

**INDEPTH or N.O.T**

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Last Name	First Name	Middle Name
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Home Address

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City	State	Zip
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Phone

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Email Address

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Parent or Guardian Name

(if under age 18)

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Parent or Guardian Address

(if under age 18)

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School & Grade Level

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Birthdate/age

I consent to enroll my child in the INDEPTH or N-O-T program. I understand that I may revoke authorization at any time by sending a written notice to the Sheridan School District to the Jacket Health and Wellness Center at 512 W. Church Street, Ste A, Sheridan, AR 72150. Otherwise, this consent will be valid until the student's separation from the district. (This is required for enrollment in INDEPTH or N-O-T program).

Student Signature	Date
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Parent or Guardian Signature	Date
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Facilitator Signature	Date
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