Morgan Autism CENTER

Dear Morgan Autism Center Adult Program Parents, Caregivers, and Group Home Staff,

Our 2026-2027 Adult Program will begin on **Wednesday, July 1, 2026**!

Please read through the following packet carefully and note important dates on your calendar. **Please make a special note of the staff in-service training days scheduled at which time clients will be dismissed at 12:15 p.m.**

It is critically important to complete these yearly forms promptly to ensure a seamless return to campus activity and to meet California Department of Social Services requirements. **All completed forms should be returned to the office by Tuesday, July 7th.** The forms in this packet are essential for your client's continued placement at Morgan Autism Center.

Absences:
When a client is absent for any reason, please **call the office to report the absence**. We will notify the Adult Program staff for you. If you need to speak with the AP directors, please reach out to them as well. **In addition, please notify any transportation services as early as possible to alert them of the absence so they may cancel the ride.**

"Day off/Vacation" policy:
Clients will have up to 10 days off per year for planned vacation days. Any sick days or doctor's visits will not count toward this total of 10 vacation days. We ask that families provide us as much notice as possible but not less than two weeks for planned vacation days. The 10 vacation days will not roll over from year-to-year. We ask families to contribute $130.80 per day for every vacation day in excess of 10 vacation days during a single program year.

Attendance:
If a client is absent for any reason, the absence is considered unexcused and we will not be able to bill regional centers for any dates the client is absent. Your client's attendance is what pays for our staff's salaries and other operating costs. Please help us minimize the financial impact of absences by limiting absences to illness/emergencies.

Please try to schedule medical and dental appointments after program hours, or bring your client to program before or after the appointment.

Please also try to schedule family vacations and camps to coincide with the Morgan Autism Center calendar vacation days if possible. The calendar may be viewed on the Morgan Autism Center's website, **www.morgancenter.org.** You can also find a copy of the calendar in this packet.

Transportation: Transportation is set up and managed through the Regional Center's Transportation Broker, R&D Transportation. Please contact the appropriate office for any changes or feedback you may have regarding your client's transportation service.
custserv@rdtsi.com
GGRC (800) 966-7114
SARC area (888) 850-2988

Parent/Physician Authorizations to Medicate & Earthquake/Emergency Medication:
If your client requires any medication (prescription or over-the-counter) to be administered during program hours, you are required to fill out **both Parent and Physician Authorization Forms** before we can do so. In addition, if you will be providing a 3-day supply of medications in the event of an earthquake or emergency that prevents clients/staff from leaving the property for an extended time, you will also be required to fill out the **Earthquake/Emergency Medication Form**. Please refer to the specific forms for more details.

Physician's Report for Community Care Facilities:
The California Department of Social Services *requires* that this physician's report be updated every year by your client's physician. This may take some time to schedule an appointment and wait for the physician to fill it out and return it to you. Please schedule a doctor's visit for your client as soon as possible to help expedite this process. In addition, the DSS also requires that all clients complete a **TB test every 4 years**. If your client's previous test will expire during this upcoming program year, please request another TB test to be done by your physician. Please include any documentation of the test result along with the physician's report form.

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 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.

We are looking forward to an exciting and productive year full of growth and progress! We will see everyone on **Wednesday, July 1, 2026!**

Morgan Autism CENTER

Contact Information

Main Office: (408) 241-8161 • 950 St. Elizabeth Drive, San Jose, CA 95126

Name	Title	Contact About	Email
Josh Drake	Executive Director	Morgan Autism Center	jdrake@morgancenter.org
Mark Nielsen	Program Director	School Program, Post Secondary	mnielsen@morgancenter.org
Hailey Barker	Program Director	School Program, Post Secondary	hbarker@morgancenter.org
Sun Garcia	Program Director/Consultant	School Program, Post Secondary, District Referrals, Behavior Strategies Team	sgarcia@morgancenter.org
Leslie Davis	New Programs Director	New Programs	ldavis@morgancenter.org
Claudine Pitpitan	Program Coach	School Program Resources	cpitpitan@morgancenter.org
Jen Gray	AST Program Director/ BCBA	AST Program	jgray@morgancenter.org
Aya Sasaki	Adult Program Director	Adult Program	asasaki@morgancenter.org
Sara Cedano	Adult Program Director	Adult Program	scedano@morgancenter.org
Jess Moses	AST Program Director	AST Program	jmoses@morgancenter.org
Christy McCue-Risner	Assistant Coordinator	School Program IEP Scheduling, Assists School Program Directors	cmccuerisner@morgancenter.org
Hannah Sepulveda	Adult Program Administrative Assistant	Assists AP/AST Directors, IPP Scheduling, AP Transportation	hasepulveda@morgancenter.org
Lisa Lemke	Director of Administration	Parent Group	llemke@morgancenter.org
Robert Freiri	Director of Development	Donations, Grants, Fundraising	rfreiri@morgancenter.org
Haley Aceves	Development & Communications Manager	Donations, Fundraising	haceves@morgancenter.org
Nicole Ferguson	Administrative Specialist	School /Adult Program Records, School Program Transportation	nferguson@morgancenter.org
Ching Young	Administrative Associate	Office Support	cyoung@morgancenter.org

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2026 - 2027 Adult Program Calendar

July '26

Su	M	Tu	W	Th	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

August '26

Su	M	Tu	W	Th	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

September '26

Su	M	Tu	W	Th	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

October '26

Su	M	Tu	W	Th	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

November '26

Su	M	Tu	W	Th	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

December '26

Su	M	Tu	W	Th	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

January '27

Su	M	Tu	W	Th	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

February '27

Su	M	Tu	W	Th	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28						

March '27

Su	M	Tu	W	Th	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

April '27

Su	M	Tu	W	Th	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

May '27

Su	M	Tu	W	Th	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

June '27

Su	M	Tu	W	Th	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

Program Break/Holidays

Staff Inservice/Minimum Day (12:15 pm dismissal)

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2026 - 2027 ADULT PROGRAM CALENDAR

First Day of 2026-2027 Program Year (12:15 pm dismissal)	**July 1, 2026**
Fourth of July Holiday (observed)	July 2 - 6
Staff Inservice/Minimum Day (12:15 pm dismissal)	**August 5**
Labor Day Holiday	September 7
Staff Inservice/Minimum Day (12:15 pm dismissal)	**September 2**
Staff Inservice/Minimum Day (12:15 pm dismissal)	**October 7**
Indigenous Peoples' Day Holiday	October 12
Staff Inservice/Minimum Day (12:15 pm dismissal)	**November 4**
Veterans' Day Holiday	November 11
Thanksgiving Vacation	November 26 & 27
Staff Inservice/Minimum Day (12:15 pm dismissal)	**December 2**
Winter Break	Dec 21 - Jan 1, 2027
Staff Inservice/Minimum Day (12:15 pm dismissal)	**January 6, 2027**
Martin Luther King, Jr. Holiday	January 18
Staff Inservice/Minimum Day (12:15 pm dismissal)	**February 3**
Presidents' Day Holiday	February 15
Staff Inservice/Minimum Day (12:15 pm dismissal)	**March 3**
Adult Program Closure	March 15
Staff Inservice/Minimum Day (12:15 pm dismissal)	**April 7**
Adult Program Closure	April 12
Staff Inservice/Minimum Day (12:15 pm dismissal)	**May 5**
Memorial Day Holiday	May 31
Staff Inservice/Minimum Day (12:15 pm dismissal)	**June 2**
Juneteenth Holiday (observed)	June 18
First Day of 2027-2028 Program Year	**July 1, 2027**

Program Days Per Month

July	20	January	19
August	21	February	19
September	21	March	22
October	21	April	21
November	18	May	20
December	14	June	21

Total Program Days: 237

Adult Program Hours

Daily Hours
8:45 am - 2:45 pm

Minimum Days
8:45 am - 12:15 pm

For client absences, please notify the office at (408) 241-8161 ASAP

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Emergency Information Form

Last Name | First Name | M.I. | D.O.B. | Room/Program

ADDRESS:

PHONE:

Modified

CONSERVED: ☐ Yes

CONSERVATOR[S]:

Father's Name

Phone Type | Phone Number

email

Mother's Name

Phone Type | Phone Number

email

EmergencyContact | Relationship | Emergency Phone Numbers

Doctor/ Dentist | Doctor's Phone # | Meds (with Dosage and Time)

EmergencyCardComments (Diagnosis, Seizure Info, Allergies, Diagnosis, Choking, Shunt, Heart, etc.)

Preferred Hospital | Insurance | Policy # | MediCal

Group Home | Group #

Plan Code

Group HomeAddress | City | State | Zip

Phone | Contact

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

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Earthquake/Emergency Medication/Transport Form

I hereby give my permission for Morgan Autism Center staff to give my student/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/program only in the original container, labeled by the pharmacist. A new prescription bottle must accompany prescription changes.

Name of Student/Client: _____

Parent(s): _____

Medication: _____

Daily Dosage: _____

Prescription Number: _____

Physician: _____

Pharmacy: _____

Emergency Medical Care -and- Transportation Permission

In the event of an emergency, I hereby authorize Morgan Autism Center personnel to obtain medical help for my child.

Parent/Guardian Signature: _____ Date: _____

I hereby authorize Morgan Autism Center personnel to provide transportation for my child to and from activities related to school programming.

Parent/Guardian Signature: _____ Date: _____

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Seizure Protocol

Date: _____ Age: _____

Name: _____

Preferred Hospital: _____

Preferred Doctor: _____

Please call 911 if seizure continues beyond _____ minutes following this specific presentation:

_____

_____

_____

_____

Current Medication	Dosage	Last Change

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

Consciousness:

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

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Activity:

☐ Repetition or pointless movements or actions ☐ Clenching or grinding teeth ☐ Staring into space ☐ Rapid blinking ☐ Vomiting	☐ Jerking of arms and legs or whole body ☐ Mild twitching and/or twitching or jerking of only one body part ☐ Trembling, shaking	☐ Drooling ☐ Falls - rigid ☐ Falls - limp ☐ Other: _____ _____ _____ _____

Appearance:	**Breathing:**	**Verbalizations:**
☐ Normal ☐ Pale skin ☐ Flushed cheeks ☐ Turns blue ☐ Sweaty ☐ Blank look on face	☐ Normal ☐ Rapid ☐ Irregular ☐ Stops breathing ☐ Chokes	☐ Odd sounds ☐ Screams ☐ Smacks lips ☐ Makes odd or incoherent statements or requests

Post-Seizure:

Communication with parents/guardian:

☐ Immediately after every case
☐ Only if unusual
☐ Only if 911 is called

Is the person generally confused after a seizure?

_____

Does the person need to sleep?

_____

Additional Information:

_____

_____

_____

_____

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Parent Authorization to Medicate at School

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 _____

PRESCRIPTION MEDICATION	DOSAGE	TIME

OVER THE COUNTER MEDICATION	DOSAGE	TIME

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 above to exchange any information needed concerning my child.

Parent/Guardian Signature _____ Date _____

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Physician Authorization to Medicate at School

Student/Client: _____

Medical Record Number: _____

Medical Facility (Kaiser, PAMF, etc.): _____

PRESCRIPTION MEDICATION	DOSAGE	TIME

OVER THE COUNTER MEDICATION	DOSAGE	TIME

_____ _____

Physician Signature Date

Physician's Stamp:

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Client TB Test Requirement

All clients attending Morgan Autism Center are required to complete a TB Test every 4 years.

If your adult client's TB results will expire at some point during this upcoming program year, please make sure to have one performed. If it will not expire during this program year, it does not need to be renewed yet.

Please make sure to update TB test results on **Morgan Autism Center's Physician's Report Form** and provide us with the current TB documentation. We are unable to accept copies of Group Home Physician's Report forms. Please use the Morgan Autism Center Physician's Report form included in this packet.

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 STREET: 950 St. Elizabeth Drive | CITY: San Jose , CA 95126

LICENSEE'S NAME: Josh Drake | 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? ☐ YES ☐ NO

TUBERCULOSIS EXAMINATION RESULTS: ☐ ACTIVE ☐ INACTIVE ☐ NONE | DATE OF LAST TB TEST:

TYPE OF TB TEST USED: | TREATMENT/MEDICATION: ☐ YES ☐ NO If YES, list below:

OTHER CONTAGIOUS/INFECTIOUS DISEASES:
A) ☐ YES ☐ NO If YES, list below:

TREATMENT/MEDICATION:
B) ☐ YES ☐ NO If YES, list below:

ALLERGIES
C) ☐ YES ☐ NO If YES, list below:

TREATMENT/MEDICATION:
D) ☐ YES ☐ 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: ☐ GOOD ☐ FAIR ☐ POOR	COMMENTS:			
	YES (Check One)	NO (Check One)	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: ☐ GOOD ☐ FAIR ☐ 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: ☐ YES ☐ NO	COMMENTS:		
	YES (Check One)	NO (Check One)	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	OVER-THE-COUNTER MEDICATION(S)
1. Headache	
2. Constipation	
3. Diarrhea	
4. Indigestion	
5. Others *(specify condition)*	

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

1.	4.	7.
2.	5.	8.
3.	6.	9.

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:

Morgan Autism CENTER

Parent/Caregiver Accessibility Acknowledgement

At times it is necessary for staff to contact parents/caregivers or group homes during the day. These calls are usually related to a student/client's well-being and therefore may need to be picked up from program. It is very important that a parent/caregiver be available to talk to us and respond to the student's/client's needs as required. Below, please provide the best contacts for Morgan Autism Center staff to contact during program hours.

Contact 1

Name: _____

Cell Number: _____

Home Phone: _____

Work Phone: _____

Contact 2

Name: _____

Cell Number: _____

Home Phone: _____

Work Phone: _____

Morgan Autism CENTER

Morgan Autism Center Peanut Policy

For All Students, Clients, and Staff

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 throughout our shared environment we have adopted the following 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 unopened. This policy only applies to peanuts and peanut products. *All other nuts are fine to bring to program unless communicated otherwise.*

We request full cooperation and apologize for any inconvenience.

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

_____

Student/Client Name (please print)

_____ _____

Parent/Guardian Signature Date

Morgan Autism CENTER

Morgan Autism Center
Student/Client Activity Fund Donation
Program Year 2026-2027

Every program year, teachers and staff plan activities that may require extra funds. Each room's activity fund covers the special activities (birthday present, holiday gift, field trips, etc.) for each individual student/client throughout the year. You are welcome to send in a check along with this form or you may make your donation through our website at **www.morgancenter.org**.

- Click on "Give Now"
- Specify the amount you'd like to contribute
- Select either "Adult Program Activity Fee" or "School Program Activity Fee" in the dropdown menu
- In the comments section at the bottom of the page, please specify the room and student/client name that the donation is intended for.

Please check donation type below.

☐ Online Donation ☐ Check Enclosed ☐ Donation not at this time

Please consider a donation of at least $150.00

_____ _____

Student/Client Name (Print) Date

Thank you!

For office use only:

Check # _____ Amount $ _____

Online Donation Amount $ _____

Date Received: _____

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Media Consent and Release Form

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

MORGAN AUTISM CENTER'S USE OF PHOTOGRAPHS/VIDEO INCLUDES:
Promotional/fundraising material, newsletters, greeting cards, MAC website, and authorized media such as TV, newspaper, or magazine.

SOCIAL MEDIA:
Facebook, X, Instagram, LinkedIn, YouTube, Vimeo, and any future social media channels.

Morgan Autism Center may use my student's/client's image for any media outlined above.

☐ **YES** ☐ **NO**

Identification (if yes):

☐ **First Name Only** ☐ **Full Name**

YEARBOOK MEDIA CONSENT: Morgan Autism Center may use my student's/client's image for the Morgan Autism Center school program/adult program yearbooks. Yearbooks are sold only to MAC families and staff.
Morgan Autism Center may use my student's/client's image for the MAC Yearbook.

☐ **YES** ☐ **NO**

1. I am aware that I will not receive monetary compensation for my student's/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.

_____
Student/Client Name (print)

_____
Parent/Guardian Name (print)

_____ _____
Parent/Guardian Signature Date

Please complete this form and return to the Morgan Autism Center Office. For more information, contact the office at (408) 241-8161. Thank you for your cooperation.

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Phone Calls During Program Hours

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/AST Program if it is an emergency as Aya, Sara, Jen, and Jess are busy with running the Programs, 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 (asasaki@morgancenter.org), Sara (scedano@morgancenter.org), Jennifer (jgray@morgancenter.org), or Jess Moses (jmoses@morgancenter.org) an email and we will make sure to check our emails before 8:30 AM and again between 2:30-3:30 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/Jen/Jess, 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

Sara Cedano
Adult Program Director

Jen Gray
AST Program Director

Jess Moses
AST Program Director

Morgan Autism CENTER

Adult Program Lunch

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

1) **Please provide utensils (reusable utensils preferred).**

2) Please pre-cut any large pieces if the client is unable to do it themselves.

3) Please provide your own 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, Jen Gray, and Jess Moses

Morgan Autism
CENTER

Procedure for Pick Up of Sick or Injured Student/Client

1. A parent (or guardian/conservator) will always be called first and notified of illness or injury of a student/client.

2. Other identified emergency contact will be called in the event the parent or conservator cannot be reached.

3. If parent, conservator, or emergency contact cannot provide transportation to pick up student/client, the Morgan Autism Center will request, if appropriate for student/client, that taxi transportation be provided, at the parent's expense.

4. If a student/client is sick or injured, and no means of transportation home is provided by the parent or conservator, the Morgan Autism Center reserves the right, in extreme cases, and as a last resort, to engage the services of the Sheriff's Department for transportation of the student / client to a County Protective Shelter.

5. If a student/client is seriously ill or injured, creating an emergency situation requiring immediate medical care, an ambulance will be called to transport the student/client to the nearest medical facility, at the parent's expense.

It is imperative that the Morgan Autism Center has the correct numbers and persons to contact in the event of an emergency, injury, or illness. Please be sure that transportation is always available at your emergency numbers.

We implore your help and cooperation in this matter for the protection and safety of your child/client.

Morgan Autism CENTER

Student/Client Illness Policy

Health and education laws in California require that children be excluded from the school/program when they have any communicable illness. Consequently, it is essential for parents/caregivers to have alternative arrangements for care available on those inevitable days when students/clients are ill.

Please see the following guidelines regarding an estimate of the average length of time that specific conditions may be communicable. We hope this information will be helpful to you.

1. **FRESH COLDS:** Since it is impossible to clinically determine the specific virus causing a cold and since the period of infectiousness from different cold viruses vary, the safest course of action is to wait until your student's/client's active coughing, sneezing, and nasal drip are substantially gone, and fever has not occurred for at **least 24 hours.** This is typically on the order of 3 days after a new cold has begun.

2. **BACTERIAL CONJUNCTIVITIS (PINK EYE):** After 24-hours of antibiotic treatment has started, bacterial conjunctivitis is not generally communicable. There is, however, a second type of conjunctivitis associated with a viral infection in epidemic form that is highly contagious for several days. Please seek the advice and consultation of your medical advisor before returning a student/client who is ill with conjunctivitis.

3. **STREP THROAT:** 24-hours after antibiotic treatment has started, an individual is no longer considered communicable. However, it is important to note that even though he/she may not be infectious, he/she often does not feel well enough to return to school after the 24-hour period. Also, the student's/client's vigor should be taken into consideration.

4. **FEVER:** Following any infection associated with a fever over 100 degrees (according to the Santa Clara County Office of Education) a student/client **should remain at home until he/she has been fever-free for at least 24 hours without the aid of medication.** During the early morning hours, a fever will often register as normal, whereas later in the afternoon the temperature may rise again. This is one reason why it is extremely important to give him/her at least a 24-hour period when he/she is completely free from elevated temperature before returning him/her to school.

5. **VOMITTING AND DIARRHEA:** If a student/client vomits or has diarrhea at school, he/she needs to go home immediately. Students/clients who have been suffering from vomiting or diarrhea should be given a period of time to regain strength before returning to school. Students/clients may return after they have been vomit/diarrhea free for at least 24-hours.

6. **LINGERING COUGHS:** It is important that lingering coughs associated with cystic fibrosis, following pneumonia or bronchitis, or associated with allergy are not contagious. Therefore, families should be sensitive to the cause of the coughing that their student/client is experiencing in order to decide whether or not school/program attendance is wise.

7. **SKIN RASHES:** Students with rashes of unknown origin or contagious skin rashes **(such as ringworm, impetigo, hand-foot-mouth disease, or scabies)** must obtain clearance from a healthcare provider before returning to school. They may return after **at least 24 hours** on prescribed treatment, though this period may be extended based on the physician's advice.

8. **LICE:** The Morgan Autism Center adheres to a "no nit" policy with regard to head lice. Students with lice will be sent home and can return when treatment t is complete and the student is nit-free.

Morgan Autism
CENTER

Annual Rights, Safety, and Reporting Acknowledgment

Our Commitment to Participant Rights, Safety, and Dignity

At Morgan Autism Center Adult Program - AP and AST, we are committed to providing a safe, respectful, inclusive, and supportive environment for all participants. Every individual receiving services has the right to be treated with dignity, respect, and freedom from abuse, neglect, exploitation, harassment, discrimination, retaliation, intimidation, or humiliation.

The program maintains a zero-tolerance policy regarding abuse, neglect, exploitation, sexual harassment, sexual misconduct, bullying, and any conduct that compromises the health, safety, or personal rights of participants.

Sexual Harassment Prevention, Abuse Prevention, and Mandated Reporting Notice

Program Participant Name: _____

Parent/Guardian/Conservator/Caregiver Name: _____

Program Year: _____

Sexual Harassment Prevention

Sexual harassment is prohibited in all program settings. Sexual harassment may include, but is not limited to:

- Unwelcome sexual comments or jokes.
- Sexual gestures or inappropriate touching.
- Requests for sexual favors.
- Displaying sexually explicit materials.
- Repeated unwanted attention of a sexual nature.
- Any behavior that creates an intimidating, hostile, or offensive environment.

All reports of sexual harassment, sexual misconduct, or inappropriate sexual behavior involving participants, staff, volunteers, visitors, or community members will be taken seriously and investigated in accordance with agency policies and applicable laws and regulations.

Participants and families are encouraged to immediately report any concerns to program leadership.

Abuse, Neglect, and Exploitation Prevention

The program is committed to protecting participants from:

Physical Abuse

Any intentional act causing physical injury, pain, or suffering.

Emotional or Verbal Abuse

Threats, intimidation, humiliation, ridicule, harassment, or other behaviors causing emotional harm.

Sexual Abuse

Any unwanted sexual contact, activity, exploitation, or behavior.

Financial Abuse

The misuse, theft, or exploitation of a participant's money, property, benefits, or resources.

Neglect

Failure to provide necessary care, supervision, support, or protection resulting in harm or risk of harm.

Mandated Reporter Responsibilities

Under California law, many employees working with individuals with developmental disabilities are designated as Mandated Reporters.

This means that staff members are legally required to report *suspected*:

- Abuse
- Neglect
- Abandonment
- Financial exploitation
- Sexual abuse
- Serious injuries of unknown origin

- Dependent adult abuse
- Other situations required by law

Reports may be made to agencies, including:

- Adult Protective Services (APS)
- Local law enforcement
- Regional Centers/Department of Developmental Services
- Community Care Licensing

Mandated reporting laws require staff to report reasonable suspicions of abuse or neglect, even when:

- The information is provided by a participant.
- The information is provided by a family member or caregiver.
- The allegation has not yet been proven.
- The concern involves a family member, caregiver, another participant, staff member, volunteer, or community member.

Staff are not permitted to investigate allegations independently before making required reports. Their legal responsibility is to report suspected abuse or neglect to the appropriate authorities. Once a report is made, the investigating agency determines whether further investigation is necessary.

Family and Caregiver Partnership

Families, caregivers, conservators, and support people play an important role in helping ensure participants' safety and well-being.

We encourage families to:

- Share concerns regarding participant safety.
- Notify the program of significant changes in behavior, health, or living situations.
- Report concerns regarding possible abuse, neglect, exploitation, or harassment.
- Cooperate with investigations conducted by authorized agencies when necessary.

The program will make every effort to communicate openly with families while maintaining confidentiality requirements established by law.

Confidentiality

Reports of suspected abuse, neglect, exploitation, or harassment will be handled as confidentially as possible. Information may only be shared with individuals or agencies who have a legal need to know to ensure participants' safety and comply with reporting requirements.

Participant Rights

Each client has rights, which include, but are not limited to the following:

(1) A right to be treated with dignity, to have privacy, and to be given humane care.

(2) A right to have safe, healthful, and comfortable accommodations, including furnishings and equipment to meet your needs.

3) A right to be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature. To be free from restraining devices, neglect, or excessive medication.

(4) A right to be informed by the licensee of provisions in the law regarding complaints, including the address and telephone number of the licensing agency, and of information regarding confidentiality.

(5) A right to attend religious services and activities. Participation in religious services and other religious functions shall be on a completely voluntary basis.

(6) A right to leave or depart the facility at any time, and to not be locked into any room or building, day or night. This does not prohibit the development of house rules, such as locking exterior doors or windows, for the protection of the consumer.

(7) A right to visit a facility with a relative or authorized representative prior to admission.

(8) A right to have communications between the facility and your relatives or authorized representative answered promptly and completely, including any changes to the needs and services plan or individual program plan.

(9) A right to be informed of the facility's policy concerning family visits. This policy shall encourage regular family involvement and provide ample opportunities for family participation in activities at the facility.

(10) A right to have visitors, including advocacy representatives, visit privately during waking hours, provided the visits do not infringe upon the rights of other consumers.

(11) A right to possess and control your own cash resources.

(12) A right to wear your own clothes, to possess and use your own personal items, including your own toilet articles.

(13) A right to have access to an individual storage space for your private use.

(14) A right to have access to telephones, to make and receive confidential calls, provided such calls do not infringe on the rights of other clients and do not restrict availability of the telephone in emergencies.

(15) A right to promptly receive your unopened mail.

(16) A right to receive assistance in exercising your right to vote.

(17) A right to receive or reject medical care or health-related services, except for those for whom legal authority has been established.

(18) A right to move from a facility in accordance with the terms of the admission agreement.

These rights apply during all program activities, including on-site programming, transportation, community integration activities, volunteer placements, vocational activities, and virtual programming.

Acknowledgment and Understanding

By signing below, I acknowledge that:

1. I have received and reviewed this Title 22 Rights, Safety, Sexual Harassment Prevention, and Mandated Reporting Notice.
2. I understand the participant's rights regarding safety, dignity, privacy, and freedom from abuse and harassment.
3. I understand that program staff are Mandated Reporters under California law and are legally required to report suspected abuse, neglect, exploitation, or other reportable incidents.

4. I understand that staff may be required to make reports even when allegations have not been substantiated.
5. I understand that mandated reporting requirements apply regardless of who may be involved in the alleged incident.
6. I understand that the program's primary responsibility is to protect the health, safety, and rights of participants.
7. I have had the opportunity to ask questions regarding these policies and procedures.

Parent/Guardian/Conservator/Caregiver

Name: _____

Signature: _____ Date: _____

Participant

Name: _____

Signature: _____ Date: _____

Program Representative

Name: _____

Signature: _____ Date: _____

This acknowledgment will be reviewed and signed upon enrollment and annually thereafter as part of the participant's reenrollment process.