Sivuniksarmut Niriungniqarniq
New Beginnings Suspension Program (NBSP)
School Referral Form

General Information

Student Name:_____
School:_____Grade: _____

Referring Teacher/Administrator:

_____

Parent/Guardian:

_____

How and when was parent notified of referral?

_____

Reason for suspension:

Please describe the specific concerns prompting this referral. What is the reason this student has been suspended? List any academic social, emotional or medical factors that negatively impact the student.

_____

_____

_____

In what setting / situations do problems occur most often?

_____

In what setting/situations does the problem occur least often?

_____

What are the student's strengths, talents or specific interests?
1._____
2._____
3._____

Parent/Guardian Contact Prior to Referral

_____Phone Call _____Note Home _____ Conference _____Home visit

Prior Suspensions:

1. Begin Date _____ End Date _____

Reason for Suspension:

What has been done to address issue of suspension?

How did it work or not work?

2. Begin Date _____ End Date _____

Reason for Suspension:

What has been done to address issue of suspension?

How did it work or not work?

What do you feel will best assist this student to work on reducing the behaviors associated with the suspensions?

Parent/Guardian Contact Information:
Name:_____
Phone:_____ Address:_____

Sivuniksarmut Niriungniqarniq
New Beginnings Suspension Program
Parent/Guardian & Student Form

Date:_____

Personal Information

Last Name:_____ First Name:_____

Age:_____ DOB:_____ Gender _____

Address

Street No. _____ Street Name:_____

Box No.:_____ City:_____ PC:_____

Home
Phone:_____CellPhone:_____

Parent/Legal Guardian Information

Relationship to Child/Youth:_____
Name:_____
Address (if different):_____
Home Phone:_____ Work Phone:_____
Cell Phone: _____

Relationship to Child/Youth:_____
Name:_____
Address (if different):_____
Home Phone:_____ Work Phone:_____
Cell Phone: _____

What do you hope for your child to get out of our services while at ACYF?:
_____

Health Information:

Do you have any allergies? If yes please list below:

Are you or have you been under the care of a Doctor for medical reasons?

Are you taking any medications at this time?

Are there any other medical concerns that we should be aware of?:

Educational Information

Are you currently in school? _____ If yes, what grade are you in_____

Please list name of your current School: _____

Name and phone number of your primary teacher:

_____

Name and phone number of your school Counselor:

_____

Describe briefly your level of Attendance:

_____

What subjects and activities do you think you currently do your best in and enjoy most?

_____

What do you like and dislike most about school?

_____

What are your educational goals? (graduation, college, learn a trade etc.):

_____

Would you be willing to work on needed school work when attending ACYF ?:

_____

Consent and Indemnity

Please read this information and sign as required.

Voluntary Participation Consent:

I acknowledge that my child has voluntarily decided to participate in Sivuniksarmut Niriungniqarniq with Arctic Children and Youth Foundation (ACYF). I have read a description of the program and understand the information contained in it. I give permission for my child to participate in Sivuniksarmut Niriungniqarniq. I agree and understand that Arctic Children and Youth Foundation reserves the right to exercise discretion to refuse to register any child upon medical and/or other grounds without providing a detailed reason for doing so.

Indemnity:

I understand that while every reasonable precaution will be undertaken to ensure the protection of my child, I hereby release the Arctic Children and Youth Foundation and its Volunteers from any and all liability in the event of any injury, accident, misfortune, damage or loss that may occur to my child and/or their property while present at Sivuniksarmut Niriungniqarniq. Further, I indemnify the Arctic Children and Youth Foundation from and against all loss, including legal expenses, connected with or arising from any claims or demands in relation to my child's attendance at Arctic Children and Youth Foundation office, including leaving the office during and after hours of attendance.

I understand that should my child leave the premises of ACYF I will be contacted immediately and that it is not the responsibility of ACYF to locate him/her, but that ACYF will attempt to keep my child safe at the premises until I can arrive.

Medical Treatment Consent:

I give permission for the Arctic Children and Youth Foundation to obtain emergency medical, hospital or ambulance assistance and/or treatment for my child at any time they consider necessary. I understand that every effort will be made for myself to be notified before instituting such procedures. I acknowledge that I will be liable for any medical, hospital or ambulance expense incurred in the treatment of my child and I agree to pay those expenses.

Privacy Declaration:

I understand that the Arctic Children and Youth Foundation may collect information about/from my child, and that they will not pass this information on to any other person or organization, unless it is information that my child may hurt him/herself or someone else.

I have read and understand the above information and give my consent as indicated by my signature below.

Full Name of Child:_____

Signature:_____ Date: _____

Full Name of Parent / Guardian: _____

Signature: _____ Date: _____