date condition commenced: \_\_\_\_\_

Probable duration of condition: \_\_\_\_\_

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?

\_\_\_ No \_\_\_ Yes. If so, dates of admission: \_\_\_\_\_

Date(s) you treated the patient for condition: \_\_\_\_\_

Was medication, other than over-the-counter medication, prescribed? \_\_\_ No \_\_\_ Yes.

Will the patient need to have treatment visits at least twice per year due to the condition? \_\_\_ No \_\_\_ Yes

Was the patient referred to other health care provider(s) for evaluation or treatment (e.g., physical therapist)?

\_\_\_ No \_\_\_ Yes. If so, state the nature of such treatments and expected duration of treatment:

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

2. Is the medical condition pregnancy? \_\_\_ No \_\_\_ Yes. If so, expected delivery date: \_\_\_\_\_

3. Describe other relevant medical facts, if any, related to the condition for which the patient needs care (such medical facts may include symptoms, diagnosis, or any regimen of continuing treatment such as the use of specialized equipment):

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

**PART B: AMOUNT OF CARE NEEDED:** When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care:

4. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery? ☐ No ☐ Yes.

Estimate the beginning and ending dates for the period of incapacity: \_\_\_\_\_

During this time, will the patient need care? ☐ No ☐ Yes.

Explain the care needed by the patient and why such care is medically necessary:

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5. Will the patient require follow-up treatments, including any time for recovery? ☐ No ☐ Yes.

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

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Explain the care needed by the patient, and why such care is medically necessary: \_\_\_\_\_

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6. Will the patient require care on an intermittent or reduced schedule basis, including any time for recovery? ☐ No ☐ Yes.

Estimate the hours the patient needs care on an intermittent basis, if any:

\_\_\_\_\_ hour(s) per day; \_\_\_\_\_ days per week from \_\_\_\_\_ through \_\_\_\_\_

Explain the care needed by the patient, and why such care is medically necessary:

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7. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activities? \_\_\_\_ No \_\_\_\_ Yes.

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: \_\_\_\_ times per \_\_\_\_ week(s) \_\_\_\_ month(s)

Duration: \_\_\_\_ hours or \_\_\_\_ day(s) per episode

Does the patient need care during these flare-ups? \_\_\_\_ No \_\_\_\_ Yes.

Explain the care needed by the patient, and why such care is medically necessary: \_\_\_\_\_

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**ADDITIONAL INFORMATION: IDENTIFY QUESTION NUMBER WITH YOUR ADDITIONAL ANSWER.**

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\_\_\_\_\_  
**Signature of Health Care Provider**

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

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210.

**DO NOT SEND COMPLETED FORM TO THE DEPARTMENT OF LABOR; RETURN TO THE PATIENT.**

**PERSONNEL SERVICES**

**Form 4321.3**

**Absences, Leaves and Vacation**

**FMLA: Employee Rights and Responsibilities under the Family and Medical Leave Act**

A copy of the Department of Labor's Employee Rights and Responsibilities WHD Publication 1420 Revised February 2013 is attached. Copies may be made of the attached Notice, or additional copies may be obtained from the U.S. Department of Labor, Wage and Hour Division.



# EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

## Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- for incapacity due to pregnancy, prenatal medical care or child birth;
- to care for the employee's child after birth, or placement for adoption or foster care;
- to care for the employee's spouse, son, daughter or parent, who has a serious health condition; or
- for a serious health condition that makes the employee unable to perform the employee's job.

## Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness\*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness.\*

**\*The FMLA definitions of "serious injury or illness" for current servicemembers and veterans are distinct from the FMLA definition of "serious health condition".**

## Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

## Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months\*, and if at least 50 employees are employed by the employer within 75 miles.

**\*Special hours of service eligibility requirements apply to airline flight crew employees.**

## Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and

a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

## Use of Leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

## Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

## Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

## Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

## Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- interfere with, restrain, or deny the exercise of any right provided under FMLA; and
- discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

## Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

**FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.**



**For additional information:**  
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627  
**WWW.WAGEHOUR.DOL.GOV**

U.S. Department of Labor | Wage and Hour Division



WHD Publication 1420 · Revised February 2013

**PERSONNEL SERVICES****Form 4321.4****Absences, Leaves and Vacation****FMLA: Notice of Eligibility and Rights & Responsibility**

A copy of the Department of Labor's Notice of Eligibility and Rights & Responsibilities Form WH-381 Revised February 2013 is attached. Copies may be made of the attached Notice, or additional copies may be obtained from the U.S. Department of Labor, Wage and Hour Division.

Notice of Eligibility and Rights & Responsibilities  
(Family and Medical Leave Act)

U.S. Department of Labor  
Wage and Hour Division



OMB Control Number: 1235-0003  
Expires: 2/28/2015

In general, to be eligible an employee must have worked for an employer for at least 12 months, meet the hours of service requirement in the 12 months preceding the leave, and work at a site with at least 50 employees within 75 miles. While use of this form by employers is optional, a fully completed Form WH-381 provides employees with the information required by 29 C.F.R. § 825.300(b), which must be provided within five business days of the employee notifying the employer of the need for FMLA leave. Part B provides employees with information regarding their rights and responsibilities for taking FMLA leave, as required by 29 C.F.R. § 825.300(b), (c).

**[Part A – NOTICE OF ELIGIBILITY]**

TO: \_\_\_\_\_  
Employee

FROM: \_\_\_\_\_  
Employer Representative

DATE: \_\_\_\_\_

On \_\_\_\_\_, you informed us that you needed leave beginning on \_\_\_\_\_ for:

- ☐ The birth of a child, or placement of a child with you for adoption or foster care;
- ☐ Your own serious health condition;
- ☐ Because you are needed to care for your \_\_\_\_\_ spouse; \_\_\_\_\_ child; \_\_\_\_\_ parent due to his/her serious health condition.
- ☐ Because of a qualifying exigency arising out of the fact that your \_\_\_\_\_ spouse; \_\_\_\_\_ son or daughter; \_\_\_\_\_ parent is on covered active duty or call to covered active duty status with the Armed Forces.
- ☐ Because you are the \_\_\_\_\_ spouse; \_\_\_\_\_ son or daughter; \_\_\_\_\_ parent; \_\_\_\_\_ next of kin of a covered servicemember with a serious injury or illness.

This Notice is to inform you that you:

- ☐ Are eligible for FMLA leave (See Part B below for Rights and Responsibilities)
- ☐ Are **not** eligible for FMLA leave, because (only one reason need be checked, although you may not be eligible for other reasons):
- ☐ You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately \_\_\_\_\_ months towards this requirement.
- ☐ You have not met the FMLA's hours of service requirement.
- ☐ You do not work and/or report to a site with 50 or more employees within 75-miles.

If you have any questions, contact \_\_\_\_\_ or view the  
FMLA poster located in \_\_\_\_\_.

**[PART B-RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE]**

As explained in Part A, you meet the eligibility requirements for taking FMLA leave and still have FMLA leave available in the applicable 12-month period. **However, in order for us to determine whether your absence qualifies as FMLA leave, you must return the following information to us by \_\_\_\_\_.** (If a certification is requested, employers must allow at least 15 calendar days from receipt of this notice; additional time may be required in some circumstances.) If sufficient information is not provided in a timely manner, your leave may be denied.

- ☐ Sufficient certification to support your request for FMLA leave. A certification form that sets forth the information necessary to support your request \_\_\_\_\_ is/ \_\_\_\_\_ is not enclosed.
- ☐ Sufficient documentation to establish the required relationship between you and your family member.
- ☐ Other information needed (such as documentation for military family leave): \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

☐ No additional information requested

If your leave does qualify as FMLA leave you will have the following **responsibilities** while on FMLA leave (only checked blanks apply):

- \_\_\_\_\_ Contact \_\_\_\_\_ at \_\_\_\_\_ to make arrangements to continue to make your share of the premium payments on your health insurance to maintain health benefits while you are on leave. You have a minimum 30-day (or, indicate longer period, if applicable) grace period in which to make premium payments. If payment is not made timely, your group health insurance may be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse, or, at our option, we may pay your share of the premiums during FMLA leave, and recover these payments from you upon your return to work.
- \_\_\_\_\_ You will be required to use your available paid \_\_\_\_\_ **sick**, \_\_\_\_\_ **vacation**, and/or \_\_\_\_\_ **other leave** during your FMLA absence. This means that you will receive your paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA leave entitlement.
- \_\_\_\_\_ Due to your status within the company, you are considered a “key employee” as defined in the FMLA. As a “key employee,” restoration to employment may be denied following FMLA leave on the grounds that such restoration will cause substantial and grievous economic injury to us. We \_\_\_\_\_ **have**/\_\_\_\_\_ **have not** determined that restoring you to employment at the conclusion of FMLA leave will cause substantial and grievous economic harm to us.
- \_\_\_\_\_ While on leave you will be required to furnish us with periodic reports of your status and intent to return to work every \_\_\_\_\_. (Indicate interval of periodic reports, as appropriate for the particular leave situation).

**If the circumstances of your leave change, and you are able to return to work earlier than the date indicated on the this form, you will be required to notify us at least two workdays prior to the date you intend to report for work.**

If your leave does qualify as FMLA leave you will have the following **rights** while on FMLA leave:

- You have a right under the FMLA for up to 12 weeks of unpaid leave in a 12-month period calculated as:
  - \_\_\_\_\_ the calendar year (January – December).
  - \_\_\_\_\_ a fixed leave year based on \_\_\_\_\_.
  - \_\_\_\_\_ the 12-month period measured forward from the date of your first FMLA leave usage.
  - \_\_\_\_\_ a “rolling” 12-month period measured backward from the date of any FMLA leave usage.
- You have a right under the FMLA for up to 26 weeks of unpaid leave in a single 12-month period to care for a covered servicemember with a serious injury or illness. This single 12-month period commenced on \_\_\_\_\_.
- Your health benefits must be maintained during any period of unpaid leave under the same conditions as if you continued to work.
- You must be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. (If your leave extends beyond the end of your FMLA entitlement, you do not have return rights under FMLA.)
- If you do not return to work following FMLA leave for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a covered servicemember’s serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you may be required to reimburse us for our share of health insurance premiums paid on your behalf during your FMLA leave.
- If we have not informed you above that you must use accrued paid leave while taking your unpaid FMLA leave entitlement, you have the right to have \_\_\_\_\_ **sick**, \_\_\_\_\_ **vacation**, and/or \_\_\_\_\_ **other leave** run concurrently with your unpaid leave entitlement, provided you meet any applicable requirements of the leave policy. Applicable conditions related to the substitution of paid leave are referenced or set forth below. If you do not meet the requirements for taking paid leave, you remain entitled to take unpaid FMLA leave.

\_\_\_\_\_ For a copy of conditions applicable to sick/vacation/other leave usage please refer to \_\_\_\_\_ available at: \_\_\_\_\_.

\_\_\_\_\_ Applicable conditions for use of paid leave: \_\_\_\_\_

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**Once we obtain the information from you as specified above, we will inform you, within 5 business days, whether your leave will be designated as FMLA leave and count towards your FMLA leave entitlement. If you have any questions, please do not hesitate to contact:**

\_\_\_\_\_ at \_\_\_\_\_.

#### PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

It is mandatory for employers to provide employees with notice of their eligibility for FMLA protection and their rights and responsibilities. 29 U.S.C. § 2617; 29 C.F.R. § 825.300(b), (c). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**

**PERSONNEL SERVICES****Form 4321.5****Absences, Leaves and Vacation****FMLA: Designation Notice**

A copy of the Department of Labor's Designation Notice Form WH-382 January 2009 is attached. Copies may be made of the attached Notice, or additional copies may be obtained from the U.S. Department of Labor, Wage and Hour Division.

Designation Notice  
(Family and Medical Leave Act)

U.S. Department of Labor  
Wage and Hour Division



OMB Control Number: 1235-0003  
Expires: 2/28/2015

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the employer must inform the employee of the amount of leave that will be counted against the employee's FMLA leave entitlement. In order to determine whether leave is covered under the FMLA, the employer may request that the leave be supported by a certification. If the certification is incomplete or insufficient, the employer must state in writing what additional information is necessary to make the certification complete and sufficient. While use of this form by employers is optional, a fully completed Form WH-382 provides an easy method of providing employees with the written information required by 29 C.F.R. §§ 825.300(c), 825.301, and 825.305(c).

To: \_\_\_\_\_

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

We have reviewed your request for leave under the FMLA and any supporting documentation that you have provided.  
We received your most recent information on \_\_\_\_\_ and decided:

☐ **Your FMLA leave request is approved. All leave taken for this reason will be designated as FMLA leave.**

**The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended, or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement:**

☐ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave entitlement: \_\_\_\_\_

☐ Because the leave you will need will be unscheduled, it is not possible to provide the hours, days, or weeks that will be counted against your FMLA entitlement at this time. You have the right to request this information once in a 30-day period (if leave was taken in the 30-day period).

**Please be advised (check if applicable):**

☐ You have requested to use paid leave during your FMLA leave. Any paid leave taken for this reason will count against your FMLA leave entitlement.

☐ We are requiring you to substitute or use paid leave during your FMLA leave.

☐ You will be required to present a fitness-for-duty certificate to be restored to employment. If such certification is not timely received, your return to work may be delayed until certification is provided. A list of the essential functions of your position ☐ **is** ☐ **is not** attached. If attached, the fitness-for-duty certification must address your ability to perform these functions.

**Additional information is needed to determine if your FMLA leave request can be approved:**

☐ The certification you have provided is not complete and sufficient to determine whether the FMLA applies to your leave request. You must provide the following information no later than \_\_\_\_\_, unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.  
(Provide at least seven calendar days)

\_\_\_\_\_  
(Specify information needed to make the certification complete and sufficient)

☐ We are exercising our right to have you obtain a second or third opinion medical certification at our expense, and we will provide further details at a later time.

☐ Your FMLA Leave request is Not Approved.

☐ The FMLA does not apply to your leave request.

☐ You have exhausted your FMLA leave entitlement in the applicable 12-month period.

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

It is mandatory for employers to inform employees in writing whether leave requested under the FMLA has been determined to be covered under the FMLA. 29 U.S.C. § 2617; 29 C.F.R. §§ 825.300(d), (e). It is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R. § 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 10 – 30 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**

**PERSONNEL SERVICES**

**Form 4321.6**

**Absences, Leaves and Vacation**

**FMLA: Certification of Qualifying Exigency for Military Family Leave**

The FMLA Certification of Qualifying Exigency for Military Family Leave WH-384 Revised February 2013 is attached. Copies may be made of the attached Notice, or additional copies may be obtained from the U.S. Department of Labor, Wage and Hour Division.

Certification of Qualifying Exigency  
For Military Family Leave  
(Family and Medical Leave Act)

U.S. Department of Labor  
Wage and Hour Division



OMB Control Number: 1235-0003  
Expires: 2/ 28/2015

**SECTION I: For Completion by the EMPLOYER**

**INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a qualifying exigency to submit a certification. Please complete Section I before giving this form to your employee. Your response is voluntary, and while you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 CFR 825.309.

Employer name: \_\_\_\_\_

Contact Information: \_\_\_\_\_

**SECTION II: For Completion by the EMPLOYEE**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section II fully and completely. The FMLA permits an employer to require that you submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a qualifying exigency. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency. Be as specific as you can; terms such as "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Your response is required to obtain a benefit. 29 CFR 825.310. While you are not required to provide this information, failure to do so may result in a denial of your request for FMLA leave. Your employer must give you at least 15 calendar days to return this form to your employer.

Your Name: \_\_\_\_\_  
First Middle Last

Name of military member on covered active duty or call to covered active duty status:

\_\_\_\_\_  
First Middle Last

Relationship of military member to you: \_\_\_\_\_

Period of military member's covered active duty: \_\_\_\_\_

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a military member's covered active duty or call to covered active duty status. Please check one of the following and attach the indicated document to support that the military member is on covered active duty or call to covered active duty status.

- ☐ A copy of the military member's covered active duty orders is attached.
- ☐ Other documentation from the military certifying that the military member is on covered active duty (or has been notified of an impending call to covered active duty) is attached.
- ☐ I have previously provided my employer with sufficient written documentation confirming the military member's covered active duty or call to covered active duty status.



**PART A: QUALIFYING REASON FOR LEAVE**

1. Describe the reason you are requesting FMLA leave due to a qualifying exigency (including the specific reason you are requesting leave):

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2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military; a document confirming the military member's Rest and Recuperation leave; a document confirming an appointment with a third party, such as a counselor or school official, or staff at a care facility; or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached.

Yes ☐ No ☐ None Available ☐

**PART B: AMOUNT OF LEAVE NEEDED**

1. Approximate date exigency commenced: \_\_\_\_\_

Probable duration of exigency: \_\_\_\_\_

2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency?

Yes ☐ No ☐

If so, estimate the beginning and ending dates for the period of absence:

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3. Will you need to be absent from work periodically to address this qualifying exigency? Yes ☐ No ☐

Estimate schedule of leave, including the dates of any scheduled meetings or appointments:

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Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time (i.e., 1 deployment-related meeting every month lasting 4 hours):

Frequency: \_\_\_\_\_ times per \_\_\_\_\_ week(s) \_\_\_\_\_ month(s)

Duration: \_\_\_\_\_ hours \_\_\_\_\_ day(s) per event.

**PART C:**

If leave is requested to meet with a third party (such as to arrange for childcare or parental care, to attend counseling, to attend meetings with school, childcare or parental care providers, to make financial or legal arrangements, to act as the military member's representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations), a complete and sufficient certification includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone or fax number or email address of the individual or entity). This information may be used by your employer to verify that the information contained on this form is accurate.

Name of Individual: \_\_\_\_\_ Title: \_\_\_\_\_

Organization: \_\_\_\_\_

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

Telephone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_

Describe nature of meeting: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PART D:**

I certify that the information I provided above is true and correct.

Signature of Employee \_\_\_\_\_ Date \_\_\_\_\_

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. 2616; 29 CFR 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE EMPLOYER.**

**PERSONNEL SERVICES**

**Form 4321.7**

**Absences, Leaves and Vacation**

**FMLA: Certification for Serious Injury or Illness of a Current Servicemember - - for  
Military Family Leave**

The FMLA Certification for Serious Injury or Illness of a Current Servicemember for Military Family Leave Form WH-385 Revised February 2013 is attached. Copies may be made of the attached Notice, or additional copies may be obtained from the U.S. Department of Labor, Wage and Hour Division.

Certification for Serious Injury or  
Illness of a Current  
Servicemember - for Military Family Leave  
(Family and Medical Leave Act)

U.S. Department of Labor

Wage and Hour Division



OMB Control Number: 1235-0003  
Expires: 2/28/2015

**Notice to the EMPLOYER**

**INSTRUCTIONS to the EMPLOYER:** The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a serious injury or illness of a current servicemember to submit a certification providing sufficient facts to support the request for leave. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 CFR 825.310. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or employees' family members created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 CFR 1630.14(c)(1), if the Americans with Disabilities Act applies.

**SECTION I: For Completion by the EMPLOYEE and/or the CURRENT SERVICEMEMBER for whom the Employee Is Requesting Leave**

**INSTRUCTIONS to the EMPLOYEE or CURRENT SERVICEMEMBER:** Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. 2613, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 CFR 825.310(f). The employer must give an employee at least 15 calendar days to return this form to the employer.

**SECTION II: For Completion by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 CFR 825.125**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** The employee listed on Page 2 has requested leave under the FMLA to care for a family member who is a current member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty in the Armed Forces or that existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a current servicemember's serious injury or illness includes written documentation confirming that the servicemember's injury or illness was incurred in the line of duty on active duty or if not, that the current servicemember's injury or illness existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces, and that the current servicemember is undergoing treatment for such injury or illness by a health care provider listed above. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA coverage. Limit your responses to the servicemember's condition for which the employee is seeking leave.

**SECTION I: For Completion by the EMPLOYEE and/or the CURRENT SERVICEMEMBER for whom the Employee Is Requesting Leave:**

(This section must be completed first before any of the below sections can be completed by a health care provider.)

**Part A: EMPLOYEE INFORMATION**

Name and Address of Employer (this is the employer of the employee requesting leave to care for the current servicemember):

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Name of Employee Requesting Leave to Care for the Current Servicemember:

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First

Middle

Last

Name of the Current Servicemember (for whom employee is requesting leave to care):

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First

Middle

Last

Relationship of Employee to the Current Servicemember:

Spouse ☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin ☐

**Part B: SERVICEMEMBER INFORMATION**

- (1) Is the Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves?  
Yes ☐ No ☐

If yes, please provide the servicemember's military branch, rank and unit currently assigned to:

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Is the servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)?

Yes ☐ No ☐

If yes, please provide the name of the medical treatment facility or unit:

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- (2) Is the Servicemember on the Temporary Disability Retired List (TDRL)?  
Yes ☐ No ☐

**Part C: CARE TO BE PROVIDED TO THE SERVICEMEMBER**

Describe the Care to Be Provided to the Current Servicemember and an Estimate of the Leave Needed to Provide the Care:

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**SECTION II: For Completion by a United States Department of Defense (“DOD”) Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs (“VA”) health care provider; (2) a DOD TRICARE network authorized private health care provider; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 CFR 825.125. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator).**

(Please ensure that Section I above has been completed before completing this section. Please be sure to sign the form on the last page.)

**Part A: HEALTH CARE PROVIDER INFORMATION**

Health Care Provider’s Name and Business Address:

\_\_\_\_\_

Type of Practice/Medical Specialty: \_\_\_\_\_

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; (4) a DOD non-network TRICARE authorized private health care provider, or (5) a health care provider as defined in 29 CFR 825.125:

\_\_\_\_\_

Telephone: (    ) \_\_\_\_\_ Fax: (    ) \_\_\_\_\_ Email: \_\_\_\_\_

**PART B: MEDICAL STATUS**

(1) The current Servicemember’s medical condition is classified as (Check One of the Appropriate Boxes):

☐ **(VSI) Very Seriously Ill/Injured** – Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ **(SI) Seriously Ill/Injured** – Illness/injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ **OTHER Ill/Injured** – a serious injury or illness that may render the servicemember medically unfit to perform the duties of the member’s office, grade, rank, or rating.

☐ **NONE OF THE ABOVE** (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a “serious health condition” under § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380-F or an employer-provided form seeking the same information.)

(2) Is the current Servicemember being treated for a condition which was incurred or aggravated by service in the line of duty on active duty in the Armed Forces? Yes ☐ No ☐

(3) Approximate date condition commenced: \_\_\_\_\_

(4) Probable duration of condition and/or need for care: \_\_\_\_\_

- (5) Is the servicemember undergoing medical treatment, recuperation, or therapy for this condition? Yes ☐ No ☐

If yes, please describe medical treatment, recuperation or therapy:

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**PART C: SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER**

- (1) Will the servicemember need care for a single continuous period of time, including any time for treatment and recovery? Yes ☐ No ☐

If yes, estimate the beginning and ending dates for this period of time: \_\_\_\_\_

- (2) Will the servicemember require periodic follow-up treatment appointments? Yes ☐ No ☐

If yes, estimate the treatment schedule: \_\_\_\_\_

- (3) Is there a medical necessity for the servicemember to have periodic care for these follow-up treatment appointments? Yes ☐ No ☐

- (4) Is there a medical necessity for the servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)?

Yes ☐ No ☐

If yes, please estimate the frequency and duration of the periodic care:

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**Signature of Health Care Provider:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years, in accordance with 29 U.S.C. 2616; 29 CFR 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE PATIENT.**

**PERSONNEL SERVICES**

**Form 4321.8**

**Absences, Leaves and Vacation**

**FMLA: Certification for Serious Injury or Illness of a Veteran for Military Caregiver Leave**

The FMLA Certification for Serious Injury or Illness of a Veteran for Military Caregiver Leave Form WH-385-V Revised February 2013 is attached. Copies may be made of the attached Notice, or additional copies may be obtained from the U.S. Department of Labor, Wage and Hour Division.



Certification for Serious Injury  
or Illness of a Veteran for  
Military Caregiver Leave  
(Family and Medical Leave Act)

U.S. Department of Labor  
Wage and Hour Division



OMB Control Number: 1235-0003  
Expires: 2/28/2015

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**Notice to the EMPLOYER**

The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking military caregiver leave under the FMLA leave due to a serious injury or illness of a covered veteran to submit a certification providing sufficient facts to support the request for leave. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 CFR 825.310. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or employees' family members, created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 CFR 1630.14(c)(1), if the Americans with Disabilities Act applies.

**SECTION I: For completion by the EMPLOYEE and/or the VETERAN for whom the employee is requesting leave**

**INSTRUCTIONS to the EMPLOYEE and/or VETERAN:** Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for military caregiver leave under the FMLA leave due to a serious injury or illness of a covered veteran. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. 2613, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 CFR 825.310(f). The employer must give an employee at least 15 calendar days to return this form to the employer.

(This section must be completed before Section II can be completed by a health care provider.)

**Part A: EMPLOYEE INFORMATION**

Name and address of employer (this is the employer of the employee requesting leave to care for a veteran):

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Name of employee requesting leave to care for a veteran:

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First	Middle	Last
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Name of veteran (for whom employee is requesting leave):

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First	Middle	Last
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Relationship of employee to veteran:

Spouse ☐    Parent ☐    Son ☐    Daughter ☐    Next of Kin ☐ (please specify relationship):

**Part B: VETERAN INFORMATION**

- (1) Date of the veteran's discharge:  
\_\_\_\_\_
- (2) Was the veteran **dishonorably** discharged or released from the Armed Forces (including the National Guard or Reserves)? Yes ☐ No ☐
- (3) Please provide the veteran's military branch, rank and unit at the time of discharge:  
\_\_\_\_\_
- (4) Is the veteran receiving medical treatment, recuperation, or therapy for an injury or illness?  
Yes ☐ No ☐

**Part C: CARE TO BE PROVIDED TO THE VETERAN**

Describe the care to be provided to the veteran and an estimate of the leave needed to provide the care:

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**SECTION II: For completion by: (1) a United States Department of Defense (“DOD”) health care provider; (2) a United States Department of Veterans Affairs (“VA”) health care provider; (3) a DOD TRICARE network authorized private health care provider; (4) a DOD non-network TRICARE authorized private health care provider; or (5) a health care provider as defined in 29 CFR 825.125.**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** The employee named in Section I has requested leave under the military caregiver leave provision of the FMLA to care for a family member who is a veteran. For purposes of FMLA military caregiver leave, a serious injury or illness means an injury or illness incurred by the servicemember in the line of duty on active duty in the Armed Forces (or that existed before the beginning of the servicemember’s active duty and was aggravated by service in the line of duty on active duty in the Armed Forces) and manifested itself before or after the servicemember became a veteran, and is:

- (i) a continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember unable to perform the duties of the servicemember’s office, grade, rank, or rating; or
- (ii) a physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50 percent or greater, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave; or
- (iii) a physical or mental condition that substantially impairs the covered veteran’s ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment; or
- (iv) an injury, including a psychological injury, on the basis of which the covered veteran has been enrolled in the Department of Veterans’ Affairs Program of Comprehensive Assistance for Family Caregivers.

A complete and sufficient certification to support a request for FMLA military caregiver leave due to a covered veteran’s serious injury or illness includes written documentation confirming that the veteran’s injury or illness was incurred in the line of duty on active duty or existed before the beginning of the veteran’s active duty and was aggravated by service in the line of duty on active duty, and that the veteran is undergoing treatment, recuperation, or therapy for such injury or illness by a health care provider listed above. Answer fully and completely all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as “lifetime,” “unknown,” or “indeterminate” may not be sufficient to determine FMLA military caregiver leave coverage. Limit your responses to the veteran’s condition for which the employee is seeking leave.

(Please ensure that Section I has been completed before completing this section. Please be sure to sign the form on the last page and return this form to the employee requesting leave (See Section I, Part A above). **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**)

**Part A: HEALTH CARE PROVIDER INFORMATION**

Health care provider’s name and business address:

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Telephone: (    ) \_\_\_\_\_ Fax: (    ) \_\_\_\_\_ Email: \_\_\_\_\_

Type of Practice/Medical Specialty: \_\_\_\_\_

Please indicate if you are:

☐ a DOD health care provider

☐ a VA health care provider

☐ a DOD TRICARE network authorized private health care provider

☐ a DOD non-network TRICARE authorized private health care provider

☐ other health care provider

## PART B: MEDICAL STATUS

Note: If you are unable to make certain of the military-related determinations contained in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as, DOD Recovery Care Coordinator) or an authorized VA representative.

(1) The Veteran's medical condition is:

- ☐ A continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember unable to perform the duties of the servicemember's office, grade, rank, or rating.
- ☐ A physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service Related Disability Rating (VASRD) of 50% or higher, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave.
- ☐ A physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment.
- ☐ An injury, including a psychological injury, on the basis of which the covered veteran is enrolled in the Department of Veterans' Affairs Program of Comprehensive Assistance for Family Caregivers.
- ☐ None of the above.

(2) Is the veteran being treated for a condition which was incurred or aggravated by service in the line of duty on active duty in the Armed Forces? Yes ☐ No ☐

(3) Approximate date condition commenced: \_\_\_\_\_

(4) Probable duration of condition and/or need for care: \_\_\_\_\_

(5) Is the veteran undergoing medical treatment, recuperation, or therapy for this condition? Yes ☐ No ☐

If yes, please describe medical treatment, recuperation or therapy:

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## PART C: VETERAN'S NEED FOR CARE BY FAMILY MEMBER

"Need for care" encompasses both physical and psychological care. It includes situations where, for example, due to his or her serious injury or illness, the veteran is unable to care for his or her own basic medical, hygienic, or nutritional needs or safety, or is unable to transport him or herself to the doctor. It also includes providing psychological comfort and reassurance which would be beneficial to the veteran who is receiving inpatient or home care.

(1) Will the veteran need care for a single continuous period of time, including any time for treatment and recovery? Yes ☐ No ☐

If yes, estimate the beginning and ending dates for this period of time: \_\_\_\_\_

(2) Will the veteran require periodic follow-up treatment appointments? Yes ☐ No ☐

If yes, estimate the treatment schedule: \_\_\_\_\_

- (3) Is there a medical necessity for the veteran to have periodic care for these follow-up treatment appointments?  
Yes ☐ No ☐
- (4) Is there a medical necessity for the veteran to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups of medical condition)? Yes ☐ No ☐

If yes, please estimate the frequency and duration of the periodic care:

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Signature of Health Care Provider: \_\_\_\_\_ Date: \_\_\_\_\_

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years, in accordance with 29 U.S.C. 2616; 29 CFR 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution Ave., NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE EMPLOYEE REQUESTING LEAVE (As shown in Section I, Part "A" above).**

**PERSONNEL SERVICES**

**Form 4810**

**Staff Welfare**

**Title IX/Section 504 Rights: Grievance Form**

**TITLE IX/SECTION 504  
GRIEVANCE FORM**

Date\_\_\_\_\_

Your name\_\_\_\_\_

Your school and/or position\_\_\_\_\_

Place where you may be reached\_\_\_\_\_

Address\_\_\_\_\_

Phone\_\_\_\_\_

Nature of your grievance. (Please describe the policy or action you believe may be in violation of Title IX/Section 504 or other civil rights statute: please identify any person(s) you believe may be responsible.)

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If others are affected by the possible violation, please give their names and/or positions:

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Please describe any corrective action you wish to see taken with regard to the possible violation. You may also provide other information relevant to this grievance.

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\_\_\_\_\_  
Signature of Grievant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Location

\_\_\_\_\_  
Signature of Person Receiving Grievance

**Staff Welfare**

**Sexual Harassment Prohibited Notice**

**SEXUAL HARASSMENT PROHIBITED  
NOTICE  
TO ALL EMPLOYEES AND STUDENTS  
REGARDING SEXUAL HARASSMENT**

The Fox C-6 School District is committed to an academic and work environment in which all students and employees are treated with dignity and respect. Sexual harassment of students and employees whether committed by supervisors, employees or students and regardless of whether the victim is an employee or student will not be tolerated.

Sexual harassment includes but is not limited to:

1. sexual slurs, threats, verbal abuse and sexually degrading descriptions
2. graphic verbal comments about an individual's body
3. sexual jokes, notes, stories, drawing, pictures or gesture
4. spreading sexual rumors
5. touching an individual's body or clothes in a sexual way
6. displaying sexually suggestive objects
7. covering or blocking of normal movements
8. unwelcomed sexual flirtation or propositions
9. acts of retaliation against a person who reports sexual harassment.

Inquiries, complaints or grievances from students and their parents and employees regarding sexual harassment or compliance with Title IX may be directed to the Superintendent of Schools, to the District's Title IX Coordinator, or the Director of the Office of Civil Rights, Department of Education, Washington, D.C.

The District's Title IX Coordinator is:

Assistant Supt-Human Resources  
Central Office  
745 Jeffco Blvd.  
Arnold, MO 63010-1432  
Telephone: 636-296-8000

**Staff Welfare****Sexual Harassment Complaint Form**

*The Fox C-6 School District will not tolerate discrimination under any circumstances. Such discrimination includes harassment creating a hostile environment, on the basis of race, color, national origin, ethnicity, sex, religion, disability, age, sexual orientation or perceived sexual orientation in its programs, activities, and with regard to employment.*

**SEXUAL HARASSMENT COMPLAINT FORM - Staff**

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

Department: \_\_\_\_\_ Job Title: \_\_\_\_\_

Immediate Supervisor: \_\_\_\_\_

Who was responsible for the harassment? \_\_\_\_\_

Describe the sexual harassment: \_\_\_\_\_

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

Date, time and place the harassment occurred: \_\_\_\_\_

Were there other employees involved with the harassment? \_\_\_\_\_

If so, who was responsible and describe their involvement: \_\_\_\_\_

\_\_\_\_\_  
List any witnesses to the harassment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What was your reaction to the harassment? \_\_\_\_\_

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

Describe any subsequent incidents: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
Signature of Complainant \_\_\_\_\_ Date \_\_\_\_\_

***Note: This form will be filed with the District's Compliance Officer, the Assistant Superintendent of Human Resources located at the District's Central Office, 745 Jeffco Blvd., Arnold, MO 63010-1432, Telephone #636-296-8000***



Adopted:	11/98	Effective:	07/99
Revised:	06/03	Effective:	06/03

**Student Welfare****Sexual Harassment Complaint Form**

*The Fox C-6 School District will not tolerate discrimination under any circumstances. Such discrimination includes harassment creating a hostile environment, on the basis of race, color, national origin, ethnicity, sex, religion, disability, age, sexual orientation or perceived sexual orientation in its programs, activities, and with regard to employment.*

**SEXUAL HARASSMENT COMPLAINT FORM - Student**

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

Site/School: \_\_\_\_\_

Place where you may be reached: \_\_\_\_\_ Telephone: \_\_\_\_\_

Who was responsible for the harassment? \_\_\_\_\_

Describe the incident(s): \_\_\_\_\_  
\_\_\_\_\_

(Attach additional pages as necessary)

Date(s), time(s), and places(s) the harassment occurred: \_\_\_\_\_

Were there other individuals involved in the harassment? \_\_\_\_\_ If so, name the individual(s)  
and what their role was: \_\_\_\_\_

Did anyone witness the harassment? \_\_\_\_\_ If so, name the witnesses: \_\_\_\_\_

What was your reaction to the harassment? \_\_\_\_\_

Describe any prior incidents: \_\_\_\_\_

Please describe any corrective action you wish to see taken with regard to the possible violation. You  
may also provide other information relative to this grievance: \_\_\_\_\_\_\_\_\_\_  
Signature of Grievant\_\_\_\_\_  
Date\_\_\_\_\_  
Signature of Person Receiving Grievance\_\_\_\_\_  
Position/Title

*Note: This form will be filed with the District's Compliance Officer, the Assistant Superintendent of Human Resources located at the District's Central Office, 745 Jeffco Blvd., Arnold, MO 63010-1432, Telephone #636-296-8000*

Adopted: 06/03 Effective: 06/03  
Consolidated School District No. 6 (Fox)

**Staff Welfare****Other Harassment Complaint Form**

*The Fox C-6 School District will not tolerate discrimination under any circumstances. Such discrimination includes harassment creating a hostile environment, on the basis of race, color, national origin, ethnicity, sex, religion, disability, age, sexual orientation or perceived sexual orientation in its programs, activities, and with regard to employment.*

**OTHER HARASSMENT COMPLAINT FORM**

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

Site/School: \_\_\_\_\_

Place where you may be reached: \_\_\_\_\_ Telephone: \_\_\_\_\_

Who was responsible for the harassment? \_\_\_\_\_

Describe the incident(s): \_\_\_\_\_

(Attach additional pages as necessary)

Date(s), time(s), and places(s) the harassment occurred: \_\_\_\_\_

Were there other individuals involved in the harassment? \_\_\_\_\_ If so, name the individual(s) and what their role was: \_\_\_\_\_

Did anyone witness the harassment? \_\_\_\_\_ If so, name the witnesses: \_\_\_\_\_

What was your reaction to the harassment? \_\_\_\_\_

Describe any prior incidents: \_\_\_\_\_

Please describe any corrective action you wish to see taken with regard to the possible violation. You may also provide other information relative to this grievance: \_\_\_\_\_

\_\_\_\_\_  
Signature of Grievant\_\_\_\_\_  
Date\_\_\_\_\_  
Signature of Person Receiving Grievance\_\_\_\_\_  
Position/Title

***Note: This form will be filed with the District's Compliance Officer, the Assistant Superintendent of Human Resources, located at 745 Jeffco Blvd. Telephone # 636-296-8000.***

Adopted: 06/03 Effective: 06/03  
Consolidated School District No. 6 (Fox)

**Policy 4850**

**Fox C-6 School District  
Grievance Form A  
Initiation at Level One (Immediate Supervisor)**

Name of Grievant \_\_\_\_\_

Building \_\_\_\_\_

Date of Occurrence of Condition \_\_\_\_\_

Date Filed \_\_\_\_\_

1. Statement of Grievance:

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2. Nature of Grievance:

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3. Resolution Requested:

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4. I understand that I may bring no more than two (2) representatives to his hearing.

I do/do not (circle one) wish to have representatives present at this conference. Please find below the names(s) of representatives who will be present during the conference.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Adopted: 11/98

Effective: 07/99

Consolidated School District No. 6 (Fox)

**Fox C-6 School District  
Grievance Form B  
Supervisor's Response**

Name of Grievant \_\_\_\_\_ Building \_\_\_\_\_

Date of Grievance Filed \_\_\_\_\_ Date of Conference \_\_\_\_\_

1. Decision Rendered:

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2. Reason for the Decision:

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\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Adopted: 11/98

Effective: 07/99

Consolidated School District No. 6 (Fox)

**Fox C-6 School District  
Grievance Form C  
Appeal to Level Two (Superintendent)**

Name of Grievant \_\_\_\_\_ Building \_\_\_\_\_

Date Level One Decision Received \_\_\_\_\_

Please find attached:

1. Grievance Form A, Initiation at Level One \_\_\_\_\_
2. Grievance Form B, Supervisor's Response \_\_\_\_\_

Because I have failed to reach a satisfactory resolution to my grievance at Level One, I wish to request a hearing of my concerns at Level Two.

I understand I may bring no more than three (3) representatives to this hearing. I do/do not (circle one) wish to have representatives present at the conference. Please find below the names(s) of representatives who will be present during the conference.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Adopted: 11/98

Consolidated School District No. 6 (Fox)

Effective: 07/99



**Fox C-6 School District  
Grievance Form D  
Superintendent's Hearing Response**

Name of Grievant \_\_\_\_\_ Building \_\_\_\_\_

Date Grievance Filed \_\_\_\_\_ Date of Conference \_\_\_\_\_

1. Decision Rendered:

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2. Reason for the Decision:

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\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Effective:  
07/99

**Policy 4835**  
**Page 10 of 14**

Adopted: 11/98

Effective: 07/99

Consolidated School District No. 6 (Fox)

**Fox C-6 School District  
Grievance Form E  
Appeal to Level Three (Board of Education)**

Name of Grievant \_\_\_\_\_

Building \_\_\_\_\_

Date Level One Decision Received \_\_\_\_\_

Date Level Two Decision Received \_\_\_\_\_

Please find attached:

1. Grievance Form A, Initiation at Level One \_\_\_\_\_
2. Grievance Form B, Supervisor's Response \_\_\_\_\_
3. Grievance Form C, Appeal to Level Two (Superintendent) \_\_\_\_\_
4. Grievance Form D, Superintendent's Hearing Response \_\_\_\_\_

Because I have failed to reach a satisfactory resolution to my grievance at Level One and at Level Two, I wish to request a hearing of my concerns at Level Three.

I understand I may bring no more than three (3) representatives to this hearing. I do/do not (circle one) wish to have representatives present at the conference. Please find below the names(s) of representatives who will be present during the conference.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Adopted: 11/98

Effective: 07/99

Consolidated School District No. 6 (Fox)

**Fox C-6 School District  
Grievance Form F  
Grievance Notification**

(To be completed by grievant)

TO: \_\_\_\_\_

FROM: \_\_\_\_\_

DATE: \_\_\_\_\_

**CHECK/COMPLETE THE APPROPRIATE ITEMS:**

In connection with a grievance currently being processed, your name was mentioned.

\_\_\_\_\_ Board Policy states: "Employees filing a grievance will send copies of the grievance document to person(s) named in writing in the grievance process."

You were named in the formal grievance filed at Level \_\_\_\_\_ on \_\_\_\_\_ (date).  
You are being provided a copy of this grievance.

\_\_\_\_\_ You were named verbally at the Level \_\_\_\_\_ Conference on \_\_\_\_\_ (date) as:

A. an example of someone who: (please explain)

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B. a witness to: (please complete)

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C. other: (please complete)

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Adopted: 11/98

Effective: 07/99

Consolidated School District No. 6 (Fox)

**Grievance Form F, page 2**  
**Grievance Notification**

You have the right as a named individual to respond in writing to this reference within three (3) working days of receipt of this notice. Should you desire to submit a written statement, please file this response with \_\_\_\_\_ (Administrator/Supervisor) and with me.

If you desire additional information, please contact me.

cc: Administrator at Level \_\_\_\_\_ Grievance Hearing

**Grievance Form G**  
**Party of Interest Notification Form**

Name of Grievant \_\_\_\_\_ Building \_\_\_\_\_

Name of Party Interest \_\_\_\_\_

Date Grievance Filed \_\_\_\_\_

Please find below the name(s) of representatives and/or witnesses who will be present at the  
Level \_\_\_\_\_ conference of the formal grievance procedure.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Adopted: 11/98

Consolidated School District No. 6 (Fox)

Effective: 07/99

**Grievance Form H**  
**Supervisor/Superintendent Conference Notification Form**

Name of Grievant \_\_\_\_\_

Building \_\_\_\_\_

Date Grievance Filed \_\_\_\_\_

Date of Conference \_\_\_\_\_

Level \_\_\_\_\_

A conference concerning this grievance will be held on \_\_\_\_\_ (date), at  
\_\_\_\_\_ (time), at \_\_\_\_\_ (location).

\_\_\_\_\_

Signature

\_\_\_\_\_

Date

Adopted: 11/98

Effective: 07/99

Consolidated School District No. 6 (Fox)

PERSONNEL SERVICES

Staff Welfare

Personnel Records

Form 4860

FOX C-6 SCHOOL DISTRICT Personnel Record Log				
Name of District Employee	Record Accessed: personnel file medical record I-9 financial record	Date and Time Record Accessed	Printed Name and Signature of District Employee Accessing Record	Reason for accessing record
		Date:		
		Time:		
		Date:		
		Time:		
		Date:		
		Time:		
		Date:		
		Time:		
		Date:		
		Time:		
		Date:		
		Time:		

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Adopted: 11/98

Effective: 07/99

Consolidated School District No. 6 (Fox)

**Staff Welfare**

**Driver Drug Testing: Applicant Consent**

**APPLICANT CONSENT FOR DRUG AND ALCOHOL TESTING**

I hereby consent for the Fox C-6 School District or its designated agents to collect a urine or blood sample from me and conduct necessary tests to determine the presence of illegal drugs, controlled substances, or alcohol.

I also consent to the release of the test results to authorized District administrators for appropriate review.

I further agree that, in the event a confirmed positive test for illegal drugs or controlled substances results, I may have to provide the laboratory or the Medical Review Officer with a list of all medications which I have used within the past thirty (30) days. I understand that this information is provided to identify false positives.

I understand that if, in the opinion of the testing laboratory or Medical Review Officer, the result of my test is positive for illegal drugs, controlled substances, or alcohol, the Fox c-6 School District may deny my application for employment.

AGREED:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Witness:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

REFUSED:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Witness:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



**Staff Welfare**

**Driver Drug Testing: Employee Consent**

**EMPLOYEE CONSENT FOR DRUG AND ALCOHOL TESTING**

I hereby consent for the Fox C-6 School District or its designated agents to collect a urine or blood sample from me and conduct necessary tests to determine the presence of illegal drugs, controlled substances, or alcohol.

I also consent to the release of the test results to authorized District administrators for appropriate review.

I further agree that, in the event a confirmed positive test for illegal drugs or controlled substances results, I may have to provide the laboratory or the Medical Review Officer with a list of all medications which I have used within the past thirty (30) days. I understand that this information is provided to identify false positives.

I understand that if, in the opinion of the testing laboratory or Medical Review Officer, the result of my test is positive for illegal drugs, controlled substances, or alcohol, the Fox C-6 School District may deny my application for employment.

AGREED:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Witness:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

REFUSED:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Witness:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Staff Welfare**

**Alcohol and Illicit Drugs**

**NOTICE**

The use of alcohol or non-prescribed controlled substances by an employee while on duty or the presence of an employee on school premises under the influence of alcohol or non-prescribed controlled substances while on duty is in violation of Board policy, and is strictly prohibited. Violations will result in disciplinary action up to and including termination and may result in limitation or forfeiture of potential workers compensation benefits.

**Safety, Security and Communications****Safety Standards**

In order to promote safety and to reduce the occurrence of injuries to the employee; to the employee's colleagues, students and visitors to our schools, the following requirements are mandated by the Board. These requirements are not intended to be exclusive, but to be illustrative for measures required to promote safety. Moreover, these requirements are in addition to all relevant requirements of federal and state law, as well as, Board policy. Employees will be required to review, sign and return this policy on an annual basis. These requirements are:

1. All accidents are to be reported, in writing, to your supervisor on the date they occur.
2. All unsafe conditions are to be reported to your supervisor immediately.
3. No running or horseplay is permitted.
4. The use of alcohol or non-prescribed drugs during work hours is strictly prohibited. The use of prescribed drugs is permitted subject to the limitations imposed by the prescribing physician.
5. Standing on chairs, desks, boxes, or any object other than a ladder or step stool is prohibited.
6. When using chemicals, all appropriate safety equipment must be used. If the appropriate safety equipment is not available, the absence of same should be reported to your supervisor immediately.
7. If your duties require you to drive, the use of a seatbelt is mandatory. The use of a cell phone for phone calls or texting is prohibited in a moving vehicle.
8. The use of employer provided safety devices is mandatory.

By signing below, I acknowledge that I have read and understand all of the General Safety Requirements. I further acknowledge that I understand that these requirements are not all inclusive. Additions can be made by the location I am working at, the supervisor I am working under, the specific job I am working on, and/or local, state or federal law. Failure to comply with one or more of these requirements will result in disciplinary action.

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Name

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Date

**Curriculum Services****ELL Student Home Language Survey****STUDENT HOME LANGUAGE SURVEY**

Dear Parent/Guardian:

The \_\_\_\_\_ School District has an English Language Learner (ELL) program to help students who may not be proficient in English because of the use of another language in the home, and who thus may have a need for additional help with the classes they are taking. If your child is not proficient in English and you feel he/she may qualify for the ELL program, please complete this form and return it to your child's school. Please call the director of the ELL program at \_\_\_\_\_ if you have any questions. Thank you for your cooperation.

Student's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Person Completing Survey:    \_\_\_\_\_ Mother        \_\_\_\_\_ Father        \_\_\_\_\_ Guardian  
   \_\_\_\_\_ Other (specify) \_\_\_\_\_

Circle the best answer to each question about your child and provide additional information if necessary:

- |   |         |              |
|---|---------|--------------|
| 1. Was the first language you learned English?  | No      | Yes          |
| 2. Can you speak a language other than English?<br>(Do not count languages learned in foreign language classes.)                          | No      | Yes          |
| 3. Is any language other than English used at home?   | No      | Yes          |
| 4. Which language do you use most often with friends?   | English | Other: _____ |
| 5. Which language do you use most often with your parents?  | English | Other: _____ |
| 6. Which language do you use most often with other relatives?   | English | Other: _____ |
| 7. Have you attended school in a country other than the U.S.?<br>(If Yes, how long and what grades? _____)                                | No      | Yes          |
| 8. Have you attended another school in the U.S.?<br>(If Yes, where and how long? _____)   | No      | Yes          |
| 9. Have you attended another school in Missouri?<br>(If Yes, where and how long? _____)   | No      | Yes          |
| 10. Please provide any other related information that would help the school identify any language instruction needs for your child. _____ |         |              |

**Instruction**

**Challenged Materials**

**REVIEW OF INSTRUCTIONAL MATERIALS**

Type of material (book, film, pamphlet, etc.): \_\_\_\_\_

Title of material: \_\_\_\_\_

Author: \_\_\_\_\_

Publisher: \_\_\_\_\_

Your name, address, telephone number: \_\_\_\_\_

Do you have a child in the school concerned? \_\_\_\_\_

Complainant also represents others: \_\_\_\_\_

(organization-name) \_\_\_\_\_

(other group-identify) \_\_\_\_\_

To what part of the material do you object? Cite words, page numbers: \_\_\_\_\_

Why do you object to this material? \_\_\_\_\_

Are you familiar with the range of materials used in the school system on this topic? \_\_\_\_\_

Do you approve of presenting a diversity of points of view about this material in the classroom? \_\_\_\_\_

Should this be withdrawn from all students? Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
Signature of Complainant

\_\_\_\_\_  
Date

Please give/send this information to:

\_\_\_\_\_  
Superintendent

\_\_\_\_\_  
Address

**Instruction****Instruction for Students with Disabilities****SPECIAL EDUCATION SERVICES FOR STUDENTS VOLUNTARILY  
ENROLLED IN PRIVATE SCHOOLS BY THEIR PARENTS**

Under the reauthorized IDEA and its implementing regulations, activities regarding the location, identification, and evaluation of private school students with disabilities are to be comparable to the activities undertaken for students in public schools. However, once identified as having a disability, a student with a disability voluntarily enrolled in a private school by his/her parents/guardians does not have an individual right under the IDEA to receive any or all of the special education and related services that the student would receive if enrolled in a public school.

In order to meet its obligations under the IDEA to students with disabilities voluntarily enrolled by their parents/guardians in private schools, the District will spend a proportionate amount of its federal IDEA Part B funds with respect to this aggregate population of students.

The IDEA requires that the District consult with representatives of private school students with disabilities to decide which students will receive services, what services will be provided, how and where the services will be provided, and how the services provided will be evaluated. The District, however, will make all final decisions regarding the services to be provided to private school children with disabilities.

Services for a private school student with a disability are not required to be provided through development and implementation of an IEP. Instead, for each private school student who is designated to receive services, the District must prepare a services plan that describes the specific special education and related services that the District will provide to the student. The District is required to ensure that a representative of the private school attends meetings to develop, review, and revise a services plan, or, if the representative cannot attend, will use other methods to ensure participation by the private school. To the extent appropriate, the services plan will be developed in a manner consistent with the requirements for an IEP.

The District will not provide special education and related services on the site of any religious school. Pursuant to the Missouri constitutional prohibition against the expenditure of taxpayer funds to support parochial schools, the District will not provide transportation for a religious school student from the student's home or the public school to the religious school.

Due process rights under the IDEA for private school children with disabilities and their parents/guardians are limited. Only issues related to child find and procedures for evaluation and determination of eligibility can be raised in a due process complaint. There is no right to due process to challenge the services that a student receives. Issues related to services may be raised through the Department of Elementary and Secondary Education's child complaint process.

**Instruction**

**Instruction for Migrant Students**

**MIGRATORY SERVICES-REGISTRATION PROCEDURES**  
**STUDENT CHECK LIST**

Please place a check mark as indicated:

- \_\_\_\_\_ 1. Enrollment process indicated parent(s) of student are seasonal or temporary workers.
- \_\_\_\_\_ 2. Parent Survey For Agricultural Related Work completed.
- \_\_\_\_\_ 3. Copy of Parent Survey and Student Information/Enrollment Form sent to Central Office - Associate Superintendent for Special Services. (Original forms should be retained in student's permanent file.)
- \_\_\_\_\_ 4. Verification should be obtained regarding the need for Residency Waiver or other special assistance and services.

\*\*\*\*\*

**PARENT SURVEY FOR AGRICULTURAL RELATED WORK**

**School:** \_\_\_\_\_

**Enrollment Date:** \_\_\_\_\_

If your child/children have moved from one school district to another school district within the past three (3) years, he/she may be eligible for a special program of supplemental education and/or health services.

Please answer the following questions or help us determine if your child is eligible.

Please circle either "yes" or "no" and fill in the blanks.

After you have done this please send the form back to the school. THANK YOU!

1. Before the move, was either parent (or guardian) employed or seeking some form of temporary or seasonal agricultural related work such as:  
☐ Planting or harvesting crops - (vegetables, melons, apples, hay, cotton, etc.)  
☐ Transporting farm products to market.  
☐ Feeding poultry, gathering eggs, working in hatchery, feed mill, or any such activity.  
☐ Processing meat, poultry, fruit, vegetables, dairy products.  
☐ Milking cows on a dairy farm.  
☐ Cutting firewood or logs to sell.  
☐ Commercial fishing or working on a fish farm  
☐ Yes ☐ No
2. Was the move made for the purpose of looking for or obtaining any of the above jobs?  
☐ Yes ☐ No
3. Is either parent (or guardian) now working in any of the above jobs or did they for a short time since moving?  
☐ Yes ☐ No
4. Have you moved away with your child/children only during the summer months to engage in fruit or vegetable harvesting which is seasonal or temporary?  
☐ Yes ☐ No
5. What was the date that you moved into this school district?

Name of child/children: \_\_\_\_\_ Grade/Grades: \_\_\_\_\_

Name of School: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Best time to contact you: \_\_\_\_\_

Please explain briefly the best way to each your house. Feel free to draw a map below or on the back of this page.

**\*\*Please return the completed form to the school office Thank you!**

School Personnel please return to: Angie Baker, Director of Federal Programs  
Fox C-6 Administration Building

\*\*\*\*\*

Effective: 12/98  
Consolidated School District No. 6 (Fox)



**Library, Media and Technology Services****Acceptable Internet/Email/and Computer Use Policy**

**FOX C-6 SCHOOL DISTRICT  
ACCEPTABLE INTERNET / EMAIL / AND COMPUTER USE POLICY**

Specific access may vary but each of the above is a privilege available to students and staff in the Fox C-6 School District through Fox C-6. The goal of the Fox C-6 School District in providing Internet, Email and computer access to students and staff is to promote educational excellence by facilitating resource sharing, research, innovation, and communication. Students are considered minors and we target our efforts for minors. Only district owned technology needs to access our network, they need the signed approval of the Building Principal and Technology Department. This approval includes purchase of district anti-virus software and using this technology in such a way that all Internet traffic is screened by our Internet filter.

Along with national and international access to computers, people, and information that is valuable to the education process comes the availability of material which may not be considered of educational value and is offensive to individuals in a school setting. Fox C-6 School District “attempts” to take precautions to restrict access to inappropriate materials by teaching students and staff responsible Internet use, and through the utilization of “filtering” software to block student and staff access to inappropriate materials. Participating in hacking, cyber-bullying, downloading video and music files, chat rooms, (free e-mail for students and instant message services) and giving out personal information is construed as inappropriate behavior.

Use of the Fox C-6 School District Internet connection is an educational privilege. Inappropriate use of computers, software, Email or the Internet connection will result in cancellation of those privileges. Before being allowed to access the Internet, or Email, or use computers, students and staff will review and sign the Acceptable Internet / Email / Computer Use Policy. Attempting to view pornography or any inappropriate use of the Internet or computers may result in disciplinary actions for students and staff. Internet access and e-mail is not provided for selling and buying personal items.

All of the above activities may be monitored. A log of activity is created that tracks usage.

**Signed copies are required before any Internet / Computer Use is allowed.**  
**Copies are to be kept on file at each school’s office.**

**Student’s Printed (Last Name)\_\_\_\_\_ (First Name) \_\_\_\_\_**

**I.D. # \_\_\_\_\_ Grade \_\_\_\_\_ 1<sup>st</sup> Hour teacher \_\_\_\_\_**

**\* STUDENT AND PARENTS MUST SIGN STUDENT AGREEMENTS**

**\* Student’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_**

**\* Parent’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_**

**\* Faculty/Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_**

**\*Signatures indicate that I have read the agreement and will abide by the guidelines.**

Adopted: 11/03

Re-adopted: 07/08, 6/11

Consolidated School District NO. 6 (Fox )

Effective: 07/08, 7/11

## **INSTRUCTIONAL SERVICES**

**Form 6320.1**

### **Library, Media and Technology Services**

#### **Fox C-6 District Agreement for Personal Technology**

##### **Laptops, Desktops, Tables, iPad, iPhone and Android like devices**

Technology and software used by students and staff for education purposes is a valuable resource in the district. The district strives to maintain the infrastructure, network, hardware, and software necessary to provide optimal availability and usage. We are also bound by the CIPA rules for the filtering of Internet content. To maximize the effectiveness of the district network, minimum standards have been established for the hardware and software.

While the use of donated or personal technology many times enhances the access of district resources for students to learn, they also can create additional complications for all users. The use of donated or personal laptops, desktops, tablets, and iPad like devices for educational purposes to access the Internet via the district network requires the following:

1. Approval from the building principal and the technology department to use the technology and/or software and approved location by the building principal.
2. Purchase the district anti-virus program for two years at a cost of approximately \$40 for one computer and \$60 for two computers. Only needed if technology uses anti-virus software.
3. Sign the Fox District Agreement for Personal Technology.
4. Personal technology will not be maintained by district personnel.
5. This agreement only needs to be signed for approved requests and kept by the buildings.

I understand the above requirements and will abide by the proper usage as stated.

\_\_\_\_\_  
Signature of Employee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Building Principal

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Technology Department

\_\_\_\_\_  
Date

Adopted: 6/11

Effective 7/11

Consolidated School District #6 (Fox)

**Site/Facilities****Community Use of School Facilities****APPLICATION FOR USE OF SCHOOL PREMISES****Fox C-6 School District - Board of Education****Administration Bldg. - Arnold, Missouri 63010**

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

**Note: Before filling application in, please read RULES and REGULATIONS (separate sheet).**

1. Organization \_\_\_\_\_
2. Name of school to be used \_\_\_\_\_  
Room \_\_\_\_\_ Time \_\_\_\_\_  
Other facilities or equipment \_\_\_\_\_
3. Approximate number of participants \_\_\_\_\_
4. Purposes (note if admission is to be charged) \_\_\_\_\_
5. Dates of use (exact schedule must be given -- use separate sheet if necessary). \_\_\_\_\_
6. **Fees: This section to be completed by the Building Usage Department Building**  
Building \_\_\_\_\_ hrs @ \_\_\_\_\_ per hour = \$ \_\_\_\_\_  
Custodian \_\_\_\_\_ hrs @ \_\_\_\_\_ per hour = \$ \_\_\_\_\_  
Other \_\_\_\_\_ hrs @ \_\_\_\_\_ per hour = \$ \_\_\_\_\_  
total cost \$ \_\_\_\_\_

**Make check payable to: Mail to:****Fox C-6 School District  
Building Usage Department - Administration Bldg.  
745 Jeffco Blvd.  
Arnold, MO 63010****7. Legal Responsibility:**

The undersigned, as the authorized representative of the organization or individual(s) (hereinafter referred to as "Indemnitor"), to whom permission is granted to use the school premises herein mentioned for such organization or individual(s) agree(s) that they will indemnify and hold harmless the Fox C-6 School District from any loss, damage, costs, charges, or expenses, whether to persons or property, to which the Fox C-6 School District may be put by reason of any action, neglect, omission, or default on the part of the Indemnitor or any person using the school grounds pursuant to authority granted to Indemnitor. In case any suit shall be brought against the Fox C-6 School District on account of any act, action, neglect, or omission or default of the Indemnitor or any of its members, agents, employees, or permittees, the Indemnitor hereby covenants and agrees to assume the defense thereof and to pay any and all costs, charges, attorney's fees and other expenses and any and all judgments entered against the Fox C-6 School District. The Indemnitor agrees to release the Fox C-6 School District from any liability of any kind or nature in any right, cause of action, or claim of any kind or nature whatsoever which may hereafter accrue to the Indemnitor, its employees or its agents by virtue of the use of the school premises, except for rights or causes of action, claims, or damages resulting solely from the negligent condition of the real estate premises of the Fox C-6 District. The person whose signature appears below represents by his signature that he is authorized to execute this indemnification in behalf of the Indemnitor. Any pronoun used to describe the Indemnitor, whether it be masculine, feminine or neuter, singular or plural, is considered appropriate and will be interpreted so as to fit the person(s) or organization so modified.

**8. Person in Charge:**

Signature \_\_\_\_\_  
Print Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Number \_\_\_\_\_

Signature \_\_\_\_\_  
Print Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_  
Phone Number \_\_\_\_\_

**Approval:**

Principal \_\_\_\_\_

Date \_\_\_\_\_

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Superintendent / Business Manager

Effective: 03/99

Revised: 03/01, 08/03, 07/04, 07/05, 07/06, 07/07, 07/08,  
07/09, 05/10, 5/11, 5/12, 5/13

Consolidated School District No. 6 (Fox)

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Date

Effective: 03/01, 08/03, 07/04, 07/05, 07/06, 10/07, 07/08  
07/09, 05/10, 5/11, 5/12, 5/13

**Site/Facilities****Rickman Auditorium****APPLICATION FOR USE OF THE JAMES J. RICKMAN AUDITORIUM-FOX CAMPUS**

1. Name Of Organization Applying: \_\_\_\_\_
2. Business Address Of Organization: \_\_\_\_\_
3. Purpose For Which Facilities Are to Be Used: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
4. Date(s) Desired-Including Rehearsals And Performances: \_\_\_\_\_  
\_\_\_\_\_
5. Hours Of Day (Form First Arrival Until Last Person Leaves):  
(Performance) Begin: \_\_\_\_\_ (a.m.) (p.m.) End: \_\_\_\_\_ (a.m.) (p.m.)  
(Rehearsal) Begin: \_\_\_\_\_ (a.m.) (p.m.) End: \_\_\_\_\_ (a.m.) (p.m.)
6. Will Admission Be Charged? \_\_\_\_\_ If so, how will proceeds be used? \_\_\_\_\_  
\_\_\_\_\_
7. Person In Charge \_\_\_\_\_  
(Name) (Address) (Phone)
8. Equipment Needed: (P.A. System, Lights, T.V., etc.): \_\_\_\_\_  
\_\_\_\_\_

The undersigned agrees to be responsible for supervision of the meeting, for the conduct of all persons present, for any damage which may result to school property, and for the observance of all regulations governing the use of school property.

Signature Of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

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

Business Telephone Number: \_\_\_\_\_ Home Phone Number: \_\_\_\_\_

**Basic Fee:** \_\_\_\_\_ **Make check payable to the Fox C-6 School District.** The organization will be billed for any additional charges which occur on the date of the meeting. The right to cancel permits is reserved.

Approved: \_\_\_\_\_  
(Fox C-6 Board of Education) (Date)

See back of application for regulations adopted by the Fox C-6 Board of Education governing community use of the school Auditorium, to be considered in addition to any law governing the use of school property.

**PLEASE SIGN AND RETURN BOTH COPIES IN THE ENCLOSED SELF ADDRESSED ENVELOPE.**  
**AUDITORIUM-(636)296-3244/ ADMINISTRATION BLDG.-(636)296-8000/ FAX-(636)282-5170**

**PER DAY CHARGES FOR THE USE OF JAMES J. RICKMAN AUDITORIUM**  
**EFFECTIVE 10-1-11**

		<u>Oct.1- Apr. 30</u>	<u>May 1- Sept 30</u>
<b>GROUP A</b>	Non-profit organizations within the C-6 School District. Special approval may be granted by the School Board if the organization is not located in the C-6 School District	\$1,575	\$1,835
<b>GROUP B</b>	Non-profit organization using facility for the purpose of selling ticketed seats plus \$2.75 per ticket sold.	\$1,060	\$1,325
<b>GROUP C</b>	Profit-making organizations located within the C-6 School District. For one 5-hr performance and one 8-hr set-up & rehearsal (same day) For each additional 5-hr performance For one 5-hr performance and no rehearsal	\$2,520 1,470 1,605	\$ 2,785 1,735 1,870
<b>GROUP D</b>	Profit-making organizations located outside the C-6 School District. For one 5-hr performance and one 8-hr set-up & rehearsal (same day) For each additional 5-hr performance For one 5-hr performance and no rehearsal	\$3,280 1,760 2,365	\$3,540 2,065 2,625

**\*\*IMPORTANT NOTICE\*\***Setup and rehearsal times figured for eight (8) hours, and performances for five (5) hours from opening until closing time. Any hours or part of any hour over the allotted hours will result in an additional charge of \$231.00 per hour. A five (5) hour minimum is required to rent the Auditorium.

**\*\*\*\*ALL PROGRAMS MUST CONCLUDE BY 11 P.M. \*\*\*\***  
**(NO ADMITTANCE BEFORE 6 A.M.)**

Included in the above pricing structure are custodial services, sound and lighting systems operation, and heating or cooling as needed. **A Twenty-percent (20%) deposit is required at the time of scheduling with the balance due fourteen (14) days prior to the performance date. Additional charges for security will be required if at the discretion of auditorium management it is deemed necessary to enforce the rules of the building.**

Arrangements to rent the Auditorium are to be made with Kathy Plemons, 296-8000. The Board of Education reserves the right to determine whether the applicant's request will be granted. Also, the Board reserves the right to waive all, or a part, of the fee schedule at its discretion.

**PLEASE NOTE: No one from the renting group will be allowed in the lighting-sound booth or the prop storage areas without prior approval of the auditorium technician. Also, nothing is to be attached to the stage floor, walls or any other fixture by tape, staples or any other means without the prior approval of the auditorium technician or custodian.**

**\*\*ABSOLUTELY NO SMOKING OR ANY ALCOHOLIC BEVERAGES ALLOWED ON THE SCHOOL PREMISES!**  
**\*\*NO SMOKING WILL BE ALLOWED IN THE AUDITORIUM, BACK STAGE, OR PROP STORAGE AREAS. NO FOOD OR DRINK WILL BE ALLOWED IN THE AUDITORIUM, BACK STAGE, OR PROP AREAS.**

No activity will be permitted that might endanger the buildings or the persons attending.

Parties signing the application must assume full responsibility for the conduct of the persons whom they admit for any infraction of regulations and agree to pay the cost of any damage caused by them or their patrons during the period of their use of the building. Cancellation of the reserved dates must be made at least thirty (30) days in advance of the reserved date, or the deposit will be forfeited. The Board of Education reserves the right to cancel any arrangements for use of District buildings. Only the lobby doors of the Auditorium are to be used for entrance and exit for audiences.

**INSURANCE REQUIREMENTS:**

The tenant will secure and furnish to “Fox C-6 School District” fifteen days prior to the event commencement, certificates of insurance, providing liability and property insurance for the tenant during the period of time they will be using the Rickman Auditorium. The certificates of insurance will name the “Fox C-6 School District” as an additional insured under said policies.

Adopted: 5/11, 5/12, 5/13  
Consolidated School District No.6 (Fox)

Effective: 5/11, 5/12, 5/13