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
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: _________________________
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: ________________________________
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.
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  ☐ Colostomy  ☐ Migraine Headaches
☐ Allergies (please describe below)  ☐ Cystic Fibrosis  ☐ Muscular Dystrophy
☐ Food Allergies  ☐ Diabetes  ☐ Orthopedic disorders
☐ Bee sting allergies  ☐ Ear problem/hearing  ☐ Scoliosis
☐ Arthritis  ☐ Eating disorder  ☐ Seizures
☐ Asthma  ☐ Eczema  ☐ Sickle-cell anemia
☐ Bleeding disorder/hemophilia  ☐ Emotional disorders  ☐ Spina bifida
☐ Blood pressure disorder  ☐ Feeding tube/ G tube  ☐ Stomach spasms/ulcers
☐ Cancer  ☐ Headaches  ☐ Thyroid condition
☐ Catheterization  ☐ Heart Condition  ☐ Tracheostomy
☐ Cerebral palsy  ☐ Hyperventilates  ☐ Vision
☐ Cochlear implant  ☐ Menstrual Disorders  ☐ Neurological disorders

Other: (please describe) __________________________________________________________________________________

________________________________________________________________________________________________________

________________________________________________________________________________________________________

________________________________________________________________________________________________________

________________________________________________________________________________________________________

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.

<table>
<thead>
<tr>
<th>Name of Drug</th>
<th>Dosage</th>
<th>How Often</th>
<th>School or Home</th>
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</tbody>
</table>

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

SIGNATURE OF PARENT/GUARDIAN

DATE
ACADEMIC YEAR 2012 – 2013
2609 McVitty Road, Roanoke, VA 24018 • Phone (800) 359-3834 • Fax (540) 774-1084

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 severely 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 ____________________________
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: ______________________________________________________________

_________________________________________  Date
Signature of Parent/Guardian

_________________________________________  Date
Physician’s Signature: ________________________________

Physician’s Name:

Address:

Telephone Number:

Please return completed form to the nearest school listed on page one of this form.
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:**
- **M.D. Signature:**
- **Phone:**
- **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:**
- **Parent/Guardian Signature:**
- **Phone:**
- **Date:**
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
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
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
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
Updated 07/2012

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