ACKNOWLEDGMENT OF PARENT OR GUARDIAN OF ANNUAL RIGHTS NOTIFICATION

Detach, sign, and return this page to your child's school indicating that you have been notified of the specified activities and whether you have a child on continuing medication.

Student's Name: _____

School: _____ Grade: _____

I hereby acknowledge receipt of information regarding my rights, responsibilities, and protections.

Signature of Parent or Guardian: _____ Date: _____

PLEASE COMPLETE THE FOLLOWING IF APPLICABLE:

1. Student is on a continuing medication program: (Please check one) YES ☐ NO ☐

   If YES, you have my permission to contact student's physician:

   Physician's Name _____ Telephone: _____

   Medication: _____ Dosage: _____

   Medication: _____ Dosage: _____

2. If you do not wish directory information released (page 10), please sign where indicated below and ensure receipt of this form by the school office within **the next 30 days.** Note that this will prohibit the district from providing the student's name and other information to the news media, interested schools, parent-teacher associations, interested employers, and similar parties.

   Do NOT release directory information regarding _____
   (Pupil's Name)

   ☐ Check if an exception may be made to include student information and photos in the yearbook.

   Signature of Parent or Guardian: _____