

**ST. PAUL PSR
SAFE TOUCH/CHASTITY PROGRAM
OPT OUT FORM**

(Please complete for each child in the PSR)

Student Name: _____

(Please Print Clearly)

Grade Level (2019-2020): _____

- **Regarding the Safe Touch Program – I request that my child (select one below):**

Participates: _____

Does Not Participate: _____

- **Regarding the Chastity Program (Grades 4-8) – I request that my child (select one below):**

Participates: _____

Does Not Participate: _____

I understand that if my child does not participate in the program presented in the classroom as a part of the PSR, materials will be provided to the Parents and it will be the parents' responsibility to cover the subject matter with their child (children).

Parent Signature:

(Signature)

(Signature)

(Please Print Name Clearly)

(Please Print Name Clearly)