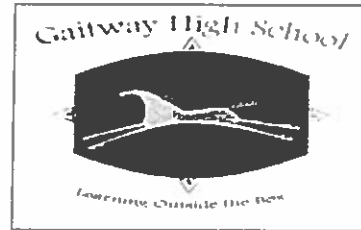


Please complete this form in its entirety and return to:

Lindsay Baar  
Gaitway High School  
PO Box 23129  
Chagrin Falls, OH 44023  
Fax: 440.708.0029



Application for Admission to Classrooms in the Geauga County  
Consortium for Emotional Support Services  
(Only School Districts can apply)

**Identifying Information**

Student Name \_\_\_\_\_ Sex M F Birthdate \_\_\_\_\_ Grade \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Relationship to Student \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Ohio Zip Code \_\_\_\_\_

Student Resides with \_\_\_\_\_

Student Address if Different than Parent \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ e-mail address \_\_\_\_\_

Placing School District \_\_\_\_\_ School \_\_\_\_\_

District Representative/Title \_\_\_\_\_ Phone \_\_\_\_\_

Please send the following for purpose of determining candidacy

\_\_\_ Attendance Record

\_\_\_ Report Card

\_\_\_ Current ETR

\_\_\_ Current IEP

\_\_\_ Discipline History

**Academic Information**

Ability (IQ) Level \_\_\_\_\_

OGT Test Results for the following:

Social Studies \_\_\_\_\_ Science \_\_\_\_\_ Reading \_\_\_\_\_ Math \_\_\_\_\_ Writing \_\_\_\_\_

Date of last ETR \_\_\_\_\_ Reevaluation Date \_\_\_\_\_

**Medical Information**

Present and Past Medical Diagnoses

\_\_\_\_\_

Present and Past Medications \_\_\_\_\_

**If Medicaid Eligible- Contact person and number**

**Community Involvement**

Case Manager/Agency \_\_\_\_\_ Phone \_\_\_\_\_

Counselor, Social Worker, Psychologist (Name/Agency Providing Service)

\_\_\_\_\_ Phone \_\_\_\_\_

Probation Officer (Name/Court) \_\_\_\_\_ Phone \_\_\_\_\_

Job & Family Svcs. Caseworker \_\_\_\_\_ Phone \_\_\_\_\_

Psychiatrist/Neurologist/Other Medical Doctor (Name/Specialty)

\_\_\_\_\_ Phone \_\_\_\_\_

Other Community Professional \_\_\_\_\_ Phone \_\_\_\_\_

**Behavioral Information**

Behavioral Profile \_\_\_\_\_

Has the student demonstrated any of the following behaviors:

Fire Setting                      Yes    No

Animal Abuse                      Yes    No

Physical Aggression            Yes    No

If so, please describe the event(s) and the treatment or supportive action taken:

---

---

**Placement Information**

Related Services required (please check)

Occupational Therapy                      \_\_\_\_\_

Physical Therapy                              \_\_\_\_\_

Speech/Language Pathology                \_\_\_\_\_

Social Work                                    \_\_\_\_\_

Other (please list) \_\_\_\_\_

Reason for Out of County Placement Request \_\_\_\_\_

---

Other information to assist with determination of placement \_\_\_\_\_

---

---

Home School Contact Person: \_\_\_\_\_



FIELDSTONE FARM

P.O. Box 23129  
Chagrin Falls, OH 44023  
Fax: 440.708.0029  
wspisak@fieldstonefarmtrc.com

### REGISTRATION AND RELEASE

Participant: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work/Cell Phone: \_\_\_\_\_

School or Institution presently attending: \_\_\_\_\_

Primary Email (used for newsletters, billing, etc.): \_\_\_\_\_

- Participant is a (circle one): minor                      adult w/a legal guardian                      independent adult  
(Only parents, legal guardians or independent adults may sign these forms.)
- Please name any caregivers/phone numbers who may transport or be responsible for Participant: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For demographic data only, please indicate participant's ethnic background. Check any that apply:

Caucasian  Asian  Hispanic/Latino  African American  Native American  Other

.....  
Parent or Guardian Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Other Parent or Guardian Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Parent or Guardian Home Address (if different): \_\_\_\_\_

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

#### In Case of Emergency

***In the event of a medical emergency, Fieldstone Farm will provide basic first aid and/or call 911 and will disclose all available health care information to emergency medical personnel***

In the event of an emergency, after any parent or guardian names, please list any other names to be contacted:

Emergency Contact Name (in addition to parents or guardians): \_\_\_\_\_

Phone #1: \_\_\_\_\_ Phone #2: \_\_\_\_\_

Please note any medical considerations including allergies (bee stings, asthma, etc.), conditions requiring regular physician's care, and prescribed medications taken regularly: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



FIELDSTONE FARM

P.O. Box 23129  
Chagrin Falls, OH 44023  
Fax: 440.708.0029  
wspisak@fieldstonefarmtrc.com

**CONSENT AND WAIVER**

I hereby request that the Participant named above be accepted into the horseback riding and driving program operated by Fieldstone Farm Therapeutic Riding Center (TRC), an Ohio non-profit organization. I acknowledge that Fieldstone Farm TRC has fully explained to me the scope of the equine program, including the potential for injury which can occur from riding, driving or caring for horses. Because of the potential benefits of Fieldstone Farm TRC's program, I hereby waive any claim which I or the Participant may have against Fieldstone Farm TRC, its Trustees, employees or volunteers arising out of any injury which the Participant may sustain while involved in the mounted or unmounted equine program at Fieldstone Farm.

I further understand that in the event of a medical emergency, Fieldstone Farm will provide basic first aid and/or call 911 and will disclose to emergency medical personnel all available health care information about the Participant. I consent to Fieldstone Farm initiating such basic first aid and/or emergency medical treatment and to Fieldstone Farm disclosing the Participant's available health care information.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
Circle one: (Independent adult participant or parent or legal guardian)

**PHOTO RELEASE**

For valuable consideration, the receipt of which from Fieldstone Farm Therapeutic Riding Center is hereby acknowledged, the undersigned hereby grants to Fieldstone Farm permission to take, or have taken, still and moving photographs, videos and films including television pictures of myself or my daughter/son/ward (strike out inapplicable words), \_\_\_\_\_

\_\_\_\_\_ and consents and authorizes  
(Participant name, please print)

Fieldstone Farm, its advertising agencies, news media, and any other persons involved with Fieldstone Farm and its programs, to use and reproduce the photographs, films, videos and pictures and to circulate and publicize the same by any means deemed appropriate by Fieldstone Farm, including without limitation newspapers, television media, brochures, pamphlets, instructional materials, books and clinical materials.

No inducements or promises have been made to me to secure my signature to this release other than the intention of Fieldstone Farm to use or cause to be used such photographs, films, videos and pictures for the primary purpose of promoting and aiding Fieldstone Farm and its programs.

\_\_\_ I DO consent \_\_\_ I DO NOT consent

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
Circle one: (Independent adult participant or parent or legal guardian)

PO Box 23129  
 Chagrin Falls, OH 44023  
 440.708.0013  
 Fax: 440.708.0029  
[wsisak@fieldstonefarmirc.com](mailto:wsisak@fieldstonefarmirc.com)

## HEALTH HISTORY

– To be completed by independent adult participant or parent/guardian. Use additional sheets if needed.  
**Important!** This form is due to Fieldstone Farm no later than one week prior to the start of initial session.

Participant Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ Male / Female

- Participant is a (circle one):  minor  adult w/a legal guardian  independent adult

Name of Parent(s) / Guardian(s): \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date of Onset: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Mobility: Ambulatory-Yes/No Crutches-Yes/No Braces-Yes/No Wheelchair-Yes/No Walker-Yes/No

Special mobility precautions: \_\_\_\_\_

Medications: \_\_\_\_\_

Allergies to any medications: \_\_\_\_\_

Allergies to any food, insect bites, plants, animal dander, other, list here: \_\_\_\_\_

History of asthma? \_\_\_\_\_

Does the participant carry an EpiPen? Yes / No Does the participant carry an inhaler? Yes / No

### GENERAL QUESTIONS

List any chronic conditions or illnesses: \_\_\_\_\_

HEALTH AND FUNCTION	Normal	DETAILS
Hearing		
Vision		
Speech		
Heart		
Circulation		
Cognitive Development		
Pulmonary		
Neurological		
Muscular		
Orthopedic (incl. spine & joints)		
Emotional & Psychological		
Behavior		

List precautions, for example, shunts, feeding tubes, etc.: \_\_\_\_\_

# HEALTH QUESTIONS

1. In the past 12 months, has the participant been hospitalized for any serious injury, condition or surgery?  
Yes / No If yes, please explain: \_\_\_\_\_

---

2. In the past 12 months, has the participant experienced loss of consciousness, traumatic or otherwise, including seizures of any type?  
Yes / No If yes, please explain: \_\_\_\_\_

---

3. In the past 12 months, has the participant experienced a psychotic crisis?  
Yes / No If yes, please explain: \_\_\_\_\_

---

4. In the past 12 months, has it been necessary to restrict the participant's activities due to medical reasons?  
Yes / No If yes, please explain: \_\_\_\_\_

---

5. Is participant unable to maintain upright sitting posture or head control without assistance?  
Yes / No If no, please explain: \_\_\_\_\_

---

Has the participant ever been treated for any of the following? If yes, check the box, give date and provide specific details below:

CONDITIONS	Date
<input type="checkbox"/> Bleeding or Clotting Disorders	_____
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Joint contractures, cerebral palsy or hip dysplasia	_____
<input type="checkbox"/> Immune Deficiency	_____
<input type="checkbox"/> Fatigue or limited endurance	_____
<input type="checkbox"/> Pathologic fractures	_____
<input type="checkbox"/> Brain injury, including stroke	_____
<input type="checkbox"/> Conditions of the spine, including, but not limited to: spinal cord injury, curvature, fusion, instability, abnormalities or Spina Bifida	_____
<input type="checkbox"/> Skin break down or pressure sores	_____

Specific details. Use additional paper if necessary: \_\_\_\_\_

I hereby affirm that, to the best of my knowledge, the health history information is complete and correct.

Signature of Person completing the Health History: \_\_\_\_\_

Relationship to Participant: \_\_\_\_\_ Date: \_\_\_\_\_

**Important!** Fieldstone Farm reserves the right to request additional information from, or an evaluation by the participant's licensed medical professional prior to or during the course of equine-assisted programming and/or to restrict or offer alternative activities until such information or evaluation is procured.



FIELDSTONE FARM

PO Box 23129  
Chagrin Falls, OH 44023  
440.708.0013  
Fax: 440.708.0029  
[wso\\_sak@fieldstonefarmirc.com](mailto:wso_sak@fieldstonefarmirc.com)

### PHYSICIAN'S RELEASE

Important! This form is required for participants who have medical issues deemed precautions to participating in equine-assisted programming.

Participant Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

A PHYSICIAN's RELEASE is required if:

- Participant has Down Syndrome
- If any of the HEALTH QUESTIONS on page 2, (#s 1, 2, 3, 4 or 5) are answered YES
- If participant has been treated for any of the CONDITIONS listed in the HEALTH QUESTIONS on page 2.

### PHYSICIAN'S REPORT

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance and Affect		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Pulses		
Heart		
Lungs		
Abdomen		
Skin		
Neurologic		
<b>MUSCULOSKELETAL</b>		
Neck		
Back		
Upper Extremities		
Lower Extremities		
<b>FOR PERSONS WITH DOWN SYNDROME</b>		
Neurologic exam reveals symptoms consistent with atlantoaxial instability?    YES    NO    DATE OF EXAM: _____		

### PHYSICIAN'S RELEASE

I have examined the above-named participant and, given the participant's diagnosis and health history, this person does not present apparent clinical contraindications for equine sports. I understand that Fieldstone Farm will weigh the medical information provided against the existing precautions and contraindications; therefore, I refer this person to Fieldstone Farm for ongoing evaluation to determine eligibility for participation.

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Name (please print): \_\_\_\_\_ Phone: \_\_\_\_\_

Address/City/Zip: \_\_\_\_\_



If participant has experienced seizure activity within the past 12 months, the following SEIZURE EVALUATION FORM is required. Participants or their parents or guardians may wish to consult with their physician when completing the following:

### SEIZURE EVALUATION FORM

Instructions: Participants/parent/guardians/treating physicians – please complete this form including as much information as possible. Since riding and working around horses is a risk activity, conditions that increase that risk are carefully analyzed. The safety of all participants, volunteers and horses is considered.

Physician Treating Seizures \_\_\_\_\_ Physician's Phone \_\_\_\_\_

Type of Seizure (if more than one, please list all types) \_\_\_\_\_

Date of Last Seizure \_\_\_\_\_ Frequency of seizures \_\_\_\_\_

Duration of Each Seizure \_\_\_\_\_

Typical Causes of Seizure Activity \_\_\_\_\_

Seizure activity indicators (aura, behaviors or manifestations of oncoming seizure activity) \_\_\_\_\_

After Affect \_\_\_\_\_

During a seizure, I / my child/patient:

- May stare briefly (How long? \_\_\_\_\_ )
- May walk around
- May perform aimless activities
- May suddenly cry / fall / become rigid, followed by muscle jerks / saliva on lips / bluish skin color
- May experience loss of bladder or bowel control
- May be confused, have a headache, be fatigued; followed by full return of consciousness
- Other. Please explain:

Are you / is your child/patient able to know and express when a seizure may occur? What are the signs? \_\_\_\_\_

Should you / your child experience a seizure while at Fieldstone Farm, beyond employing general first aid, what actions do you suggest we take?

- Do nothing
- Report observations to parents/guardians immediately
- Dismount from horse
- Send note home to parent/guardian
- Allow \_\_\_\_\_ minutes to rest and reorient
- Other. Please specify:

Participant/Parent/Guardian \_\_\_\_\_

Date \_\_\_\_\_

## STUDENT MEDICAL HISTORY

Student Name: \_\_\_\_\_ District/Residence: \_\_\_\_\_  
 Student Address: \_\_\_\_\_ District/Placement: \_\_\_\_\_  
 City & Zip: \_\_\_\_\_ School Phone: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Family Physician: \_\_\_\_\_  
 Student Soc. Sec. #: \_\_\_\_\_ Physician Phone: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Guardian Name: \_\_\_\_\_  
 Parents Name: \_\_\_\_\_ Guardian Address: \_\_\_\_\_  
 Father Work #: \_\_\_\_\_ Guardian Phone #: \_\_\_\_\_  
 Mother Work #: \_\_\_\_\_ Pager or Cell Phone #: \_\_\_\_\_

In case of an emergency list two people who can be contacted if parents can't be reached:

Name	Phone	Address
1. _____	_____	_____
2. _____	_____	_____

If (s)he has a history of any of the following, please check appropriate space:

Allergies: explain: \_\_\_\_\_ Dizziness: explain: \_\_\_\_\_  
 Heart Problems: explain: \_\_\_\_\_ Asthma: treatment: \_\_\_\_\_  
 Seizure Disorder: explain: \_\_\_\_\_  
 Diabetes: treatment: \_\_\_\_\_  
 Hearing Problems: explain: \_\_\_\_\_  
 Speech Problems: explain: \_\_\_\_\_  
 Vision Problems: explain: \_\_\_\_\_ Glasses: \_\_\_\_\_ Contacts: \_\_\_\_\_  
 Medications: \_\_\_\_\_

Name of Drug	Dosage	Times Dispensed

Therapy: types currently receiving:  
 \_\_\_\_\_ Occupational \_\_\_\_\_ Physical \_\_\_\_\_ Psychotherapy \_\_\_\_\_ Counseling  
 \_\_\_\_\_ Other: explain: \_\_\_\_\_  
 Attendant care for personal needs: explain: \_\_\_\_\_  
 Adaptive devices:  
 \_\_\_\_\_ Wheel Chair \_\_\_\_\_ Braces \_\_\_\_\_ Cane/Walker  
 Medical Limitations: explain: \_\_\_\_\_  
 Seizures: explain: \_\_\_\_\_  
 \_\_\_\_\_ Generalized \_\_\_\_\_ Tonic clonic \_\_\_\_\_ Absence  
 Other Health Problems: Explain: \_\_\_\_\_

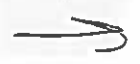
My child is covered by:

Insurance Plan \_\_\_\_\_ (required information for student to attend community training)  
 Policy Number \_\_\_\_\_

**PURPOSE:** To enable parents or guardians to authorize the provision of emergency treatment for a student who becomes ill or injured while under school authority, while parents or guardians cannot be reached.

Student Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Parent/Guardian Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_

The staff at GAITWAY is very interested in providing a safe valuable experience in the community for your son/daughter. If you have any questions at all, please feel free to call and discuss your concerns.



Signature required on back Please turn over →

**MEDICAL CONSENT** PART I OR PART II MUST BE COMPLETED.

**PART I: TO GRANT CONSENT**

In the event reasonable attempts to contact me have been unsuccessful I hereby give my consent for the administration of any treatment deemed necessary by Dr. \_\_\_\_\_ (preferred physician) or

Dr. \_\_\_\_\_ (preferred dentist), or in the event the designated preferred practitioner is not available, by another licensed physician or dentist, and the transfer of the student to \_\_\_\_\_ (preferred hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity of such surgery, are obtained prior to the performance of such surgery.

DATE \_\_\_\_\_

SIGNATURE OF PARENT/GUARDIAN \_\_\_\_\_

**DO NOT COMPLETE PART II IF YOU HAVE COMPLETED PART I**

**PART II: REFUSAL TO CONSENT**

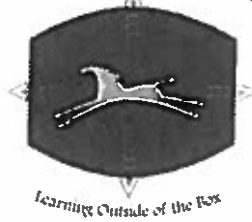
I do not give my consent for emergency medical treatment for my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action to:

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

DATE \_\_\_\_\_

SIGNATURE OF PARENT/GUARDIAN \_\_\_\_\_

Gaitway High School



August 5, 2013

Dear Parents/Guardians,

Gaitway High School staff has been certified by the State of Ohio to transport students in the school van. The van will allow the vocational program to travel to different work sites, be used for fieldtrips, and as a positive reinforcement (getting ice cream, lunch, etc.).

To ensure safety of all students and staff, we are using this permission slip to be an umbrella form to use the van to transport students, when needed by certified staff. Please sign the bottom portion of this sheet and return to Gaitway High School. If you have any questions or concerns of this matter, please call Lindsay Baar at (440)708-0013 ext. 152.

Sincerely,

Gaitway High School Staff

---

Van Permission Slip

Yes, I give my child permission to be transported in the Gaitway High School van

No, I do not give my child permission to be transported in the Gaitway High School van

Student's name (please print) \_\_\_\_\_

Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Parent Communication Information**

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

Parent/Guardian	Home Phone	Cell Phone	Work Phone	Home Email	Work Email

\* Sign and return

Gaitway High School



## Gaitway High School

### Actions Which Violate the Gaitway High School Computer Use Agreement

Committing any of the violations below may result in the suspension of computer privileges. Repeated infractions will result in evaluation of continued use.

- Bringing *any* food or drink (including water) into any computer area.
- Behaving in an inappropriate manner in, or violating the specific rules of, any computer area.
- Downloading and/or installing *any* programs (e.g., *AOL Instant Messenger, MSN Messenger, Yahoo Companion, Yahoo Messenger, Google Earth, Google Toolbar, iTunes, WinRAR, WinZIP*) or *any* inappropriate or unauthorized files (e.g., copyrighted music) into your computer account or on a local hard disk drive.
- Engaging in daytrading or online auctions or any other form of personal business or exchange of money.
- Viewing *any* inappropriate Web site or file.
- Scanning inappropriate documents (e.g., money, I.D., legal documents, pornography).
- Modifying the hardware and/or software of any computer system or file server in *any* way.
- Sending *any* inappropriate e-mail (e.g., pornography, criminal activity, hacking information, threats).
- Using and/or tampering with *any* other person's computer account, or allowing someone else to use your account.
- Printing multiple copies of any document, printing any document that is not school-related, or printing more than ten (10) pages in one day without specific permission.
- Connecting any non-Gaitway hardware (e.g., your own laptop, personal computer, mp player, phone, camera, external drive, CD-RW, DVD-RW, or non-approved memory storage device) to any computer or to Gaitway's computer network from within Gaitway without specific permission.

Violations that are deemed serious (by a system or school administrator) may result in legal action being taken against the offending student. If you are ever unsure about whether a particular Web site, file, or behavior is appropriate, err on the side of caution and do not load or save the site/file. For definitions of "inappropriate" and for more information, read the Gaitway High School Terms and Conditions for Computer and Network Use and talk to a system administrator.

While computer privileges will be suspended immediately upon the discovery of or suspicion of an infraction, the counting of account suspension days begins with the next day after contact is made with the offending student. It is the responsibility of any student who finds his/her account disabled to contact a Mr. Bob Chiancone.

activity that occurs with your account. Attempts to login to the network as a system administrator or gain unauthorized access will result in the cancellation of your computer privileges.

#### **Vandalism**

Vandalism will result in the cancellation of your computer privileges. Vandalism is defined as any malicious attempt to alter, harm, or destroy data of another user, computers, accessories, the Internet, or any of the above listed agencies or other networks that are connected to the Internet. This includes, but is not limited to, the uploading, downloading, or creation of computer viruses.

#### **Restitution and Consequences of Contract Violation**

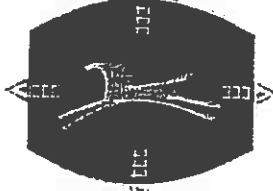
Students may be suspended or subject to other disciplinary actions for violation of this contract as provided in the current school Student/Parent Handbook. Students will be required to provide restitution for damages to their assigned laptop or network while the student is in possession of or logged on to the network or using their assigned machine. In the case of no physical damage, but the requirement of staff time to reconfigure a system, students will be charged at the rate of \$119/hour for a minimum of one hour.

#### **Duration of Agreement**

The duration of this agreement begins upon signing and ends when the student leaves Gaitway High School.

\* Sign and Return

Gaitway High School



Learning Outside of the Box

**Contract Agreement for Student and Parent**

*Gaitway High School / Fieldstone Farm TRC*

**Directions:** Please read and fill out the following contract completely and legibly. The signature of a parent or guardian is also required. Please return the contract to your teacher immediately. Any questions should be addressed to Mr. Bob Chiancone at 440.708.0013 ext. 155. Keep the copy of the Terms and Conditions Computer and Network Use for your records.

**Student Contract:** I have read the Terms and Conditions Computer and Network Use. I understand and will abide by the stated Terms and Conditions. I further understand that violation of the regulations is unethical and may constitute a criminal offense. Should I commit any violation of the regulations, my computer access privileges may be revoked, school disciplinary action may be taken, and/or appropriate legal action may be pursued against me.

Student Name (Please PRINT) \_\_\_\_\_

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

**Parent or Guardian:** (If the applicant is under the age of 18, a parent or guardian must also read and sign this agreement.) As the parent or guardian of this student, I have read the Terms and Conditions. I understand that violation of the regulations is unethical and may constitute a criminal offense. Should my child commit any violation of the regulations, his or her computer access privileges may be revoked, school disciplinary action may be taken, and/or appropriate legal action may be pursued against my child. I further understand that this access is designed for educational purposes and that Fieldstone Farm TRC and Geauga Co. Educational Service Center have taken reasonable precautions to eliminate access to controversial material. However, I also recognize that it is impossible to restrict access to all controversial materials, and I will not hold them responsible for materials acquired by my child through the network. I hereby certify that the information contained on this form is correct.

Parent or Guardian Name (Please PRINT) \_\_\_\_\_

Parent or Guardian Signature \_\_\_\_\_

Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_

Date \_\_\_\_\_



Having your computer privileges suspended means that you are not allowed to use any computer anywhere at Gaitway, even if that computer does not require a local or network login. Doing so constitutes a more serious violation of the Gaitway Computer and Internet Use Agreements.

**Gaitway High School administrators reserve the right to suspend the computer privileges of any student who violates any part of the Terms and Conditions for Computer and Network Use. This includes any and all activities that may or may not be specifically listed on this page.**

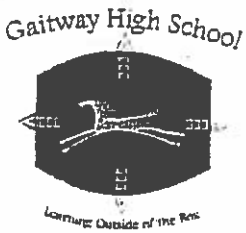
Student Name (Please PRINT) \_\_\_\_\_

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

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

\* Sign and return

\* Sign and return



# Gaitway High School

## Actions Which Violate the Gaitway High School Computer Use Agreement

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- Engaging in daytrading or online auctions or any other form of personal business or exchange of money.
- Viewing *any* inappropriate Web site or file.
- Scanning inappropriate documents (e.g., money, I.D., legal documents, pornography).
- Modifying the hardware and/or software of any computer system or file server in *any* way.
- Sending *any* inappropriate e-mail (e.g., pornography, criminal activity, hacking information, threats).
- Using and/or tampering with *any* other person's computer account, or allowing someone else to use your account.
- Printing multiple copies of any document, printing any document that is not school-related, or printing more than ten (10) pages in one day without specific permission.
- Connecting any non-Gaitway hardware (e.g., your own laptop, personal computer, mp player, phone, camera, external drive, CD-RW, DVD-RW, or non-approved memory storage device) to any computer or to Gaitway's computer network from within Gaitway without specific permission

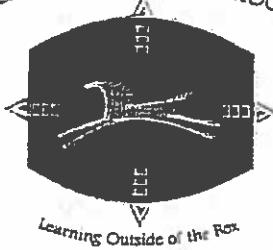
Violations that are deemed serious (by a system or school administrator) may result in legal action being taken against the offending student. If you are ever unsure about whether a particular Web site, file, or behavior is appropriate, err on the side of caution and do not load or save the site/file. For definitions of "inappropriate" and for more information, read the Gaitway High School Terms and Conditions for Computer and Network Use and talk to a system administrator.

While computer privileges will be suspended immediately upon the discovery of or suspicion of an infraction, the counting of account suspension days begins with the next day after contact is made with the offending student. It is the responsibility of any student who finds his/her account disabled to contact a Mr. Bob Chiancone.

\* Sign and Return

Gaitway High School

Contract Agreement for Student and Parent



Gaitway High School / Fieldstone Farm TRC

**Directions:** Please read and fill out the following contract completely and legibly. The signature of a parent or guardian is also required. Please return the contract to your teacher immediately. Any questions should be addressed to Mr. Bob Chiancone at 440.708.0013 ext. 155. Keep the copy of the Terms and Conditions Computer and Network Use for your records.

**Student Contract:** I have read the Terms and Conditions Computer and Network Use. I understand and will abide by the stated Terms and Conditions. I further understand that violation of the regulations is unethical and may constitute a criminal offense. Should I commit any violation of the regulations, my computer access privileges may be revoked, school disciplinary action may be taken, and/or appropriate legal action may be pursued against me.

Student Name (Please PRINT) \_\_\_\_\_

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

**Parent or Guardian:** (If the applicant is under the age of 18, a parent or guardian must also read and sign this agreement.) As the parent or guardian of this student, I have read the Terms and Conditions. I understand that violation of the regulations is unethical and may constitute a criminal offense. Should my child commit any violation of the regulations, his or her computer access privileges may be revoked, school disciplinary action may be taken, and/or appropriate legal action may be pursued against my child. I further understand that this access is designed for educational purposes and that Fieldstone Farm TRC and Geauga Co. Educational Service Center have taken reasonable precautions to eliminate access to controversial material. However, I also recognize that it is impossible to restrict access to all controversial materials, and I will not hold them responsible for materials acquired by my child through the network. I hereby certify that the information contained on this form is correct.

Parent or Guardian Name (Please PRINT) \_\_\_\_\_

Parent or Guardian Signature \_\_\_\_\_

Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_

Date \_\_\_\_\_