

Packet E  
Siblings  
of  
Returning  
Students

**Department of Defense Education Activity (DoDEA) Computer and Internet Access Agreement  
Parent Notice of Expectations at Patrick Henry Elementary School 2006-2007**

**Privacy Act Statement**

Authority: DoD Directive 1342.6, DoD Education Activity, DoDDS System Notice 22

Principal Purpose(s): To permit an individual's use of government-owned computer resources in accordance with DoDEA policies governing use of the Internet and to permit enforcement of DoDEA policies governing access to computers and the Internet.

Routine Use(s): In accordance with DoD published routine uses.

Disclosure: Voluntary; however no individual is permitted to use DoDEA-controlled computer resources until they have signed this statement indicating agreement to use such equipment only in accordance with DoDEA Computer and Internet Access Policies.

Student Name: Print clearly

Grade:

\*\*I, (Parent or Guardian) (Print Clearly) have read the Terms and Conditions below. I understand that network access is designed for educational purposes. DoDEA has taken precautions to eliminate controversial material. However, I also recognize it is impossible for DoDEA to restrict access to all controversial materials and I will not hold them responsible for materials acquired on the network. Further, I accept full responsibility for supervision if and when my child's use is not in a school setting. \*\*I understand, consistent with DoDEA policy to protect individual privacy, my child's written and art work and his or her name may be published, but DoDEA does not authorize the use of photographs, home address, or home telephone number in association with my child's name. I also understand DoDEA does not authorize the use of the school's Internet service for commercial activity or personal use inconsistent with the Terms and Conditions. \*\*I understand: (1) This form does not relinquish my child's rights in his or her work. (2) DoDEA is not responsible for subsequent copying or unauthorized use of the work by an outside person or agency. (3) The only personal identification of the work will be my child's name. (4) My child cannot be directly contacted through the page. All contacts will go through the teacher.

Parent/Guardian Signature

Date

Student Signature

Date

**Terms and Conditions For Students**

**I. Acceptable Use**

- a. I agree to use DoDEA's computer services only in support of my education and research consistent with the educational objectives of the DoDEA. I will not download files or subscribe to bulletin boards that are not related to my educational activities. If I have questions about my computer use, I will ask my teacher.
- b. I will respect and adhere to all of the rules governing access to DoDEA computing resources and the rules of any other network or computing resource to which I have access through the DoDEA equipment.
- c. I understand transmission (sent or received) of any material in violation of any U.S. or state regulation is strictly prohibited and may violate criminal law. I will not transmit obscene, sexually suggestive or offensive, lascivious, harassing, or abusive messages, copyrighted material, or material protected by trademark or as a trade secret.
- d. I will not publish the name, photograph, home address or telephone number of myself, another student, faculty, or any other person.
- e. I understand using the DoDEA computer equipment for commercial, product advertisement or political lobbying is prohibited and may be illegal.

**II. Privileges**

- a. I understand that the use of the network is a privilege, not a right, and use inconsistent with these Terms and Conditions may result in a cancellation of those privileges. (Each student will receive instruction regarding the terms and protocols referenced in this document before network access is provided.)
- b. I will be disciplined if I send messages or download files inconsistent with these Terms and Conditions. At the discretion of the principal and teacher, I may lose the privilege of using the Internet permanently and face suspension or expulsion. Copies of the inappropriate materials will be reported to the building administration and kept on file.

**III. Internet Etiquette**

- a. I will be polite. I will not use sexual or abusive language in my messages to others.
- b. I will use courteous, respectful language. I will not swear, use vulgarities, sexual, harsh, or disrespectful language. Illegal activities are strictly forbidden.
- c. I understand any transmission, including electronic mail, is not private and that my communications and access will be monitored.
- d. I will evaluate information carefully. As with any research material, I must review it for accuracy and bias.
- e. I will not use the network in such a way as to disrupt the use of the network by other users. This can be avoided by not sending "chain letters," or "broadcast" messages to lists or individuals.

**IV. No Warranties**

- a. I understand DoDEA makes no warranties of any kind, whether expressed or implied, for the service it is providing. DoDEA is not responsible for any damages I may suffer. This includes loss of data, delays, non-deliveries, misdeliveries, or service interruptions caused by its own negligence or my errors or omissions.
- b. I understand the use of any information obtained via DoDEA is at my own risk. DoDEA specifically denies any responsibility for the accuracy or quality of information obtained through its services. I understand DoDEA has no obligation or authority to defend me against any legal actions brought against me by anyone arising from my misuse of DoDEA computer resources or violations of any U.S. or foreign laws.

**V. Security**

- a. I understand security on any computer system is a high priority, especially when the system involves many users. I will notify my teacher if I notice a security problem. I will not demonstrate the problem to other users.
- b. I will not give my user password to other individuals. Any activity associated with my account will be considered my activity. It is my responsibility to protect my account and password.
- c. I may be denied access to the network if I am identified as a security risk.

**VI. Vandalism**

- a. I understand vandalism will result in cancellation of privileges. I will not maliciously attempt to harm or destroy data of another user, Internet, or any other network. This includes, but is not limited to, the uploading or creation of computer viruses.

**Weapons/Prohibited Substances/Anti-Bullying Policy**

**Weapons:** Students shall not transport, exchange, and carry on their person, nor cause to be stored, objects that are generally considered to be weapons. These include, but are not limited to firearms, knives, club type weapons (for example, blackjacks, brass knuckles, nunchaku), gas pistols and shooting pens, straight razors, razor blades, Exacto knives, ice picks, clubs, or any object that may be used as a club to inflict bodily harm (for example, pieces of wood or pipe, stones, or bricks). Also banned is any object that might be used readily to inflict bodily harm on self or others (for example, chains, canes with sharp points, broken bottles or glasses, spiked leather, lighters or laser pointers). Authentic appearing replicas of a firearm are classified as weapons (for example, toy guns). Possession of weapons by students while on school property (to include while riding to or from school or school events on school buses) or in attendance at a school function, or whenever under the jurisdiction of the school, is grounds for expulsion and referral to law enforcement agencies.

**Possession, Sale and/or Use of Alcoholic Beverages, Narcotics, Illegal Drugs and/or Prohibited Substances:** Notice is hereby given that possession, use, or sale of controlled (prescription) or mind altering (illegal) substances by any student while the student is on school property (to include while riding to or from school on school buses or at bus stops) or in attendance at a school sponsored function or whenever under the jurisdiction of the school, is grounds for expulsion. Student possession of or being under the influence of alcoholic beverages, and/or hallucinogenic drugs or combinations of drugs or paraphernalia expressly prohibited by federal, or local laws, including prohibited substances which shall include those substances possessed, sold, and/or used that are held out to be, or represented to be, controlled substances, illegal substances, or counterfeit in any respect illegal or controlled substances shall be grounds for expulsion and referral to law enforcement agencies. Prescription medication is not to be transferred to another. Over-the-counter medications are not to be transferred to another or used without parental and nurse knowledge. Students should have no more than one dose and the nurse has been informed of the presence of that dose.

**Sexual Harassment Policy:** Sexual harassment will not be tolerated at PHVES. Any student who sexually harasses another student will be counseled and/or disciplined. PHVES uses the following definition: sexual harassment is any unwanted and unwelcome sexual behavior, which interferes with a person's education or employment. It can include sexual comments, sexual advances, sexual notes (written or electronic), or sexual contact. Any student who is being sexually harassed should notify a teacher, a counselor or an administrator. Offenders will be counseled once, and then disciplinary action will be taken until the harassment stops.

**Bullying/Harassment/Relational Aggression Policy:** Bullying, Harassment and Relational Aggression will not be tolerated at PHVES. Any student who bullies or harasses another student will be counseled and/or disciplined. PHVES uses the following definition: a student is being bullied or victimized when he or she is exposed to negative actions on the part of one or more students. Negative actions can be verbal, non-verbal, or physical. Additionally, cyber-aggression, which is bullying via computer means, will not be tolerated. Bullying is aggressive behavior or intentional "harm-doing." It occurs within an interpersonal relationship and is characterized by an imbalance of power. Students are instructed to notify an adult if their efforts to stop bullying are ineffective. School personnel will intervene on behalf of students and parents in an effort to stop the negative actions that are occurring at school.

**I am aware of the zero-tolerance policies listed above.**

**Parent Signature** \_\_\_\_\_

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

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

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



## MEDICAL POWER OF ATTORNEY

In the event that my dependent \_\_\_\_\_, is injured or becomes ill, necessitating immediate medical examination or care, while under the supervision of or while participating in any activities sponsored by Patrick Henry Elementary School, I authorize and release to any agent or employee of Patrick Henry Elementary School to take my dependent to any U.S. military facility or any civilian hospital if deemed necessary by the above referenced individual.

I understand that the above named personnel of Patrick Henry Elementary School will use all diligent and reasonable efforts to contact my spouse or me. If personnel of Patrick Henry Elementary School or the U.S. treatment facility can contact neither my spouse nor me after reasonable attempts, I authorize and release any physician or other qualified medical personnel to examine my child. I authorize any and all emergency care necessary for treating injuries or illness involving immediate danger to life or limb of my dependent. I further authorize non-emergency care and necessary treatment such as suturing superficial lacerations; treating colds, minor allergies, and minor gastro-intestinal upsets; splinting sprains; casting uncomplicated fractures; or other similar treatments.

**MEDICAL INFORMATION ABOUT THE ABOVE NAMED DEPENDENT** (to be completed by parent/guardian) for the purpose of sharing information with teachers and health care personnel on a need- to-know basis.

My dependent has the following medical problems (such as diabetes, seizures, asthma, heart and kidney disease):

\_\_\_\_\_

My dependent is allergic to the following: \_\_\_\_\_

My dependent takes the following medications on a regular and/or "as needed" basis (list name, amount, and purpose of each medication): \_\_\_\_\_

Date of last tetanus booster: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION** (to be completed by parent)

Sponsor's home address: \_\_\_\_\_ Home phone #: \_\_\_\_\_

Sponsor's name: \_\_\_\_\_ Rank: \_\_\_\_\_

Sponsor's unit: \_\_\_\_\_ Work phone #: \_\_\_\_\_

Spouse's name: \_\_\_\_\_ Work phone #: \_\_\_\_\_

Cell phone #1: \_\_\_\_\_ Cell phone #2: \_\_\_\_\_

Other names and phone numbers to use in case of emergency if parents/guardians are unavailable:

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

Additional comments: \_\_\_\_\_

**I AGREE TO NOTIFY THE SCHOOL IMMEDIATELY OF ANY CHANGES IN THE ABOVE INFORMATION.**

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Sponsor's Social Security Number \_\_\_\_\_

Are you a civilian "Pay Patient"?  Yes  No

**PRIVACY ACT NOTICE:** AUTHORITY: Title V, Sec. 301. PRINCIPAL PURPOSE: To refer to emergency medical facilities in parents'/guardians' absence. ROUTINE USES: (a) To obtain emergency medical care when parents cannot be reached; (b) To provide emergency contact names; (c) To supply health and medical information about student. This form is used by DoDEA employees and trained medical personnel in emergency. Social Security number of sponsor is required by military medical facilities in case of emergency referral. MANDATORY/VOLUNTARY DISCLOSURE/EFFECT OF NONDISCLOSURE: Mandatory. School personnel will not be able to provide emergency care and health services in parents' absence.

# SCHOOL HEALTH RECORD

DEPARTMENT OF DEFENSE DEPENDENTS SCHOOLS

Patrick Henry Elementary School

HOME PHONE NUMBER \_\_\_\_\_ WORK NUMBER \_\_\_\_\_

MOM CELL \_\_\_\_\_

DAD CELL \_\_\_\_\_

INSTRUCTIONS: 1. ANNUALLY COMPLETED BY SPONSOR/PARENT. 2. PRINT ALL ENTRIES 3. CHECK (4) ALL CONDITIONS THAT APPLY

Student #	STUDENT'S NAME			CHECK	4	
Birth Date:				Last	MI	
	First		Male	<input type="checkbox"/>		

## HEALTH HISTORY

VISUAL DEFECT	4	COMMENTS	CARDIOVASCULAR	4	COMMENTS
WEARS GLASSES	<input type="checkbox"/>		SICKLE CELL ANEMIA	<input type="checkbox"/>	
CONTACTS	<input type="checkbox"/>		CONGENITAL HEART	<input type="checkbox"/>	
OTHER	<input type="checkbox"/>		RHEUMATOID HEART	<input type="checkbox"/>	
MULTIPLE	<input type="checkbox"/>		HEART MURMUR	<input type="checkbox"/>	
HEARING DEFECT	4	COMMENTS	NO RESTRICTIONS	<input type="checkbox"/>	
MILD LOSS	<input type="checkbox"/>		RESTRICTION	<input type="checkbox"/>	
BOTH	<input type="checkbox"/>		LEUKEMIA	<input type="checkbox"/>	
RIGHT	<input type="checkbox"/>		OTHER	<input type="checkbox"/>	
LEFT	<input type="checkbox"/>		MULTIPLE	<input type="checkbox"/>	
MODERATE LOSS	<input type="checkbox"/>		RESPIRATORY	4	COMMENTS
BOTH	<input type="checkbox"/>		ASTHMA	<input type="checkbox"/>	
RIGHT	<input type="checkbox"/>		BRONCHITIS	<input type="checkbox"/>	
LEFT	<input type="checkbox"/>		CYSTIC FIBROSIS	<input type="checkbox"/>	
SEVERE LOSS	<input type="checkbox"/>		OTHER	<input type="checkbox"/>	
BOTH	<input type="checkbox"/>		MULTIPLE	<input type="checkbox"/>	
RIGHT	<input type="checkbox"/>		DERMATOLOGY	4	COMMENTS
LEFT	<input type="checkbox"/>		ACNE	<input type="checkbox"/>	
WEARS AID	<input type="checkbox"/>		ECZEMA	<input type="checkbox"/>	
BOTH	<input type="checkbox"/>		PSORIASIS	<input type="checkbox"/>	
RIGHT	<input type="checkbox"/>		OTHER	<input type="checkbox"/>	
LEFT	<input type="checkbox"/>		MULTIPLE	<input type="checkbox"/>	
TUBES IN EAR(S)	<input type="checkbox"/>	DATE: _____ AFF. EAR: _____	ENDOCRINE	4	COMMENTS
EAR INFECTIONS	<input type="checkbox"/>		DIABETES	<input type="checkbox"/>	
OTHER	<input type="checkbox"/>		HYPERTHYROID	<input type="checkbox"/>	
MULTIPLE	<input type="checkbox"/>		HYPOTHYROID	<input type="checkbox"/>	
ALLERGIES	4	ANA KIT:	OTHER	<input type="checkbox"/>	
BEE STING	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	MUSCULOSKELETAL	4	COMMENTS
DRUG	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	OSTEOARTHRITIS	<input type="checkbox"/>	
FOOD	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	RHEUMATOID ARTHRITIS	<input type="checkbox"/>	
INSECT BITES	<input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	MUSCULAR DYSTROPHY	<input type="checkbox"/>	
HAYFEVER	<input type="checkbox"/>		OSGOOD-SCHLATTER	<input type="checkbox"/>	
OTHER	<input type="checkbox"/>		SCOLIOSIS	<input type="checkbox"/>	
MULTIPLE	<input type="checkbox"/>		OTHER	<input type="checkbox"/>	

*CONTINUE ON REVERSE SIDE*

**HEALTH HISTORY CONTINUED**

NEUROLOGY	4	COMMENTS	PSYCHIATRIC CONT	4	COMMENTS
CEREBRAL PALSY	<input type="checkbox"/>		MULTIPLE	<input type="checkbox"/>	
HEADACHE	<input type="checkbox"/>		<b>GASTROINTESTINAL/ GENITOURINARY</b>	4	
MIGRAINE	<input type="checkbox"/>		BLADDER CONTROL PROBLEM	<input type="checkbox"/>	
SEIZURE DISORDER	<input type="checkbox"/>		BOWEL CONTROL PROBLEM	<input type="checkbox"/>	
SEIZURE DISORDER HISTORY	<input type="checkbox"/>	MOST RECENT DATE: SPECIFY:	FREQUENT URINARY INFECTION	<input type="checkbox"/>	MOST RECENT DATE:
OTHER	<input type="checkbox"/>		OTHER	<input type="checkbox"/>	
MULTIPLE	<input type="checkbox"/>		MULTIPLE	<input type="checkbox"/>	
PSYCHIATRIC	4	COMMENTS	OTHER MEDICAL	4	COMMENTS
ATTENTION DEFICIT	<input type="checkbox"/>		DENTAL	<input type="checkbox"/>	
ANOREXIA	<input type="checkbox"/>		NUTRITIONAL DEFICIENCY	<input type="checkbox"/>	
BULIMIA	<input type="checkbox"/>		OBESITY	<input type="checkbox"/>	
DEPRESSION	<input type="checkbox"/>		OTHER	<input type="checkbox"/>	
OTHER	<input type="checkbox"/>		MULTIPLE	<input type="checkbox"/>	

CHECK 4

DOES YOUR CHILD TAKE DAILY MEDICATIONS?  
 Permission for medication form signed by a physician and a parent, must accompany prescribed medications. All medications taken at school must be maintained and administered from the health office under school personnel supervision.  
 SPECIFY ALL CURRENT MEDICATIONS (to include medications taken at home):

YES <input type="checkbox"/>	NO <input type="checkbox"/>	NOTES

HAS YOUR CHILD BEEN HOSPITALIZED? Specify the date and reason:  
 DATE: D \_\_\_\_ M \_\_\_\_ Y \_\_\_\_  
 REASON:

YES <input type="checkbox"/>	NO <input type="checkbox"/>	NOTES:

## EMERGENCY CONTACT INFORMATION

NAME \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_  
 CELL NUMBER \_\_\_\_\_  
 NAME \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_  
 CELL NUMBER \_\_\_\_\_

**PRIVACY ACT NOTICE**

AUTHORITY: Title x, Section 133 7 1076, Title V, Section 301. PRINCIPAL PURPOSE: To record pertinent data concerning student's health.  
 ROUTINE USES: Data is collected and entered into the automated School Information Management System for use by professional health and education agencies.  
 MANDATORY/VOLUNTARY DISCLOSURE/EFFECT OF NON-DISCLOSURE: Voluntary. Without this information school personnel will not be able to provide appropriate education and health services.

Parent/Sponsor's Signature: \_\_\_\_\_

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

Parent/Sponsor's Signature: \_\_\_\_\_

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