RECORD KEEPING PROCEDURES

1. All statements should be objective;
2. Entries should be made in chronological order and should be dated;
3. Subsequent alterations or additions should be made openly, with the original entry left intact and legible (i.e. with a straight line through the incorrect information);
4. Any corrections should be initialed, and dated;
5. The author should sign the record and indicate his or her position;
6. The record should be made in dark ink and be legible;
7. The record should be limited to issues that are relevant to the student's treatment/program;
8. Items that are relevant should not be omitted simply because they are embarrassing or uncomplimentary;
9. Information should be recorded contemporaneously – when the event occurs or as soon as possible thereafter.

CONTENTS OF STUDENT SERVICES FILE

NOTE: IEP REFERS TO SSP/BIP/ITP

The following shall be kept in the student services file:

1. A copy of referral form(s) completed by the school, student services, clinicians, consultants, other agencies
2. Clinician Reports – Speech Language Pathologist, Psychologist (assessment reports and year end reports)
3. IEP(s) (the original of each IEP a student has throughout school) and/or Behavior Plans
4. Student Services Report(s)
5. Reports from service providers such as agencies, hospitals, doctors, occupational/physiotherapy
6. Ongoing health/psycho-social/counselling information whether psychological, medical, or behavioral
7. Level II and III funding applications.
8. Minutes or team meetings/Contact logs
9. Other reports deemed necessary

Once a student services file has been opened, a Blue Insert should be placed in the cumulative file indicating type of services student is receiving. When the cumulative file is requested by another school, written consent should be obtained before student services information is released.

The student services file shall be kept in the student services teacher's filing cabinet, not in the school office.

Procedural Guidelines for Cumulative File Inserts

1. Each June, complete or add Blue student services form in the student cumulative file.
2. Check off services, indicate date and year, and sign.

Retention and Disposition of the Pupil Support File

1. The Pupil Support file must be retained for a minimum of 10 years after the student ceases to attend a school in Turtle Mountain School Division if the pupil file has not been transferred to another school.

2. When any part of a pupil file is no longer required, or if the authorized retention period has expired, destruction of the information in a pupil file must be carried out in a manner that protects the privacy of the pupil that the information is about (i.e. shredding)

Clinicians, Guidance Counsellors, and Student Services Teachers will ensure the following:

(Please review Policy I-7 Student Records and Records Management 9-C, Administrative Manual)

1. Log of Destruction of original documents will be completed.

2. An Individual Record of Destruction will be placed in all student services, clinical, and counselling student files to be completed when necessary.

3. A Divisional Record of Destruction will be completed on an annual basis and submitted to the principal of the school and the Secretary-Treasurer of the Division.

4. Health Plans – the original plan will be kept and all other copies shredded annually in a confidential and secure manner.

5. Individual Education Plans – the original plan will be kept in the Student Services file and all other copies will be shredded annually in a confidential and secure manner.

6. Contact Notes from clinicians will be shredded annually in a confidential and secure manner.

7. Medication Administration – original copies and signed medication records to be kept on file with student services.

8. Culling Files – when students transfer out of the Division or graduate and the files are to be placed at the Division office, the student services teacher should, in collaboration with the principal remove and destroy irrelevant documentation.

   (i.e.- testing booklets, C-notes, vision screening forms)

9. Information to remain would be the following: Latest IEP, latest Health Plan, copies of formal reports and assessments, formal minutes of team and transition meetings and any other information relevant to future decision making.

   (Please see Records Management)

10. A log of destruction must be completed for all material destroyed.

TRANSMISSION OF CONFIDENTIAL INFORMATION

1. Confidential information that is provided over the telephone must only be given if the identification of the requester is verified. This information must not be left on the answering machine.

2. Confidential information must be faxed only when required for urgent or emergent purposes and only sent under the following conditions:

   - There is no chance the information being transmitted can be intercepted during transmission by unauthorized personnel;
   - The individual sending the fax is authorized to release the information;
   - Cover page of fax indicates, where applicable, *"Confidential information". Disclosure, distribution or copying of the content is strictly prohibited. If you have received this fax in error, please notify the sender immediately.*

3. Transmitting information via e-mail must only be done if the venue of transmission is secure or the data is encrypted.