Updated 07/2012

Lutheran Family Services of Virginia

Administration: 2609 McVitty Rd., Roanoke, VA 24018 • Phone (800) 359 3834 • Fax (540) 774-1084

Roanoke: 775 Dent Rd., Roanoke, VA 24019 • Phone (540) 265- 4281 • Fax (540) 265- 4287

Wytheville: 425 Grayson Rd., Building 6, Wytheville, VA 24308 • Phone (276) 228- 8088 • Fax (276) 228- 9087

Harrisonburg: 779 Massanutten St., Harrisonburg, VA 22802 • (540) 437- 1814 • Fax (540) 437- 1816

Wise: P.O. Box 828, 515 Hurricane Rd., Building N, Wise, VA 24293 • Phone (276) 328 -7181 • Fax (276) 328- 9362

Dear Colleague,

Thank you for your interest in Minnick Schools. To complete the application process, please provide the following information:

- ☐ Completed Application Packet
- ☐ Signed FAPT release listing Minnick Schools
- ☐ Most recent eligibility components to include minutes
- ☐ Current IEP
- ☐ Immunization Record
- ☐ Most recent physical
- ☐ SOL score records
- ☐ Other standardized testing records
- ☐ Transcript and/or grade reports
- ☐ Most recent report card (please include grade summary if student is admitted mid-grading period)
- ☐ Transcript analysis signed by guidance counselor indicating courses taken and coursework needed to graduate (**including verified credit analysis**)

***Please note that we cannot enroll a student until all components have been submitted.**

Please coordinate times for the parents/guardians to visit the school and meet with the staff during the admissions procedure. We require that the student also attend the visit. If it is not appropriate for the student to attend the initial visit, we will schedule a visit for the student prior to the enrollment date.

Please contact me if you have any questions or require clarification.

Sincerely yours,

Terri Lockhart Webber
Director of Education
Minnick Schools

Lutheran Family Services of Virginia

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PUBLIC SCHOOL REFERRAL TO MINNICK SCHOOLS

Date of Referral: _____

Student's Full Name: _____ Race/Ethnicity: _____

Birth Date: _____ Birth Place: _____

Social Security Number: _____ Birth Registration Number: _____

Referring School System: _____

Director of Special Education: _____

Address: _____

_____

Telephone Number: _____

Mother/Legal Guardian: _____ Occupation/Employer: _____

Address: _____

_____

Home Phone Number: _____ Work Phone Number: _____

Cell Phone Number: _____

Father/Legal Guardian: _____ Occupation/Employer: _____

Address: _____

_____

Home Phone Number: _____ Work Phone Number: _____

Cell Phone Number: _____

PUBLIC SCHOOL REFERRAL TO MINNICK SCHOOLS

School Student Currently Attending: _____

Primary Disability: _____

Current Grade Level (as of referral date): _____

Reason for Referral: _____

_____

_____

School Contact Person(s)

(Please list case manager and any other school personnel that will need to receive student updates. Include title, address, phone and other contact information for each)

Name: _____ Title: _____

Address: _____

_____

Phone Number: _____ Email address: _____

Name: _____ Title: _____

Address: _____

_____

Phone Number: _____ Email address: _____

Name: _____ Title: _____

Address: _____

_____

Phone Number: _____ Email address: _____

Lutheran Family Services of Virginia

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Application

CONFIDENTIAL – FOR PROFESSIONAL USE ONLY

Date: _____

Student Name: _____ Current Grade Level: _____

Date of Birth: _____ Place of Birth: _____

Sex: Male ☐ Female ☐ Social Security Number: _____

Address: _____

_____

Mother or Guardian

Name: _____

Address: _____

Home Phone Number: _____ Cell Phone Number _____

Employer: _____ Work Phone Number: _____

Father or Guardian

Name: _____

Address: _____

Home Phone Number: _____ Cell Phone Number _____

Employer: _____ Work Phone Number: _____

Child is in custody of: ☐ **Both** ☐ **Mother** ☐ **Father** ☐ **Other** (please list) _____

Person to call in case of emergency if parent/guardian is not available: (**Must be able to pick child up from school**)

Name: _____ Relationship: _____ Phone #:_____

Name: _____ Relationship: _____ Phone #:_____

Name: _____ Relationship: _____ Phone #:_____

For Office Use:

Date Enrolled: _____ *Processed by:*_____

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AUTHORIZATION TO RELEASE PROFESSIONAL INFORMATION

Student Name: _____

Date of Birth: _____

Social Security Number: _____ - _____ - _____

This form fully protects your civil liberties when the conditions are met.

1. Make sure all blanks are filled in before you sign.
2. Do not sign this form as a required condition for treatment.
3. Sign this form only after a specific request for information has been made.
4. Make sure the release of information is in your best interest.
5. Make sure you understand that the release of information is limited to the person, agency, or insurance company named below and that this information is not to be passed on to anyone else or to be used for any other purpose than the one specified below.

I authorize the release of professional information between Minnick Schools and

_____

In regard to (whom) _____ for the purpose of assessment planning and implementation of educational services. Any information you authorize other professionals to release to this facility will be held strictly confidential and will not be released without your permission.

Signature of Parent/Guardian Date

Signature of Student Date

Witness Date

*Expiration Date: 1 year from this date or upon student's discharge.

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HEALTH INFORMATION FORM

Dear Parent: Please provide a current health history so we can help your child benefit from his/her school experience.

Student Name: _____

Physician's Name: _____ Physician's Phone #: _____

Preferred Hospital: _____

Medicaid: ☐ Yes ☐ No Medicaid # _____

Other Insurance: ☐ Yes ☐ No Policy # _____ Policy Holder: _____

Insurance Company: _____ Phone Number: _____

(please continue on next page)

PAST AND PRESENT HISTORY – STUDENT HEALTH PROBLEMS (please check and explain below)

☐ ADD/ADHD
☐ Allergies (please describe below)
☐ Food Allergies
☐ Bee sting allergies
☐ Arthritis
☐ Asthma
☐ Bleeding disorder/hemophilia
☐ Blood pressure disorder
☐ Cancer
☐ Catheterization
☐ Cerebral palsy
☐ Cochlear implant
☐ Other: (please describe)

☐ Colostomy
☐ Cystic Fibrosis
☐ Diabetes
☐ Ear problem/hearing
☐ Eating disorder
☐ Eczema
☐ Emotional disorders
☐ Feeding tube/ G tube
☐ Headaches
☐ Heart Condition
☐ Hyperventilates
☐ Menstrual Disorders

☐ Migraine Headaches
☐ Muscular Dystrophy
☐ Orthopedic disorders
☐ Scoliosis
☐ Seizures
☐ Sickle-cell anemia
☐ Spina bifida
☐ Stomach spasms/ulcers
☐ Thyroid condition
☐ Tracheostomy
☐ Vision
☐ Neurological disorders

_____

_____

_____

_____

HEALTH PROBLEMS: Please explain any problems checked above.

_____

_____

_____

_____

_____

_____

(please continue on next page)

ALLERGIES: List known allergies to food, environment, medication, or other. Describe reaction and treatment.
***If student has allergies, please provide medical documentation so an appropriate health care plan can be written for your student.**

_____

_____

_____

_____

_____

_____

MEDICATIONS: All medication that needs to be administered during the school day must be provided to the designated medication management personnel by the parent/guardian. Written parent permission and/or doctor's order is required before medication will be administered at school. See the Minnick School handbook for further information.

Is your child currently taking any medications (prescription and over-the-counter) at home or at school?

☐ Yes ☐ No If yes, please describe below.

Name of Drug	Dosage	How Often	School or Home

***Please inform the school of any changes to your child's medications.**

SIGNATURE OF PARENT/GUARDIAN **DATE**

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HEALTH INFORMATION ACKNOWLEDGEMENT FORM

STUDENT NAME: _____

PLEASE CHECK THE BOXES AND SIGN AT THE BOTTOM OF THE FORM INDICATING THAT YOU UNDERSTAND EACH OF THE FOLLOWING:

☐ The information provided on the Health Information Sheet is correct to the best of my knowledge.

☐ I give permission for the school to contact my child's physician when necessary.

Yes No

☐ All medication (over-the-counter and prescribed) must be provided by the parent and must have written permission before any medication may be administered.

☐ Keep your child home if he/she has any of the following symptoms:

A) an oral temperature 100° or greater
B) vomiting
C) diarrhea
D) rash with fever
E) appears severly ill

☐ Please call the school if your child is sick.

☐ Update the school of any changes to your child's medications.

☐ Keep school immunization records up-to-date. If your child receives immunizations after initial enrollment in the school, please give a copy to the school.

SIGNATURE OF PARENT/GUARDIAN **DATE**

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PARENT/PHYSICIAN CONSENT FORM FOR THE ADMINISTRATION OF MEDICATION

POLICY STATEMENT: No youth is permitted to have in his/her possession either prescription or non-prescription medication. Non-prescription medication will not be administered without written permission from a physician. When a youth must take medication, whenever possible, it should be administered before or after school hours. However, when it is necessary for a youth to take prescription or non-prescription medication during school hours, it is to be given to and administered by staff if the following procedures are followed: (If a youth is taking more than one medication, additional forms must be completed for each medication.)

I, _____, parent/guardian of _____ do hereby request that Minnick School personnel administer the following medication to my child:

Medication Name: _____

Description of Medication (color, capsule, tablet, or liquid, dosage): _____

Time to be given: _____

Amount to be given: _____

Date to be given: (beginning) _____ (ending) _____

Reason for giving medication: _____

Physician who prescribed medication: _____

Please note: Prescribed medication must be in the pharmacy issued container with the name of the prescription, the dosage, and the means of administration, etc. printed clearly on the label. Non-prescription medications must be in the original package or bottle with direction clearly indicated. Please do not send medications in any other type of container.

Additional comments or instructions:

_____

Signature of Parent/Guardian Date

Physician's Signature: _____ Date: _____

Physician's Name:

Address:

Telephone Number:

Please return completed form to the nearest school listed on page one of this form.

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MEDICAL ORDERS FOR SPECIAL HEALTHCARE NEEDS

Student Name: _____

Grade: _____ **Date of Birth:**

_____

Effective Date: _____ (plan in effect for one academic year – may extend through ESY)

Form to be completed by diagnosing/treating physician as needed. Parent/guardian must provide all necessary medical supplies to the school.

HEALTH STATUS
Diagnosis and description of medical concern: **List relevant medical history (surgery, hospitalizations, allergies, etc.):**
ACTIVITY
Are there health related absences expected? ☐ Yes ☐ No **Comment:** **Level of participation in PE and/or recess:** ☐ Full ☐ Restricted ☐ Partial **Comment:**
EMERGENCY PLAN
Are there any emergency medical interventions needed? ☐ Yes ☐ No **Comment:**

PROCEDURES

Are procedures required for this student to attend school? ☐ Yes ☐ No

Does the student require assistance from additional staff? ☐ Yes ☐ No

☐ PRN Unskilled (non-licensed) ☐ PRN Skilled (RN or LPN)

☐ Full-time ☐ Part-time

Describe medical procedures that are required for this student to attend school (equipment, time intervals, positioning, etc.)**:**

MEDICATIONS

Please list relevant medications (dosage, time given, how given, and if it will be administered at home or at school)**:**

AUTHORIZATION OF MEDICAL PROVIDER

M.D. Print Name: **Phone:**

M.D. Signature: **Date:**

PARENT/GUARDIAN CONSENT

I agree with this plan of care and I give permission for the school to contact the above provider.

Parent/Guardian Print Name: **Phone:**

Parent/Guardian Signature: **Date:**

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

I, _____, hereby give any paid staff and/or designated volunteer of Minnick Schools bearing this notification, full permission to seek the services and carry out the recommendations of medical and/or dental and/or psychological/psychiatric professionals to provide on-going medical, dental, psychiatric needs pertaining to my child, _____.

It is understood that in the case of a crisis or emergency situation when immediate care is necessary, the parent/guardian of the above-name youth will be notified immediately. However, in the event all efforts to contact the parent/guardian have proven unsuccessful, I further authorize Minnick Schools to seek immediate medical, dental, mental health care. I understand this care will not include any surgical procedure or any experimental procedure without written informed consent.

_____

Signature of Father/Guardian Date

_____

Signature of Mother/Guardian Date

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PARENTAL CONSENT FORM FOR THE ADMINISTRATION OF ACETAMINOPHEN

To Minnick Schools Staff:

I, _____, parent/guardian of _____, a student at Minnick Schools, hereby (please check one)

☐ **Give Permission**

☐ **Do Not Give Permission**

to the staff of Minnick Schools to administer Acetaminophen (Tylenol) to my child, according to the dosage and frequency recommended by the manufacturer of this non-prescription medication. I further understand that I will be notified of the administration of the non-prescription medication via telephone and documentation on my child's daily behavior sheet.

_____

Signature of Parent/Guardian Date

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STUDENT INFORMATION AND PERMISSION FOR COUNSELING

Date: _____

Student's Name: _____

Parent/Guardian Name: _____ Relationship: _____

Home Phone Number: _____ Work Phone Number: _____

Cell Phone Number: _____

Presenting Behaviors (please check all that apply):

☐ **Threatened to run away**	☐ **Past runaway - # of times _____**	
☐ **Skipping school**	☐ **Threatened suicide**	☐ **Attempted suicide**
☐ **Currently suicidal**	☐ **Family conflicts**	☐ **Substance abuse**
☐ **Anger problems**	☐ **Depressed mood**	☐ **Grief or loss**
☐ **Lying**	☐ **Negative attitude**	☐ **Anxiety**
☐ **Sexual Abuse**	☐ **Physical abuse**	☐ **Family Substance Abuse**

☐ **Exposed to traumatic event - Specify: _____**

ADDITIONAL INFORMATION/CONCERNS:

I, _____, parent/guardian of _____, give my permission for my child to participate in counseling services at school. I understand that the information shared in individual and group counseling will remain confidential. As mandated reporters, Minnick Schools is required to report any information which indicates abuse or neglect of a child and any information regarding suicidal or homicidal behaviors to the appropriate person or agency. I understand that I can contact the counseling department at any time regarding the services provided to my child or to request additional services. I understand I may withdraw this consent to participate in individual or group counseling at any time.

_____

Signature of Parent/Guardian Date

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Permission to Transport

My child has permission to be transported by MINNICK SCHOOLS and/or staff personal vehicles. I understand off campus activities may include educational or therapeutic recreation field trips as well as earned special activities. I further understand my child may be transported home or to an agreed upon supervised destination as a result of illness, injury, or serious disciplinary action.

Parent Signature Date

Lutheran Family Services of Virginia

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STATEMENT OF STUDENT RIGHTS

Having been enrolled at Minnick Schools, I, _____,

parent of _____ verify that:

A. I have read or have read to me the Parent/Student Handbook.
B. I have had an opportunity to ask questions regarding the Parent/Student Handbook and these questions have been answered to my satisfaction.
C. I understand my rights as a parent/student at Minnick Schools.
D. I understand staff will maintain confidentiality unless information conveys the potential for self-harm, harm to others, or any type of physical, sexual, or emotional abuse.
E. I understand the staffs of Minnick Schools have a legal obligation to report all incidents of physical, sexual, or emotional abuse to the proper authorities.
F. I agree to support the behavior management procedures at Minnick Schools by being an active participant in on-going communications with Minnick Schools via school notes, daily behavior reports, parent/teacher conferences, annual and triennial reviews, and by supporting the consistency of my child's program while he/she is at home.
G. I accept responsibility for the financial obligations incurred by my child through his/her vandalism or excessive destruction of school property. I understand these charges will be billed separately and are not part of the regular financial terms.
H. I understand that regardless of the reason for the absences, Minnick Schools staff will report absences to the home school and/or the LEA's Director of Special Education. I understand that if my child is absent from school 15 days in a row, he/she will be discharged from the program on the 16th day.

By initialing the following statements, I give my permission for:

Yes _____ No _____ My child to be transported in Minnick Schools vehicles.

Yes _____ No _____ My child to be photographed and/or videotaped for educational or recreational purposes, provided that the student consents at the time the photograph/video is being taken.

Yes _____ No _____ My child to participate in the behavior management system as described in the Parent/Student Handbook – including the use of Safety-Care and/or time-out.

_____

Signature of Student Date

_____

Signature of Parent Date

_____

Signature of LEA Representative Date