Dear Colleague,

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

- Completed Minnick Application Packet
- Signed FAPT release listing Minnick Schools
- Most recent eligibility components to include minutes
- Current IEP
- CANS Assessment (Child and Adolescent Needs and Strengths)
- Immunization Record
- Functional Behavioral Analysis, Behavior Intervention Plan, or other behavioral documentation
- 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
PUBLIC SCHOOL REFERAL TO MINNICK SCHOOLS

Minnick School Location: ________________________________

Date of Referral: ________________________________

Student’s Full Name: ___________________________ Race/Ethnicity: ____________________________

Birth Date: ____________________________ Birth Place: ____________________________

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 REFERAL TO MINNICK SCHOOLS

School Student Currently Attending: ____________________________________________________________

State Testing Identifier: _________________________________________________________________

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: ________________________________
MINNICK SCHOOLS
CONSENT TO EXCHANGE INFORMATION

I understand that different agencies provide different services and benefits. Each agency must have specific information in order to provide services and benefits. By signing this form, I am allowing agencies to exchange certain information so it will be easier for them to work together effectively to provide or coordinate these services or benefits.

I, ________________________________________________________ am signing this form for ________________________________________________________

(Full Printed Name of Consenting Person(s))

________________________________________
(Full Printed Name of Student)

________________________________________
(Street Address of Student)

________________________________________
(City, State, Zip)

________________________________________
(Student’s Date of Birth)

Phone: (Home) _____________________ (Cell) ____________________ (Work) _______________

My Relationship to the student is _______ Self _______ Parent _______ Guardian

I want the following confidential information about the student (except drug or alcohol abuse diagnoses or treatment information) to be exchanged.

___Medical Records ___Psychological Records ___Assessment Information
___Medical Diagnosis ___Educational Records ___Discharge Summaries
___Mental Health Diagnosis ___Psychiatric Records ___Other (specify) __________________

I want the following: Minnick Schools Phone: ___________ Fax: ___________
and the following agencies to be able to exchange this information:

_____ Social Services ____________________________ _____ Department of Rehabilitative Services ______
----- Health Department ____________________________ _____ LEA __________________
----- Physician ________________________________ _____ Court Service Unit __________________
_____ Residential Facility _________________________ _____ Family Education Services __________
----- Psychiatrist ________________________________ _____ Foster Care Agency _____________
----- Detention Facility ____________________________ _____ FAPT _________________________
_____ Other ____________________________

his consent is good until: ______________________________________________________________ I can withdraw this consent at any time by telling the referring agency. This will stop the listed agencies from sharing information after they know my consent has been withdrawn. I have the right to know what information about me has been shared, and why, when, and with whom it was shared. If I ask, each agency will show me this information. I want all the agencies to accept a copy of this form as a valid consent to share information.

If I do not sign this form, information will not be shared and I will have to contact each agency individually to provide the information that they need.

Signature(s)____________________________________ Date:________________________
(Consenting Person or Persons)

Person Explaining Form: _________________________________________________________
(Name) (Title) (Phone Number)
Media Release Form  
2019 - 2020 School Year (August 1, 2019, to July 31, 2020) 

Thank you for taking the time to read this form. We would like to share the Minnick School experience with our community. By consenting to have your student’s name, photo or voice used in our online and print publications, you are helping us tell the Minnick story!

In this form, the undersigned student refers to youth attending a Minnick School, which is part of Lutheran Family Services of Virginia. The undersigned guardian refers to the legal guardian or parent holding custody of the student. The guardian represents the student and assures Lutheran Family Services of Virginia that she or he has full power and authority to sign this document.

The undersigned student and the guardian each consent to use of the following information in LFSVA promotional materials. Please check the lines that apply:

- **Full name:** Yes_____ No_____  
  **First name only:** Yes_____ No_____  
- **Photograph:** Yes_____ No_____  
  **Voice:** Yes_____ No_____  
- **Film/Video:** Yes_____ No_____  

Promotional materials include, but are not limited to, printed or electronic publications, Web sites, social media, such as LFSVA Facebook and Twitter, and all other electronic or print communications of Lutheran Family Services of Virginia, Inc.

We rely on the permission you have given us so that we are confident in incurring the production costs of these materials. All of these materials -- negatives, positives, prints, digital reproductions and videotape -- remain the property of Lutheran Family Services of Virginia. The student and guardian may receive a copy of any printed materials using their name, photograph, or identifiable interview content. And lastly, the student and guardian acknowledge that they will not receive any monetary compensation.

Date: ____________________  
Signature: _______________________________________

**Student**

Date: ____________________  
Signature: _______________________________________

**Legal guardian or parent**
ACADEMIC YEAR 2019 - 2020

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.

<table>
<thead>
<tr>
<th>HEALTH STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis and description of medical concern:</td>
</tr>
</tbody>
</table>

List relevant medical history (surgery, hospitalizations, allergies, etc.):

<table>
<thead>
<tr>
<th>ACTIVITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there health related absences expected?  □ Yes □ No</td>
</tr>
<tr>
<td>Comment:</td>
</tr>
</tbody>
</table>

Level of participation in PE and/or recess: □ Full □ Restricted □ Partial

Comment:

<table>
<thead>
<tr>
<th>EMERGENCY PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there any emergency medical interventions needed? □ Yes □ No</td>
</tr>
<tr>
<td>Comment:</td>
</tr>
<tr>
<td>PROCEDURES</td>
</tr>
<tr>
<td>------------</td>
</tr>
<tr>
<td>Are procedures required for this student to attend school? [ ] Yes [ ] No</td>
</tr>
<tr>
<td>Does the student require assistance from additional staff? [ ] Yes [ ] No</td>
</tr>
<tr>
<td>□ PRN Unskilled (non-licensed)  □ PRN Skilled (RN or LPN)</td>
</tr>
<tr>
<td>□ Full-time  □ Part-time</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>MEDICATIONS</th>
</tr>
</thead>
</table>
| Please list relevant medications (dosage, time given, how given, and if it will be administered at home or at school):

<table>
<thead>
<tr>
<th>AUTHORIZATION OF MEDICAL PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>M.D. Print Name:</td>
</tr>
<tr>
<td>Phone:</td>
</tr>
<tr>
<td>M.D. Signature:</td>
</tr>
<tr>
<td>Date:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PARENT/GUARDIAN CONSENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>I agree with this plan of care and I give permission for the school to contact the above provider.</td>
</tr>
<tr>
<td>Parent/Guardian Print Name:</td>
</tr>
<tr>
<td>Phone:</td>
</tr>
<tr>
<td>Parent/Guardian Signature:</td>
</tr>
<tr>
<td>Date:</td>
</tr>
</tbody>
</table>
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) a temperature greater than 100°
   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
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 bilida
☐ 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.

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________
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 handbook for further information.

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

☐ Yes  If yes, please describe below.  ☐ No

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

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

SIGNATURE OF PARENT/GUARDIAN  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 Mother/Guardian

____________________________________________________
Signature of Father/Guardian
ACADEMIC YEAR 2019 - 2020

Application

CONFIDENTIAL – FOR PROFESSIONAL USE ONLY

Student Name: ________________________________  Current Grade Level: __________________

Date of Birth: ________________________________  Place of Birth: ______________________

Sex: Male ☐   Female ☐

Address: ____________________________________________

__________________________________________________________________________________

Mother or Guardian

Name: ____________________________________________

Address: (If different from that student): ____________________________________________

Primary Phone: ____________________  Secondary Phone: _____________________________

Employer: ________________________________  Work Phone Number: ____________________

Father or Guardian

Name: ____________________________________________

Address: (If different from that student): ____________________________________________

Primary Phone: ____________________  Secondary Phone: _____________________________

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: _________________________
ACADEMIC YEAR 2019 – 2020

Student Data

CONFIDENTIAL – FOR PROFESSIONAL USE ONLY

Date: ____________________________

Student Name: __________________________  Current Grade Level: __________________________

Date of Birth: __________________________  Place of Birth: ____________________________

Sex:  Male ☐  Female ☐  Social Security No: __________________________

Address: _______________________________________________

Parent or Guardian:

Name: _____________________________________________________________________________

Address: ___________________________________________________________________________

Home Phone Number: __________________________  Cell Phone Number: _____________________

Employer: __________________________  Work Phone Number: __________________________

Email address: _______________________________________________________________________

Parent or Guardian:

Name: _____________________________________________________________________________

Address: ___________________________________________________________________________

Home Phone Number: __________________________  Cell Phone Number: _____________________

Employer: __________________________  Work Phone Number: __________________________

Email address: _______________________________________________________________________

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

Person to call in case of emergency if parent/guardian is not available:

Name: __________________________  Relationship: __________________________  Phone #: __________________________

Name: __________________________  Relationship: __________________________  Phone #: __________________________

Name: __________________________  Relationship: __________________________  Phone #: __________________________
Permission to Transport

My child has permission to be transported by MINNICK SCHOOL vehicles and/or staff personal vehicles. I understand off campus activities may include educational or 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 because of illness, injury, or serious disciplinary action.

Parent Signature ____________________________ Date ____________

ACADEMIC YEAR 2019 - 2020
PARENTAL CONSENT FORM FOR THE ADMINISTRATION OF ACETAMINOPHEN

To Minnick School Staff:

I, ______________________________, parent/guardian of ______________________________, a student at Minnick, 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
ACADEMIC YEAR 2019 - 2020

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 by being an active participant in on-going communications with Minnick 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 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 School vehicles.
Yes _____ No _____ My child to be photographed for educational purposes.
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
ACADEMIC YEAR 2019 - 2020

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:

Bristol Minnick: 1225 Janie Hammit Drive, Bristol, VA 24201 • Phone (276) 494 - 0539 • Fax (276) 494 - 0538
Harrisonburg Minnick: 1661 Virginia Ave., Harrisonburg, VA 22802 • (540) 437 – 1814 • Fax (540) 615-5412
Roanoke Minnick: 775 Dent Rd., Roanoke, VA 24019 • Phone (540) 265 – 4281 • Fax (540) 265 – 4287
Starkey Station: 6405 Merriman Road, Roanoke, VA 24018 • Phone (540) 206-3270, ext. 3401 • Fax (540) 265 – 4287
Wise Minnick: P.O. Box 828, 515 Hurricane Rd., Building N, Wise, VA 24293 • Phone (276) 328 – 7181 • Fax (276) 328 – 9362
Wise Adapted Program: 6408 Glamorgan Chapel Road, Wise VA 24293 • Phone (276) 321 – 7768
Wytheville Minnick: 425 Grayson Rd., Building 6, Wytheville, VA 24308 • Phone (276) 228 – 8088 • Fax (276) 228 – 9087
ACADEMIC YEAR 2019 - 2020

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