School of Excellence

Student Information

2883 South Circle Drive
Colorado Springs, CO 80906
Phone (719) 635-6333
Fax (719) 380-6249

Website: www.ppboces.org
Email: soe@ppboces.org
Student Hours: 8:50-3:15 (no drop offs prior to 8:50 and must be picked up by 3:30)
Office Hours: 7:45-3:45

2025 – 2026

- *Student Information packet, Immunizations and district paperwork must be completed and submitted before your child may begin.*
- *SOE contracts with Harrison School District for meals. Lunch form is required for all students.*
- *SOE follows District 11 for weather cancellations and delays. Sign up for Notify Me at www.ppboces.org to receive additional notifications.*

Caryl Manuszak
Director of Exceptional Students

Jeanine Charlton
Assistant Director

Amber Bumgardner
Dean of Programs
- Pathways Program (Grades K-10)
- LIBERTY Program (Grades K-12)
- COLA Program (Grades K-12)

Student Information

Start Date:	**Returning Student** ☐ Yes ☐ No	**Program:** ☐ Liberty ☐ COLA ☐ Pathways
Student Full Name:	**Nickname:**	**Gender** ☐ Female ☐ Male ☐ Prefer Not to Say ☐ Other (specify below): _____
Date of Birth: **Grade:** **Height:** **Weight:**	**Distinguishing Marks or Features:**	**Ethnicity:** ☐ White ☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ Hawaiian or Pacific Islander ☐ Other (specific below): _____
Student Address: **City and Zip:**	**Guardian in which the student is living with:**	**Does your student have the following:** ☐ Cell Phone ☐ Tablet ☐ Computer ☐ Additional Items that will come to school (specify below):

Other Household Members

1. Name	Relationship:	Age:
2. Name:	Relationship	Age:
3. Name:	Relationship	Age:
4. Name:	Relationship	Age:

Guardian Information

1. Parent/Guardian Name:	**2. Parent/Guardian Name:**
Address:	**Address:**
Phone Number/Cell:	**Phone Number/Cell:**
Email Address:	**Email Address:**
Occupation:	**Occupation:**
Contact Instructions: Primary Contact Name and Number: Secondary Contact Name and Number:	
Emergency Contact: Name: Phone Number:	
Authorization to Pick Up Student:	
Name: Relationship: Phone:	Name: Relationship: Phone:

Legal Contacts

Does the Student have a **DHS Caseworker?** ☐ Yes ☐ No	Does your student have a **Probation Officer?** ☐ Yes ☐ No	Does your student have a **Guardian ad Litem (GAL)?** ☐ Yes ☐ No	Does your student have **other Legal Contacts?** ☐ Yes ☐ No
Name:	Name:	Name:	Name:
Phone:	Phone:	Phone:	Phone:
Email:	Email:	Email:	Email:
Information Needed: ☐ Daily Emails ☐ Seclusion/Restraint ☐ Attendance ☐ Meeting Invites	**Information Needed:** ☐ Daily Emails ☐ Seclusion/Restraint ☐ Attendance ☐ Meeting Invites	**Information Needed:** ☐ Daily Emails ☐ Seclusion/Restraint ☐ Attendance ☐ Meeting Invites	**Information Needed:** ☐ Daily Emails ☐ Seclusion/Restraint ☐ Attendance ☐ Meeting Invites

If there are any special circumstances regarding parental or educational rights, court orders, or any other legal concerns, it is your responsibility to notify the school and supply documentation.

____ ***(Initial here)***

Community Based Therapies/Outside Provider

Does your student receive any therapies outside of school? Outside or private therapies can include but are not limited to; occupational therapy, speech/language therapy, physical therapy, ABA (applied behavior analysis), cognitive/behavioral therapy.

Please list these below. Contact your student's case manager if you would like the school and agency to share information to better support your student.

Type Of Therapy	Agency	Phone Number

Although services look different within the school setting, it can be beneficial for school counterparts to be aware of these services and communicate with those providers, if guardians agree.

Guardians can complete a Release of Information to allow the school staff to share information with outside agencies. Parents can limit what information they want to share and can revoke this consent at any time. If you would like to give permission for your student's school staff to share information with outside providers, please complete the following information:

All information released or secured will be in compliance with the Family Education Rights and Privacy Act and the Colorado Open Records Law. No additional information will be released or secured without prior approval from the parent, except as provided by law.

Student _____ is enrolled at the Pikes Peak BOCES School of Excellence and the team would like to be able to exchange information with outside providers.

This permission is valid for the 2025 – 2026 school year and 2025 Extended School Year if applicable

- ☐ I understand that consent is voluntary and may be revoked at any time in writing. I hereby authorize the transfer of information as indicated above.

Parent Signature: _____ Date: _____

Parent/Guardian Consent

Consent to Photograph and/or Videotape

All students will have photographs taken for use in the student database program and for safety purposes.

Aside from these required photos, occasions may arise during the school year where photographing, videotaping and/or audio taping of your student can be used for educational, social or therapeutic purposes. Students usually enjoy seeing themselves in pictures or on videotape and this can be an opportunity to practice their skills.

I understand that my student will be photographed. Photos may be used on bulletin boards, yearbooks, or other documents that might be seen by other families. My student may be video/audio taped for therapeutic/educational purposes as deemed appropriate. I give consent for my student to be video/ audio taped.

Parent/Guardian: _____ Date:_____

Permission for Off Campus Activities

Pikes Peak BOCES School of Excellence must have the following signed permission slip for your child to participate in incentives such as going to the gas station, McDonalds, and any other incentive off campus. I give consent for my student to earn off-campus incentives.

Transportation, when necessary, will be provided by school vehicles or buses. Students may not be in their usual bus harness while on a BOCES vehicle.

Parent/Guardian: _____ Date: _____

Pikes Peak BOCES School of Excellence Movie/Film Permission

As part of our incentive program at school, students may earn the privilege of watching a movie on Friday afternoon. Occasionally, teachers may also utilize films in the classroom for instructional purposes related to curriculum. These movies may be rated G, PG or PG-13. Please indicate below the ratings you give your student permission to view.

- ☐ G
- ☐ PG
- ☐ PG-13

Parent/Guardian: _____ Date: _____

Green Machines/Play Equipment

Students have been informed of safety expectations while using play equipment (including riding the Green Machine Bikes). Students will lose access if they do not follow the rules. If you would like your student to have access to the Green Machine Bikes and any other play equipment we may obtain, please sign below:

Parent/Guardian: _____ Date: _____

Caffeinated Beverages

Students will have access to the building wide store for incentives based on behavior. If you would like your student to have access to caffeinated beverages, please sign below:

Parent/Guardian: _____ Date: _____

Parent/Student Handbook

I, _____, have read a copy of the handbook containing school policies, dress code, technology usage, immunization requirements, and other procedures. In addition, I have been made aware that the handbook is available on the ppboces.org website and in the front office of the school.

Parent/Guardian: _____ Date: _____

*****Pikes Peak BOCES School of Excellence requests permission to send special education documents and/or records (IEP documents, progress reports, grades, seclusion/ restraint/ incident and daily communication logs, etc.) for your child electronically. Should you have further questions please feel free to contact the School of Excellence registrar or program coordinator at 719-635-6333.**

☐ I **GIVE** Pikes Peak BOCES permission to send special education documents and/or records electronically.

☐ I **DO NOT GIVE** Pikes Peak BOCES permission to send special education documents and/or records electronically.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Name Printed: _____

Email Address (s) to be used for electronic forms: _____

Pikes Peak BOCES

School of Excellence

INFORMATION REGARDING THE USE OF RESTRAINT

Physical restraint and/or seclusion might be used in an emergency situation. Emergency means serious, probable, imminent threat of bodily injury to self or others with the present ability to affect such bodily injury. Emergency includes situations in which the student creates such as a threat by abusing or destroying property.

Physical restraint is the use of bodily physical force to involuntarily limit an individual's freedom of movement, and it typically involves some type of "hold." A hold used to protect a child or others from harm that lasts less than one minute is not a restraint. Seclusion is the placement of a student alone in a room from which egress is prevented.

If there is a need to use restraint/seclusion:

1. It will only be used as a means to protect your child or others from a serious, probable, and imminent threat of bodily injury.
2. It will only be used as a last resort.
3. It will be administered only by staff who have received appropriate training.
4. Staff will continuously monitor your child's physical safety during any use of restraint,
5. Opportunities to have the restraint end will be provided if the child appears safe as indicated by a willingness to cease the violent and dangerous behavior.
6. Every effort will be made to assist the child to regain self-control.
7. If seclusion is used, staff will reintegrate the student or clearly communicate to the student that he/she is free to leave the area used for seclusion.
8. A review process will be conducted for each incident of restraint/seclusion. As part of this process, the Dean of Programs designee will verbally notify you as soon as possible, but no later than the end of the school day if restraint has been used. Additionally, a written report will be mailed, e-mailed or faxed to you within five (5) calendar days following the use of any restraint over 5 minutes or a seclusion.
9. Guardians will be provided written notification for any restraint between 1 and 5 minutes the day of the event via daily communication log that will be sent home with student or emailed. No report will be mailed; however, additional details can be obtained by contacting your student's classroom teacher.

Additional information regarding the use of restraint can be found in District Policy JKA and Regulation JKA-R; and can contact the building administrators with any questions or concerns.

SOE Annual Health Update (For School Nurse)

Student's Name: _____ Grade: _____

Has your student had any immunizations in the last year? ☐ Yes (If so, list in next section) ☐ No	Immunization:	Date Administered:
List any serious injuries, illnesses or hospitalizations in the past year: _____ _____ _____	**Are there any physical conditions limiting your child's activity in school?** ☐ Yes (Describe Below) ☐ No _____ _____ _____	
List any prosthetic devices, hearing aids, crutches, wheelchair, knee brace, dental appliance/braces etc.: _____ _____	**Does your child wear glasses or contacts?** ☐ Glasses ☐ Contacts ☐ Both ☐ Not Applicable Additional Information: _____ _____	**Last Eye Exam:** Date: _____ Doctor Conducting Exam: _____
Any dietary restrictions (food allergy/sensitivity) for your child? List below:	**If applicable, describe reaction:**	
Please be advised Harrison School District 2's "Medical Disability Meal" form is required for the school food service program to provide a food substitution or modification. Forms may also be found at the SOE front office		

Medications

Name of Medication:	Dose:	Time(s) Taken at Home:	Time(s) Taken at School:	Provider/ Physician Prescribing Medication

Any medication administered by school staff must have signed medical provider and parent authorization. All medication administered at school must be provided in its' original pharmacy labeled container, brought to school by the parent and turned into the office staff.

Please note:

- *All emergency costs are at the expense of the family.*
- *Please be advised that emergency care is provided by the most qualified school staff and the local emergency response system.*
- *In the event of an emergency, all efforts will be made to contact parents or medical provider and then alternate emergency contacts.*

List all diagnosis(es) including mental health:	Provider/Physician making diagnosis(es):	Approximate date of diagnosis(es):
Does your student have allergies? ☐ Yes (Specify Below) ☐ No **If yes, please specify allergies and potential reactions below:**	**Does your child run/elope/hide?** ☐ Yes ☐ No **Is your student sensitive to flash photography?** ☐ Yes ☐ No	**In the event of an emergency, are there any language barriers staff need to be aware of when contacting parent/guardian?** ☐ Yes (Specify Below): ☐ No **If yes, specify potential barriers below:**

Hospital of Choice:	Physician:	Phone Number:
Insurance Carrier:	**Policy Number:**	

Pikes Peak BOCES School of Excellence does not assume responsibility for injury to your child at school, nor payment for doctor, hospital or ambulance fees if a medical emergency should occur on the grounds or at school-sponsored activities.

I do hereby authorize Pikes Peak BOCES School of Excellence to obtain emergency medical treatment in case parents(s)/guardian(s) cannot be contacted.

Parent/Guardian: _____ Date

Authorization to Administer Medication

STUDENT: DOB: GRADE:

**************************************MEDICAL PROVIDER SECTION**

Medication Allergies

- ☐ Yes (please List): ____
- ☐ No

Known condition (s)/diagnosis: ____

Pikes Peak BOCES School of Excellence houses educational programs for students with highly specific needs. Health condition/diagnosis documented by a medical provider is required to complete necessary educational documentation.

Please list all medication taken routinely, prescribed and over the counter:

Medication	Dose	Route	Time Given at Home	Time Given at School

Medical Provider, over-the-counter medications listed below can also be distributed by school if provided by parent. Please indicate if school staff may administer OTC medication to this child/student, the dose and frequency.

Oral Medications:

Acetaminophen tablet for c/o pain or to reduce fever

- ☐ Yes, _________________ tablet(s) every___________ hours
- ☐ No

Cough Drops for c/o sore throat or cough

- ☐ Yes, _________________ tablet(s) every___________ hours
- ☐ No

Tums/antacid tablets for c/o heartburn, indigestion, sour stomach

- ☐ Yes, _________________ tablet(s) every___________ hours
- ☐ No

Topical Medications/applications if provided by parent:

Triple antibiotic ointment apply to minor cuts/abrasions after cleaning with soap/water; cover with bandage

- ☐ Yes
- ☐ No

Sunscreen, broad-spectrum/SPF 30 apply to unbroken skin that is exposed to sun

- ☐ Yes
- ☐ No

Medical Provider Signature: _____ Date:_____

Medical Provider print/stamp name, address, phone, Fax:

PARENT SECTION: REQUEST THAT SCHOOL ADMINISTER MEDICATION

ECTION: REQUEST THAT SCHOOL ADMINISTER MEDICATION**

- I understand that my child attending Pikes Peak BOCES School of Excellence does not self-carry or self-administer medication(s)
- I request and authorize that the medication(s) listed above be administered to my child by qualified school personnel in the manner specified as authorized by the medical provider.
- I understand that it is my responsibility to furnish the prescription medication to the school in its original pharmacy container with current labeling of medication, dose, frequency, and child's name.
- I understand that if my child requires prescribed emergency medication, the medication is available to him/her when needed.
- I will notify the school immediately if the medication is to be changed or terminated or if we change physicians.
- It is understood that the medication is administered solely at the request of and as accommodation to the undersigned parent or guardian.
- In consideration of the acceptance of the request to perform this service by the school nurse or other designee employed by Pikes Peak BOCES School of Excellence, the undersigned parent or guardian hereby agrees to release Pikes Peak BOCES School of Excellence and its personnel from any legal claim which they now have or may hereafter have arising out of side effects or other medical consequences of the medication.

I hereby give permission for my child to take the above-named prescription medication and/or OTC medication at school as prescribed.

Parent/Guardian Signature: _____ Date: _____

ANNUAL MEDICAID NOTIFICATION UNDER 34 CFR § 300.154(d)(2)(v)

The regulations implementing the Individuals With Disabilities Education Act (IDEA), afford parents of eligible students certain rights with respect to a school district's ability to access private insurance or public benefits, such as Medicaid, to help pay for certain services that are provided at school. These rights are as follows:

1. YOU HAVE THE RIGHT TO RECEIVE NOTICE IN AN UNDERSTANDABLE LANGUAGE*.* The school district must give you an annual written notice of your rights, which must be written in language understandable to the general public; and also provided in the native language of the parent or other mode of communication used by the parent, unless it is clearly not feasible to do so.

2. YOUR CHILD'S CONFIDENTIAL INFORMATION CANNOT BE DISCLOSED WITHOUT YOUR CONSENT. Parental consent must be obtained under the Family Educational Rights and Privacy Act (FERPA) regulations at 34 CFR part 99 and the IDEA regulations at §300.622 before the school district discloses, for claiming purposes, your child's personally identifiable information to the agency responsible for the administration of the State's public benefits or insurance program (e.g., Medicaid);

3. ***YOUR CHILD HAS A RIGHT TO SPECIAL EDUCATION AND RELATED SERVICES AT NO COST TO YOU.*** This means that, with regard to services required to provide a Free Appropriate Public Education ("FAPE") to an eligible child under IDEA, the school district

- May not require parents to sign up for or enroll in public benefits or insurance programs in order for their child to receive FAPE;
- May not require parents to incur an out-of-pocket expense such as the payment of a deductible or co-pay amount incurred in filing a claim for services provided pursuant to this part, but may pay the cost that the parents otherwise would be required to pay;
- May not use a child's benefits under a public benefits or insurance program if that use would:
  - Decrease available lifetime coverage or any other insured benefit;
  - Result in the family paying for services that would otherwise be covered by the public benefits or insurance program and that are required for the child outside of the time the child is in school;
  - Increase premiums or lead to the discontinuation of benefits or insurance; or
  - Risk loss of eligibility for home and community-based waivers, based on aggregate health-related expenditures.

4. YOU MAY WITHDRAW CONSENT AT ANY TIME. Once you've given consent for disclosure of confidential information about your child to the agency responsible for the administration of the State's public benefits or insurance program (e.g., Medicaid), you have a legal right under the FERPA regulations to withdraw that consent whenever you wish.

5. IF YOU REFUSE CONSENT, OR WITHDRAW CONSENT, THE SCHOOL DISTRICT STILL HAS TO PROVIDE REQUIRED SERVICES AT NO COST TO YOU. If you refuse to provide consent for the disclosure of personally identifiable information to the agency responsible for the administration of the State's public benefits or insurance program (e.g., Medicaid), or, if you give consent but then later withdraw consent, that does not relieve the school district of its responsibility to ensure that all required services are provided at no cost to the parents.

PPBOCES School of Excellence Notice of Privacy Practices

FERPA addresses the security and privacy of Protected Health Information (PHI)* (definition at bottom of page). FERPA requires SOE to provide this notice to you. As a parent/legal guardian of a student at SOE, you are the student's "personal representative." Please read this notice with the understanding that we are discussing "you" to mean the student.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Who Will Follow this Notice

This notice describes our practices and that of:

All employees, contract staff, volunteers and student interns of Pikes Peak BOCES/SOE. Any health care or educational professional authorized to enter information into a student's file or authorized to conduct testing/assessments on our premises.

Our Pledge Regarding Protected Health Information

We understand that information about you and your health is personal and sensitive in nature. We are committed to protecting the privacy of this information. We will create a record of the care and services you receive at the SOE. This record is needed to provide you with quality care and to comply with legal requirements. This notice applies to all of the records of your care generated by the SOE. This notice will tell you about the ways in which we may use and share your PHI. We also describe your rights and certain obligations we have regarding the use and sharing of PHI.

Our Responsibilities

Our primary responsibility for your PHI is to keep it safe. We must also give you this notice of privacy practices, and we must follow the terms of the notice. Ordinarily your PHI is confidential and will not be used or disclosed, except as described below.

How We May Use and Disclose Health information About You

The following categories describe different ways in which we use your PHI within the SOE and release your PHI to persons outside of SOE. We have not listed every use of PHI or every release of PHI, however all permitted uses will fall within one of the following categories. The uses and disclosures listed below are generally allowed for one of two reasons: (1) health concerns or (2) legal concerns. These are uses/disclosures not requiring the student's consent.

Health Concerns

Health Care Operations – We may use or disclose your PHI for facility operations. These uses and disclosures are necessary to provide quality care. For example, we may use protected health information to review our treatment and services and to evaluate the performance of our staff. In addition we will share limited PHI with employees working out of the PPBOCES' building to carry out certain aspects of healthcare operations, such as billing, student counts, etc.

Health Oversight Activities - We will disclose PHI as required by law to health oversight agencies for activities authorized by law. These oversight activities might include audits, investigations and inspections. For example, we will share PHI with our Department of Human Services Licensing Specialist for the purposes of a DHS licensing inspection.

Individuals Involved in Your Care – We may share your PHI with your next of kin (who is substantially involved in your care) if the responsible professional determines that such disclosure is in your best interest. We will honor your request not to share your PHI with this next of kin if you tell us in advance not to do so, unless there is some overriding reason to share your PHI, such as a safety consideration.

Payment – We may use or disclose your PHI so that the treatment and services you receive may be billed to and payment collected from an insurance company or a third party (such as Medicaid or Aspen Pointe).

*Protected Health Information (PHI): Any information, whether oral or recorded in any form or manner that is created or received by a health care provider health plan, public health authority, employer, life insurer, school or university, or health care clearing house; and relates to the past, present or future physical or mental health or condition of a student; the provision of health care to a student; or past, present, or future payment for the provision of health care to a student.

Public Health Risks – We will share your PHI for public health reporting required by federal or state law. These activities generally include the following:

* To prevent or control disease, injury or disability
* To report reactions to medications or problems with products
* To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease.

To Avert a Serious Threat to Health or Safety – We may disclose your PHI when we deem it necessary to prevent a serious threat to your health and safety or the health and safety of another person or the public, as authorized by applicable federal or state law. If we believe that you are at imminent risk of inflicting serious harm to yourself, we may disclose information necessary to protect you. If you communicate a serious threat of imminent physical violence against a specific person or persons, we have a duty to notify this person or persons of the threat as well as a duty to notify an appropriate law enforcement agency.

Treatment – We may use or disclose your PHI to provide, coordinate or manage your medical or psychiatric treatment or services. For example, we will share your PHI with our contract psychotherapists, school nurse; speech and occupational therapists; school psychologist; or other personnel who have a legitimate need for such information in your care and treatment. We may also share PHI with a receiving facility if you are sent there on an emergency basis (e.g. Memorial Hospital or The Crisis Center). We provide PHI in this circumstance so that you can be afforded good continuity of care. This does not typically pertain to outpatient mental health or physical health providers. We must have a signed release to communicate with outpatient providers unless we are referring you on an emergent basis and we do not already have a signed release. We attempt to get signed releases with all relevant professionals involved in your care at the time of intake.

Legal Concerns

As Required by Law – We will disclose Protected Health Information (PHI) about you when required to do so by federal, state or local laws.

Child Abuse or Neglect – If we have reasonable cause to know or suspect that a child has been subjected to abuse or neglect, we must report this to the appropriate authorities.

Juvenile Detention – If you are incarcerated in a correctional institution (for instance Spring Creek Detention Center), we may share your health information with the correctional institution or law enforcement official. This is necessary for the correctional institution to provide you with healthcare, to protect your health and safety and the health and safety of others, or for the safety and security of the correctional institution.

Law Enforcement – We may release PHI if asked to do so by a law enforcement official under the following circumstances when permitted by state or federal law:

- In response to a court order
- If required by state or federal law
- To identify or locate a suspect, fugitive, material witness or missing person
- About the victim of a crime if, under certain circumstances, we are unable to obtain the person's agreement
- About a death we believe may be the result of criminal conduct
- In emergency circumstances to report a crime, the location of the crime or victims or the identity, description or location of the person who committed the crime
- About crimes that occur on our premises
- If we believe there is a likelihood of the commission of a felony or violent misdemeanor, or if you leave campus without permission, and we believe it is in your best interest to inform law enforcement of your absence.

Lawsuits and Disputes – If you are involved in a lawsuit or a dispute, we will disclose PHI about you when properly ordered to do so by a court.

Situations that Require Your Specific Written Authorization:

Without your authorization, SOE may not disclose your PHI to persons outside of SOE for purposes other than treatment, payment, healthcare operations or the other special circumstances as listed above. If you authorize us to use or share your PHI, you may cancel that authorization in writing at any time. If you cancel your authorization, we will no longer use or share your PHI for the reasons covered by your written authorization. Some typical situations that require your authorization are as follows:

Drug and Alcohol Abuse Treatment Disclosures – We will share drug and alcohol treatment information about you only in accordance with the Federal Privacy Act. In general, the Privacy Act requires your written authorization.

Disclosure of Mental Health Treatment Information – We will share your mental health treatment information only in accordance with state law. In most cases, Colorado law requires your written authorization or the written authorization of your representative.

Your Health Information Rights

Although your health records are the physical property of the healthcare provider who completed them, you have certain rights with regard to the information contained therein.

Right to Inspect and Copy – You have the right to inspect and copy PHI that is contained in your record, for as long as we maintain the information, so long as federal or state law does not prohibit access to that information. Under federal law however, you may not inspect or copy the following records: psychotherapy notes, information compiled in a reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and PHI that is subject to law that prohibits access. We may charge you a fee for the cost of copying and/or mailing it to you.

We may deny your request to inspect and copy in certain very limited circumstances, for instance:

If we believe that access to such information could cause harm to your physical or mental well-being. If the PHI makes reference to another person (other than a healthcare provider) and a licensed healthcare provider has determined, that in the exercise of professional judgment, that providing access is reasonably likely to cause substantial harm to such other person.

If you are denied access to PHI, under some circumstances you may request that the denial be reviewed. Another licensed health care professional chosen by someone on our SOE/BOCES team will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend – You may request an amendment of your PHI if you feel the information is incorrect or incomplete. We may deny your request for an amendment if:

- Your request for an amendment is not made in writing
- Does not include a reason to support the request
- The PHI was not created by our staff
- It is not part of the information that you would be permitted to inspect and copy.
- The information already in the record is accurate and complete.

Please note that even if we accept your request, we are not required to delete any information from your health record. If we disagree with your request you have the right to submit a statement of disagreement to be enclosed with future releases of the information in question.

Right to Request Restrictions – You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. To request restrictions, you must make your request in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply. If we believe that the restriction is not in the best interest of either party, or if we cannot reasonably accommodate the request, we are not required to agree. If the restriction is mutually agreed upon, we will not use or disclose your PHI in violation of the restriction, unless it is needed to provide emergency treatment. You may revoke a previously agreed upon restriction, at any time, in writing.

Right to Request Confidential Communications – You may request that we communicate with you using alternative means or at an alternative location. We will not ask you the reason for your request. We will accommodate reasonable requests, when possible.

You Have a Right to a Paper Copy of this Notice.

Right to File a complaint – If you believe your privacy rights have been violated, you may file a complaint with SOE or Pikes Peak BOCES. You also have the right to complain to the U.S. Secretary of Health and Human Services by sending your complaint to the Secretary of Health and Human Services, 200 Independence Ave., S.W., Washington, D.C. 20201. You may be assured there will be no retaliation for filing a complaint

Change to this Notice

We reserve the right to change this notice. This Notice is not a legal contract. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will provide a copy of this notice to the parent/legal guardian of every new student in our program as part of our enrollment process. In addition, we will provide a copy to any student or student's parent or guardian upon request.

Signing below only acknowledges receipt of SOE's Notice of Privacy Practices (pages 9 -13).

Name of Student (Please Print): _____

Signature of Parent/Guardian: _____ Date:_____

Relationship to Student:_____

Or:

Student or Parent/Guardian refused or was unable to sign but was given a copy of this notice on _____(Date)

Student or Parent/Guardian refused or was unable to sign for the following reason (s):

_____

_____

SOE Staff Signature

Date

Student/Family Grievance Procedure

You may use the Student/Family Grievance Procedure if you have a concern about Pikes Peak BOCES separate programs.

Students and families are encouraged to submit grievances directly to the Program Coordinator (or designee) via written documentation.

1. We encourage students and/or families to submit any grievances in writing, but you may also file a verbal grievance by calling your student's Program Coordinator (or designee) at 719-635-6333.

2. All grievances will be investigated by the Program Coordinator (or designee), with the involvement of any staff members or other students cited in the complaint.

3. We hope to quickly resolve grievances to the satisfaction of both students/families and staff members. The individual filing the grievance will receive a written response within 15 business days.

4. If the student or family member is dissatisfied with the results of the investigation by the Program Coordinator, the student/family member may request (in writing) that his/ her grievance be reviewed by the Pikes Peak BOCES Executive Director. The Executive Director will provide the student with disposition of the grievance within 7 business days.

5. If the student and/or family member continues to be dissatisfied with the results of the report by the BOCES Executive Director, he or she may register a written complaint with the Department of Human Services, Division of Child Care, 1575 Sherman Street, Denver, CO 80203-1714; the Colorado Department of Education, 201 East Colfax Ave., Denver, CO 80203-1799; or the home school district special education director.