
Welcome to
HELPING HAND
SCHOOL

HELPING HAND
SCHOOL

Melissa MacKay

VP of School Services

Dear Families,

As we gear up for a brand-new school year, I wanted to take a moment to extend the warmest of welcomes to each and every one of you. Whether you are an old friend returning or brand new to our community, I am beyond excited to have you with us!

I am Melissa MacKay, your Vice President of School Services. It is my firm belief that every student is unique and valued, and it's our collective responsibility to nurture their growth and curiosity. I have the privilege to make sure every student feels like a superstar and receives the quality education they deserve.

We can't do this alone; we need you, the awesome families to team up with us. Together AMAZING things will happen!

Please know that my door is always open. Whether you have questions, concerns, or simply want to say hello, I am here to support you in any way I can.

I look forward to meeting each of you and working together to make this school year an extraordinary one for our students.

All the best,

Melissa MacKay
Vice President of School Services
Helping Hand School

Inspiration

"No matter what anybody tells you, words and ideas can change the world."

John Keating

melissa.mackay@helpinghand-il.org | (708) 966-5767

HELPING HAND
SCHOOL

Dr. Sara Svetich

Director of School Services

Dear Families,

I am delighted to extend a warm welcome to you as the Director of School Services at Helping Hand School. It is with great pleasure that I introduce myself and express my enthusiasm for the opportunity to work alongside you and your children in this exceptional educational environment.

As a dedicated clinical professional with 10 years of experience working with children with special needs, I am deeply committed to providing an inclusive and nurturing learning environment where every child can thrive academically, socially, and emotionally. I firmly believe that every child deserves access to quality education tailored to their unique strengths, challenges, and individual learning styles. At HH School we recognize that each child is a unique individual with their own set of strengths and challenges, and our team of experienced educators, therapists, and support staff are dedicated to providing the individualized attention and support necessary for success.

As we embark on this journey together, I invite you to reach out to me or any member of our dedicated team with any questions, concerns, or suggestions you may have. Your feedback is invaluable to us, and we are committed to continuously improving and refining our programs and services to better meet the needs of our students and families.

Thank you for entrusting us with the privilege of educating and supporting your child. I am truly excited about the opportunities that lie ahead, and I look forward to partnering with you to help your child achieve their fullest potential.

Warm regards,

Dr. Sara Svetich
Director of School Services
Helping Hand School

Inspiration

"Think left and think right and think low and think high. Oh, the things you can think up if you only try."

Dr. Seuss

sara.svetich@helpinghand-il.org | (708) 966-5794

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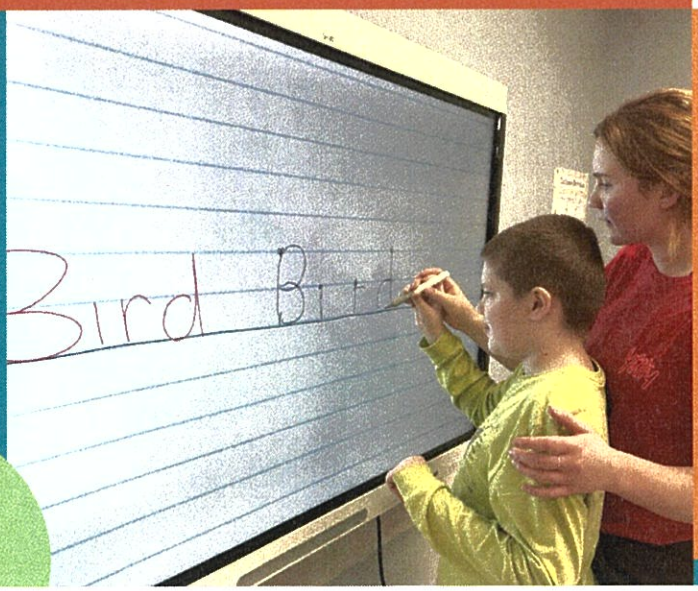
About Us

HH School is a non-profit private outplacement therapeutic day school serving children ages 3-22 years. HH School serves over twenty school districts in the Chicagoland area.

Related Services

- Occupational Therapy
- Speech Language Pathology
- Physical Therapy
- Behavior Services



Schedule

HH School is a year round therapeutic day school. Classroom schedules and individual student schedules are based on student's needs and focuses. The school calendar(s) can be found on the Helping Hand website at helpinghand-il.org. School days are from 8:15 am - 2:15 pm year round.

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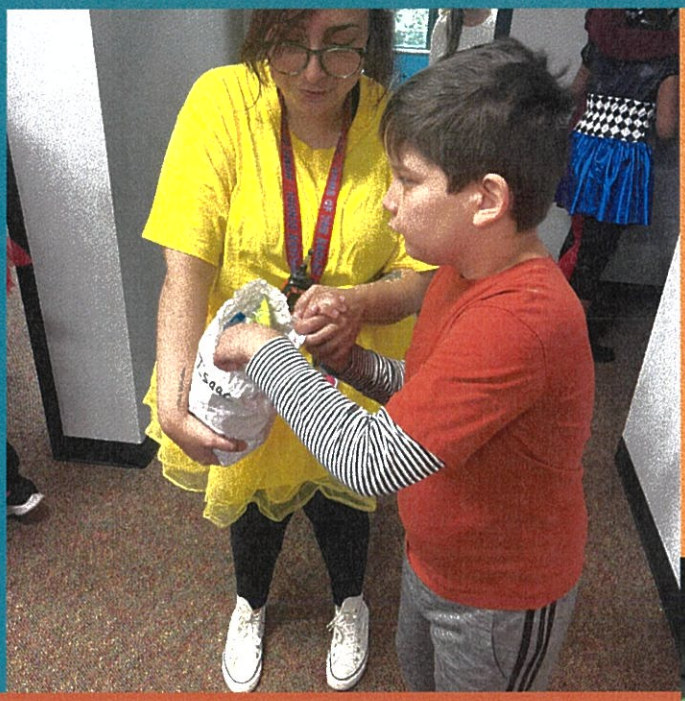
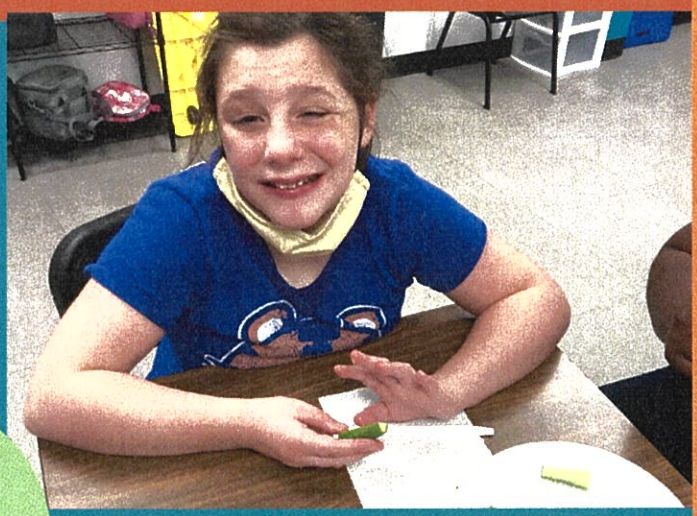


Events

- Fall Fest
- Costume Parade
- Open House
- Parent Teacher Conferences
- Holiday Pageant
- Valentine's Day Party
- School Photos
- Field Day
- Graduation

Family Connection

Our student families meet periodically throughout the year in our Community Space to share resources, ideas, and provide support. Our families have a Facebook group to easily communicate and share resources.



Curriculum

At HH School we use the following curriculums and modify as needed for individual student needs:

- Unique Learning System
- Reading A-Z
- Functional Academics

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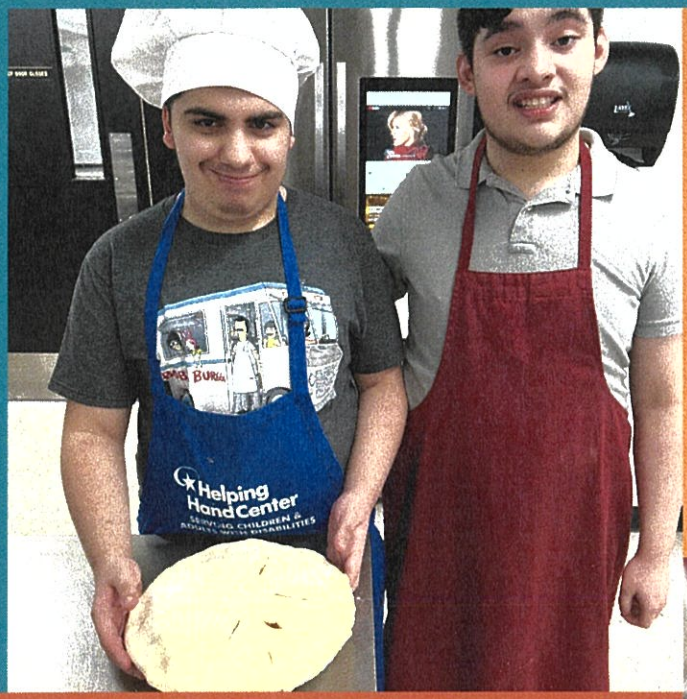
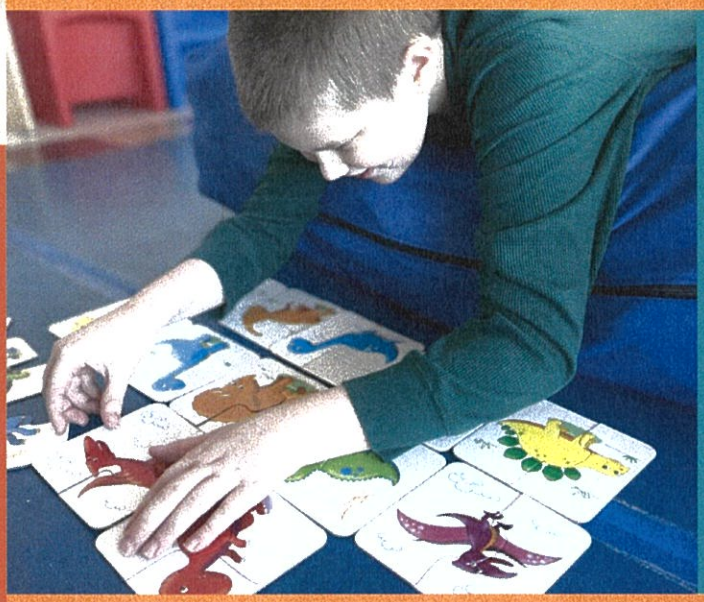


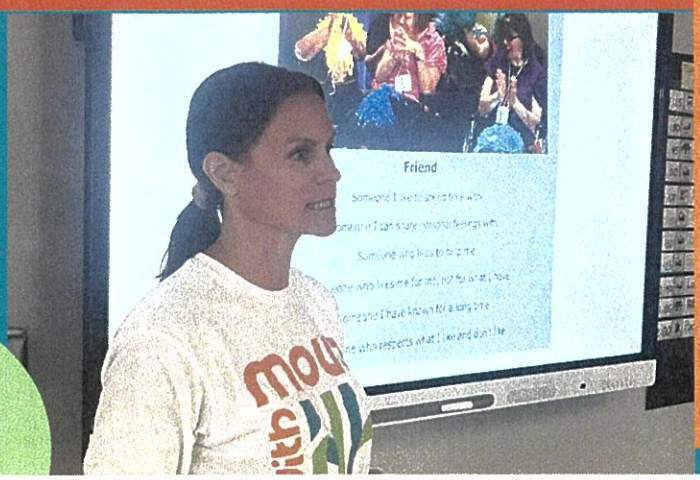
Cooking Group Curriculum

Our cooking group curriculum focuses on various recipes and executive processes from start to finish when prepping a meal or food item. Students explore new tastes and textures with varied recipes.



Gross Motor Curriculum

Our gross motor curriculum focuses on functional gross motor skills while incorporating recreational skills with influences from the academic curriculum.



Social Group

Our team utilizes the Circles Curriculum to teach our students how to identify their relationship to others and the appropriate social boundaries based on that relationship. This also teaches self-care through personal hygiene skills, coping stragies, personal safety, and self-advocacy skills.

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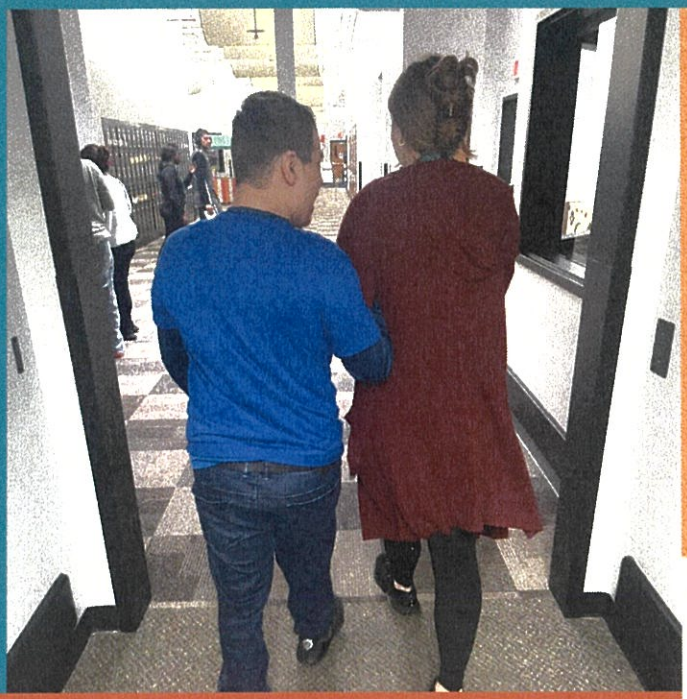
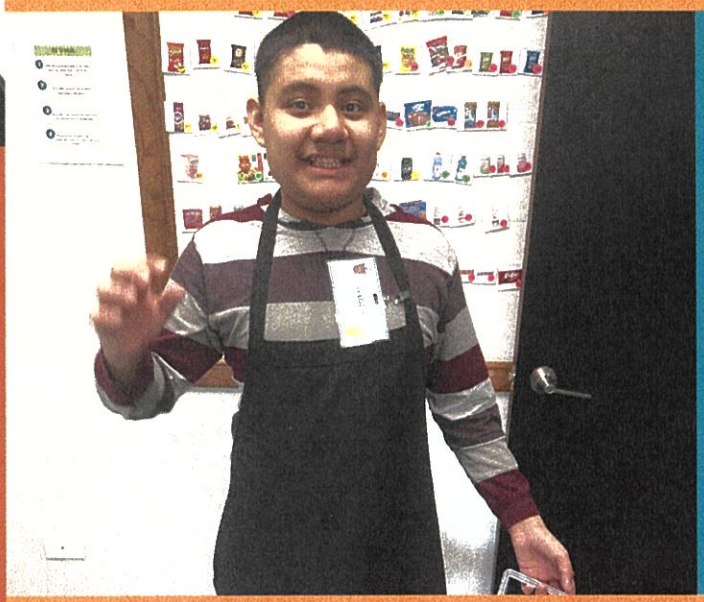


ABA Services

HH School uses evidence based behavior analytic practices to increase our students engagement in adpative behaviors. We focus on increasing language and communication skills, focus, social skills, and functional skills to help reduce behaviors that interfere with learning.



School Cafe

Students have the opportunity to practice employment skills and utilize executive functioning skills in our school cafe. Students work varied shifts and complete different tasks such as managing the register, completing inventory, supply shopping, and preparing orders.

Functional Spaces

The school has various areas to practice functional skills, including but not limited to the following:

- Garden
- Post Office Stand
- Library Stand
- Connection Apartment
- Laundry Room
- School Cafe

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Community Visits

This school year we are continuing to expand on our Community Visits to the following locations:

- Post Office
- Library
- Hanson Center Farm
- Grocery Store
- Restaurant (Burger King)

Exciting Updates

HH is continuing to update and add services. This year we are focusing on the following projects.

- Sensory Playground - Coming 2024!
- New School Flooring
- New Classroom Furniture
- Updated Teaching Kitchen
- Updated Curriculum

Agency Services

As an agency, we are able to connect our students with additional services and supports in transitions in our outpatient clinic, adult programming, employment services, and residential homes. If you and your family are interested in learning more, please reach out to the school team to be connected.

2024 Checklist

HELPING HAND SCHOOL

2024-2025 School Year at Helping Hand

DIRECTIONS: Each school year, the following documents must be provided for all students. Please, use this checklist to ensure all forms are complete(including signatures.) When completed, return them in the envelope provided. We use this information to serve your child as effectively as possible. We appreciate your help in starting the school year off right!

NOTE: All signatures lines are highlighted in yellow. Some forms are 2-sided. Some forms require a doctor signature. Please keep the School Parent Information Handbook and the 2024-2025 School Year Calendar for reference. **Forms A will only be provided if it is required for your student's. Forms C,D,and E,** please complete per your student's grade level.
Please return all forms before your child start date.

Check Off	Number on Form	Name of Form	Parent Signature Required	Physician Signature Required
	A	Application for Services (New Students)	yes	~~no~~
	B	School Introduction Forms	~~no~~	~~no~~
	C	Illinois Vision Exam Form— filled out by Optometrist	yes	yes
	D	Illinois Health Exam Form--filled out by Physician	~~no~~	yes
	E	Illinois Dental Exam Form—filled out by Dentist	yes	yes
	F	Student Services Questionnaire (if applicable)	yes	~~no~~
	G	Documentation of Custodial Rights/Guardianship -- Separated/Divorced/Other Individuals	~~no~~	~~no~~
	H	Certification of Authority Form -- Separated/Divorced/Other Individuals	yes	~~no~~
	1	Parent Contact Information Update /Emergency Information Form	yes	~~no~~
	2	Release of Information Consent	yes	~~no~~
	3	Student Health Information (allergy and asthma reports if applicable, seizure protocol)	yes	yes
	4	Hospital To School Transition Form(Only following hospitalization)	yes	yes
	5	Physicians Prescription Form for Therapy Services (w/letter)	yes	yes
	6	Parental Authorization for Administering Medications	yes	~~no~~
	7	Emergency Medical Release	yes	~~no~~
	8	Physician's Prescription or Over-the Counter Approval (w/letter)	yes	yes
	9	Consent for Release of Photo and Video Image	yes	~~no~~
	10	Authorized Individuals for Student Drop-off/Pick-up	yes	~~no~~
	11	Behavior Management Procedures	yes	~~no~~
	12 (a)	Consent Form for Testing and Assessments	yes	~~no~~
	13	School Event Information(Community Outings, Yearbook, Cooking Group)	yes	~~no~~
	14	School Parent Information Handbook **(sign and return the form stapled to the handbook)**	yes	~~no~~
	15	School Supply List for 2024-2025	~~no~~	~~no~~
	16	School Closings 2024-2025	~~no~~	~~no~~
	17	Therapy Minute Calculations	~~no~~	~~no~~
	18	Student Record Request	~~no~~	~~no~~
	19	Student Cell Phone Policy	~~no~~	~~no~~
	20	Inclement Weather	~~no~~	~~no~~
	21	Parent Comportment Policy	~~no~~	~~no~~
	22	Parent Guide	~~no~~	~~no~~

HELPING HAND SCHOOL

Application for Services

Gender: ☐Male ☐Female

Name of Child: _____

DOB: _____ SSN: _____

Parent / Guardian(s):

Name: _____ Relationship: _____

Address: _____ Day Telephone: _____

_____ Evening Telephone: _____

_____ Alternate Telephone: _____

Email Address: _____

Name: _____ Relationship: _____

Address: _____ Day Telephone: _____

_____ Evening Telephone: _____

_____ Alternate Telephone: _____

Email Address: _____

Emergency Contact: (additional phone number(s) or name and Number of Emergency Contact Person):

Name: _____ Relationship: _____

Address: _____ Day Telephone: _____

_____ Evening Telephone: _____

_____ Alternate Telephone: _____

Other Person(s) Living in the home:

Name	Relationship To Student	Age

_____ Alternate Telephone: _____

_____ Fax: _____

Current Medications

Medication	Dosage	Frequency	Reason	Prescribed By

Allergies:

No/Yes (Please explain): _____

_____

Hospitalizations:

Date	Location	Reason

Other Information:

Primary Language (Spoken/Understood): _____

Mode Of Communication:

Uses Verbal Communication (briefly describe skills – how many words, how well is the student understood, etc.) _____

_____

_____

Uses Sign Language (briefly describe – number of words, how well understood) _____

_____

Uses Pictures (describe)

_____

Other (describe)

_____

Toilet Training (Describe level of support needed (if any) for toileting)

_____

Letter w/#11

HELPING HAND
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Dear Parents/Guardians,

All medical forms have been included in your 2024-2025 Parent Packets. The medical forms are required based on a student's grade level. Those grade levels are listed below for each type of physical exam. If your child is in one of the grades listed, please return the appropriate medical forms with the rest of your packet. Thank you.

1. Illinois Vision Exam – Kindergarten

2. Illinois Health Exam – Early Childhood, Kindergarten, 1st Grade, 6th Grade, 9th Grade

3. Illinois Dental Exam – Kindergarten, 2nd Grade, 6th Grade, 9th Grade

Sincerely,

Lizbet Gomez
Administrative Coordinator
Helping Hand School
9649 W. 55th Street
Countryside, IL 60525
708-352-3580 x246
Lizbet.Gomez@helpinghand-il.org

State of Illinois
Illinois Department of Public Health

State of Illinois
Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides eye examinations be submitted to the school no later than October 15 of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

Student Name _____
(Last) (First) (Middle Initial)

Birth Date _____ Gender _____ Grade _____
(Month/Day/Year)

Parent or Guardian _____
(Last) (First)

Phone _____
(Area Code)

Address _____
(Number) (Street) (City) (ZIP Code)

County _____

To Be Completed By Examining Doctor

Case History

Date of exam _____

Ocular history: ❑ Normal or Positive for _____

Medical history: ❑ Normal or Positive for _____

Drug allergies: ❑ NKDA or Allergic to _____

Other information _____

Examination

	Distance			Near
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation? ❑ Yes ❑ No

	Normal	Abnormal	Not Able to Assess	Comments
External exam (lids, lashes, cornea, etc.)	❑	❑	❑	_____
Internal exam (vitreous, lens, fundus, etc.)	❑	❑	❑	_____
Pupillary reflex (pupils)	❑	❑	❑	_____
Binocular function (stereopsis)	❑	❑	❑	_____
Accommodation and vergence	❑	❑	❑	_____
Color vision	❑	❑	❑	_____
Glaucoma evaluation	❑	❑	❑	_____
Oculomotor assessment	❑	❑	❑	_____
Other _____	❑	❑	❑	_____

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

Diagnosis

❑ Normal ❑ Myopia ❑ Hyperopia ❑ Astigmatism ❑ Strabismus ❑ Amblyopia

Other _____

Continued on back

State of Illinois
Illinois Department of Public Health

State of Illinois
Eye Examination Report

Recommendations

1. Corrective lenses: ❑ No ❑ Yes, glasses or contacts should be worn for:
   ❑ Constant wear ❑ Near vision ❑ Far vision
   ❑ May be removed for physical education

2. Preferential seating recommended: ❑ No ❑ Yes

   Comments _____

   _____

3. Recommend re-examination: ❑ 3 months ❑ 6 months ❑ 12 months

   ❑ Other _____

4. _____

5. _____

Print name _____

Optometrist or physician (such as an ophthalmologist) who provided the eye examination ❑ MD ❑ OD ❑ DO

License Number _____

Address _____

_____

Phone _____

Consent of Parent or Guardian

I agree to release the above information on my child or ward to appropriate school or health authorities.

_____
(Parent or Guardian's Signature)

_____
(Date)

Signature _____ Date _____

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Printed by Authority of the State of Illinois

IOCI 15-391

State of Illinois

Certificate of Child Health Examination

Student's Name (Last / First / Middle)	Birth Date (Mo/Day/Yr)	Sex	Race/Ethnicity	School/Grade Level/ID#

Street Address / City / ZIP Code	Parent/Guardian / Telephone (home/work)

HEALTH HISTORY: MUST BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)	☐ Yes ☐ No	List:	MEDICATION (Prescribed or taken on a regular basis)	☐ Yes ☐ No	List:

Diagnosis of Asthma?	☐ Yes ☐ No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	☐ Yes ☐ No	
Child wakes during night coughing?	☐ Yes ☐ No		Hospitalization? When? What for?	☐ Yes ☐ No	
Birth Defects?	☐ Yes ☐ No		Surgery? (List all) When? What for?	☐ Yes ☐ No	
Developmental delay?	☐ Yes ☐ No		Serious injury or illness?	☐ Yes ☐ No	
Blood disorder? Hemophilia, Sickle Cell, Other? Explain.	☐ Yes ☐ No		TB skin test positive (past/present)?	☐ Yes* ☐ No	*If yes, refer to local health department
Diabetes?	☐ Yes ☐ No		TB disease (past or present)?	☐ Yes* ☐ No	
Head injury/Concussion/Passed out?	☐ Yes ☐ No		Tobacco use (type, frequency)?	☐ Yes ☐ No	
Seizures? What are they like?	☐ Yes ☐ No		Alcohol/Drug use?	☐ Yes ☐ No	
Heart problem/Shortness of breath?	☐ Yes ☐ No		Family history of sudden death before age 50? (Cause?)	☐ Yes ☐ No	
Heart murmur/High blood pressure?	☐ Yes ☐ No				
Dizziness or chest pain with exercise?	☐ Yes ☐ No				

Eye/Vision problems? _____ ☐ Glasses ☐ Contacts Last exam by eye doctor _____

☐ Dental ☐ Braces ☐ Bridge ☐ Plate ☐ Other

Other concerns? (Crossed eye, drooping lids, squinting, difficulty reading) _____

Additional Information:

Ear/Hearing problems?	☐ Yes ☐ No	
Bone/Joint problem/injury/scoliosis?	☐ Yes ☐ No	

Information may be shared with appropriate personnel for health and educational purposes.

Parent/Guardian Signatures: _____ **Date:** _____

IMMUNIZATIONS: To be completed by health care provider. The mo/day/yr for *every* dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.

REQUIRED Vaccine/Dose	DOSE 1 MO DA YR	DOSE 2 MO DA YR	DOSE 3 MO DA YR	DOSE 4 MO DA YR	DOSE 5 MO DA YR	DOSE 6 MO DA YR
DTP or DTaP						
Tdap; Td or Pediatric **DT** (Check specific type)	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophiles Influenza Type B						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles, Mumps, Rubella						
Varicella (Chickenpox)						
Meningococcal Conjugate						
RECOMMENDED, BUT NOT REQUIRED Vaccine/Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

Comments: * indicates invalid dose

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.
If adding dates to the above immunization history section, put your initials by date(s) and sign here.

Signature _____ Title _____ Date _____

Student's Name Last First Middle	Birth Date (Mo/Day/Yr)	Sex	School	Grade Level/ID#

Certificates of Religious Exemption to Immunizations or Physician Medical Statement of Medical Contraindication are reviewed and *Maintained* by the School Authority.

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.

*MEASLES (Rubeola) (MO/DA/YR) _____ **MUMPS (MO/DA/YR) _____ HEPATITIS B (MO/DA/YR) _____ VARICELLA (MO/DA/YR) _____

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official. Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease _____ Signature _____ Title _____

3. Laboratory Evidence of Immunity (check one) ☐ Measles* ☐ Mumps** ☐ Rubella ☐ Varicella Attach copy of lab result.

*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.
**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Physician Statements of Immunity MUST be submitted to IDPH for review.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE if < 2-3 years old _____ HEIGHT _____ WEIGHT _____ BMI _____ BMI PERCENTILE _____ B/P _____

DIABETES SCREENING: (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** ☐ Yes ☐ No And any two of the following: **Family History** ☐ Yes ☐ No

Ethnic Minority ☐ Yes ☐ No **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) ☐ Yes ☐ No **At Risk** ☐ Yes ☐ No

LEAD RISK QUESTIONNAIRE: Required for children aged 6 months through 6 years enrolled in licensed or public-school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high-risk zip code.)

Questionnaire Administered? ☐ Yes ☐ No **Blood Test Indicated?** ☐ Yes ☐ No **Blood Test Date** _____ **Result** _____

TB SKIN OR BLOOD TEST: Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

☐ No test needed ☐ Test performed **Skin Test:** Date Read _____ Result: ☐ Positive ☐ Negative mm _____

Blood Test: Date Reported _____ Result: ☐ Positive ☐ Negative Value _____

LAB TESTS (Recommended)	Date	Results	SCREENINGS	Date	Results
Hemoglobin or Hematocrit			Developmental Screening		☐ Completed ☐ N/A
Urinalysis			Social and Emotional Screening		☐ Completed ☐ N/A
Sickle Cell (when indicated			Other:		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin	☐		Endocrine	☐	
Ears	☐	Screening Result:	Gastrointestinal	☐	
Eyes	☐	Screening Result:	Genito-Urinary	☐	LMP:
Nose	☐		Neurological	☐	
Throat	☐		Musculoskeletal	☐	
Mouth/Dental	☐		Spinal Exam	☐	
Cardiovascular/HTN	☐		Nutritional Status	☐	
Respiratory	☐	☐ Diagnosis of Asthma	Mental Health	☐	
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g., Short Acting Beta Agonist) ☐ Controller medication (e.g., inhaled corticosteroid)			Other	☐	

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES (e.g., safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup)

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?

If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?

☐ Yes ☐ No If yes, please describe:

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)

PHYSICAL EDUCATION ☐ Yes ☐ No ☐ Modified **INTERSCHOLASTIC SPORTS** ☐ Yes ☐ No ☐ Modified

Print Name _____ ☐ MD ☐ DO ☐ APN ☐ PA Signature _____ Date _____

Address Phone

State of Illinois
Illinois Department of Public Health

PROOF OF SCHOOL DENTAL EXAMINATION FORM

Illinois law (Child Health Examination Code, 77 Ill. Adm. Code 665) states all children in kindergarten and the second, sixth and ninth grades of any public, private or parochial school shall have a dental examination. The examination must have taken place within 18 months prior to May 15 of the school year. A licensed dentist must complete the examination, sign and date this Proof of School Dental Examination Form. If you are unable to get this required examination for your child, fill out a separate Dental Examination Waiver Form.

This important examination will let you know if there are any dental problems that need attention by a dentist. Children need good oral health to speak with confidence, express themselves, be healthy and ready to learn. Poor oral health has been related to lower school performance, poor social relationships, and less success later in life. For this reason, we thank you for making this contribution to the health and well-being of your child.

To be completed by the parent or guardian (please print):

Student's Name: Last	First	Middle	Birth Date: (Month/Day/Year)
Address: Street	City		ZIP Code
Name of School:	ZIP Code	Grade Level:	Gender: ☐ Male ☐ Female
Parent or Guardian: Last Name	First Name		

Student's Race/Ethnicity:

☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian
☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ Multi-racial ☐ Unknown
☐ Other_____

To be completed by dentist:

Date of Most Recent Examination:_____ (Check all services provided at this examination date)

☐ Dental Cleaning ☐ Sealant ☐ Fluoride treatment ☐ Restoration of teeth due to caries

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present on Permanent Molars**

☐ Yes ☐ No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

☐ Yes ☐ No **Untreated Caries —** At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

☐ Yes ☐ No **Urgent Treatment —** abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling.

Treatment Needs (check all that apply). For Head Start Agencies, please also list appointment date or date of most recent treatment completion date.

☐ **Restorative Care** — amalgams, composites, crowns, etc. Appointment Date:_____
☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis Appointment Date:_____
☐ **Pediatric Dentist Referral Recommended** Treatment Completion Date:_____

Additional comments: _____

Signature of Dentist _____ License #:_____ Date:_____

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.dph.illinois.gov

State of Illinois
Illinois Department of Public Health

DENTAL EXAMINATION WAIVER FORM

Please print:

Student's Name: Last	First	Middle		Birth Date: (Month/Day/Year)
Address: Street	City			ZIP Code
Name of School:	ZIP Code		Grade Level:	Gender: ☐ Male ☐ Female
Parent or Guardian: Last Name	First Name			
Student's Race/Ethnicity: ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ Multi-racial ☐ Unknown ☐ Other_____				

I am unable to obtain the required dental examination because:

☐ My child is enrolled in the free and reduced lunch program and is not covered by private or public dental insurance (Medicaid / All Kids).

☐ My child is enrolled in the free and reduced lunch program and is ineligible for public insurance (Medicaid / All Kids.

☐ My child is enrolled Medicaid / All Kids, but we are unable to find a dentist or dental clinic in our community that is able to see my child and will accept Medicaid / All Kids.

☐ My child does not have any type of dental insurance, and there are no low-cost dental clinics in our community that will see my child.

Parent or Guardian Signature _____ Date:_____

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.dph.illinois.gov

IOCI 0600-10 Printed by Authority of the State of Illinois

HELPING HAND
SCHOOL

Student Services Questionnaire

Student Name: _____ Birthdate: _____

In order to best serve your child, we are asking that you fill out the questionnaire below in regards to services or funding you may be receiving.

1) Are you on the PUNS (Prioritization of Urgency of Need for Services) list?
   Yes____ No____ Unsure____

   If yes, list PAS agency: _____ (i.e. Suburban Access, PACT Inc.)

2) Are you receiving any DRS Step Grant funding?
   Yes____ No____ Unsure____

   If yes, list the name of your DRS Counselor: _____

3) Do you have funding through Department of Human Services (DHS) Developmental Disability (DD) Division?
   Yes____ No____ Unsure____

4) Do you receive home-based funding through DORS?
   Yes____ No____ Unsure____

5) Do you receive funding from other agencies?
   Yes____ No____ Unsure____

6) Do you have a special needs trust set-up?
   Yes____ No____ Unsure/Need Info____

High School/Transition Students answer the following 3 questions

7) Would you like to be contacted by Helping Hand to discuss potential services (i.e. After hour Programs, Residential Services, Adult Day Services, Summer programs, Employment Services)?
Yes___ No___

Best way to contact you:
Phone _____ Email_____

8) Would you like information about other service providers in the area?
Yes____ No____

Please indicate specific providers of interest: _____

9) Would you like more information about:

Guardianship____ Lawyers____ Power of Attorney____

Special Needs Trust ____ Other: _____

Thank you for providing the above information. If you have any questions, please feel free to contact Lizbet Gomez at 708-352-3580 ext. 246.

_____ _____

Date Parent or Legal Guardian

HELPING HAND
SCHOOL

RIGHTS OF NON-CUSTODIAL PARENTS & OTHERS

This policy explains the obligations of Helping Hand School staff with respect to the rights and authority of divorced or separated parents (specifically, the non-custodial parent), and other individuals (e.g., grandparents, step-parents) regarding students who are minors.

It is the policy of Helping Hand School to uphold the equal rights of each parent with respect to their child(ren), unless and until taken away or altered by a valid court order, divorce decree, or other legal document executed by both parents. If a parent/guardian wishes that the rights of the other parent with respect to their child(ren) be restricted, it is that parent/guardian's responsibility to provide the school with a valid, current and legible court order and/or divorce decree indicating any such restriction on the parent's rights. Helping Hand School reserves the right to check the actual court file to verify either parent's authority at any time.

In addition, a non-custodial parent or other individual (e.g., grandparents, step-parents, etc.) claiming any authority with regard to consent for a student at Helping Hand School and/or the right to school records and related information, must complete a Certification of Authority form. This form will be shared with the custodial parent of the child for verification purposes. This form may be picked up in the back of the student handbook, or requested from the school.

Please send in any custodial documentation stating legal guardianship and/or custodial rights with the Annual Packet for your student at Helping Hand School even if a Certification of Authority form will not be completed.

HELPING HAND
SCHOOL

CERTIFICATION OF AUTHORITY

The undersigned, _____, by signature below, hereby certifies to Helping Hand School that he/she has full legal authority, pursuant to a divorce decree currently on record or otherwise, to do the following with regard to _____, a student at the school: (Please check all that apply)

o Consent to the administration of educational evaluations

o Consent to the initiation of educational programs

o Consent to the release of confidential education information from the temporary and permanent school files

o Consent to the release of confidential mental health information pursuant to the Illinois Mental Health and Developmental Disabilities Confidentiality Act

o Right to receive and review all school records from the student's temporary and permanent school file, including day-to-day school related information (e.g., grade reports, parent notifications, student work, etc.)

o Other authority (explain in detail)

_____

_____

_____

The undersigned acknowledges that once he/she has signed below, this form will be forwarded for verification to the other parent. If no objection to the assertions contained herein is received within 7 days of transmittal to the parent, Helping Hand School will comply with all requests from the undersigned in conformity with this document. The undersigned recognizes that it is a criminal offense to execute a fraudulent document in the state of Illinois. Helping Hand School reserves the right to check the actual court file, if applicable, to verify each parent's authority at anytime. Parents may be asked to update this form from time-to-time as required by the school and due to any change in circumstances.

Print Name: _____ Signature: _____ Date: _____
Non-Custodial Parent Non-Custodial Parent

Witness: _____ Witness Signature: _____ Date: _____
Print Name

HELPING HAND
SCHOOL

Parent/Guardian
Contact Information Update

If during the year any of the information given below changes, please update Helping Hand as soon as possible. You are welcome to send the information by:

-Email to Lizbet.Gomez@helpinghand-il.org;
-Fax it to 708-966-5898; ATTN: Lizbet Gomez;
-Or leave a message at 708-352-3580 ext. 246 for Lizbet.

It is very important that we have correct information for each of our students. Contacting you without delay is important to us. Thanks for your help.

	Father/Guardian	**Mother/Guardian**
Full Name		
Address		
City		
Zip Code		
Home Number		
Work Number		
Mobile Number		
Email		
Preferred Method of Contact:	**Phone / Email** (please circle one)	**Phone / Email** (please circle one)

Notes:

_____

_____

_____

September 2024

Additional Emergency Contacts

In the case that the indicated parents/guardians cannot be reached via phone in the case of an emergency or student illness, please provide additional emergency contacts below if able.

Name	Relationship to Student	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

HELPING HAND
SCHOOL

RELEASE OF INFORMATION CONSENT FORM

Student Name: _____ Birthdate: _____
Address: _____ Telephone: _____

The signature below grants permission for Helping Hand School to request and receive information regarding the identified student from the professionals or agencies specified below and to provide information regarding the identified student as requested to the professionals or agencies specified below in order to assist in treatment planning and coordination of services. **Please provide the name and contact of your child's primary physician and agency. This can include outside or in-home therapists, behavior analysts or other individuals working with your child.**

Any documentation provided by Helping Hand School for these purposes will be available to parents upon request.

Helping Hand School has permission to release and request information from the following (please fill in name and contact information):

Doctor: _____ Phone: _____ Fax:_____

Doctor: _____ Phone: _____ Fax:_____

Agency: _____ Phone: _____ Fax:_____

Agency: _____ Phone: _____ Fax:_____

Tx/Other: _____ Phone: _____ Fax:_____

Tx/Other: _____ Phone: _____ Fax:_____

_____ _____

Date Parent or Legal Guardian

Questions: Contact Lizbet Gomez at 708-352- 3580 ext. 246
This consent is valid for one year from the above date as signed by parent or guardian

HELPING HAND
SCHOOL

3

Student Health Information Sheet
(Completed by Parent)

School Medical Form:	
Student Name: _____	Birthdate: _____
	Weight:/Height: _____
Primary Diagnosis: _____	Age of onset : _____
Secondary Diagnosis: _____	Age of onset : _____
Other Diagnosis: _____	Age of onset : _____

Physician:	
Name: _____	
Address: _____	Day Telephone: _____
_____	Email: _____
_____	Fax: _____

Other Medical Professional Providing Consult / Services:	
Name: _____	
Address: _____	Day Telephone: _____
_____	Email: _____
_____	Fax: _____
Name: _____	
Address: _____	Day Telephone: _____
_____	Email: _____
_____	Fax: _____

Current Medications

Medication	Dosage	Frequency	Reason	Prescribed By

Allergies:

No/Yes (Please explain): _____

Hospitalizations:		
Date	Location	Reason

Illnesses:		
	(Current diagnosis only)	**Please explain any areas marked YES.**
Asthma	**YES / NO**	
Seizures	**YES / NO**	
Diabetes	**YES / NO**	
Headaches	**YES / NO**	
TB (Disease or positive skin test)	**YES / NO**	
Ear/Hearing Problems	**YES / NO**	
Birth Defects	**YES / NO**	
Heart Problems/Murmur	**YES / NO**	
Vision Problems	**YES / NO**	
Bone/Joint Problems / Scoliosis	**YES / NO**	
Immunizations up to date	**YES / NO**	

Other:

In the event that my child has a medical emergency at any time while on the school premises, in a school vehicle, or at a school sponsored activity, whether during the school day or otherwise, I authorize emergency measures necessary to protect my child's health and welfare. I will assume the responsibility for any fees incurred in the administration of such medical treatment.

I authorize Helping Hand School to share pertinent medical information regarding my child's health with the appropriate personnel within the building.

Signature of Parent/Guardian Date

HELPING HAND
SCHOOL

PHYSICIAN'S REPORT ON CHILD WITH ALLERGIES

(Child's Last Name) (First) (Middle) (DOB)

(Home Address) (City) (State) (Zip Code)

(Father's Name) (Phone #) (Mother's Name) (Phone #)

(School Name) (Grade)

Dear Doctor,
Helping Hand School is requesting your cooperation in completing the following questions. Please return this form to us and retain a duplicate copy for your files.

Student has an allergy to what specific things? Please check all that apply.
□ Milk □ Drugs □ Latex □ Peanuts □ Pollens □ Animal Dander □ Trees/Grasses □ Molds □ Dust □ Bee Stings
□ Other: _____
Skin Test Completed? □ No □ Yes **Date:** _____

When is the child most affected by the allergies? □ Fall □ Winter □ Spring □ Summer

Student Symptoms (circle all that apply):

Mouth	Itching	Swelling of Lips	Tongue	Mouth
Throat	Itching	Hoarseness	Sense of Tightness in Throat	Hacking Cough
Skin	Itchy Rash	Hives	Itching/Swelling of the Face or Extremities	
Gut	Nausea	Abdominal Cramps	Vomiting	Diarrhea
Lungs	Wheezing	Shortness of Breath	Repetitive Coughing	
Heart	"Thready" Pulse		"Passing Out"	
Nose	Stuffy	Runny	Itchy	Sneezing
Eyes	Dark Circles	Bags	Watery	
Neuro	Headaches	Irritability	Anaphylactic Shock Reaction	
Other				

Special Needs (Check if modifications required):
___ P.E./Exercise Modifications ___ Gym ___ Classroom ___ Lunch ___ Animals in Class

___ Other: _____

Medical Treatment Prescribed: _____

_____

_____

How often is the Student Seen by the Physician? _____ **Next Scheduled Appointment: Date:** _____

Daily Medication Plan

Medication Name	Dosage	Scheduled Time
1.		
2.		
3.		

Physician's Name: _____ **Hospital Affiliation:** _____
(Please Print or Type)

Address: _____ **Telephone:** _____ **Fax:** _____

Physician's Signature: _____ **Date:** _____

HELPING HAND SCHOOL

Emergency Action Plan

Student's Name: _____ Date of Birth: _____

Grade: _____ Classroom Teacher: _____

Allergic to: _____

Asthmatic: Yes* ☐ No ☐ * higher risk for severe reaction

◊ Step 1: Treatment ◊

Symptoms:		**Give Checked Medications:** To be determined by physician authorizing treatment	
NONE:	If a food allergen has been ingested, but no symptoms	☐ Epinephrine	☐ Antihistamine
LUNG[Y]:	Shortness of breath, wheezing, or hacking cough	☐ Epinephrine	☐ Antihistamine
HEART[Y]:	Pale, blue, faint, weak pulse, dizzy, confused	☐ Epinephrine	☐ Antihistamine
THROAT[Y]:	Tightening of throat, hoarseness, or trouble swallowing	☐ Epinephrine	☐ Antihistamine
MOUTH:	Itching, tickling, or swelling of lips, tongue and mouth	☐ Epinephrine	☐ Antihistamine
SKIN:	Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine	☐ Antihistamine
ABDOMEN:	Nausea/vomiting, abdominal cramps, or diarrhea	☐ Epinephrine	☐ Antihistamine
OTHER[Y]:	_____	☐ Epinephrine	☐ Antihistamine
If reaction is progressing (several of the above affected), give:		☐ Epinephrine	☐ Antihistamine

The severity of symptoms can quickly change. [Y]Potentially life threatening

Dosage:

Epinephrene: inject intramuscularly (circle one) EpiPen® EpiPen®Jr. Twinject™0.3mg Twinject™0.15mg

Antihistamine: give (medication/dose/route) _____

Other: give (medication/dose/route) _____

◊ Step 2: Emergency Calls ◊

1. Call 911: State that an allergic reaction has been treated, and additional epinephrine may be needed.
2. Call Dr. _____ at _____
3. Emergency Contacts:

Name/Relationship	Phone Number	
a._____	1._____	2._____
b._____	1._____	2._____
c._____	1._____	2._____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian Signature _____ Date: _____

Doctor's Name (Printed) _____ Phone # _____

Doctor's Signature: _____ Date: _____

(Required)

HELPING HAND
SCHOOL

PHYSICIAN'S REPORT ON CHILD WITH ASTHMA

(Child's Last Name) (First) (Middle) (DOB)

(Home Address) (City) (State) (Zip Code)

(Father's Name) (Phone #) (Mother's Name) (Phone #)

(School Name) (Grade)

Physician student sees for asthma: _____ **Phone:** _____

Dear Doctor,

Helping Hand School is requesting your cooperation in completing the following questions. Please return this form to us and retain a duplicate copy for your files.

Severity Classification For Asthma: __ Intermittent __Mild __Persistent Moderate __Persistent Severe Persistent

Asthma Triggers (list): _____

Peak Flow Meter Personal Best _____

Daily Treatment Plan:

Please list any medication taken daily to manage asthma including nebulizer treatments, with specific instructions

Name	Purpose	Dosage	When to use

These medications are prescribed for the time period_____ until_____

Medical Equipment:

Please list any medical equipment this student will need to treat his/her asthma at school.
(i.e. spacer, nebulizer, oxygen, pulse oximeter etc.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Additional Information:

_____

_____

_____

EMERGENCY ASTHMA ACTION PLAN:

Emergency Action is necessary when this student has symptoms such as:

1. _____ 2. _____

3. _____ 4. _____

Steps to take during an asthma episode:

1. Give emergency medications:

A. Bronchodilator (quick - relief medication)

Name: _____

Purpose: _____

Dosage: _____ **When to use:** _____

Can be repeated for severe breathing difficulty _____ times _____ minutes apart
Oxygen saturation with pulse oximeter (if available): Norms expected for student _____ % to _____%

Call 911 or EMS if minimal or no improvement

B. Other medications:

Name: _____

Purpose: _____

Dosage: _____

When to use: _____

Additional instructions: _____

These medications are prescribed for the time period _____ until _____

2. Seek emergency care if this student experiences any of the following:
   - No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached
   - Oxygen saturation is at or below _____ %.
   - Student exhibits:

Chest and neck pulled in with breathing	Struggling to breathe	Stops playing and cannot start activity again
Hunched over while breathing	Trouble walking or talking	Lips or fingernails turn gray or blue

Comments and special instructions: _____

_____

Healthcare Provider Name _____ Phone (_____) _____-_____

Signature _____ Date _____

Parent/Guardian

___ I give permission for the medicines listed in the action plan to be administered in school by the nurse or other

school staff as appropriate.

___ I consent to communication between the prescribing health care provider or clinic, the school nurse, the school medical advisor and schoolbased health clinic providers necessary for asthma management and administration of this medicine.

Name _____ Date _____

Phone (_____) _____-_____ Signature _____

School Nurse

Name _____ Phone (_____) _____-_____

Signature _____ Date _____

HELPING HAND
SCHOOL

Dear Parents/Guardians,

Enclosed is Helping Hand's standard seizure protocol, please read over it. Our staff and nurses will be following this protocol.

If, however, you would like a more standardized or thorough Seizure Action Plan for your family member, the enclosed Seizure Action Plan will need to be completed by their legal guardian and physician, along with signing the bottom of the plan. This form must be returned to the nursing department at Helping Hand as soon as possible. The nurses and staff will follow this Seizure Action Plan.

If you have any questions, please contact the nursing department at (708) 352-3580 ext. 265.

____ Yes, this protocol is acceptable

X_____

Parent/Guardian Signature

____ No, this protocol is not acceptable. Please see the personalized protocol.

X_____

Parent/Guardian Signature

X_____

Physician Signature

Helping Hand
Seizure Protocol

HELPING HAND
SCHOOL

GENERAL PROTOCOL

Generalized Tonic-Clonic (Grand Mal) Seizures

1. **STAY CALM** and reassure other people who may be nearby
   NOTIFY NURSE and Case Manager.
2. **DON'T HOLD THE PERSON DOWN** or try to stop his/her movements.
3. **TIME THE SEIZURE** with your watch.
   If repeated seizures occur, or a single seizure lasts longer than 5 minutes, ***CALL 911****, UNLESS client has an Individual Seizure Action Plan on file.*
4. **PROTECT FROM INJURY**
   - Guide person to the floor, if possible.
     Put something flat and soft under the head (like a folded jacket).
     Turn him/her onto LEFT side. This will keep the airway clear.
   - If person is in wheelchair, be sure the chair is in "partial recline" and brakes are locked.
   - Loosen anything around the neck that may make breathing difficult (such as ties and shirt buttons).
   - Clear the area around the person of anything sharp or hard.
5. **NEVER INSERT ANYTHING INTO THE MOUTH** nor try to force mouth open. A Person having a seizure CANNOT swallow his tongue.
6. **AFTER SEIZURE HAS SUBSIDED**
   - Don't attempt artificial respiration unless the person does NOT start breathing again after the seizure has stopped.
   - Stay with the person until the seizure ends naturally.
   - Be friendly and reassuring as consciousness returns.

CALL 911 IMMEDIATELY when these conditions exist:

- Difficulty breathing
- Change in color
- No history of seizures
- Unusual pain felt after seizure
- Consciousness doesn't return after seizure
- Confusion lasts more than 1 hour after seizure
- Brain infections
- Diabetes
- Head injury
- Heat exhaustion
- High fever
- Hypoglycemia
- Poisoning
- Pregnancy

NON-CONVULSIVE SEIZURES:

If a person has brief periods of shaking of the limbs, staff doesn't have to do anything.

If a person has a seizure that produces a dazed state and automatic behavior:

1. Watch the person carefully.
2. Speak quietly and calmly in a friendly way.
3. Guide the person away from any danger.
4. Stay with the person until full consciousness returns.

PROLONGED SEIZURES IN CHILDREN

Call 911 if:

- Seizure lasts more than 5 minutes, UNLESS client has an Individual Seizure Action Plan on file.
- Seizure is unusual in some way
- Child has trouble breathing
- Child appears to be injured or in pain, or
- Recovery is different than usual

Source: Based on Epilepsy Foundation guidelines May 2011

Helping Hand
Seizure Protocol

HELPING HAND
SCHOOL

SEIZURE ACTION PLAN

Effective Date:_____

THIS CLIENT IS BEING TREATED FOR A SEIZURE DISORDER. THE INFORMATION BELOW SHOULD ASSIST YOU IF A SEIZURE OCCURS DURING FACILITY HOURS.

Client's Name: DOB:

Parent/Guardian: Phone: Cell:

Other Emergency Contact: Phone: Cell:

Treating Physician: Phone:

Significant Medical History:

CLIENT SEIZURE CHARACTERISTICS:

Seizure Type	Duration	Frequency	Description

Describe seizure triggers or warning signs:

NON-CONVULSIVE SEIZURES	**TONIC-CLONIC SEIZURES**		**EXPECTED AFTER SEIZURE**
Typical client behaviors: __Lip Smacking __Behavioral outburst __Staring __Twitching __Other:_____	Typical client behaviors: __Sudden cry or squeal __Falling down __Rigidity/stiffness __Thrashing/jerking __Shallow breathing __Stops breathing __Blue color to lips __Froth from mouth __Gurgling or grunting nois __Loss of bowel/bladder c __ Loss of consciousness __Other:_____		__Tiredness __Weakness __Sleeping, difficult to arouse __Somewhat confused __Regular breathing __Other:_____ Can Last a Few Minutes to a Few Hours
STANDARD DANGER SIGNS	**DANGER SIGNS FOR CLIENT**	**STANDARD SEIZURE FIRST AID**	**MEDICAL RESPONSE FOR CLIENT**
A seizure is generally considered emergency when: ▪ Seizure lasts more than 5 minutes ▪ Another seizure stars right after the 1st seizure ▪ Loss of consciousness ▪ Stops or difficulty breathing ▪ Diabetes or hypoglycemia ▪ If seizure is the result of an injury or client is injured during seizure ▪ No history of seizures ▪ Change in color ▪ Unusual pain felt after seizure ▪ Confusions lasts more than 1 hour after seizure ▪ Heat exhaustion	What is a "seizure emergency" for the client? ▪ Seizure lasts more than ____ minutes ▪ Other (describe below):	Basic Seizure First Aid: ▪ Stay calm & track time ▪ Keep client safe ▪ Do not restrain ▪ Do not put anything in mouth ▪ Stay with client until fully conscious ▪ Record seizure in log For tonic-clonic (grand mal) seizure: ▪ Protect head ▪ Keep airway open/watch breathing	If different from standard first aid at left, describe basic first aid procedures for the client: Seizure Emergency Protocol: __ Call 911 for transport to: _____ __Notify parent or __ emergency contact __Administer emergency medications indicated on next page __Other:

HELPING HAND
SCHOOL

▪ High		▪ Turn client on left side	

SEIZURE MEDICATIONS: Treatment protocol during facility hours. Indicate if (D) and/or emergency (EM)

D	EM	Medication	Dosage	Administration (timing*&method**)	Special Instructions & Common Side Effects

* ex. After 2nd or 3rd seizure, for cluster of seizure, etc. **Orally, under tongue, rectally, etc.

Physician Signature: _____ Date: _____

Parent Signature: _____ Date: _____

HELPING HAND
SCHOOL

HOSPITAL TO SCHOOL TRANSITION FORM

This must be completed in full at least one school day prior to a student's return to school following hospitalization. Please, attach any discharge paperwork or corresponding documentation to this form.

Please, notify the administrative coordinator and classroom teacher with the anticipated return to school date as soon as possible.

Student Name: _____ **Date of Hospital Discharge:** _____

Date(s) of Hospitalization: _____

Facility/Hospital Name: _____

Reason for Hospitalization: _____

Medication Updates: *(Please, fill out the following form for any medication changes)*

Team Communication: *(Please, fill out the following form to provide permission for the hospital or facility team to communicate with the Helping Hand team.)*

Considerations or Modifications for Return to School:

_____
_____
_____
_____
_____
____

Will an IEP amendment be requested based on changes in support required?

- ❑ No
- ❑ Yes – Please, provide details:

  _____
  _____
  _____

HELPING HAND
SCHOOL

RELEASE OF INFORMATION CONSENT FORM

Client Name: _____ Birthdate: _____
Address: _____ Telephone: _____

The signature below grants permission for Helping Hand School to request and receive information regarding the identified student from the professionals or agencies specified below and to provide information regarding the identified student as requested to the professionals or agencies specified below in order to assist in treatment planning and coordination of services. **Please provide the name and contact of your child's primary physician and agency. This can include outside or in-home therapists, behavior analysts or other individuals working with your child.**

Any documentation provided by Helping Hand School for these purposes will be available to parents upon request.

Helping Hand School has permission **to release and request information** from the following (please fill in name and contact information) :

Doctor: _____ Phone: _____
Fax:_____

Doctor: _____ Phone: _____
Fax:_____

Agency: _____ Phone: _____
Fax:_____

Agency: _____ Phone: _____
Fax:_____

Tx/Other: _____ Phone: _____
Fax:_____

Tx/Other: _____ Phone: _____
Fax:_____

_____ _____

Date Parent or Legal Guardian

Questions: Contact Lizbet Gomez at 708-352- 3580 ext. 246
This consent is valid for one year from the above date as signed by parent or guardian

HELPING HAND
SCHOOL

Helping Hand School

DAILY & PRN MEDICATION AUTHORIZATION FORM

Student's Name: _____ Date: _____

TO BE COMPLETED BY THE STUDENT'S PARENT/GUARDIAN

Helping Hand School policy and guidance from the Illinois State Board of Education states that all prescription and nonprescription medications that are given during the school hours must have this form completed prior to the administration of any medication. No medication will be given during the school day unless absolutely necessary for the critical health and wellbeing of the student. By signing below, I authorize Helping Hand School, and its employees and agents, on my behalf and in my stead, to administer medication to my child. I acknowledge that it may be necessary for the administration of medication to my child to be performed by an individual other than the school nurse and specifically consent to such practices. I also give my permission for Helping Hand School to share all pertinent medical information about my child with school staff members involved with my child.

All medications must be:

1) In the original prescription container or original manufacturer's package if non-prescription;
2) Properly labeled with the name of the student, the prescribing physician, name of the medication, dosage, route, the time to be given, name of the pharmacy, and
3) Medication should be brought to school by the parent or other responsible adult. Controlled medications must be counted in the presence and with the signatures of the parent/guardian and two staff members. This medication form must be completed with the medication packaged properly as outlined above or the medication will not be given.
4) This form must be completed at the beginning of each school year and/or when changes to medication occur.
5) If a student is on multiple medications, a form must be completed in its entirety for each medication.

Name of medication, dosage, route & time: _____

_____

_____

_____

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

****

*** TO BE COMPLETED BY THE STUDENT'S LICENSED PRESCRIBER/PHYSICIAN**

Student Name: _____ DOB: _____

Medication: _____ Dosage and Route_____

Administration Time(s): _____ Is there a time when the medication should **NOT** be administered_____

Is this a PRN medication: YES or NO If Yes, what is the intended outcome: _____

Start Date: _____ End Date: _____

Physician Phone Physician Print Name

Physician Address Physician Signature Date

HELPING HAND
SCHOOL

Dear Parents/Guardians,

Re: Physician's Prescription for **School Therapy Services** Form

A Physician's prescription is required yearly for students to receive clinical related services as noted in their Individualized Education Plan (IEP). This refers to your child's Occupational, Physical, and/or Speech and Language services. The Physician's prescription must be on file for the student's therapy to be administered or an evaluation to be conducted.

Please send current prescriptions for clinical services stated on your child's IEP so that current IEP services are not interrupted. Prescriptions must be provided each school year.

Your Physician may use the attached form or their own prescription form.
The prescription must include the following details.

- The prescription states that clinicians may evaluate and provide services for your student.
- The prescription states your student's diagnosis.
- The prescription states whether there are any contraindications or special considerations for treatment.
- The prescription states which clinical therapies are required.

Your Physician may fax the prescription to us, c/o Lizbet Gomez at 708-966-5898. Please don't hesitate to contact me with any questions by email at Lizbet.Gomez@helpinghand-il.org or by phone at (708) 352-3580 ext. 246.

Thank you,

Lizbet Gomez
Administrative Coordinator
Helping Hand School
9649 W. 55th Street
Countryside, IL 60525
708-352-3580 x246

HELPING HAND
SCHOOL

PHYSICIAN'S PRESCRIPTION FOR SCHOOL THERAPY SERVICES

Student's Name: _____ Date of Birth: _____
Address: _____ City, State, And Zip: _____
Parent's Name: _____ Telephone: _____

To be completed by the Physician:

The following services are indicated:

_____ Occupational Therapy Evaluation/Treatment as Indicated

_____ Physical Therapy Evaluation/Treatment as Indicated

_____ Speech/Language Therapy Evaluation/Treatment as Indicated

Diagnosis: _____

Significant Medical History: _____

_____

Contraindication or Special Precautions: _____

_____

Physician's Name: _____
Address: _____
Telephone: _____
FAX: _____
Email: _____

Physician's Signature: _____

Date: _____

HELPING HAND
SCHOOL

Parental Authorization for Administering Medications

I acknowledge that I am responsible for administering medications to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize Helping Hand and its employees and agents, on my behalf and stead, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of the Helping Hand), lawfully prescribed medication in the manner described above. I acknowledge and agree that, when the lawfully prescribed medication is so administered or attempted to be administered, I waive any claims I might have against Helping Hand, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify Helping Hand, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

Parent/Guardina Name (Print) _____ Parent/Guardian Signature _____

Home Phone _____ Business Phone _____

Date _____

Additional Information:

_____

_____

_____

HELPING HAND
SCHOOL

Dear Parent(s)/Guardian(s):

Should an emergency ever arise with your child at Helping Hand School during school hours and medical services need to be contacted, Helping Hand School with your consent will release the Emergency Medical Release form to the Emergency Medical Responders.

Please fill out the attached form.

Please return with all forms at your earliest convenience.

Sincerely,

Lizbet Gomez
Administrative Coordinator

Emergency Medical Release
School Year: 2024-2025

HELPING HAND SCHOOL

Student Name: _____ **DOB:** _____

Communication(Circle One): Verbal Nonverbal Sign-Language Uses Communication Device
Behavior: _____

Parent/Guardian Contact Information:

Mother's Name: _____
Phone Number: _____
Home Address: _____
_____
Email: _____

Father's Name: _____
Phone Number: _____
Home Address: _____
_____
Email: _____

Emergency Contact Information:

Name: _____
Phone Number: _____

Name: _____
Phone Number: _____

Name: _____
Phone Number: _____

Name: _____
Phone Number: _____

Diagnosis:

Allergies:

Current Medications:

In an event of an emergency, the signature below grants permission for Helping Hand School to release the above information to the Emergency Medical Responders. The information above is as current as families made Helping Hand aware.

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

HELPING HAND
SCHOOL

Letter w/#8

Dear Parents/Guardians,

If your child will need to be administered medication (prescription or over the counter) during the school day, 8:15 am – 2:15 pm, the attached medications forms must be completed by your child's Physician. Please return all forms at your earliest convenience.

Approval of Over-the-Counter Products by a Physician Form must meet the following guidelines for the item to be administered to your child.

Please read the following guidelines that must be met before medications or healthcare products can be administered to your child. For future reference, see page 9 of the 2024-2025 Parent Information Handbook.

1. **Authorization signed and dated from Parent/Guardian to administer the medication or product.**
2. **Authorization signed and dated from Physician/prescriber to administer medication or product.**
3. **The medication or product is in the original labeled container: either from pharmacy or the manufacturer.**
4. **The medication or product label contains the client name, name of medication, directions for useand the date.**
5. **Annual renewal of authorization and immediate notification in writing of changes.**

Please don't hesitate to contact me with any questions by email at Lizbet.Gomez@helpinghand-il.org or by phone at (708) 352-3580 ext. 246. Thank you!

Sincerely,

Lizbet Gomez
Administrative Coordinator

HELPING HAND
SCHOOL

Physician's Prescription Approval

Student Name (First/Last): _____
Date of Birth: _____
Allergies: _____

All medications and health care products MUST be approved by parent and physician prior to administering it to a student. This includes over-the-counter medications, lotions, sunscreens, sprays, etc. The instructions below explain the process for approving any prescription or non-prescription items.

1. **Authorization signed and dated from Parent/Guardian to administer the medication or product.**
2. **Authorization signed and dated from Physician/prescriber to administer medication or product.**
3. **The medication or product is in the original labeled container: either from pharmacy or the manufacturer.**
4. **The medication or product label contains the student's name, name of medication, directions for use and the date.**
5. **Annual renewal of authorization and immediate notification in writing of changes.**

PRESCRIPTIONS:

Please, include the dosage, time to be administered, intended effect, expected side effects if any, and indication for discontinuation or contacting the physician.

Name of Medication/Product: _____
Dosage: _____
Time of Administration: _____
Intended Effect:

_____
_____
Possible Side Effects:

_____
_____
Other:

_____
_____

_____

Name of Medication/Product: _____
Dosage: _____
Time of Administration: _____
Intended Effect:

_____
_____
Possible Side Effects:

_____
_____

Other:

_____

_____

_____

Name of Medication/Product: _____

Dosage: _____

Time of Administration: _____

Intended Effect:

_____

_____

Possible Side Effects:

_____

_____

Other:

_____

_____

Other medications, vitamins, or supplements student is taking outside of school hours:

_____

_____

_____

Physician/Prescriber signature: _____ Date: _____ Emergency #: _____

Guardian signature: _____ Date_____

Helping Hand/Helping Hand School, 9649 West 55th Street, Countryside, IL 60525, Ph. 708/352-3580
Fax 708/966-5898

HELPING HAND
SCHOOL

CONSENT FOR RELEASE OF PHOTO/VIDEO IMAGE FOR MEDIA & AGENCY PROMOTION

The undersigned hereby _____(print name parent/guardian name) the parent/guardian of _____(print student name) consent OR decline consent to having his/her photo or video taken and releases this media (image, video, and/or audio) to be used to promote Helping Hand to the public and all media in print or digital/electronic formats. Additionally, this media may be used in the future for other fundraising, marketing, and public relations purposes by Helping Hand, including the internet, our website, or the website of an authorized Helping Hand agent to promote the mission of the agency, and where it may be viewed by the public. I also understand that I may change my mind and revoke this consent in writing at any time.

- I consent to the use of a photo of my child for this purpose _____ (please initial)
- I decline consent to the use of a photo of my child _____ (please initial)

- I consent to the use of a video of my child for this purpose _____ (please initial)
- I decline consent to the use of a video of my child _____ (please initial)

- I consent to the use of my child's journey for this purpose _____ (please initial)
- I decline consent to the use of my child's journey _____ (please initial)

- I consent to the use of my child's name (first name only) for this purpose _____ (please initial)
- I decline consent to the use of my child's name (first name only _____ (please initial)

I understand that there is no consequence if I do not wish to release my child's information. I also understand that I may change my mind and revoke this consent in writing at any time.

This consent is valid for **three years** from the date signed.

Name of Student (Please print) Birth Date

_____

_____

Name of Parent/Guardian (Please print)

_____

___

Signature Parent/Guardian Date

HELPING HAND SCHOOL

AUTHORIZED INDIVIDUALS FOR STUDENT DROP-OFF/PICK-UP

School Year 2024-2025

Student Name: **Birth Date:**

Primary Guardian:

Name: ______________________ Relationship: ______________

Day Telephone: ______________

Evening Telephone: ______________

Alternate Telephone: ______________

Other Family Member or Individual Authorized to Drop-off / Pick-up Student Named Above:

Name: ______________________ Relationship: ______________

Day Telephone: ______________

Evening Telephone: ______________

Alternate Telephone: ______________

Other Family Member or Individual Authorized to Drop-off / Pick-up Student Named Above:

Name: ______________________ Relationship: ______________

Day Telephone: ______________

Evening Telephone: ______________

Alternate Telephone: ______________

Other Family Member or Individual Authorized to Drop-off / Pick-up Student Named Above:

Name: ______________________ Relationship: ______________

Day Telephone: ______________

Evening Telephone: ______________

Alternate Telephone: ______________

Other Family Member or Individual Authorized to Drop-off / Pick-up Student Named Above:

Name: ______________________ Relationship: ______________

Day Telephone: ______________

Evening Telephone: ______________

Alternate Telephone: ______________

______________________________ ______________

Guardian Signature Date

HELPING HAND
SCHOOL

BEHAVIOR MANAGEMENT PROCEDURES

Helping Hand School is committed to using schedules of reinforcement and non-aversive approaches to behavior management with the students that we serve. The strategies utilized are individualized to each student and are based on the systematic implementation of the principles of Applied Behavior Analysis. Educational strategies and an individualized treatment plan are developed to prevent the occurrence of behaviors that can be dangerous to the student, staff members, or classmates. Helping Hand School follows all State regulations and mandates in our behavior procedures. This includes notifying parents within 24 hours using ISBE Form 11-1: "Physical Restraint and Time Out Form" if a physical restraint or time-out procedure is implemented for their child. This same form is submitted to the student's home School District and State within 48 hours of the use of a physical restraint or time-out procedure.

Trained and certified Helping Hand staff use physical procedures and techniques according to the Professional Crisis Management (PCM) system. The focus of PCM training is to use prevention and de-escalation strategies to reduce the occurrence of crisis situations.

While behavior strategies are applied to prevent the occurrence of aggressive or dangerous behavior, on occasion, a staff person may need to use physical contact to prevent injury to self, the student, or classmates. The use of physical intervention to manage behavior is seen as the last resort.

The use of physical methods to control behavior involves briefly blocking attempts to harm oneself, a staff member, or a classmate. On occasion, the staff member may need to briefly hold a body part (arm or leg for example) in order to prevent harm. In situations where a student is engaging in behaviors that pose a safety risk to themselves or others, PCM trained staff may implement a transportation procedure or use a vertical immobilization. As soon as there is a reduced risk of harm, the intervention immediately ends and blocking or physical procedure will be faded and attempts are made to help the student engage in more appropriate and safe behavior.

Helping Hand staff will not use physical restraint as a form of routine behavior control. Only in extremely rare circumstances where the student's behavior has been fully assessed are such procedures implemented. These procedures will only be implemented by PCM certified staff and follow State mandates and law.

When the use of physical restraint presents a danger to the student or staff, the student may be transported to a Low Stimulation Room (LSR) using a PCM transportation procedure. Staff members are always present with the student and working to deescalate the behaviors. Additionally, staff members will ensure that the student remains in line of sight throughout the use of the LSR. These rooms are fully padded for the student's protection and a Behavior Analyst is notified immediately if a student is taken to a LSR.

The LSRs are not used for punishment or disciplinary purposes. They are utilized when a student's behavior presents severe danger to him/herself, staff, or other students and is considered a safer alternative to a physical restraint. The student leaves the LSR as soon as he/she has regained composure to be reintegrated into their classroom.

If Physical Intervention or LSR is utilized and lasts 15 minutes, a nurse will confirm that the procedure poses no undue risk to the individual's health.

_____

Student's Name (Print)

_____

Parent/Guardian Name (Print)

_____ _____

Parent/Guardian Signature Date

12a

HELPING HAND
SCHOOL

CONSENT FOR TESTING AND ASSESSMENTS

I give permission for Helping Hand to utilize the following tests/assessments throughout the year as standard on-going assessments with my child.
(For 2024-2025 School Year)

Student's Name:_____

ACADEMIC/OTHER TESTS AND ASSESSMENTS:

-ABLLS: The Assessment of Basic Language and Learning Skills

I ____ **consent** / ____ **do not consent** to my child participating.

-AFLS: The Assessment of Functional Living Skills

I ____ **consent** / ____ **do not consent** to my child participating.

The signature below grants permission for Helping Hand to administer the above tests and assessments to my child as standard procedure throughout the school year.

Parent and/or Legal Guardian Signature _____ Date _____

This consent is valid for one year from the above date as signed by parent and/or guardian.

HELPING HAND
SCHOOL

Dear Helping Hand Families,

Welcome to the 2024-2025 school year! We are thrilled to have your student as a part of our school community at Helping Hand School. We believe in celebrating our students' achievements, capturing memorable moments, and fostering their success in various activities and events.

Throughout the academic year, to ensure we have your permission to include your student in these activities and events, we kindly ask you to review and sign the consent form below. More details regarding events and support for students in these events will be provided by your classroom team.

Thank you for your cooperation and support! This form can be returned with your enrollment packet. If requesting further information for any items, events, or activities below, please contact the Director of School Services, Sara Svetich, at sara.svetich@helpinghand-il.org or (708) 352-2715.

School Events

I, _____, give consent for my student, _____, to participate in the following school events for the 2024-2025 school year. *Mark those that you provide consent for your student to attend.*

_____ Fall Fest

_____ Costume Parade

_____ Holiday Pageant

_____ Valentine's Day Party

_____ Field Day

_____ Graduation

Community Outings

I, _____, give consent for my student, _____, to participate in the following school community outings for the 2024-2025 school year. *Mark those that you provide consent for your student to attend.*

_____ Post Office

_____ Library

_____ Park

_____ Grocery Store

_____ Restaurant

_____ Hanson Center Farm

Yearbook

I, _____, give consent for my student, _____, to participate in the HH School Yearbook 2024-2025 school year based on the following specifications.

_____ BOTH my student's first name and photo to be used in the yearbook.

_____ ONLY first name, no photo to be used in the yearbook.

_____ ONLY photo, no use of first or last name to be used in the yearbook.

_____ I DO NOT give consent for either my student's name or photo to be used in the yearbook

Student Name:_____

Parent Signature: _____

Date: _____

HELPING HAND
SCHOOL

Cooking Group Consent Form
2024-2025 School Year

Dear parents and guardians,

Helping Hand School offers a once per week cooking group facilitated by the clinical team. In a group, the students work on requesting, waiting, following a recipe, fine motor control, visual motor skills, peer interaction, teamwork, patience, food exploration, requesting, sensory exploration, and more. All cooking group recipes are nut free with the opportunity to try a variety of foods.

Please fill out and return the consent below:

- ❑ Yes, my child _____ is able to participate in cooking group.

  Dietary restrictions include:

  _____
  _____
  _____
  _____

- ❑ No, my child _____ is not able to participate in cooking group for the 2024-2025 school year.

HELPING HAND
SCHOOL

Parent Information Handbook Sign-Off

The Parent Information Handbook of individuals served by Helping Hand School has been reviewed with me.

I understand the rights and guidelines outlined as they have been presented to me and I have been advised that any questions I may have at any time should be directed to the Program Director.

_____ _____

Name of Child Date

_____ _____

Parent/Guardian Signature of Parent/Guardian

HELPING HAND

SCHOOL

2024-2025 Parent Information Handbook

9649 W. 55th Street
Countryside, IL 60525
Phone: 708.352.3580
Fax: 708.966.5898
https://helpinghand-il.org/

HELPING HAND
SCHOOL

Dear Parents and Guardians:

Welcome to the 2024-2025 School Year at Helping Hand School!

Our school has been built on research of "Best Practices" in the field of autism, intellectual, and developmental disabilities. Combined with a highly select and trained staff, we believe that together with you, (our families and professionals) we can make a significant difference in your student's life.

Helping Hand has a 66-year history of providing valued services to the community. The agency has a full array of services delivered to individuals from birth through adulthood. We look forward to working together to meet or to exceed your student's functional and educational needs.

This handbook was developed to provide you with some basic information about our school program. I and the rest of the Helping Hand staff are always available to answer any specific questions that you may have. We value your input and welcome comments and suggestions!

Sincerely,

Melissa MacKay

Melissa MacKay
Director of Helping Hand School
9649 W. 55th Street
Countryside, IL 60525
708-352-3580 x276
Melissa.Mackay@helpinghand-il.org
https://helpinghand-il.org/

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GENERAL INFORMATION

About Helping Hand

Helping Hand is a CARF (Commission on Accreditation of Rehabilitation Facilities) accredited, non-profit, community-based rehabilitation center. Helping Hand School is approved by the Illinois State Board of Education as a Nonpublic Alternative Placement Facility (N.A.P.F.). Helping Hand provides high quality services for individuals with developmental delays and disabilities from birth through life. Services for individuals beyond the age of 21 years are typically provided through our Adult Services program. The Helping Hand School, however, serves children 3 to 22 years of age.

Mission
Transforming all lives connected to Helping Hand through genuine care and education.

PROGRAM OBJECTIVES

The IDEAL model is based on services developed for each child's individual educational, behavioral and clinical needs:

- **INDIVIDUAL SKILLS:**
  Each child is a unique individual with specific motivators and learning channels. All interventions and supports will be designed to meet the individual needs of the child.

- **DIAGNOSTIC:**
  The school utilizes diagnostic testing and assessment to clearly identify the learning strengths and barriers of each child. This process is vital for streamlining the effectiveness of treatment.

- **EDUCATIONAL:**
  The school will focus on the development of teaching strategies and supports that match the learning styles of each student.

- **ALLIANCE:**
  A key factor in this model is forming an alliance between the Helping Hand School, the family, and the child's home school. The emphasis is a team approach utilizing specialized teachers and therapists that can assist the team in meeting the needs of the whole child.

- **LONGEVITY:**
  Teaching strategies will focus on the development of skills that the student will be able to generalize to the home environment as well as the community.

The IDEAL Model utilizes individualized strategies combined with frequent measurement of progress to provide the child with the optimal learning environment. Another important element to the effectiveness of the IDEAL Model is family training and support. The school provides family outreach and program development in the home. School staff assists the family in assuring that the individualized supports

continue after class is over. This consistency in support provides maximum benefit to the student.

The last critical component of the IDEAL Model is continual preparation for a transition back to the student's home school. School staff focuses on skill development so the student is able to return as quickly as possible to his/her home school. Consultation and training for home school staff as well as assistance with curricula modification is available before, during, and after transition to the home school. The decision to return to the home school is based on the I.E.P. Team.

Utilization of the IDEAL Model and recruitment of the highest qualified staff allows the Helping Hand School to achieve three primary outcomes:

1. Each student will develop skill sets that promote learning, social interaction, and independence that will allow him/her to participate in the least restrictive educational environment.
2. Each student will experience a decrease in maladaptive behaviors that interfere with growth.
3. Each family will develop the knowledge and skills to assist their child with participation in family life.

Eligibility Requirements:

1. The student must have a diagnosis of autism, intellectual and/or development disability
2. Be between the ages of 3 to 21.

THE SCHOOL TEAM

The primary objective of the program is to teach skills that allow the students to be as independent as possible at home, school, and in the community. The emphasis of our program is to develop receptive and expressive language and reduce or eliminate maladaptive behaviors that interfere with learning in order to increase educational skill sets. Enhancing our students' social and educational skill sets allows the student's need for intensive instruction to be reduced. Helping Hand has dedicated nine classrooms to the school. These classrooms are designed to offer individualized instruction in a structured setting. The school team includes several professionals who

work together collaboratively to develop individual programs based on a holistic approach. The following list describes the staff who work with our students throughout the day as part of this collaborative team.

THE TEACHER: A Certified LBS1 (Learning Behavior Specialist) is responsible for developing and implementing the individual instruction following the I.E.P. and utilizes assessments that might indicate additional special needs. The teacher reviews student data and makes necessary revisions based on effective teaching strategies.

THE BEHAVIOR ANALYST: Assists in the development of the curriculum and provides training and support to staff based on functional behavior principles. The Behavior Analyst also develops individualized behavior plans utilizing a functional assessment designed to enhance the student's pro-social behaviors and reduce incidents of maladaptive or disruptive behaviors.

THE SPEECH AND LANGUAGE PATHOLOGIST (SLP): Provides instruction to the individual student based on the needs outlined in the student's I.E.P. and incorporates this instruction into the student's daily programming. The speech and language pathologist works with children who possess a wide variety of speech delays and disorders. Emphasis is placed on functional communication skills.

THE OCCUPATIONAL THERAPIST (OT): Provides instruction to the individual student based on the needs outlined in the student's I.E.P. and incorporates this instruction into the student's daily programming. An occupational therapist assesses and treats a child's ability to perform tasks relating to fine motor, self-help (dressing, eating, grooming, etc.), problem solving, oral-motor/feeding, social, vocational, perceptual, and adaptive play skills, including sensory processing abilities and attention.

THE PHYSICAL THERAPIST (PT): Provides instruction to the individual student based on the needs outlined in the student's I.E.P. The primary focus of the physical therapist is to improve functional gross motor skills (large muscle movements) helping children achieve developmental milestones. These skills may include: sitting, standing and walking taught in a therapeutic play-based environment.

INSTRUCTIONAL TEACHING ASSISTANT (ITA): ITAs aid the Teaching Team in providing direct instruction to the students during individual work times and within group activities.

REGISTERED BEHAVIOR TECHNICIAN (RBT): RBTs aid the Behavior Team in providing support for each student's individual behavior intervention plan. They provide feedback and support to classroom team members focusing on reducing maladaptive behaviors.

THE NURSE: Available for administration of medicine, and for consultation in the case of specific medical concerns or emergencies that might require immediate medical attention.

ADMINISTRATIVE COORDINATOR:

The Administrative Coordinator (AC) provides administrative support to the Helping Hand School with ongoing assistance. While the AC is responsible for utilizing skills to improve the quality of communication, the AC is also responsible for maintaining records and all documentation for the school, and for coordinating and facilitating services with Districts and the Illinois State Board of Education.

IEP COORDINATOR and TEACHER MENTOR: Under the direction of the Director of the Helping Hand School, and in accordance with State agency policies and procedures, the IEP Coordinator and Teacher Mentor is responsible for providing support services to staff in the Helping Hand School for IEP development and staff development/training for teachers.

DIRECTOR OF SCHOOL SERVICES: Under the direction of the Vice President of Education/Senior Director and in accordance with state agency policies and procedures, the Director of School Services is responsible for providing assistance and support to the Vice President via staff supervision, classroom management, procedural facilitation, strategic thinking, consensus building, and influencing better outcomes for students, families and staff.

HELPING HAND SCHOOL POLICIES

Attendance Policy:

It is the policy of the Helping Hand School that students attend all scheduled days of school.

It is understood that parents will inform the school when students will be absent due to illness, emergencies or family vacations. The family is expected to contact the Helping Hand School by calling the Student Cancellation Line, 708-352-3580 ext. 478. **Reporting the absence on the Cancellation Line is mandatory**.

If a student is absent, and there is no message left on the Cancellation Line, the student's absence will be considered *unexcused*. If the student is absent for three

consecutive days with no message on the Cancellation Line, the Helping Hand School will contact the referring school district.

Following three consecutive days of absence due to illness a doctor's note is required prior to the student's return. The doctor's note must be provided via email, or hard copy to the school nurse before the student returns to school.

Parents/Guardians should refer to their home school district truancy policy for their specific rules regarding truancy as the Helping Hand School will hand over responsibility for responding to truancy to the home school district after notification.

Attendance Procedure:

This procedure promotes timely communication regarding absences between school and family. Additionally, the procedure defines excused versus *unexcused* absences. When *unexcused* absences have become too abundant, the following outlined communication protocol will be followed by the school in order to support better attendance, communication of absences, and ultimately a student's continued progress at Helping Hand School.

Parents/Guardians are to report a student's absence by calling into the Student Cancellation Line by 8:30 am on the day of an unplanned absence, and we ask that you provide a notice two weeks prior for planned absences for the absence to be considered excused.

(Student Cancellation Line – 708-352-3580 x478)
When calling the number above, as soon as the recorded message begins, go ahead and enter the extension number, 478, then follow the prompts to leave the required information.

If the action noted in the previous two paragraphs is not taken, the student will receive an *unexcused* absence for the day.

A student will be out of compliance with our attendance procedure after
3 *unexcused absences* during **a one-month** time frame.

The following procedures will be taken by the school for *unexcused* absences:

- 1 *unexcused* day: Oral reminder of attendance procedure.
- 2 *unexcused* days: Oral warning and written letter of attendance procedure.
- 3 *unexcused* days: Discussion between the Sr. Director of the school and the Parents/Guardian regarding appropriateness of placement. The student's District will be notified of the discussion.

Schools must assure 176 days of actual student attendance (minimum of 5 hrs. of instructional time on each of these days. **Instructional time does not include lunch, passing time, and/or recess**)
18-8.05 of School Code (Sect. 10-19)

Summer School must provide at least 120 hours of instruction.
(Equal to 24 five-hour days)

Combining the Regular School Year with ESY, students must be available to receive an absolute minimum of 1000 hours of instruction or face consequences. (Including loss of opportunity to promote to next grade level.)

Sign-In Procedure:

When visiting the school please sign-in at the front desk and wait for a staff member to escort you to the appropriate location or retrieve your student for pick up.

Food/Lunches:

Helping Hand School does not provide any type of lunch programming or hot lunches. Parents and/or guardians are responsible for sending a snack and lunch every day for their child.

Please let the Helping Hand staff know if there are any food allergies preparations for food.

Helping Hand School is equipped with a microwave if lunches or snacks need to be warmed. Students should bring their lunch/snack in an insulated lunchbox with icepacks if food needs to be kept cool. Students should bring any utensils or dishes needed for their lunch or snack. These items will be returned home daily in the student's lunchbox. The school does not provide utensils.

Illness Policy:

Children should **not** be sent to school or be seen on a home visit if they exhibit an obvious or diagnosed illness. Children showing any of the following symptoms will not be allowed to attend school:

Fever –Nausea –Vomiting –Sore Throat –Chills –Cough –Diarrhea –Fatigue –Skin Rash Headache –Pinkeye –Muscle and body aches –Congestion or runny nose

New loss of taste or smell Uncontrolled yellow/green nasal secretions

Shortness of breath or trouble breathing

If a student experiences any of these symptoms at school, parents may be called to pick up their child. Students will be sent home if they experience vomiting, diarrhea, or a fever; or if the nurse feels a condition may be contagious.

Parents must have an emergency pick-up plan in place in case their child needs to be picked up at school.

Students must be **free** of the above symptoms, and/or medication for a minimum of **24 hours** before returning to school.

- **If your child has an outpatient medical procedure, is hospitalized for any reason or contracts a contagious illness or condition, a parent or guardian must produce a signed release from your physician that lists any restrictions and clears your child to return to school.**
- **A physician's release to return to school must also be provided if your child is absent three or more days from school due to illness.**

A physician's release to return to school must also be provided if your child is absent three or more days from school due to illness or following release from the ER or hospital.

Virtual Home Visits:

One of the benefits of the Helping Hand School is the ability to make virtual home visits. This allows services to remain consistent and for us to suggest in-home strategies that have proven successful in the classroom. The student's Teacher or Behavior Analyst will contact each family to make routine virtual home visits. The purpose of these visits is to share information, observe the child in their home setting and coordinate services between the family and any support services they may receive at home and school.

Teachers/Therapists may suggest programming ideas that could help the student and family in their home environment. If you have any questions in regard to these suggestions feel free to discuss them with the teacher or therapists at any time. As always, consistency in treatment is best for receiving the greatest possible outcome. Additional costs for treatment materials are solely at the parent's discretion. If you would like further information about specific home programming strategies please address this with the team.

School Hours: School hours are 8:15 a.m. – 2:15p.m.

No Smoking Policy:

By State Law, smoking is not allowed anywhere on school property. Since we are a school at the Countryside location, there should be no smoking anywhere on the Helping Hand Countryside location, including the parking lot.

Smoking is prohibited for any school staff, students, or other persons in the Countryside location. This includes cigarette, cigar, or tobacco in any other form, including smokeless tobacco which is any loose, cut, shredded, ground, powdered, compressed or leaf tobacco that is intended to be placed in the mouth without being smoked. Vaping or e-cigarettes of any kind are also prohibited at the Countryside location.

Helping Hand Center Countryside is a Smoke-Free Environment

Drugs/Alcohol:

Helping Hand School will not tolerate the use, possession, or sale of any illegal or controlled substance, including alcohol, unlawful drugs, or "look-alike" drugs by students anywhere in the school building, on school grounds, on school buses, or at any school-sponsored function, social gathering, or field trip. Failure to follow these guidelines will result in disciplinary action.

Field Trips:

Students going on school trips will be under the supervision of Helping Hand staff and the same general rules apply that are enforced during school hours. Parents must sign a written notification slip prior to the trip in order for the child to be able to participate.

Dress Code:

Helping Hand School does not have a specific dress uniform. We do ask that children be dressed daily with appropriate items for current weather conditions. Clothes displaying profanity, advertisements for drugs, alcohol, tobacco products, or other inappropriate sayings are strictly prohibited. Parents should send a couple spare set of clothes to be kept in the classroom. Teachers will notify parents when extra clothes are needed.

Student Cell Phone Policy: If a student desires to bring a cell phone to school, the cell phone must be kept in their personal locker or backpack during school hours on silent. If a parent desires to reach a student during the school day, the administrative

coordinator or classroom teacher can be contacted via phone and/or email to provide communication to the student.

Classroom Schedules:

Each classroom will have an individual schedule that fits the needs of the students within that classroom. Lunch, snack, gym, individual work times, and group activities will all be scheduled according to the needs of the individual students. The Teacher will send home a copy of the current schedule upon new student arrivals.

Confidentiality Policy:

Helping Hand abides by the guidelines and provisions of HIPAA (Health Insurance Portability and Accountability Act) and The Confidentiality Act. No information about a child (verbally, written, or on tape) will be released without the signature of the parent/guardian.

- Only information generated by Helping Hand can be released to others. Reports generated outside of Helping Hand must be obtained directly from the party who wrote the report.
- All client records are secured from theft, loss, fire and access.
- Access to your child's records is restricted to persons authorized by the Confidentiality Act, including the family.

Notices:

Special notices may be handed out by your child's teacher/therapist when appropriate.

Occasionally, notices will be sent to you at home regarding upcoming Helping Hand events. All families will receive a monthly School Newsletter via email.

Entrance After Hours:

Helping Hand School closes at 4:00 PM. After-hours entrance is permitted by appointment only.

MEDICATION & HEALTHCARE PRODUCTS INFORMATION

Updating Medical Information and Records:

It is the parent's responsibility to keep staff informed of any changes in personal information such as home address and phone number. Likewise, it is a parent's responsibility to update the school on any new medical information or other factors that affect his/her child's educational program.

General Medication Information:

Medications are never to be sent to school in the student's backpack.

All medications should be brought to school by a parent/guardian and handed directly to a Helping Hand School staff member or given to the student's bus or van driver who will hand the medication directly to a Helping Hand School staff member. The Helping Hand Staff member will take the medication directly to the school Nurse.

Administration of medications to students must be managed by the school's nurse. Teachers and other non-administrative employees cannot be required to administer any prescribed medications.

All medications are stored in a separate, locked drawer or cabinet. Any medications requiring refrigeration are kept in a locked refrigerator separate from food products. At the end of the treatment regime, the student's parent(s)/guardian will be responsible for removing from the school any unused medication. Nurses have the right and responsibility to decline to administer a medication if they feel it jeopardizes the student's safety. A student's parent or guardian may come to the school to administer medications to his/her own child.

The following list gives a general description of health-related items that require physician's approval.

These items include but are not limited to:

- prescription medications,
- over-the-counter medications
  - such as aspirin, cough syrup, or Tylenol,
- health care products
  - such as vitamins, hand lotion, lip balms, diaper creams, Vaseline

For a student to receive <u>any type of health care related item</u> like those listed above, the parent must meet the following requirements:

1. **Authorization signed and dated from Parent/Guardian to administer the medication or product.**
2. **Authorization signed and dated from Physician/prescriber to administer medication or product.**
3. **The medication or product is in the original labeled container: either from pharmacy or the manufacturer.**
4. **The medication or product must be labeled with the client name, name of medication, directions for use and the date.**
5. **Annual renewal of authorization and immediate notification in writing of changes.**

It is the parent/guardian's responsibility to ensure the above requirements are met and that all parts are submitted to school.

Medical Cannabis:

Administration of Medical Cannabis will be allowed **ONLY** after the following has been provided:

- Copies of caregiver and student registry identification cards issued by the Illinois Department of Public Health identifying a person as a registered qualifying patient or registered designated caregiver are obtained and verified by the School.

- The written authorization and a copy of the registry identification cards must be kept on file in the office of the school nurse.
- The authorization for a student to self-administer medical cannabis infused products is effective for the school year in which it is granted and must be renewed each subsequent school year upon fulfillment of the requirements of 105 ILCS 5/22-33.

- Written authorization from parent/guardian is obtained: The written authorization must specify the times where, or the special circumstances under which, the medical cannabis infused product must be administered.
- Training has been completed by the school nurse and/or school director

Administration:

Medical Cannabis Infused Products may be administered in a School Setting by:

• Designated caregiver:

A parent, guardian, or any other individual registered with the Illinois Department of Public Health as a designated caregiver of a student who is a registered qualifying Patient.

After administering the product, the designated caregiver shall remove the product from the school premises or school bus

• Trained school nurse or school director

- ✓ **The school nurse and directors must complete the ISBE annual training curriculum on medical cannabis prior to administering medical cannabis to students.**
- ✓ **Nothing requires a member of a school's staff to administer a medical cannabis infused product to a student.**

• Student, under the direct supervision of a school nurse or director:

A student, who is a registered qualifying patient, may self-administer a medical cannabis infused product under the direct supervision of a school nurse or school director.

Administration of medical cannabis infused products must not:

- Create a disruption to the school's educational environment.
- Cause exposure of the product to other students.

Medical Cannabis Infused Products that can be administered at School:

• Oils • Ointments • Foods • Patches • Other products that contain usable cannabis but are **NOT** smoked or vaped:

- ✓ Products must be – Purchased by a qualifying patient/caregiver from a licensed dispensing organization – In a verifiable container from licensed dispensary – Properly labeled with qualifying patient information – Packaged according to the Compassionate Use of Medical Cannabis Program Act,410 ILCS 130/80.
- ✓ Most Common forms of Medical Cannabis are:
  - Oral route
    - Edibles, gummies, food products
  - Sublingual route •
    - Dissolved under the tongue
  - Cutaneous route •
    - Topical
  - Transdermal route
    - Patch
- ✓ Generally Not Practiced:

- Rectal route
  - Suppositories
- Injection route
- Ocular route
  - Eye drops
- Other

✓ Adequate Supply:

- 410 ILCS 130/10 (a) (1) states that an adequate supply is 2.5 ounces of usable cannabis during a period of 14 days and that is derived solely from an intrastate source.

Medical Cannabis Infused Products may be administered to a student who is a registered qualifying patient:

- While on school premises
- While at a school-sponsored activity
- Before or after normal school activities
- While the student is being transported on a school bus.

Storage and Supply:

Any product administered by a school nurse or director, or self-administered under the supervision of a school nurse or director, must always be stored:

- With the school nurse in a matter consistent with the storage of other student medication at the school.
- Where it is accessible only by the school nurse or a school director.

PROGRAM SERVICES

Development of the Individualized Education Plan (I.E.P.):

The student's I.E.P. is developed by the child's I.E.P. team, which may include instructional and therapeutic providers, representatives from the student's home district, and family members. The home district facilitates the I.E.P. meeting and finalizes the paperwork. Soon after the initial 30 days at Helping Hand School, an I.E.P. meeting will be scheduled to review current, future, and family goals. This meeting includes the child's home district, family members, and Helping Hand team members.

Case Record/Rights:

Upon admission, a file is opened on your child. The file contains: intake records, reports from other service providers; reports from Helping Hand, prescriptions, physicals, case notes and documentation regarding your child.

Files are safeguarded at Helping Hand and are kept in locked cabinets. Only staff in the Helping Hand School have access to your file. These records are property of the home school and are shared freely with the appropriate representative from the home school district.

A Release of Information Form must be signed by the legal care giver of the child to allow us to share information with another party, other than the child's home school.

You will also need to sign a Release of Information Form for us to receive information from another service provider or school. All information is kept confidential and cannot be released without your permission.

You have the right to look at your child's case file.

A file is kept open while the child is receiving services. By law, Helping Hand must return all files to the referring school district when the child leaves the Helping Hand School.

If you have questions about your child's case file, please contact the Program Director.

STUDENT RIGHTS

The child's home school is responsible for passing out a notice of parent/student rights. Please contact your child's home school to receive a copy. Student's rights include:

- A free and appropriate education.
- Equal treatment in all aspects of the educational system.
- The right to be treated with dignity.
- The opportunity to understand and adhere to reasonable rules and regulations established by the Board of Education and implemented by the school administrators and faculty.

VIOLATION OF REGULATIONS:

Actions that will subject a student to disciplinary action include but are not limited to the following:

- Arson or otherwise starting a fire
- Bomb Threats, false fire alarms, and false 911 calls
- Damaging school property
- Forgery/using forged or stolen school documents
- Gang/secret society membership or representation
- Intent to do bodily harm
- Possession /use / distribution/sale of alcohol, drugs/controlled substances, drug paraphernalia, look-alike drugs, tobacco, marijuana
- Possession/use/delivery/distribution/sale of weapons to include any firearm, knife, gun, rifle, air or spring gun, revolver, pistol, switch blade, pocket knife, brass knuckles, fireworks, ammunition, explosives, or any look alike for any variety of weapons

DISCIPLINE:

When breeches of school disciplinary rules and regulations occur, it is the responsibility of the involved staff and administrators to work with the student, his/her parents, appropriate home district staff and other support personnel to help correct the behavior. All disciplinary actions shall be directed towards the welfare of the school community as well as helping the student develop self-discipline. Any violations of regulations will be considered on an individual basis and may result in the suspension, probation, or expulsion of the student.

SUGGESTIONS or CONCERNS:

We greatly appreciate and want your feedback. Please do not hesitate to notify us of any suggestions or concerns that you may have. We pride ourselves in individualizing services and are always striving to offer the best services to you. You are always welcome to discuss ideas with the staff directly.

SERVICES TO CAREGIVERS

Family Socials:

Do you want to just get together with other families and relax? Look for flyers and invitations in the mail to attend various socials at Helping Hand. Holiday parties, picnics and fund-raising events are just some of the available activities at Helping Hand.

Family/Caregiver Resources:

Please look for monthly communication regarding resources, including training opportunities and information sessions.

Crisis Management Policy

Helping Hand School is committed to using schedules of reinforcement and non-aversive approaches to behavior management based on a functional assessment, and educational strategies to prevent the occurrence of behaviors that can be dangerous to the student, staff persons or classmates.

Staff at Helping Hand are trained in the use of crisis prevention strategies and intervention procedures through Professional Crisis Management (PCM).

While behavior strategies are applied to prevent the occurrence of aggressive or dangerous behavior, on occasion a staff person may need to use a physical procedure to prevent injury to self, the student, or classmates.

The use of physical procedures to manage behavior is seen as the last resort.

As soon as there is a reduced risk of harm, physical procedures are faded and attempts are made to help safely reintegrate the student back into classroom activities (the student engage in more appropriate and safe behavior.)

The Helping Hand team will not use physical procedures as a form of routine behavior management. Only in extreme circumstances where the child's behavior has been fully assessed are such procedures implemented. These procedures are reviewed by the Behavior Team and The Helping Hand Human Rights Committees. (no longer reviewed by HRC).

PHYSICAL INTERVENTION AND BEHAVIOR CRISIS PROCEDURES

Helping Hand School is committed to using schedules of reinforcement and non-aversive approaches to behavior management based on a Functional Behavior Assessment, and educational strategies to prevent the occurrence of behaviors that can be dangerous to the student, staff or classmates. We follow all State regulations and mandates in our behavior procedures. This includes notifying parents within 24 hours using ISBE Form 11-1: "Physical Restraint and Time Out Form" if a physical restraint or use of a Low Stim Room is implemented for their child. This same form is submitted to the district and State within 48 hours of the use of physical restraint or a Low Stim Room. Additionally, any restrictive procedure is recorded on the daily take-home note to the parents and on the Helping Hand School Restrictive Procedures Report for internal reporting and review.

While behavior strategies are applied to prevent the occurrence of aggressive or dangerous behavior, on occasion, a staff person may need to use physical contact to prevent injury to self, the student, or classmates.

What is a Physical Intervention?

A Physical Intervention is a safe, non-harmful behavior management system designed to help human service professionals provide for the best possible care, welfare, safety, and security for any individuals who are engaging in behaviors that are a danger to themselves or others. The use of physical procedures to manage behavior is seen as the last resort.

Who can implement a Physical Intervention?

Anyone who is certified in Professional Crisis Management (PCM) procedures by the Professional Crisis Management Association (PCMA) can implement a physical Intervention procedure. Those who are not trained in PCM procedures are prohibited from physically intervening with any individual in the school. All PCM certified staff are required to participate in an annual PCM recertification to maintain their certification.

Types of Physical Interventions used:

All Physical Intervention procedures are implemented according to the Professional Crisis Management (PCM) system. This includes transportation procedures and 1,2 and 3 person vertical immobilization procedures.

The State of Illinois defines physical restraint this way: *"Physical restraint" means holding a student or otherwise restricting the student's movements. "Physical restraint" as permitted pursuant to this Section includes only the use of specific, planned techniques (e.g., the "basket hold" and "team control"). A physical restraint shall not impair a student's ability to breathe or communicate speak normally, obstruct a student's airway, or interfere with a student's primary mode of communication.*

Helping Hand School does not utilize prone or supine forms of physical restraint.

As soon as there is a reduced risk of harm, physical interventions are systematically faded, and attempts are made to safely reintegrate the student into the classroom.

Helping Hand staff will not use physical interventions as a form of routine behavior control. Only in extremely rare circumstances where the child's behavior has been fully assessed are such procedures implemented. These procedures were reviewed and approved by the Helping Hand Behavior Team and follow State mandates and law.

When the use of physical intervention presents a danger to the student or staff, the student may be transported to a Low Stimulation Room (LSR) using a PCM transportation procedure. The LSRs do not have doors and students are never in isolation. Staff is always present with the student. Staff are always in direct eye sight of the student. These rooms are fully padded for the student's protection. A Behavior Analyst is summoned immediately to monitor the situation if a student is taken to a LSR.

The LSRs are not used for punishment or disciplinary purposes. They are utilized when a student's behavior presents imminent danger to him/herself, staff, or other students and is considered a safer alternative to a physical restraint. The student leaves the LSR as soon as he/she has regained composure.

If the Physical Intervention lasts 30 minutes, a nurse will confirm that the Physical Intervention poses no undue risk to the individual's health.

When are Physical Interventions used?

Physical interventions will be used as a last resort when a student is engaging in continuous aggression, continuous self-injury or high magnitude disruption that poses a safety risk to the students or staff. This is when all less restrictive methods of intervening have been exhausted, and when the individual presents a danger to self or others. The physical intervention is faded once the student is no longer a danger to themselves or others. If the Physical Intervention lasts more than 30 minutes, a nurse will confirm that the Physical Intervention poses no undue risk to the individual's health.

When are Physical Interventions not used?

Physical Interventions are prohibited unless someone is engaging in continuous aggression, continuous self-injury or high magnitude disruption and/or is in imminent danger. Physical Interventions cannot be used as a form of punishment or to discipline an individual. Physical Interventions may not be used for the convenience of staff.

Recording of a Physical Intervention:

After a Physical Intervention has occurred it must be documented immediately after it has happened. This document includes the following:

- Individuals name being restrained
- Date
- Location
- Type of Physical Intervention being used
- Time Physical Intervention began (Transportation procedures, Immobilizations and Time-outs)
- Time Physical Intervention ended (Immobilizations and Time-outs only)
- Total Physical Intervention time (Immobilizations and Time-outs only)
- Name of staff person(s) applying Physical Intervention
- Name of witnesses
- When the parents/guardians were notified
- When the Classroom Behavior Analyst was notified
- When the Lead Behavior Analyst was notified
- When the supervisor was notified
- Staff Signatures
- Classroom Behavior Analyst Signature
- Lead Behavior Analyst Signature
- Supervisor signature
- Injuries or property damage
- BCBA Notes
- Student debriefing notes
- Staff members debriefing notes
- Brief description of what happened prior to, during, and after the incident

- Reason why the Physical Intervention is being implemented

Additionally, we follow all State regulations and mandates in reporting the use of physical restraint or use of the LSR. This includes notifying parents within 24 hours using ISBE Form 11-01 – revised form: "Physical Restraint and Time Out Form" if a physical restraint or use of a Low Stim Room is implemented for their child. This same form is submitted to the district and State within 48 hours of the use of physical restraint or a Low Stim Room. Additionally, any restrictive procedure is recorded on the daily take-home note to the parents.

Review of Physical Intervention:

All Physical Intervention forms are reviewed by the Sr. Director/ Director of the school and classroom behavior analyst. Following three instances of a non-therapeutic use of a LSR for a specific student, a review will be initiated by the team to review data, reviewing the functional behavioral analysis, considering developing additional or revised positive behavioral interventions and supports, considering actions to reduce the use of restrictive procedures. A team review is held and documented following three incidents of using physical restraint or the LSR for a student.

Preapproval of Physical Interventions:

Physical Interventions are only used in situations in which the individual is a danger to themselves or others. All Physical Interventions are used in emergency situations in which all other least restrictive interventions have failed. Anyone trained to administer PCM may do so. If the Physical Intervention lasts more than 30 minutes, the nurse will immediately be notified and assess the individual. Prior to the use of physical interventions, the team conducts and reviews a functional behavioral analysis and other data; considers development of additional or revised positive behavioral interventions and supports, and actions to reduce the use of restrictive procedures; or, if applicable, modifies the individualized educational program or the behavior intervention plan, as appropriate; and reviews any known medical or psychological limitations that contraindicate the use of a restrictive procedure, considering whether to prohibit that restrictive procedure, and, if applicable, documenting any prohibition in the individualized education program or behavior intervention plan.

Special Circumstance:

If a client's primary mode of communication is sign language, the individual will be permitted to have his hands free from Physical Intervention for brief periods each hour, except when doing so may result in physical harm. Physical Interventions are only administered or continued if the individual is an immediate danger to themselves or others.

Training of staff:

Helping Hand School staff are trained in Professional Crisis Management (PCM). All PCM certified staff participate in an annual recertification course. Staff are trained in the safety and humane application and implementation of each type of physical intervention used at Helping Hand Center.

Only individuals who currently hold a Professional Crisis Management Practitioner or Instructor certification are authorized to implement PCM physical procedures.

Holds

- If an individual is placed in a hold a behavior analyst must be called to assess the situation.
- If a hold lasts more than 15 minutes, a behavior analyst must be called to assess the situation every 15 minutes.
- If a hold lasts more than 30 minutes, a nurse must be called to assess the student and make sure he/she is free of injury.

Low Stim Room

- If a student is transported to the Low Stim Room, a behavior analyst must be called to assess the situation.
- If a student is in the Low Stim Room for more than 30 minutes, a behavior analyst must be called to assess the situation every 30 minutes.

Debriefing

- After all uses of a physical intervention or a Low Stim Room, staff must debrief the student and staff involved. Any staff **directly** involved in the physical restraint or Low Stim Room instance will debrief the student. The behavior analyst will debrief the staff involved in the incident.

Parent Comportment Policy

Helping Hand School believes that a positive and constructive working relationship between the school and a student's parent (or guardian) is essential to fulfilling the School's mission and creating a culture in which students, parents, and school personnel work together with respect, civility and trust. As such, Helping Hand School reserves the right not to continue enrollment or not to re-enroll a student if the School reasonably concludes that the actions and behaviors of a parent (or guardian) make it impossible to foster a positive and constructive relationship or cause serious interference with the School's accomplishment of its educational purposes and mission.

RIGHTS OF NON-CUSTODIAL PARENTS & OTHERS

This policy explains the obligations of Helping Hand School staff with respect to the rights and authority of divorced or separated parents (specifically, the non-custodial parent), and other individuals (e.g., grandparents, stepparents) regarding students who are minors.

It is the policy of Helping Hand School to uphold the equal rights of each parent with respect to their child(ren), unless and until taken away or altered by a valid court order, divorce decree, or other legal document executed by both parents. If a parent/guardian wishes that the rights of the other parent with respect to their child(ren) be restricted, it is that parent/guardian's responsibility to provide the school with a valid, current and legible court order and/or divorce decree indicating any such restriction on the parent's rights. Helping Hand School reserves the right to check the actual court file to verify either parent's authority at any time.

In addition, a non-custodial parent or other individual (e.g., grandparents, stepparents, etc.) claiming any authority with regard to consent for a student at Helping Hand School and/or the right to school records and related information, must complete a Certification of Authority form. This form will be shared with the custodial parent of the child for verification purposes. This form may be picked up in the back of the student handbook, or requested from the school. (See Next Page)

CONTACT INFORMATION CORRECTIONS:

If during the year, any of your contact information changes, please update the Administrative Coordinator of Helping Hand School.

You can:

-Email to Lizbet.Gomez@helpinghand-il.org,
-Send a note to school with your child,
-Fax it to 708-966-5898, ATTN: Lizbet, or
-Leave a message at 708-352-3580 Ext. 246 for Lizbet

It is very important that we have correct information for each of our students. Contacting you without delay is important to us. Thanks for your help.

HELPING HAND
SCHOOL

CERTIFICATION OF AUTHORITY

The undersigned, _____, by signature below, hereby certifies to Helping Hand School that he/she has full legal authority, pursuant to a divorce decree currently on record or otherwise, to do the following with regard to _____, a student at the school: (Please check all that apply)

☐ Consent to the administration of educational evaluations

☐ Consent to the initiation of educational programs

☐ Consent to the release of confidential education information from the temporary and permanent school files

☐ Consent to the release of confidential mental health information pursuant to the Illinois Mental Health and Developmental Disabilities Confidentiality Act

☐ Right to receive and review all school records from the student's temporary and permanent school file, including day-to-day school related information (e.g., grade reports, parent notifications, student work, etc.)

☐ Other authority (explain in detail)

_____

_____

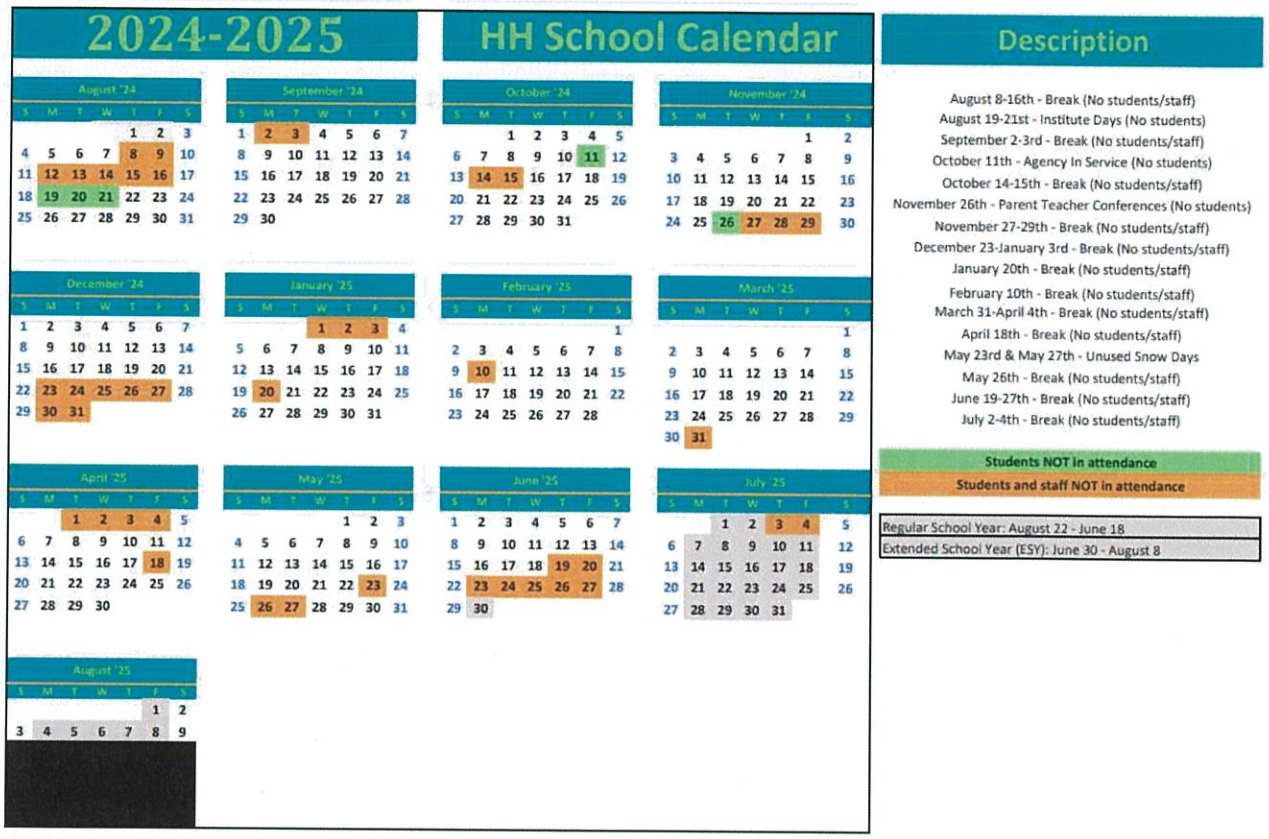
_____

The undersigned acknowledges that once he/she has signed below, this form will be forwarded for verification to the other parent. If no objection to the assertions contained herein is received within 7 days of transmittal to the parent, Helping Hand School will comply with all requests from the undersigned in conformity with this document. The undersigned recognizes that it is a criminal offense to execute a fraudulent document in the state of Illinois. Helping Hand School reserves the right to check the actual court file, if applicable, to verify each parent's authority at anytime. Parents may be asked to update this form from time-to-time as required by the school and due to any change in circumstances.

Signed: _____ Date: _____
Non-Custodial Parent

Witness: _____ Date: _____

A separate calendar is included in the packet. Be sure to post it for easy reference throughout the school year!



ISBE Special Education Support Services Complaint Investigation:

ISBE Special Education Support Services Complaint Investigation:

An individual believes that a school district has not complied with the law or that a child's education rights have been violated, the individual should try to resolve the issue with the local school district, through the following steps:

- Communicating directly with the school staff, principal, superintendent, or director of the special education cooperative.
- Requesting an Individualized Education Program (IEP) meeting to discuss the issues with the IEP team.
- Utilizing the state-sponsored mediation system to resolve the areas of concern. Additional information about mediation may be found at: http://www.isbe.net/spec-ed/html/mediation.htm.

Early resolution is an informal means for districts and parents to resolve complaints at the local level. It is not uncommon for disagreements to occur between parents and school districts regarding a child's special education services. Those disagreements can often be resolved at the local level with open communication between the parties. The process of resolving disagreements at the local level can be a quick alternative to using a state-sponsored dispute resolution system, and can have the added benefit of improving communication between both parties in the future. Parents seeking guidance on how to resolve disputes at the local level may contact the Special Education Division of the Illinois State Board of Education at 217/782-5589, or through the agency's toll-free parent line at 866/262-6663 and ask to speak to a consultant. Additional information on resolving disputes at the local level can be found by visiting the website of the Consortium for Appropriate Dispute Resolution in Special Education (CADRE) at http://www.directionservice.org/cadre/.

HELPING HAND SCHOOL

Parent Guide

PUNS automated number directing the caller to local DD service information	1-888-337-5267

Please refer to pages 6-8 for additional resources

3 years old

- Apply for prioritization for Urgency of Need for Services(PUNS) with your Pre-Admission Screening(PAS) Agency
- Apply for a Social Security Card
- Contact your local park district or agency to inquire about programming that may interest your student.
- Develop self-care and daily living skills and routines
- Work on appropriate social skills at school and home
- Work on functional communication

4 years old

- Update PUNS information
- Contact your local park district or agency to inquire about programming that may interest your student.
- Continue to develop self-care and daily living skills and routines
- Continue to work on appropriate social skills at school and home
- Continue to work on functional communication

5 years old

- Update PUNS information
- Contact your local park district or agency to inquire about programming that may interest your student.
- Continue to develop self-care and daily living skills and routines
- Continue to work on appropriate social skills at school and home
- Continue to work on functional communication

Elementary School Age (6-10 years old)

- Update PUNS every year
- Contact your local park district or agency to inquire about programming that may interest your student.
- Introduce the concept of work into everyday activities
- Have students become familiar with all types of careers
- Continue to develop self-care and daily living skills and routines
- Continue to work on appropriate social skills at school and home

- Explore vocational opportunities closer to the end of elementary school
- Introduce chores at home
- Continue to work on functional communication

Middle School Age (11-13 years old)

- Update PUNS every year
- Contact your local park district or agency to inquire about programming that may interest your student.
- Begin career exploration
- Vocational training should start to be introduce at school
- Continue to introduce the concept of work into everyday activities
- Continue to develop self-care and daily living skills and routines
- Continue to work on appropriate social skills at school and home
- Continue to have chores at home
- Continue to work on functional communication
- Volunteer in the community
- Begin looking into transition to prepare for age 14

14 years old

- Apply for PUNS if not done already
- Special Needs Trusts (See info attached)
- Apply for state ID if you have not already done so
- Contact your local park district or agency to inquire about programming that may interest your student
- Complete questionnaire on transition needs
- Make transition goals a part of the IEP
- Develop independent living skills
- Begin early career exploration
- Increase self-advocacy skills
- Explore recreation and leisure activities

15 years old

- Update PUNS information
- Make transition goals a part of the IEP
- Attend transition fairs for students with special needs
- Contact your local park district or agency to inquire about programming that may interest your student.
- Develop independent living skills
- Increase self-advocacy skills

- Look into SSI
- Explore recreation and leisure activities
- Explore adult service providers

16 years old

- Update PUNS
- Obtain state ID card
- Make transition goals a part of the IEP
- Contact your local park district or agency to inquire about programming that may interest your student.
- Increase self-advocacy skills
- Develop independent living skills
- Consideration of vocational interest survey for parents and students
- Discuss Supported Employment Program (SEP) and job coaching
- Explore recreation and leisure activities
- Explore adult service providers
- Explore guardianship, wills, and trust
- Explore residential programs

17 years old

- Update PUNS
- Make transition goals a part of the IEP
- Contact your local park district or agency to inquire about programming that may interest your student
- Develop independent living skills
- Increase self-advocacy skills
- Explore Guardianship
- Explore SSI and medical benefits
- Explore adult service providers and consider waiting list
- Explore recreation and leisure activities
- Explore residential programs and consider waiting list

18 years old

- Update PUNS

- Parents will submit a release of information for district to communicate with the PAS agency and invite caseworker to IEP meetings
- Make transition goals a part of the IEP
- Apply for SSI and Medicaid
- Contact your local park district or agency to inquire about programming that may interest your student
- Implement guardianship, power of attorney, wills and trust
- Work experience (volunteering, completing jobs around the school, in the community)
- Increase self-advocacy skills
- Develop independent living skills

- Pursue recreation/leisure activities
- Explore adult service providers (tours)
- Refer to adult service providers and include in transition planning meetings
- Register to votes and males register for selective service
- Start to fade some 1:1 assistance (if student has 1:1)
- Begin to incorporate larger student to staff ratios in group settings

19 years old

- Update PUNS
- Parents will submit a release of information for district to communicate with the PAS agency and invite caseworker to IEP meetings
- Make transition goals a part of the IEP
- Contact your local park district or agency to inquire about programming that may interest your student
- Increase self-advocacy skills
- Develop independent living skills
- Work experience(volunteering, jobs around the school, in the community)
- Pursue recreation/leisure activities
- Explore adult services providers(tours)
- Participation with adult service providers
- Continue to fade 1:1 assistance (if student has 1:1)
- Work on larger student to staff ratios in group settings

20 years old

- Update PUNS
- Parents will submit a release of information for district to communicate with the PAS agency and invite caseworker to IEP meetings
- Make transition goals a part of the IEP

- Contact your local park district or agency to inquire about programming that may interest your student
- Work experience (volunteering, jobs around the school, in the community)
- Increase self-advocacy skills
- Develop independent living skills
- Pursue leisure/recreation activities
- Explore adult service providers(tours)
- Explore transportation needs after graduation
- Fading 1:1 assistance (if student has 1:1)
- Larger student to staff ratios in group settings

21 years old

- Update PUNS
- Parents will submit a release of information for district to communicate with the PAS agency and invite caseworker to IEP meetings
- Make transition goals part of the IEP
- Contact your local park district or agency to inquire about programming that may interest your student
- 1:1 assistance should be faded by this point
- Work experience(volunteering, jobs around the school, in the community)
- Increase self-advocacy skills
- Develop independent living skills
- Pursue recreation/leisure activities
- Have at least 3 adult service providers in mind for the student to transition to after graduation
- Know what form of transportation the student will utilize after graduation

HELPING HAND
SCHOOL

Activity	Age	Additional Information
Apply for a Social Security Card	**All Ages**	You can apply for a social security card as soon as you have a birth certificate
Recreational/Community Involvement Fees are Involved- Contact your park district to see about fees/waivers	**All Ages**	**Parents:** Contact your local park district or agency to inquire about programming that may interest your student. **Students:** Tell your parents what types of Programs you would be interested in participating in. **School:** Will answer any questions and assist with accommodation information if requested by the family.
SPECIAL NEEDS TRUSTS For students who plan to apply for SSI benefits at age 18. Assets kept in a Special Needs Trust do not disqualify individuals from becoming eligible for benefits in the future. Special Needs Trust can be coordinated by an attorney	**14**	**PARENTS:** Contact an attorney who is capable of completing the Special Needs Trust documents. Complete the process by opening the trust at participating banks. **STUDENT:** Attend the meeting with attorney. **SCHOOL:** Provide any documentation that is requested with a release of information

Seek Legal Counsel		
STATE ID Disabled Person's Identification Card (Free) vs. General ($20) https://www.cyberdriveillinois.com/publications/disabilitypub.html	**14+**	**PARENTS:** Bring student to Driver Services Facility; obtain doctor's signature on form for proof of disability. **STUDENT:** Will complete necessary forms and go to facility for ID **SCHOOL:** Provide any documentation that is requested with a release of information
DEPARTMENT OF HUMAN SERVICES DIVISION OF REHABILITATIVE SERVICES	**16**	**PARENTS:** Will provide the School District with a copy of their students' signed social security card and meet with DRS Representative for intake meeting. **STUDENTS:** Will attend intake meeting **District:** Will submit DRS referral paperwork and invite representative to IEP meeting to become a collaborative partner in transition planning.

Prioritization of Urgency of Need for Services ~PUNS	**18-21**	**District:** Submit a release of information to communicate with the PAS agency and invite caseworker to IEP meetings
SOCIAL SECURITY DISABILITY BENEFITS Students may qualify for disability benefits prior to the age of 18 if the family meets the income requirements. www.socialsecurity.gov	**18**	**PARENTS:** View website or call to get information about eligibility requirements. **STUDENTS:** Will bring their state ID to the interview. **SCHOOL:** Provide requested school documentation
MEDICAID	**18**	**PARENTS:** First apply for SSI, if your student is eligible for SSI he is eligible for Medicaid. You must take your student to the office for the interview process. **STUDENTS:** should attend intake interview at Medicaid office. **SCHOOL:** Provide requested school documentation

GUARDIANSHIP Parents of a child with disabilities will want to explore legal options and learn about the different levels of guardianship as well as power of attorney for medical and business decisions. **Equip for Equality, Legal Advocacy Program** 20 N. Michigan, Suite 300 Chicago, IL 60602 (800) 537-2632 **contactus@equipforequality.org** **Daley Center** Monday through Thursday-law students free of charge http://powerofattorney.com/illinois/	**18**	**PARENTS:** After you determine the level of guardianship you wish to peruse, contact your attorney or advocacy program for assistance. **STUDENTS:** Attend court hearing when called to do so. **SCHOOL:** Provide any records requested and comply with any release of information request.
SELECTIVE SERVICE REGISTRATION http://www.sss.gov/default.htm	**18**	**PARENTS:** will assist their SON in registering for selective service **STUDENTS:** will go online and register for selective service
HOME-BASEDSERVICES **Eligibility Requirements:** Persons age 18 or older with developmental disabilities who risk placement in an intermediate care facility for persons with Developmental Disabilities (ICF/DD)	**Based On Need/ Urgency**	**PARENTS**: Call your student's PUNS caseworker annually to update application and be sure to alert them of any substantial life changes as soon as possible. **SCHOOL:** Provide any records requested and comply with any release of information request.

2024-2025 HH School Calendar

August '24

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

September '24

S	M	T	W	T	F	S
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8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

October '24

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20	21	22	23	24	25	26
27	28	29	30	31		

November '24

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17	18	19	20	21	22	23
24	25	26	27	28	29	30

December '24

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15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

January '25

S	M	T	W	T	F	S
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12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

February '25

S	M	T	W	T	F	S
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23	24	25	26	27	28	

March '25

S	M	T	W	T	F	S
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23	24	25	26	27	28	29
30	31					

April '25

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20	21	22	23	24	25	26
27	28	29	30			

May '25

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18	19	20	21	22	23	24
25	26	27	28	29	30	31

June '25

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15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

July '25

S	M	T	W	T	F	S
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6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

August '25

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9

Description

August 8-16th - Break (No students/staff)
August 19-21st - Institute Days (No students)
September 2-3rd - Break (No students/staff)
October 11th - Agency In Service (No students)
October 14-15th - Break (No students/staff)
November 26th - Parent Teacher Conferences (No students)
November 27-29th - Break (No students/staff)
December 23-January 3rd - Break (No students/staff)
January 20th - Break (No students/staff)
February 10th - Break (No students/staff)
March 31-April 4th - Break (No students/staff)
April 18th - Break (No students/staff)
May 23rd & May 27th - Unused Snow Days
May 26th - Break (No students/staff)
June 19-27th - Break (No students/staff)
July 2-4th - Break (No students/staff)

Students NOT in attendance

Students and staff NOT in attendance

Regular School Year: August 22 - June 18
Extended School Year (ESY): June 30 - August 8

HELPING HAND
SCHOOL

HH School

Therapy Minute Calculations

A student's determined related services minutes for occupational therapy, speech language pathology, and physical therapy services is finalized at the student's IEP meeting based on clinical assessments and individualized student needs. Minute calculations start being calculated for the IEP year the first school day following the IEP meeting. If compensatory minutes for therapy are required for any reason, they carry over into the following IEP year. Compensatory minutes are determined based on the student's progress toward goals and current functional and academic focus within their programming.

Therapy minutes are provided during individual sessions, groups, activities, and daily routines in and out of the classroom environment. The therapy team is available for consultation for the classroom team and family at any time. Consult minutes are imbedded in the HH School program and are not calculated in the related services minute calculation.

Therapy minutes are calculated at the conclusion of each month by the Associate Director of Clinical Services. These minutes are totaled based on documented sessions within the HH School system. In the case that a clinical team member is absent or unavailable for any reason, the student session is rescheduled and provided at a different time within the month. In the case that a student is absent or unavailable for their scheduled session, the session is not rescheduled. Absent minutes are documented and calculated within the monthly totals for each student. Absent minutes include but are not limited to when the student is not present at school, is unavailable due to engagement in maladaptive behaviors, or any other instance that the student is not available to receive therapy minutes. To progress toward goals, additional sessions may be scheduled at the discretion of the treating clinician.

If requesting any records pertaining to related service sessions and minutes for students, please contact the Administrative Coordinator or school district representative for assistance.

HELPING HAND
SCHOOL

HH School

Student Record Request

Helping Hand School, with the student's district, keeps student records and files only while the student is attending HH School. If the student transitions from HH School or ages out of the program, the records and files are provided in full, along with any physical materials or belongings, to the student's home school district.

In the case that any records are requested, the student's family or representative is to contact the home school district representative. Once a student leaves Helping Hand, their records are returned to the district. Helping Hand does not keep any student documents. The representative will then contact HH School if needed for additional support.

HELPING HAND
SCHOOL

Helping Hand School
Student Cell Phone Policy

Cell phone use by Helping Hand students is prohibited during the school day, between the hours of 8:15 am and 2:15 pm, unless otherwise stated by a teacher or interdisciplinary team member. During the instructional day, cell phones must remain out of sight and in silent mode in a locker, or personal belonging such as a backpack.

If a student needs to make an emergency phone call determined appropriate by the interdisciplinary team, they will be provided a private space in which to do so and can utilize a school phone.

We ask that families needing to relay messages to students contact Helping Hand School's Administrative Coordinator to relay the message or retrieve the student from the classroom to be provided information in a private space. The Administrative Coordinator can be contacted by email at lizbet.gomez@helpinghand-il.org or by phone at (708) 352-3580 ext. 246.

HELPING HAND
SCHOOL

Dear Parent/Guardian,

In the event of inclement weather, please refer to the attached document in order to check on the status of closure for Helping Hand School. Below are just a few items to note when checking for school closures:

-Though your home school district may be closed, Helping Hand may be open. Please refer to the emergency closings website to find out whether or not Helping Hand is closed.

-Your home district provides/sets up transportation for your child. In the event that your home district is closed, their transportation may also be cancelled. Please, check with your transportation company directly.

-Please use your discretion if you feel the weather is unsafe to transport your child to and from Helping Hand School. Communicate with the school for any absences or late arrivals.

-If Helping Hand is open, and your child will be absent the day of inclement weather, you are still required to call the cancellation line at 708-352-3580 ext. 478 by 8:30 am.

Should you have any further questions, concerns or needs please feel free to contact me by phone at (708) 352-3580 ext. 246 or by email at Lizbet.Gomez@helpinghand-il.org.

Sincerely,

Lizbet Gomez

Administrative Coordinator
Helping Hand School
9649 W. 55th Street
Countryside, IL 60525
708-352-3580 x246
Lizbet.Gomez@helpinghand-il.org

HELPING HAND
SCHOOL

Parent Comportment Policy

Helping Hand School believes that a positive and constructive working relationship between the school and a student's parent (or guardian) is essential to fulfilling the School's mission and creating a culture in which students, parents, and school personnel work together with respect, civility and trust. As such, Helping Hand School reserves the right not to continue enrollment or not to re-enroll a student if the School reasonably concludes that the actions and behaviors of a parent (or guardian) make it impossible to foster a positive and constructive relationship or cause serious interference with the School's accomplishment of its education purposes and mission.