ALIQUIPPA SCHOOL DISTRICT

Home of the Quips

REGISTER FOR ALERTS

Want to go to school online?

We've got that covered with our own online education program. Contact us today for more information.

Aliquippa Cyber Program
Grades: K-12
District Contact: Brandon Ledonne bledonne@quipsd.org

Beaver County Local Cyber Options

View text-based website

WANTO TO GO TO SCHOOL ONLINE?

Are you thinking about sending your child to a cyber school, well did you know that Aliquippa School District can provide you with that opportunity, right here?

The Aliquippa School District Cyber Program utilizes the platform Edgenuity to provide students with an online learning experience for their education. The Edgenuity program is available 24 hours a day, seven days a week and can be accessed via an Internet connection.

Aliquippa students will have the opportunity to be full-time cyber students. Our program offers the students the ability to work on their courses utilizing a flexible schedule.

Contact us today for more information.

Aliquippa Cyber Program

Grades K-12

District Contact: Brandon LeDonne at 724-857-7500 x 4011 or bledonne@quipsd.org.

ALIQUIPPA SCHOOL DISTRICT
CONFIDENTIAL

NEW/RETURNING STUDENT REGISTRATION FORM

Verification of residency, age and immunizations must be presented at time of enrollment

Student: ____
Last Name, First Name Middle Name Preferred First Name

Current Address: ____

Home Phone: ____________________ Cell Phone: ____________________

Proof of Residency: ____

Place of Birth: ______________ Date of Birth: ______________ Proof of Age: __________

Gender: Male ________ Female ________ Race: (Black, Non-White) (White, non-Hispanic) (Latino/Hispanic) (Asian/Pacific Islander) (Am. Indian/Alaskan Native) (Multi-Racial)

Father's Name: ______________________________ Place of Employment: ________________

Mother's Name: ______________________________ Place of Employment: ________________

Guardian's Name: ____________________________ Place of Employment: ________________

Marital Status of Parents: Married __________ Unmarried __________ Divorced __________ Separated __________

EMERGENCY CONTACT: ______________________________ Phone #: ________________
Person to contact if Parent or Guardian is unavailable /Relationship

Are you a Foster Parent to this child? Yes______ No______
Do the Biological Parents of the Foster Child live in the Aliquippa School District? Yes______ No______
Has the student ever attend Aliquippa School District? Yes______ No______

If yes, which Building: ____________________________________ Grade: __________

Name of the last school attended/if attended less than 6 weeks, what School District did child attend before

Name of School:

____

Phone #: ________________________________ Fax: ______________________________

Address:

____

Grade Student is Entering: ______________

Does this child have an IEP for Special Education Services?

(ES, LS, Speech/Language, Hearing or Gifted) Yes______ No______

Does this Child have a 504 Plan Yes______ No______

Does this Child receive English as a Second Language Services Yes______ No______

Date Family/Student moved into Aliquippa School District (Month:________Day:______Year:_______

DISTRICT USE

Date of Official Entry (Month: _________Day:__________Year:__________)

Grade: ______________ Homeroom: ____________________

Student ID#: ____________________ Bus/Walker: ____________________ Lunch Qualification: ______________

ALIQUIPPA SCHOOL DISTRICT

REQUEST FOR STUDENT RECORDS

ADMISSION FORM

TO: ____

____

____

PHONE: ____________________ FAX: ____________________

NAME OF STUDENT: ______________________________

DATE OF BIRTH: ______________________________

GRADE LEVEL: ______________________

PLEASE SEND A COPY OF THE RECORDS INDICATED:

_______ ACADEMIC _______ TEST SCORES _______ ATTENDANCE RECORDS

_______ 9TH GRADE ENTRY DATE _______ STATE ENTRY DATE _____IEP/ER _______ 504 PLAN

_______DISCIPLINE RECORDS _______PSYCHOLOGICAL EVAL ______ IMMUNINZATIONS

PLEASE INCLUDE PA SECURE ID#: ____________________

PLEASE SEND RECORDS TO:

RECORDS OFFICE

ALIQUIPPA SCHOOL DISTRICT
800 TWENTY FIRST STREET
ALIQUIPPA, PA 15001
PHONE: (724) 857-7500 EXT: 4170 FAX: (724) 857-7560

I HEREBY AUTHORIZE THE RELEASE OF THE RECORDS INDICATED:

____

PARENT/GUARDIAN SIGNATURE DATE

ALIQUIPPA SCHOOL DISTRICT
800 Twenty First Street
Aliquippa, PA 15001
(724) 857-7500

Request for Transfer of Disciplinary Records

To: ____ School District

Re: ____ Student's Name

Pursuant to Section 105-A of the Public School Code of 1949 as an amended by Act 26 of 1995, 24P.S.13-1305-A we are hereby requesting that a certified copy of the disciplinary record of the above names student to ALIQUIPPA SCHOOL DISTRICT.

This student is seeking to transfer from the above named school to the ALIQUIPPA SCHOOL DISTRICT.

Please provide the certified copy within ten (10) days upon your receipt of this request.

____

Records

ALIQUIPPA SCHOOL DISTRICT
800 Twenty-First Street
Aliquippa, PA 15001

Aliquippa School District Medical Information Authorization Form

In order to comply with Federal and State Laws, the Aliquippa School District requires that this form be completed in its entirety.

I authorize ____; to use/disclose the following Protected Health Information from the records of:

______________________________ ______________________
Individual/Student Name Birth Date

As described below to: Any other ASD staff member, including substitutes, who may be responsible for my child.

The information is requested for the purpose of informing any such staff member who may be responsible for my child of any serious medical conditions, allergies, medications and/or emergency contacts.

The information to be used/disclosed is identified as follows (please check all that apply):

______ Medical History & Physical Exams
______ Occupational Therapy
______ IEP
______ Discharge Summary/Instructions
______ Physician Orders
______ Psychiatric/Psychological Evaluations
______ Physical Therapy
______ ER's
______ Immunization Records
______ Verbal Information
______ Other (Please specify): Written communications via Action Plans or Student Information Cards

I understand the following:

- That the information used or disclosed may include records relating to my identity, diagnosis, prognosis and treatment.
- That the information used or disclosed may relate to psychiatric disorders, drug and/or alcohol use, AIDS and HIV, as the same are permitted by the Mental Health Procedures Act, the Confidentiality of Alcohol and Drug Abuse Individual Records Act, the Confidentiality of HIV-Related Information Act and the Privacy Rule of the Health Insurance Portability and Accountability Act;
- That I have the right to revoke this authorization at any time, except to the extent that Aliquippa School District has already acted in reliance on the Authorization and the such revocation must be made in writing and directed to the Privacy Officer, Superintendent, Dr. Peter M. Carbone.
- That the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer subject to privacy protections provided by law;
- That Aliquippa School District may not condition the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on whether I sign this Authorization, except as provided by law; and
- That if the Aliquippa School District seeks this Authorization for the use or disclosure of Protected Health Information, the district must provide me with a copy of the signed Authorization.

______________ ____________________________________
Date Signature of Individual/Student

______________ ____________________________________
Date Signature of Parent/Legal Guardian/Personal Representative

____
Print Name

____
Specify Relationship/Authority

ALIQUIPPA SCHOOL DISTRICT
SCHOOL NURSE
STUDENT INFORMATION SHEET

Student Name: ____ Teacher/Grade: ________

Home Address: ____

Parent/Guardian Name: ____

Who Does your Child Currently Live with? ____

Mother Phone #: (H) _______________ (W) ___________________ (C) _________________

Father Phone #: (H) _______________ (W) ___________________ (C) _________________

Email Address: ____

Person(s) to contact if Parent(s) aren't available:

Name: ____________________________________ Relationship: ______________________

Phone #: __________________________________

Name: ____________________________________ Relationship: ______________________

Phone #: __________________________________

Do we have your permission to call an ambulance in case of a serious injury/illness? Yes/No

Do you need information on how to obtain health insurance for your child? Yes/No

Is your child currently under Doctor's care? Yes/No
Reason under Dr.'s care: ____

Has your child ever hit his or her head, had a head injury, or told that he or she had a concussion?
Yes/No If yes, explain: ____

List any allergies or health problems: ____

Does your child take any medication? Yes/No
If yes, please list: ____

____

Do we have your permission to share medical information regarding your child with school personnel (Teachers, Administration, Counselors, Nurse and Psychologist)? Yes/No

If yes, please sign the attached Confidentiality HIPAA form.

DATE: __________ PARENT SIGNATURE: ______________________________________

PARENTAL REGISTRATION STATEMENT

Student Name: ____

Date of Birth: ________________________ Grade: ________________

Parent/Guardian Name: ____

Address: ____

Telephone Number: ____

> Pennsylvania School Code 13-1304-A states in part "prior to admission to any school entity, The parent/guardian or other person having control or charge of a student shall, upon Registration, provide a sworn statement or affirmation stating whether the pupil was previously or is presently suspended or expelled from any public or private school of this Commonwealth or any other state for an act of offense involving weapons, alcohol or drugs, or willful infection to another person or for any act of violence committed on School property.

Please complete the following:

I hereby swear or affirm that my child was __________ was not __________ previously suspended or expelled, or is __________ is not ___________ presently suspended from any public or private school of this Commonwealth or any other state for an act or offense involving weapons, school or drugs, or for the willful infliction of injury to another person or for any act of violence committed on school property. I make this statement subject to the penalties of 24 P.S. 12-1304-AS (b) and 18 PA C.S.A. 4904, relating to unworn falsification to authorities, and the facts contained herein are true and correct to the best of knowledge, information and belief.

If this student has been or is presently suspended or expelled from another school, please complete:

Name of the school from which student was suspended or expelled:

____

Date of suspension or expulsion: ____________________________________

Reason for suspension/expulsion (optional):

____

____

____
Signature of Parent or Guardian

____
Date

FERPA REQUEST FOR ACCESS

The following form is a Request for Access to be maintained in compliance with the Family Educational Rights and Privacy Act of 1974.

This form must be completed by the requesting party and the written consent of the parent or eligible student must be obtained prior to the disclosure of the information from a student's educational records, unless the disclosure is (1) parent or eligible student; (2) of directory information only, (3) an Aliquippa School District official with a legitimate educational interest including teachers, whom the District has determined to have legitimate educational interest; or (4) as otherwise permitted under 34 CFR Section 99.31.

____

Student Name and ID Number

____

Name/Title/Organization of the Person Requesting Information

____

Records/Information Requested

____

Legitimate Interest in Records/Information or Purpose

The party requesting such information is hereby notified that the Aliquippa School District discloses such information only upon the written authorization of the parent or eligible student, that such disclosure is made only on the condition that the party to whom the information is disclosed, will not disclose such information to any other party without the prior consent of the parent or eligible student and will only use such information for the specified purpose.

________ Parent or eligible student authorizes this disclosure.

________ Parent or eligible student does not authorize this disclosure.

______________________________ __________________

Signature of Student or Parent Date

Disclosed by: ____________________________________

Print Name and Title

Date of disclosure: ________________________

Requesting party must be notified not to release the information to anyone else unless permissible under FERA. Was such notice given in this case? Yes ______ No ______

This form is to be kept with the student's records

ALIQUIPPA SCHOOL DISTRICT
STUDENT INTERNET ACCOUNT ASSIGNMENT FORM
(Neighborhood Protection Law, 2001, requires that this be signed and returned BEFORE privileges are issued)

MUST READ & SIGN

Last Name: ______________________ First Name: ________________________

I am requesting Internet student user privilege. I have read the District's Acceptable Use Policy. I understood that should I commit any violation of the policy my access privileges may be revoked, school disciplinary action may be taken and/or appropriate legal action may be pursued in the context of School Board policies and the legal system.

______________________________ ______________________________
Student Signature Date

Students under the age of eighteen (18) must have the signature of a parent/guardian.

Parent/Guardian Permission Form

As the parent/guardian of the above named student, I have read the Acceptable Use Policy of the Aliquippa School District. I understand that access to and use of the network is designed for educational purposes and that the Aliquippa School District has taken some precautions to control access to controversial material. This is the responsibility of the student.

I give my permission to issue an account for my child.

______________________________ ______________________________
Parent/Guardian Signature Date

FOR SCHOOL USE ONLY**********************************

Username: ____

Date of Account Creation: ______________________________

Approved By: ______________________________________

ALIQUIPPA SCHOOL DISTRICT

HOME LANGUAGE SURVEY

The Civil Rights Law of 1964, Title VI requires that School District/Charter Schools identify limited English proficient (LEP) students, Pennsylvania has selected the Home Language Survey as the method of identification.

School District: Aliquippa Date: ________________

School: ____

Student's Name: ___________________________ Grade: ________________

1. What was the student's first language? ____________________________
2. Does the student speak a language other than English? _______________
   If yes, specify language______________________________________
   (Does not include languages learned in school)
3. What language(s) is/are spoken in your home? _______________________

Person completing this form (if other than parent/guardian): ______________________

Parent/Guardian Signature: ____

*The School District/Charter School has the responsibility under the Federal Law to serve students who are limited to English proficient and need English instructional services. Given this responsibility, the School District/Charter School has the right to Ask for the information it needs to identify English language Learners (ELLs). As part of the responsibility to locate and identify (ELLs), the School District/Charter School may conduct screening or ask for information about students who are already enrolled in the District as well as from students who enroll in School District/Charter School in the future.

ATTN: PARENT/GUARDIAN

ALIQUIPPA SCHOOL DISTRICT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

OF PRIVACY PRACTICE

The Aliquippa School District is required by law to maintain the privacy of certain information. You are required to sign the attached form and return the signature page to:

Aliquippa School District School

ATTN: Suprena Sheppard

800 Twenty First Street

Aliquippa, PA 15001

Copy of this acknowledgement will be kept in your child's personal file. If you have any questions, please contact the Central Registration Office at (724) 857-7500.

Thank you,

Dr. Phillip K. Woods
Aliquippa School District
Superintendent of Schools
100 Harding Avenue
Aliquippa, PA 15001
Email: pwoods@quipsd.org
Cell: (412) 816-7912

Phone: (724) 857-7500 ext. 1100

Dear Parent/Guardian:

Enclosed please find the ASD Notice of Privacy Practices, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), ASD is required to provide each of our students with such notice and to make a good faith effort to obtain the written Acknowledgement of receipt of such notice.
Please complete and sign the enclosed ASD Acknowledgement of Receipt of Notice of Privacy Practice Form and have your child return it to his/her Homeroom Teacher. The ASD Notice of Privacy Practices is for you to keep.

Thank you for your assistance. We greatly appreciate your cooperation.

Sincerely,

Dr. Phillip K. Woods
Aliquippa School District
Superintendent of Schools
100 Harding Avenue
Aliquippa, PA 15001
Email: pwoods@quipsd.org
Cell: (412) 816-7912

Phone: (724) 857-7500 ext. 1100

ALIQUIPPA SCHOOL DISTRICT
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
OF PRIVACY PRACTICE

I hereby acknowledge that I have received a copy of Aliquippa School District's Notice of Privacy Practices.

____
Date

____
Signature of Parent/Guardian or Other Representative

____
Print Name of Student

ALIQUIPPA SCHOOL DISTRICT
NOTICE OF PRIVACY PRACTICES

Aliquippa School District ("ASD") is committed to protecting the privacy of our students. We take very seriously our obligation to maintain the privacy of healthcare information that is shared with us confidential and secure. The terms "you" and "your" used throughout this Notice refer to the individual student to whom the healthcare information pertains.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW IT CAREFULLY

Purpose of this Notice. ASD is required by law to maintain the privacy of certain Healthcare information, known as Protected Health Information or "PHI" PHI may include your child's name, address, and other indentifying data or information on your child's health or the health services that have been or may be furnished to your child. ASD is also required to provide your child with a notice of its legal duties and privacy practices regarding your child's PHI and to abide by the terms of this notice currently in effect. This notice describes ASD's privacy practices, lets you know when the district is permitted to use and disclose your child's PHI and advises you of your rights. ADS requires that all of its employees, staff, and independent contractors comply with these privacy practices.

Use and Disclosure of PHI for Treatment, Payment and Health Care Operations. By law, ASD is permitted to use and disclose PHI for treatment. Payment and health care operations in most cases, without your permission for the following reasons:

1. **Treatment** generally means the care and services provided by doctors, hospitals and other healthcare providers. ASD at times, performs various functions which make it a healthcare provider, for example: state mandated physicals, dental exams, or hearing tests; distribution of first aid and medication; athletic training or conditioning; occupational or physical therapy; student assistance; or psychological counseling services. When we perform such healthcare services or the related assessment, referral or support activities, either directly or through a third party, we are permitted to obtain, use and disclose verbal and written information about you and regarding your medical condition. This includes PHI received or treatment by phone, fax, written, electronic or other means.
2. **Payment** means any activities that ASD must take in order to get reimbursed for services we provide to you and includes: organizing your PHI; verifying, eligibility for services; coordinating benefits; submitting bill or accessing available funding for such services, either directly or through a third party. For example, ASD seeks funding for payments from various federal and /or state programs for some health related services provided to our students.
3. **Health Care Operations** means activities undertaken by ASD that are required for its operation. Such activities may be performed by ASD or in some instances by a third party. These activities may include: quality assessment and improvement activities; credentialing and licensing; training programs; and other management, legal or financial services. For example, ASD evaluates staff performance to ensure that our policies and procedures are followed for internal reviews.

Reminders, Information and Fundraising ASD may contact you to remind you of scheduled appointments for healthcare related services, to notify you about other services we provide or health-related benefits and services that may be of interest to you. For example, mandated student physicals, dental exams or athletic training events.

Use and Disclosure of PHI Without Your Authorization. Under certain circumstances, ASD may use or disclose your child's medical information without your written authorization or other permission, or your opportunity to object. These circumstances are as follows:

1. In treatment situations by receiving and disclosing medical and identifying information about your child via telephone, written, electronic or other oral means; communicating with the appropriate parties and completing and filing the required written documentation regarding treatment.
2. In treatment situations, for our use in order to treat your child, to obtain payment for services provided to your child, or for other health care operations.
3. To another health care provider for the treatment activities of that provider.
4. To another health care provider or entity for payment activities of that provider or entity.
5. To another health care provider or entity for the health care operations of that provider or entity if provider receiving the information has or had a relationship with your child and the PHI pertains to that relationship.
6. To a family member, relative, friend or other individual involved in your child's care, or for disaster relief. ASD may provide medical information about your child to such individuals if we obtain your verbal agreement, if we give you an opportunity to object to such disclosure and you do not object, or if we infer from the circumstances that you would not object. When we are not able to obtain your agreement or because you are not immediately present, we will use our professional judgment to determine whether it is in your child's best interest to disclose such information to a family member, relative, friend or other individual involved in your child's care. Only health information relevant to that person's involvement with your child's care will be disclosed. For example, we may inform the person whom you list as an emergency contact for your child in emergency or health related situations involving your child.
7. As required by law. Numerous state, federal and local laws permit or require certain uses and disclosures of medical information. In such cases, ASD may only use or disclose your child's medical information to the extent authorized by law.
8. To a public health authority. ASD may be asked to required by law to disclose medical information to a public health authority under the following circumstances:
    a. To report a birth, death, disease or injury;
    b. As part of a public health investigation;
    c. To report child or adult abuse or neglect, or domestic violence;
    d. To report adverse events such as product defects, to tract products or assist in product recalls or repairs or replacements, or to conduct post-marketing surveillance as required by the Food and Drug Administration; and
    e. To notify a person about exposure to a possible communicable disease.
9. For health oversight activities including: audits, government investigation, inspections, disciplinary proceedings and other administrative and judicial actions undertaken by the government or its contractors by law to oversee the health care system;
10. For health care fraud and abuse detection or compliance related activities.
11. For judicial and administrative proceedings. ASD may disclose medical information as required by a court administrative order or in some cases pursuant to subpoena, discovery request or other legal process.
12. To law enforcement. Police and other law enforcement may seek medical information from ASD. We may release this information to law enforcement under limited circumstances, such as when the request is accompanied by a warrant, or when law enforcement needs specific information to locate a suspect or to stop a crime.
13. To coroners, medical examiners and funeral directors. ASD may release information regarding a decedent to such persons as authorized by law or in order to identify the deceased, determine cause of death, or carry out other duties.
14. For organ, eye and tissue donation. ASD may release medical information to organ, eye and tissue procurement organizations and similar entities in order to facilitate such types of donation, if applicable.
15. For research purposes. ASD may be approached by researchers to provide medical information for research purposes, such as tracking a particular condition. We may provide medical information to a researcher if the researcher has obtained a special waiver from a committee established under federal law to oversee medical research to allow the researcher to not have to obtain the individual's permission prior to

16. collecting the information. Also, the researcher must demonstrate that the information is necessary to the research and poses a minimal risk of an inappropriate use or disclosure. If the researcher does not obtain the waiver, then ASD may not disclose the information without your Authorization.
17. To avert a serious threat to health and safety. ASD may use or disclose your child's medical information to avert a serious and imminent threat to an individual or the public's health and safety.
18. For military and other specialized governmental functions. Medical information may be disclosed for military, defense, national security, intelligence or correctional activities.
19. For workers' compensation. ASD may share medical information regarding work related illness and injuries in order to comply with workers' compensation laws.
20. In a manner that does not personally identify your child.

Any other use or disclosure of PHI, except those listed above will only be made by ASD after receiving a written authorization for your child. An Authorization is a written document that must specifically identify the information that we seek to use or disclose and when and how we seek or disclose it. You may revoke an Authorization at any time, in writing, except to the extent we have already used or disclosed medical information in reliance on your Authorization.

Individual Rights. You have a number of rights with respect to your child's PHI. Such rights are as follow:
1.Restrictions. You have the right to restrict how we use and disclose your child's medical information that we have for treatment, payment or health care operations purposes, or restrict the information provided to family, friends and other individuals involved in your child's health care. However, we do not have to agree to any restrictions, but if we do, we will abide by our agreement unless the information is needed in order to provide your child with emergency treatment. For example, if you request a restriction on information that is needed to provide your child with emergency treatment, then we may use information and disclose it to a health care provider so that they may provide your child with emergency treatment. Any restrictions must be agreed to in writing by ASD. Please contact the Privacy Officer listed at the end of this notice if you wish to request a restriction.
2. Confidential Communications. You have the right to request that ASD reasonably accommodate you the way in which we communicate to you involving your child's health , health care or payment. For example, you may ask that we communicate with you only at your home. If we receive such a request in writing, we will do our best to reasonably accommodate such request.
3. Access. You have the right to review your child's educational records as defined under the Family Educational Rights and Privacy Act (FERPA). FERPA controls the privacy of information entered into a student's record, including health related information. However, there may be instances where health information is not entered into the student's educational record by school personnel or is not considered a part of the educational record and in such cases, FERPA does not apply and HIPAA does. Under HIPAA, you have the right to inspect and copy most of your child's medical information maintained by ASD under HIPAA. We have forms available for you to use to request access to your child's PHI. Normally, we will provide you with access within 30 days of your request. We may charge you a reasonable copying fee. In limited cases, we may deny you access to your child's medical information. You may appeal certain types of denials. If we deny access, we will provide you with a written response and inform you about your appeal rights. Please contact the Privacy Officer listed at the end of this notice if you wish to inspect and copy your child's medical information maintained under HIPAA.
4. Amendment. You have the right to ask ASD to amend written medical information that we may have about your child under HIPAA. For example, you can request that we correct incorrect information in your records. We will generally amend your information within 60 days of your request and will notify you when we have amended your child's information. We are permitted by law to deny your request to amend only in certain circumstances, such as when we believe that the information that you have asked us to amend is accurate and complete. You can appeal our denial of your request to amend the written medical information. Please contact the Privacy Officer listed at the end of this notice to request an amendment to your child's medical information.
5. Accounting. You have the right to request an accounting from ASD of certain disclosure of your child's PHI made by us during the last six (6) years prior to the date of your request after April 14, 2004. We will generally provide you with an accounting within 60 days of your request. We are not required to give you an accounting of information that we have used or disclosed or treatment, payment or health care

operations, or when we share your child's PHI with our business associates. We are also not required to give you an accounting of PHI for which you have already provided us with a written authorization. Please contact the Privacy Officer listed at the end of this notice if you wish to request an accounting of your child's medical information that we have used or disclosed, which is not exempt from the accounting requirement.

6. Electronic and Paper Notice. We currently maintain a web site that provides information about our school district. ASD is required to prominently post its Notice of Privacy Practices on such web site and to make the notice available electronically through the web site. If you have obtained this Notice electronically, you may obtain a paper copy by requesting such notice from the Privacy Officer listed below. ASD's Web site is found at www.aliquippa.k12.pa.us.

7. Complaints. You may complain to ASD, or the Secretary of the United States Department of Health and Human Services if you believe that your privacy rights have been violated. Under no circumstances will ASD take and retaliation against your child for filing a complaint. If you have any questions, comments or complaints, please contact the Privacy Officer listed below.

Revision to Privacy Notice . ASD reserves the right to change the terms of this Notice at any time. Any revised Notice will be promptly posted at the Administration Offices and also posted to our web site, if we maintain a web site at the time of such revision and available at the Administration Offices for you to request a copy. We also reserve the right to make the new Notice provisions effective for all PHI that we maintain.

Privacy Notice/Compliance Contract Officer. If you any questions or comments or if you wish to file a complaint or exercise any of your individual rights listed in this Notice, please contact:

Dr. Peter M. Carbone, Ed.D.
Superintendent of Schools
800 Twenty First Street
Aliquippa, PA 15001
(724)857-7500

Effective Date. The effective date of this Notice of Privacy Practice is April 14, 2004.