

June 1, 2023

Dear Morgan Autism Center Adult Parents and Group Home Staff,

Please read through the following information carefully and note important dates on your calendar. **All necessary forms should be returned to the office as soon as possible and no later than Wednesday, August 16th.** The forms in this packet are essential for the client's continued placement at Morgan Autism Center.

CLIENT FORMS

1. **Emergency Information Form** – Please update - a copy of the most current form on file is enclosed.

It is imperative that our emergency and medication information be current. Information should be updated regularly as information changes. Medication given at home should be noted on the form.

If your client is taking any medication(s) at home, or if there are medication changes throughout the year, our office must be informed with complete information regarding all medication(s) for each client.

1a. In case of an earthquake or other disaster we must have a 3-day supply of the client's home medications, and those they take at Morgan Autism Center, along with a Parent's Authorization to Medicate form.

Stopping medication abruptly can often cause serious side effects. We want to be able to care for your client in the event of a serious emergency.

Medicine containers must be correctly labeled from the pharmacy (no handwritten dosage changes, etc.)

2. **Medication Information / Permission to Medicate Form** – If your client has medication regularly administered at our center **both a "Parent Permission to Medicate" form and a "Physician's Permission" form must be completed.** This form **must be updated and signed each year, and/or each time prescriptions change.**
3. **Medical Emergency Authorization/Transportation Authorization Form**
(combined form)
4. **Immunization Record** (with all updated immunizations as required by law)
- **TB Testing** – A current TB test is required for everyone and must be on file. This is California state law.

- **Hepatitis B Vaccination** – California state law requires that any client must have the Hepatitis B-3 – shot series record on file.
- 5. **Seizure Protocol Form** *(if applicable)*
- 6. **Peanut Policy** *(signature required)* – Renewed annually
- 7. **Media Consent and Release Form** – Renewed annually
- 8. **Physician's Report**, we ask that you please provide us with these updated forms regularly
- 9. **Sexual Harassment Acknowledgement Form** – Please sign and date the acknowledgement form that you have "received, read, and understand" the California State Department of Ed Code Sections 200, 201, 212.5, 220, and 230 guidelines which are included in this packet. Please return the acknowledgement form only.

Parent/Caregiver Accessibility: At times it is necessary for us to contact parents or group homes during the day. These calls are usually related to a client's illness or a behavior issue. The client may need to be picked up from program. It is very important that either the parent or a person authorized to act on your behalf be available to talk to us and respond to the client's needs, as required. Due to Covid-19, Parent/Caregiver accessibility is more important than ever.

- Please sign to acknowledge and agree to be available for emergencies on the **Parent/Caregiver Accessibility Form** in this packet.

Absences: When a client is absent for any reason, please call or email the office to report the absence. We will notify the program staff for you. If you need to speak with the director(s), please do so.

Please notify transportation services as early as possible to alert them of the absence so they may cancel transportation.

Attendance:

If a client is absent for any reason, the absence is considered unexcused and we will not receive payment for any dates the client is absent. This will result in a loss to Morgan Autism Center for each date of absence, plus the cost of our staffing, even if the absence is for an illness. Please help us minimize the financial impact of absences by limiting absences to illness/emergencies.

Please schedule medical and dental appointments after school hours, or bring your client to school after or before the appointment. **Please understand that if you take a client out of the program for camp, family vacations, and/or other recreational activities during the program year there is a substantial financial impact (\$94.00 minimum per day).** Please consider making a donation to offset this cost. Please schedule your family vacations and camp to coincide with the Morgan Autism Center

calendar vacation days. *The Adult Program calendar may be viewed on the Morgan Autism Center's website. A copy is included in this packet.*

Proof of Conservatorship: All conserved clients **must have a copy of their Letters of Conservatorship on file** at the Morgan Autism Center. Morgan Autism Center will abide by the Letters of Conservatorship in regard to medical issues, and in dealing with district and regional centers. Protect your rights as conservators by ensuring we have the proper documentation. If you are not sure whether or not copies of your Letters of Conservatorship are on file at the Morgan Autism Center, please call the office for verification.

The 2023-2024 Adult Program year will begin on Wednesday, August 16th. This year's calendar is included in this packet. You may also view the calendar on the Morgan Autism Center's Website - <http://www.morgancenter.org>.

Please make a special note of the in-service training days scheduled at which time the client will be dismissed at 1:00 p.m.

Phone Numbers: Main office 408 241-8161

Emails: Josh Drake, Executive Director: joshdrake@morgancenter.org
Aya Sasaki, Adult Program Director: aya@morgancenter.org
Sara Cedano, Community Intergration Program Director: sara@morgancenter.org
Nicole Ferguson, Administrative Specialist: nicole@morgancenter.org
Ching Young, Administrative Associate: ching@morgancenter.org

Save the dates:

Parent/Caregiver Open House: Wednesday, October 18th *(tentative time will be 5-7 p.m.)*
A flyer with details will be sent home prior to the date.

Parent Group: First meeting date TBD. *Future meeting dates and times will be discussed at the first meeting. We will notify you once dates and times are arranged. All parents are encouraged to attend.*

We are looking forward to an exciting and productive year, full of growth and progress. We will see everyone on **Wednesday, August 16th, 2023.**



MORGAN AUTISM CENTER ADULT PROGRAM CALENDAR 2023-2024

Last Day of June Program 2023 * (Minimum day)	June 22, 2023
Summer Session	July 5 - July 31
Staff Inservice Day (no clients)	August 16
First Day of 2023-2024 Program	August 17
Labor Day Holiday	September 4
Indigenous Peoples' Day Holiday	October 6 & 9
**Minimum Day for Staff Inservice	October 18
Family Night * (Minimum day)	October 18
Veterans' Day Holiday	November 10
**Minimum Day	November 21
Thanksgiving Vacation	November 22 - 24
**Minimum Day	December 21
Holiday Vacation	December 22 - January 3, 2024
Return from Holiday Break	January 4, 2024
**Minimum Day for Staff Inservice	January 10
Martin Luther King Holiday	January 15
Presidents' Day Holiday	February 19 - 20
Spring Vacation	April 1 - 2
Memorial Day Holiday	May 27
Juneteenth Holiday	June 19
Last Day of June Program 2024 * (Minimum day)	June 21
Summer Session 2024	July 1 - July 30
Fourth of July Holiday	July 4 - 5

****On Minimum Days, Adult Clients are dismissed at 1:00 PM**

ADULT CALENDAR 2023-2024

Number of Program days by month

2023

July	19
August	11
September	20
October	20
November	18
December	15

2024

January	19
February	19
March	21
April	20
May	22
June	14

Total: 218

Daily Program hours:	9:00am – 2:30pm
Minimum Days:	9:00am – 1:00pm

****On Minimum Days, Adult Clients are dismissed at 1:00 PM**

Contact Information

Main Office: (408) 241-8161

Name	Title	Email	Ext.
Josh Drake	Executive Director	joshdrake@morgancenter.org	108
Mark Nielsen	Program Director	mark@morgancenter.org	127
Hailey Barker	Program Director	hailey@morgancenter.org	107
Sun Garcia	Program Specialist/Consultant	sun@morgancenter.org	103
Jonnetta Quesada	Director of Finance & Business	jonnetta@morgancenter.org	
Sally Hird	Office Manager	sally@morgancenter.org	104
Haley Sepulveda	Development & Communications Manager	haley@morgancenter.org	101
Nicole Ferguson	Administrative Specialist	nicole@morgancenter.org	105
Ching Young	Administrative Associate	ching@morgancenter.org	125
Tyler Jakaitis	Specially Designed PE Coordinator	tyler@morgancenter.org	122



To all Adult Program parents and/or caregivers,

We are writing this notice to ask that phone calls to the Adult Program be kept to a minimum. Please only call the Adult Program if it is an emergency as Aya and Sara are busy with running the Program, spending time with clients, training new staff, interviewing applicants and giving tours. With ~50 clients, you can imagine how disruptive it can be to receive phone calls on a regular basis during program hours.

Please send Aya (aya@morgancenter.org) and Sara (sara@morgancenter.org) an email and we will make sure to check our emails before 8:30 AM and again between 1:30-2:30 PM. We will make every effort to reply to your emails on the same day. Should there be a non-emergency matter, but a matter that needs to be addressed that day nonetheless (such as a client getting picked up early,) please call the office at 1 (408) 241-8161 and they will relay the message to AP in person.

If you would like to talk to Aya/Sara, please email us and we will call you at our earliest convenience or schedule a face-to-face meeting.

In addition, please call the office to report any absences and illnesses and email us as well so we are aware of what to expect for the day. Looking out for all of our clients and staff takes a lot of juggling of the different schedules so advance notices on absences is always appreciated.

Thank you for your understanding on this matter-

Aya Sasaki
Adult Program Director



Parent Accessibility: At times it is necessary for us to contact parents or group homes during the day. These calls are usually related to a student's illness or a behavior issue. The student may need to be picked up from program. It is very important that either the parent or a person authorized to act on your behalf be available to talk to us and respond to the student's needs, as required.

Please print and sign your name that you understand and agree to be available or have an authorized person available to make decisions/pick up your client if needed.

Please print

Parent/Guardian name _____

Signature _____

Date _____



MORGAN AUTISM CENTER

Emergency Information Form

Last Name	First Name	M.I.	D.O.B.	Room/School
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
ADDRESS: <input type="text"/>				Modified
PHONE: <input type="text"/>				
CONSERVED: <input type="checkbox"/> Yes		CONSERVATOR(S): <input type="text"/>		
Father's Name		Mother's Name		
<input type="text"/>		<input type="text"/>		
Phone Type	Phone Number	Phone Type	Phone Number	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
email <input type="text"/>		email <input type="text"/>		
Emergency Contact		Emergency Phone Numbers		
<input type="text"/>		<input type="text"/>		
<input type="text"/>		<input type="text"/>		
<input type="text"/>		<input type="text"/>		
<input type="text"/>		<input type="text"/>		
<input type="text"/>		<input type="text"/>		
Doctor/ Dentist	Doctor's Phone #	Meds (with Dosage and Time)		
<input type="text"/>	<input type="text"/>	<input type="text"/>		
<input type="text"/>	<input type="text"/>	<input type="text"/>		
<input type="text"/>	<input type="text"/>	<input type="text"/>		
<input type="text"/>	<input type="text"/>	<input type="text"/>		
<input type="text"/>	<input type="text"/>	<input type="text"/>		
Emergency Card Comments (Diagnosis, Seizure Info, Allergies, Diagnosis, Choking, Shunt, Heart, etc.)				
<input type="text"/>				
Preferred Hospital	Insurance	Policy #	MediCal	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Group Home	Group #		<input type="text"/>	
<input type="text"/>	<input type="text"/>		<input type="text"/>	
Group Home Address	City	State	Zip	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Phone	Contact	<input type="text"/>		
<input type="text"/>	<input type="text"/>	<input type="text"/>		

Consent for emergency treatment: (If it is deemed necessary by the program authorities, your son/daughter will be taken by ambulance at parent's expense to the nearest emergency facility).
I authorize and direct the attending physicians or dentist on duty to perform emergency treatment on my son/daughter.

Parent or Guardian

Date

Earthquake/Emergency Medication Form

I hereby give my permission for the staff of Morgan Autism Center to give my child/client medication, in the event of an earthquake (or other emergency) in which the student/client is unable to get home and must remain at the school site.

Medication may be legally given at school **only** in the original container, labeled by the pharmacist. A new prescription bottle must accompany prescription changes.

(please print information below)

Name of Child/Client: _____

Parent(s): _____

Medication: _____

Daily dosage: _____

Prescription number: _____

Physician: _____

Pharmacy: _____

Parent/Legal Guardian Signature:

Date: _____

Medicine disposal (not to be filled out until medication expires or is disposed of)

Signed: _____ Date: _____



EMERGENCY MEDICAL CARE - and -
TRANSPORTATION PERMISSION *(please print)*

Student/Client's Name: _____

Birth Date: _____

Parent's Address: _____

Home Phone: _____

Father's Name: _____

Cell Phone: _____ Business Phone: _____

Employer: _____ Dept./Position: _____

Mother's Name: _____

Cell Phone: _____ Business Phone: _____

Employer: _____ Dept./Position: _____

Child's/Client's Physician: _____

Address: _____

Telephone Number(s): _____

.....
In the event of an emergency, I hereby authorize the personnel of Morgan Autism Center to obtain medical help for *(pls. print name)*

Signature: _____ Date: _____

.....
I hereby authorize the personnel of Morgan Autism Center to provide transportation for _____ to and from activities related to the program.

Signature: _____ Date: _____

950 St. Elizabeth Drive, San Jose, CA 95126-3900 • P(408) 241-8161 F(408) 241-8231
Email info@morgancenter.org • Website www.morgancenter.org

Seizure Protocol

Date: _____

Name _____

Age: _____

Preferred hospital _____

Preferred doctor _____

If seizure continues beyond _____ minutes, CALL 911

Current medication:

Dosage:

Last Change:

Please complete the following checklist, giving us as much information about the seizure activity of your child / client.

Consciousness:

- ☐ Fully conscious throughout
- ☐ Partially conscious (incoherent, dreamy)
- ☐ Loses consciousness (at least part of the time)
- ☐ Stopped all activity

Activity:

- | | |
|--|---|
| <input type="checkbox"/> Repetitious or pointless movements or actions (e.g. picking at clothing, opening or closing doors, jumping, etc.) | <input type="checkbox"/> Mild twitching |
| <input type="checkbox"/> Clenching or grinding teeth | <input type="checkbox"/> Trembling, shaking |
| <input type="checkbox"/> Staring into space (not at anything) | <input type="checkbox"/> Drooling |
| <input type="checkbox"/> Jerking of arms, legs, and/or whole part | <input type="checkbox"/> Falls-rigid |
| <input type="checkbox"/> Twitching/jerking-only one body part | <input type="checkbox"/> Falls-limp |
| <input type="checkbox"/> Rapid blinking | <input type="checkbox"/> Sits |
| | <input type="checkbox"/> Body stiff, rigid |

☐ Other (*specify*)

Appearance:

- ☐ Normal
- ☐ Pale Skin
- ☐ Flushed
- ☐ Turned blue briefly
- ☐ Sweaty
- ☐ Blank look on face

Breathing:

- ☐ Normal
- ☐ Rapid
- ☐ Irregular
- ☐ Stopped
- ☐ Choked

Verbalization:

- ☐ Odd Sounds
- ☐ Screamed
- ☐ Lip-smacked
- ☐ Made odd or
incoherent statements
or requests

Post Seizure:

Is the person generally confused after a seizure?

Does the person need to sleep?

Do you want to be notified immediately in every case?

Only if unusual?

Additional information:



Parent Permission to Medicate at School

To: Parent/Guardian and Attending Physician,

California Education Code section 49423 provides statutory authority for providing assistance in administering medication in California schools. These regulations apply to “over the counter” as well as prescription medications. The requirements of this section are as follows:

a written statement from the California licensed Health Care Provider (Physician) detailing the medication, dosage, time and delivery method (see details below)

- signed statement from parents/guardians giving Morgan Center permission to assist in medication administration

To that end, parents must secure a supply of medication to be administered at school. **This must be in a pharmacy labeled container that contains the following information: pupil's name, physician's name, medication name and dosage, prescription number, time and frequency of administration, as well as the pharmacy name and phone number.** Each new supply of medication should contain the above information.

“Over the Counter” medication must also be kept in the original manufacturers labeled container, **with a prescription if** it is to be administered in a manner other than the directions on the label.

In compliance with these regulations, we request the following information.

Student/Client Name

Birthdate

Physician Name

I request that Morgan Autism Center assist me with the administration of medication during school hours. I give my consent to the school and Physician named below to exchange any information needed concerning my child.

Signature of Parent/Guardian

Date

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Email info@morgancenter.org • Website www.morgancenter.org



Physician's Authorization to Medicate at School

Student/Client _____

Medical Record # _____

Medical Facility (Kaiser, PAMF, etc) _____

MEDICATION	DOSAGE	TIME

Over the Counter medications – please circle all that apply:

Allergy Medication - yes/no _____

Pain relievers - yes/no _____

Supplements – yes/no _____

Other _____ (as needed)

Physician's signature

Date

Please use stamp of print Physician's name, address and telephone number below.

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IMPORTANT

MEMO:

To: The Morgan Autism Center Parents and Group Home Staff

Subject: Required Client TB Test

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All students and clients attending Morgan Autism Center are required to have a TB Test every 4 years. You are receiving this notice because your son/daughter('s) TB test is expired or soon to expire.

Please make sure to update his/her TB test and provide us with current documentation.

If you have any questions, please call Morgan Autism Center at 408-241-8161.

Thank you.

PHYSICIAN'S REPORT FOR COMMUNITY CARE FACILITIES**For Resident/Client Of, Or Applicants For Admission To, Community Care Facilities (CCF).****NOTE TO PHYSICIAN:**

The person specified below is a resident/client of or an applicant for admission to a licensed Community Care Facility. These types of facilities are currently responsible for providing the level of care and supervision, primarily nonmedical care, necessary to meet the needs of the individual residents/clients.

THESE FACILITIES DO NOT PROVIDE PROFESSIONAL NURSING CARE.

The information that you complete on this person is required by law to assist in determining whether he/she is appropriate for admission to or continued care in a facility.

FACILITY INFORMATION (To be completed by the licensee/designee)

NAME OF FACILITY: Morgan Autism Center			TELEPHONE: 408-241-8161
ADDRESS: NUMBER 950 St. Elizabeth Drive	STREET	CITY San Jose , CA 95126	
LICENSEE'S NAME: Brad Boardman	TELEPHONE: 408-241-8161	FACILITY LICENSE NUMBER: 435202688	

RESIDENT/CLIENT INFORMATION (To be completed by the resident/authorized representative/licensee)

NAME:			TELEPHONE:
ADDRESS: NUMBER	STREET	CITY	SOCIAL SECURITY NUMBER:
NEXT OF KIN:		PERSON RESPONSIBLE FOR THIS PERSON'S FINANCES:	

PATIENT'S DIAGNOSIS (To be completed by the physician)

PRIMARY DIAGNOSIS:				
SECONDARY DIAGNOSIS:				LENGTH OF TIME UNDER YOUR CARE:
AGE:	HEIGHT:	SEX:	WEIGHT:	IN YOUR OPINION DOES THIS PERSON REQUIRE SKILLED NURSING CARE? <input type="checkbox"/> YES <input type="checkbox"/> NO
TUBERCULOSIS EXAMINATION RESULTS: <input type="checkbox"/> ACTIVE <input type="checkbox"/> INACTIVE <input type="checkbox"/> NONE				DATE OF LAST TB TEST:
TYPE OF TB TEST USED:			TREATMENT/MEDICATION: <input type="checkbox"/> YES <input type="checkbox"/> NO	If YES, list below:

OTHER CONTAGIOUS/INFECTIOUS DISEASES: A) <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, list below:		TREATMENT/MEDICATION: B) <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, list below:	
ALLERGIES C) <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, list below:		TREATMENT/MEDICATION: D) <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, list below:	

Ambulatory status of client/resident:

1. This person is able to independently transfer to and from bed: ☐ Yes ☐ No

2. For purposes of a fire clearance, this person is considered:

☐ Ambulatory ☐ Nonambulatory ☐ Bedridden

Nonambulatory: A person who is unable to leave a building unassisted under emergency conditions. It includes any person who is unable, or likely to be unable, to physically and mentally respond to a sensory signal approved by the State Fire Marshal, or to an oral instruction relating to fire danger, and persons who depend upon mechanical aids such as crutches, walkers, and wheelchairs.

Note: A person who is unable to independently transfer to and from bed, but who does not need assistance to turn or reposition in bed, shall be considered non-ambulatory for the purposes of a fire clearance.

Bedridden: For the purpose of a fire clearance, this means a person who requires assistance with turning or repositioning in bed.

I. PHYSICAL HEALTH STATUS: <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR			COMMENTS:	
	YES (Check One)	NO	ASSISTIVE DEVICE	COMMENTS:
1. Auditory impairment				
2. Visual impairment				
3. Wears dentures				
4. Special diet				
5. Substance abuse problem				
6. Bowel impairment				
7. Bladder impairment				
8. Motor impairment				
9. Requires continuous bed care				

II. MENTAL HEALTH STATUS: <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR			COMMENTS:	
	NO PROBLEM	OCCASIONAL	FREQUENT	IF PROBLEM EXISTS, PROVIDE COMMENT BELOW:
1. Confused				
2. Able to follow instructions				
3. Depressed				
4. Able to communicate				

III. CAPACITY FOR SELF CARE: <input type="checkbox"/> YES <input type="checkbox"/> NO			COMMENTS:	
	YES (Check One)	NO	COMMENTS:	
1. Able to care for all personal needs				
2. Can administer and store own medications				
3. Needs constant medical supervision				
4. Currently taking prescribed medications				
5. Bathes self				
6. Dresses self				
7. Feeds self				
8. Cares for his/her own toilet needs				
9. Able to leave facility unassisted				
10. Able to ambulate without assistance				
11. Able to manage own cash resources				

PLEASE LIST OVER-THE-COUNTER MEDICATION THAT CAN BE GIVEN TO THE CLIENT/RESIDENT, AS NEEDED, FOR THE FOLLOWING CONDITIONS:

CONDITIONS

1. Headache
2. Constipation
3. Diarrhea
4. Indigestion
5. Others(*specify condition*)

OVER-THE-COUNTER MEDICATION(S)

PLEASE LIST CURRENT PRESCRIBED MEDICATIONS THAT ARE BEING TAKEN BY CLIENT/RESIDENT:

- | | | |
|----------|----------|----------|
| 1. <hr/> | 4. <hr/> | 7. <hr/> |
| 2. <hr/> | 5. <hr/> | 8. <hr/> |
| 3. <hr/> | 6. <hr/> | 9. <hr/> |

PHYSICIAN'S NAME AND ADDRESS:

TELEPHONE:

DATE:

PHYSICIAN'S SIGNATURE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (TO BE COMPLETED BY PERSON'S AUTHORIZED REPRESENTATIVE)

I hereby authorize the release of medical information contained in this report regarding the physical examination of:

PATIENT'S NAME:

TO (NAME AND ADDRESS OF LICENSING AGENCY):

SIGNATURE OF RESIDENT/POTENTIAL RESIDENT AND/OR HIS/HER AUTHORIZED REPRESENTATIVE

ADDRESS:

DATE:



To All Adult Program Parents, Group Homes, and Caretakers,

In order to do our share for the environment, to maximize staff's time, and to spend as little of our funds on disposable items, please help us with client lunches.

- 1) **Please provide utensils (silverware preferred)**
- 2) If client is unable to cut their own foods, such as meats, apples, etc. (which requires one staff to prepare it all before lunch) please send it all pre-cut.
- 3) Please provide your own clearly marked plastic plates, cups, and plastic containers (instead of baggies) etc.
- 4) Please make sure everything is well marked, so it does not get lost.
- 5) Cloth napkins would be great as well.
- 6) **Please avoid sending in lunches which require heating up as it takes up one staff's time before lunch, and does not promote Independence for your client. You may send already warmed meals in an unbreakable thermos so it all stays warm until noon.**

Please let us know should you have any questions-

Thank you,

Aya Sasaki & Sara Cedano



Morgan Autism Center Peanut Policy

Morgan Autism Center recognizes that peanut allergies can pose a significant health and safety hazard to those affected by such allergies. **In order to protect these students and/or clients** throughout our shared environment we have adopted the following Peanut Allergy Policy.

All Students / Clients Peanut Allergy Policy

As part of our overall safety practices and policies at Morgan Autism Center, we adhere to a total peanut free policy throughout the school/adult program. This includes all campus environments (indoor and outdoor), all program related activities (on or off campus) and all school/adult program personnel.

It is essential for us to provide a safe environment for all. Please check food product labels and help us screen all potentially harmful snack and lunch items. Should any peanut products mistakenly make it to school, we will return them to you in the lunch box unused.

We appreciate full cooperation and apologize for any inconvenience.

Please sign below and return indicating that you have received, understand, and will adhere to the Morgan Autism Center's Peanut Allergy Policy.

Parent/guardian Signature

Name of Student/Client: _____ (Pls. print)

Date

950 St. Elizabeth Drive, San Jose, CA 95126-3900 • P(408) 241-8161 F(408) 241-8231

Email info@morgancenter.org • Website www.morgancenter.org

Peanut Policy

Media Consent and Release Form

Morgan Autism Center (MAC) is proud of the work of its students and adult clients. Throughout the school year, MAC may want to promote some of our many activities and achievements. For example, we may feature students or adult clients in materials to train teachers and/or increase public awareness of our organization and autism. Please consider giving MAC permission to highlight the achievements of your student or adult client by giving your consent below.

I hereby give Morgan Autism Center permission to use my student/adult client for the following **(please accept by placing checkmarks in the applicable boxes below.)**

IDENTIFICATION: ☐ First name only ☐ Full Name

MORGAN AUTISM CENTER'S USE OF PHOTOGRAPHS/VIDEO INCLUDES:

Promotional/fundraising material-printed material, DVD, Video, MAC website and authorized media such as TV, newspaper, magazine, or radio.

SOCIAL MEDIA: Facebook, Twitter, Instagram, Linkedin, YouTube, Vimeo and any future social media channels.

Morgan Autism Center ☐ **MAY/** ☐ **MAY NOT**
use my student's/adult client's photo for the above.

1. I am aware that I will not receive monetary compensation for my child/adult client's participation.
2. I further release and relieve Morgan Autism Center, its Board of Trustees, employees and other representatives from any liabilities, known or unknown, arising out of the use of this material.

I certify that I have read the Media Consent and Release Form, and fully understand its terms and conditions. For more information, contact the office at (408) 241-8161. **Please complete this form and return to Morgan Autism Center.** Thank you for your cooperation.

Please print

Student or adult client name _____

Parent or guardian name _____

Signature _____ Date _____

For more information, contact Administrative Specialist, Nicole Ferguson at nicole@morgancenter.org or call (408) 241-8161.

950 St. Elizabeth Drive • San Jose, CA 95126-3900 (408) 241-8161 • Fax (408) 241-8231

info@morgancenter.org

www.morgancenter.org



**Morgan Autism Center
Student/Client Activity Fund/Donation
School Year 2023-2024**

This covers the special activities (birthday, holiday gift, field trips, etc.)
for each individual student/client throughout the year.

Please consider a donation of \$150.00

Student/Client's Name:
(Please print)

Room #

Thank you

For office use only:

Received: Check # _____ *Currency* _____

Date: _____

950 St. Elizabeth Drive, San Jose, CA 95126-3900 • P(408) 241-8161 F(408) 241-8231
Email info@morgancenter.org • **Website** www.morgancenter.org



Dear Parent / Guardian / Conservator:

The State Department of Education requires that each student “receive, read, and understand” Ed Code Sections 200, 201, 212.5, 220, and 230 guidelines on sexual harassment. They will check our compliance with this in our Certification Review, which occurs annually.

Because our students are generally not able to meet this requirement, we may satisfy it by providing you with a copy of the policy as it pertains to students, and having you acknowledge that you have received it.

Please note: We are not asking you to share this information with your student/client. Just acknowledge that you have received it on their behalf.

Please sign the form below, detach and return to the Morgan Autism Center.

Thank you.

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I have received a copy of the State Department of Education Ed Code Sections 200, 201, 212.5, 220, and 230 guidelines on sexual harassment. I understand that the Morgan Autism Center adheres to this policy as it pertains to students/clients.

Parent’s/Guardian’s /Conservator’s Signature

Date

Student’s / Client’s Name

Please Print

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California Law – State Department of Education – Ed Code

ARTICLE 1. Declaration of Purpose [200 - 201]

(Article 1 added by Stats. 1982, Ch. 1117, Sec. 1)

200.

It is the policy of the State of California to afford all persons in public schools, regardless of their disability, gender, gender identity, gender expression, nationality, race or ethnicity, religion, sexual orientation, or any other characteristic that is contained in the definition of hate crimes set forth in Section 422.55 of the Penal Code, including immigration status, equal rights, and opportunities in the educational institutions of the state. The purpose of this chapter is to prohibit acts that are contrary to that policy and to provide remedies therefor.

(Amended by Stats. 2017, Ch. 493, Sec. 2. (AB 699) Effective January 1, 2018.)

201.

(a) All pupils have the right to participate fully in the educational process, free from discrimination and harassment.

(b) California's public schools have an affirmative obligation to combat racism, sexism, and other forms of bias, and a responsibility to provide equal educational opportunity.

(c) Harassment on school grounds directed at an individual on the basis of personal characteristics or status creates a hostile environment and jeopardizes equal educational opportunity as guaranteed by the California Constitution and the United States Constitution.

(d) There is an urgent need to prevent and respond to acts of hate violence and bias-related incidents that are occurring at an increasing rate in California's public schools.

(e) There is an urgent need to teach and inform pupils in the public schools about their rights, as guaranteed by the federal and state constitutions, in order to increase pupils' awareness and understanding of their rights and the rights of others, with the intention of promoting tolerance and sensitivity in public schools and in society as a means of responding to potential harassment and hate violence.

(f) It is the intent of the Legislature that each public school undertake educational activities to counter discriminatory incidents on school grounds and, within constitutional bounds, to minimize and eliminate a hostile environment on school grounds that impairs the access of pupils to equal educational opportunity.

(g) It is the intent of the Legislature that this chapter shall be interpreted as consistent with Article 9.5 (commencing with Section 11135) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code, Title VI of the federal Civil Rights Act of 1964 (42 U.S.C. Sec. 1981, et seq.), Title IX of the Education Amendments of 1972 (20 U.S.C. Sec. 1681, et seq.), Section 504 of the federal Rehabilitation Act of 1973 (29 U.S.C. Sec. 794(a)), the federal Individuals with Disabilities Education Act (20 U.S.C. Sec. 1400 et seq.), the federal Equal Educational Opportunities Act (20 U.S.C. Sec. 1701, et seq.), the Unruh Civil Rights Act (Secs. 51 to 53, incl., Civ. C.), and the Fair Employment and Housing Act (Pt. 2.8 (commencing with Sec. 12900), Div. 3, Gov. C.), except where this chapter may grant more protections or impose additional obligations, and that the remedies provided herein shall not be the exclusive remedies, but may be combined with remedies that may be provided by the above statutes.

(Added by renumbering Section 45 by Stats. 1998, Ch. 914, Sec. 5. Effective January 1, 1999.)

Article 2. Definitions

212.5.

“Sexual harassment” means unwelcome sexual advances, requests for sexual favors, and other verbal, visual, or physical conduct of a sexual nature, made by someone from or in the work or educational setting, under any of the following conditions:

- (a) Submission to the conduct is explicitly or implicitly made a term or a condition of an individual’s employment, academic status, or progress.
- (b) Submission to, or rejection of, the conduct by the individual is used as the basis of employment or academic decisions affecting the individual.
- (c) The conduct has the purpose or effect of having a negative impact upon the individual’s work or academic performance, or of creating an intimidating, hostile, or offensive work or educational environment.
- (d) Submission to, or rejection of, the conduct by the individual is used as the basis for any decision affecting the individual regarding benefits and services, honors, programs, or activities available at or through the educational institution.

(Amended by Stats. 1998, Ch. 914, Sec. 12. Effective January 1, 1999.)

Article 3. Prohibition of Discrimination

220.

No person shall be subjected to discrimination on the basis of disability, gender, gender identity, gender expression, nationality, race or ethnicity, religion, sexual orientation, or any other characteristic that is contained in the definition of hate crimes set forth in Section 422.55 of the Penal Code, including immigration status, in any program or activity conducted by an educational institution that receives, or benefits from, state financial assistance, or enrolls pupils who receive state student financial aid.

(Amended by Stats. 2017, Ch. 493, Sec. 3. (AB 699) Effective January 1, 2018.)

Article 4. Sex Equity in Education Act

230.

For purposes of this chapter, harassment and other discrimination on the basis of sex include, but are not limited to, the following practices:

- (a) On the basis of sex, exclusion of a person or persons from participation in, denial of the benefits of, or subjection to harassment or other discrimination in, any academic, extracurricular, research, occupational training, or other program or activity.
- (b) On the basis of sex, provision of different amounts or types of student financial aid, limitation of eligibility for student financial aid, or the application of different criteria to applicants for student financial aid or for participation in the provision of student financial aid by others. Nothing in this subdivision shall be construed to prohibit an educational institution from administering, or assisting in the administration of, scholarships, fellowships, or other forms of student financial aid, established pursuant to domestic or foreign wills, bequests, trusts, or similar legal instruments or by acts of a foreign government, which require that awards be made to members of a particular sex; provided, that the

overall effect of the award of these sex-restricted scholarships, fellowships, and other forms of student financial aid does not discriminate on the basis of sex.

(c) On the basis of sex, exclusion from participation in, or denial of equivalent opportunity in, athletic programs. For purposes of this subdivision, "equivalent" means equal or equal in effect.

(d) An educational institution may be found to have effectively accommodated the interests and abilities in athletics of both sexes within the meaning of Section 4922 of Title 5 of the California Code of Regulations as that section exists on January 1, 2003, using any one of the following tests:

(1) Whether interscholastic level participation opportunities for male and female pupils are provided in numbers substantially proportionate to their respective enrollments.

(2) Where the members of one sex have been and are underrepresented among interscholastic athletes, whether the school district can show a history and continuing practice of program expansion that is demonstrably responsive to the developing interest and abilities of the members of that sex.

(3) Where the members of one sex are underrepresented among interscholastic athletes, and the institution cannot show a history and continuing practice of program expansion as required in paragraph (2), whether the school district can demonstrate that the interest and abilities of the members of that sex have been fully and effectively accommodated by the present program.

(e) If an educational institution must cut its athletic budget, the educational institution shall do so consistently with its legal obligation to comply with both state and federal gender equity laws.

(f) It is the intent of the Legislature that the three-part test articulated in subdivision (d) be interpreted as it has been in the policies and regulations of the Office of Civil Rights in effect on January 1, 2003.

(g) On the basis of sex, harassment or other discrimination among persons, including, but not limited to, students and nonstudents, or academic and nonacademic personnel, in employment and the conditions thereof, except as it relates to a bona fide occupational qualification.

(h) On the basis of sex, the application of any rule concerning the actual or potential parental, family, or marital status of a person, or the exclusion of any person from any program or activity or employment because of pregnancy or related conditions.

(Amended by Stats. 2003, Ch. 660, Sec. 1. Effective January 1, 2004.)