

APPLICATION PROCEDURES

1. The parent, guardian, and/or placing agency must complete and submit the following documents prior to the student's enrollment date:
 - Application for Admission
 - Student Enrollment Agreement
 - Parental Consent & Authorization
 - OTC/Epinephrine Medication Release Form
 - Health Information and Emergency Release Form
 - Commonwealth of Virginia School Entrance Health Form
 - Copy of birth certificate
 - Copy of Social Security Card
 - Consent for Behavior Management
 - Photo Release Form
 - Agreement of Proper Conduct in School Vehicles

2. If the student will be receiving prescribed medications while at school, the following forms must be submitted prior to enrollment **for each medication**:
 - Medication Consent Form (1 per prescription)
 - Asthma Action Plan (asthma medication ONLY)
 - Permission to Carry Inhaler (if student will self-administer)

3. If the student has an IEP or 504 plan, an **updated** IEP/504 Plan, signed by the parent, with change of placement must be submitted prior to enrollment.

4. Transcripts are required of all applicants. If not already received as part of the pre-admissions process, the Request for Student Records included in this packet must be delivered to the proper school official at the applicant's current school.

5. Mail or fax the completed Application for Admission, including all relevant additional required documents listed on the application to:
 - Admissions Coordinator
 - Bear Creek Academy
 - P.O. Box 192
 - Cumberland, VA 23040
 - Fax: 804-492-9942

All admissions paperwork must be received by the school on or prior to the student's scheduled enrollment date. Incomplete admissions paperwork may result in the postponement of the student's enrollment date.



Application for Admission

Student Information

_____	_____	_____	_____
Last Name	First Name	MI	Nickname
_____		_____	
Date of Birth		Place of Birth	
_____		_____	
Social Security Number		Race/Ethnicity	
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Height: _____	Weight: _____	Eyes: _____
			Hair: _____

Address			

Parent/Legal Guardian Information

_____		_____	
Legal Guardian		Relationship to Student	

Address			

_____	_____	_____	_____
Home Phone	Work Phone	Cell Phone	E-mail

_____		_____	
Father's Name		Address	
_____		_____	
Date of Birth		Marital Status	
_____		_____	
_____	_____	_____	_____
Home Phone	Work Phone	Cell Phone	E-mail

_____		_____	
Mother's Name		Address	
_____		_____	
Date of Birth		Marital Status	
_____		_____	
_____	_____	_____	_____
Home Phone	Work Phone	Cell Phone	E-mail

Please list any siblings of student. Indicate relationship to student and date of birth or age.

_____	_____	_____	_____
Name	Relationship	DOB (or age)	Address
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Emergency Contact Information

Please list someone other than the parent(s)/guardian(s) that we may contact in an emergency.

Contact Person

Phone Number

Address

Placing Agency Information

Placing Agency

Address

Contact Person

Phone Number

Fax Number

E-mail

Special Education? Yes No

Student's Grade Level

Full-Scale IQ

SPED Designation:

Current Schooling: Regular School Alternative School Homebound Expelled/Suspended

Educational Needs:

School Name

Contact Person

Phone Number

Fax Number

E-mail Address

Social Services Agency (if applicable)

Address

Contact Person

Phone Number

Fax Number

Cell Phone Number

E-mail Address

Juvenile Court Services Agency (if applicable)

Address

Contact Person

Phone Number

Fax Number

Cell Phone Number

E-mail Address

Please list any legal charges and their dispositions:

Placement Information

Reason for Placement: _____

Previous placement & reason discharged: _____

Presenting Problems (check all that apply): Verbally Abusive Physically Aggressive Moody Steals
Runs Away Lies Often Poor Academic Performance Self-destructive Substance Abuser Low Motivation
Negative Peer Relationships Poor Family Relationships Low Self-Esteem Passive-Aggressive Depressed

DSM IV Diagnosis (if any): _____

Please list any special mental health needs: _____

Please list any special physical health needs: _____

Please list any history of abuse/victimization: _____

Please list any other significant risk factors: _____

Additional Required Documents

Please include the following documents with this application:

- | | |
|--|---|
| <input type="checkbox"/> Student Enrollment Agreement | <input type="checkbox"/> Commonwealth of Virginia School Entrance Health Form |
| <input type="checkbox"/> Payment Agreement | <input type="checkbox"/> Standards of Student Conduct Acknowledgment |
| <input type="checkbox"/> Parental Consent Form | <input type="checkbox"/> Student Expectations Agreement |
| <input type="checkbox"/> Medication Release Form | <input type="checkbox"/> Student Rights & Responsibilities |
| <input type="checkbox"/> Health Information and Emergency Release Form | <input type="checkbox"/> Current IEP (special education students only) |
| <input type="checkbox"/> Request for Student Records | <input type="checkbox"/> Social History (if available) |
| <input type="checkbox"/> Most Recent School Transcript | <input type="checkbox"/> Educational Evaluations (if available) |
| <input type="checkbox"/> Copy of birth certificate | <input type="checkbox"/> Psychological Evaluations (if available) |
| <input type="checkbox"/> Copy of Social Security Card | |

Name of Person Submitting Application

Signature

Today's Date

Phone

E-mail Address

Mail or fax this application and the additional required documents to:

Bear Creek Academy
P.O. Box 192
Cumberland, VA 23040
804-492-9942



Student Enrollment Agreement

I. General Conditions

- A. The undersigned parent(s), legal guardian(s), and/or representative of the legal guardian (hereinafter the "Sponsor"), agree to the conditions outlined in this Enrollment Agreement and hereby enroll _____ (hereinafter the "Student") as a student at Bear Creek Academy (hereinafter the "School") for the academic year beginning _____ (month and year). Sponsor understands that this Enrollment Agreement is between the Sponsor of the above-named student and Bear Creek Academy. It is not binding on the School until signed by the School Administrator or his/her authorized designee. The School reserves the right to accept or reject students for enrollment for any reason, notwithstanding the submission of the Agreement. In the event that the School is unable to provide or continue its educational or therapeutic services to the student for any cause, the School shall not be liable for claims for any costs or expenses incurred as a result.

II. Consent for Educational & Therapeutic Services

- A. The Student and Sponsor consent to this admission and to the provision by the School of such educational and therapeutic services as may be deemed necessary and appropriate. Sponsor understands that no guarantees have been made to us by the School as to the results of any educational or therapeutic methods used while a student is enrolled in the School.
- B. The Student and Sponsor agree to and sign the Student Expectations Agreement, the Student Rights & Responsibilities, and the acknowledgment of the Standards of Student Conduct prior to admission. Sponsor also understands that the student shall remain enrolled at Bear Creek Academy until such time as the School, the parent(s), or the legal guardian(s) agree it is time for enrollment to terminate.
- C. The Student and Sponsor consent to the use of educational and psychometric testing for purposes of formulating educational and therapeutic program plans and evaluating the Student's academic and emotional progress at the School.
- D. In order to protect the Student from harming himself/herself or others and/or destroying property, the use of containments may be necessary. Should the use of containments become necessary, the Student and Sponsor indemnify the School and its employees from any loss due to injury that may occur as a result of such containment. The Student and Sponsor shall reimburse the School for any damage caused by the Student to School property and shall reimburse any other party for any damage caused to that party's property while either on School grounds or participating in a school-sponsored activity.
- E. Sponsor understands that the School may conduct a personal search of the Student and/or his/her personal belongings. A search may be performed if the School faculty have reasons to believe a student is concealing a physical problem or injury or prohibited or dangerous items. Such activity will be conducted in the most sensitive, private, and respectful manner possible, and shall be conducted by a School employee. There will always be another individual present during the procedure to serve as a witness that it was conducted properly and professionally.
- F. Students may on occasion leave the School grounds to participate in school-sponsored therapeutic or educational activities. If the Student participates in such activities, the Student and Sponsor indemnify the School from any such loss resulting from injury that may occur as a result of said participation.
- G. Sponsor agree to allow the above student to participate in school-sponsored activities off-campus. These activities may involve overnight trips supervised by School staff. Sponsor indemnifies Bear Creek Academy from any loss resulting from injury that may occur as a result of said participation. Sponsor understands that Sponsor will be informed of any trips planned by the school that will last longer than one night. Sponsor also agrees to allow the above student to participate in occasional off-campus paid work opportunities. If the Student participates in such functions, Sponsor indemnifies Bear Creek Academy and its employees from any loss resulting from injury that may occur as a result of said participation.
- H. The Student and Sponsor understand that the Student may be offered instruction and discussion of topics outlined in the Virginia Department of Education Family Life Curriculum. These topics include the following: Human Development and Sexuality; Dating; Premarital Sex; AIDS; Teenage Pregnancy; Pregnancy Prevention and Disease Control; Prevention of Sexual Assault, Rape, Incest, and Molestation; Birthing; Parenting; Alcohol and Drug Abuse. Students and/or Sponsors who do not wish for the Student to participate in such instructional courses should sign their initials next to the statement below.

_____ I do not wish for the above-named student to participate in instruction or discussion of topics from the Virginia Department of Education Family Life Curriculum.

III. Assumption of Risks; Releases and Indemnities

- A. Sponsor acknowledges the potential hazards and dangers, known and unknown, that a student may encounter while attending the School, including but not limited to vocational activities, service work projects, emotional and physical injuries, injury or death that may arise from hiking, climbing and camping in a natural environment, exposure to the elements, plants and animals, running away from the School, "acts of God" (nature), the ropes course, canoing, water sports, stress, involvement with other students, self-inflicted injuries, and transportation to and from school-sponsored activities. Sponsor understands that by participating in the School, Student may be in locations and using facilities where hazards exist and is aware of and appreciates the risks which may result. Sponsor understands that accidents may occur during such activities due to the negligence of others which may result in death or serious injury. Sponsor and Student are voluntarily participating in the School with knowledge of the dangers involved and agree to accept any and all risks.
- B. In consideration for being permitted to participate in the Schools, Sponsor agrees to not sue, to assume all risks and to release, hold harmless and indemnify Bear Creek Academy and any and all of its predecessors, successors, officers, directors, trustees, insurers, employees, managers, agents, volunteers, community organizations, administrators, heirs, attorneys, executors, assigns and/or related or affiliated business entities (collectively all of the above persons and entities shall be referred to as the "Released Parties" hereafter) who, through negligence, carelessness or any other cause, might otherwise be liable to Sponsor or Student under theories of contract or tort law.
- C. Sponsor intends by this Waiver and Release to release, in advance, and to waive his or her rights and discharge each and every one of the Released Parties, from any and all claims for damages for death, personal injury or property damage which Sponsor may have, or which may hereafter accrue as a result of Student's participation in any aspect of the Schools, even though that liability may arise from negligence or carelessness on the part of the persons or entities being released, from dangerous or defective property or equipment owned, maintained or controlled by them or because of their possible liability without fault. Additionally, Sponsor covenants not to sue any of the Released Parties based upon their breach of any duty owed to Sponsor or Student as a result of their participation in any aspect of the Schools. Sponsor understands and agrees that this Waiver and Release is binding on his or her heirs, assigns and legal representatives and that the Released Parties shall be exempt from liability to Sponsor, his or her heirs, assigns and legal representatives.
- D. Student is physically capable of participating in the School, and his or her medical care provider has approved his or her participation. If Sponsor is aware that Student is under treatment for any physical infirmity, ailment or illness, Student's medical care provider knows of and has approved Student's participation in the Schools. Sponsor acknowledges that Sponsor, and Sponsor alone, is solely responsible for Student's personal health and safety, and the personal property Student brings with him or her.
- E. Sponsor acknowledges that the medical information Sponsor has provided on the Medical Form is current and complete and that Sponsor is solely responsible for procuring and maintaining any medical insurance Sponsor deems necessary and that the Released Parties have recommended that Sponsor procures and/or maintains medical insurance. Sponsor accepts full responsibility for any costs incurred for medical treatment due to failure to procure or maintain insurance. Sponsor understands that it is ultimately Sponsor's responsibility to provide payment to any hospital/emergency response technicians/emergency transport company that may provide services to Student as a result of injury/illness that occurs during school.
- F. Sponsor agrees that this Release extends to all claims of every nature and kind whatsoever, and hereby expressly waives all rights as allowable under Virginia law. Sponsor agrees to indemnify the Released Parties from any and all actions, causes of action, claims, demands, damages, costs (including attorneys' fees), expenses, liabilities and charges, known or unknown (the "Liabilities") arising out of or in connection with claims and/or actions relating to or brought by or on behalf of Student, including, without limitation, claims related to or arising out of the Minor's participation in the School. Initials: _____.

IV. Subcontracted Services

Sponsor agrees and consents to Bear Creek Academy's subcontracting certain services to be rendered under this Agreement to persons or entities deemed by Bear Creek Academy to be properly qualified to provide said services, at no additional cost to Sponsor unless otherwise agreed to by both parties. Bear Creek Academy is not responsible for the services provided by such third-party contractors and is hereby released from any liability arising from such services.

V. Personal Information and Confidentiality

- A. The Family Education Rights and Privacy Act (FERPA) affords parents and students over 18 years of age ("eligible student") certain rights with respect to the students education records, specifically: the right to inspect and review the student's education records within 45 days of the day the school receives a request for access; the right to request the amendment of the student's education record that the parent or eligible student believes are inaccurate or misleading; the right to consent to disclosures of personally identifiable information contained in the student's education record, except to the extent that FERPA authorizes disclosure without consent; and the right to file a complaint with the U.S. Department of Education concerning alleged failures by the school to comply with the requirements of FERPA. Personally identifiable information includes the following: (1) names of student in attendance or no longer in attendance; (2) address; (3) date and place of birth; (4) birth certificate serial number; (5) telephone listing; (6) dates of attendance; (9) awards and honors received; and (10) other similar information.

- B. Federal laws and regulations (see 42 U.S.C. 290dd-3 and 290ee-3 for federal laws, and 42 C.F.R. Part 2 for federal regulations) provide special protection for the confidentiality of certain alcohol and drug abuse treatment records. The School will not disclose information identifying the Student as an alcohol or drug abuser unless (1) the Student consents in writing; (2) the disclosure is allowed by court order; or (3) the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or school evaluation. Violation of these federal laws and regulations is a crime. Suspected violations may be reported to appropriate authorities in accordance with these federal laws and regulations. Federal laws and regulations do not protect disclosures of information about any crime committed by the Student either at the School or against any person who works for the School or about any threat to commit such a crime. Federal laws and regulations also do not protect disclosures of information regarding suspected child abuse or neglect reported under state law to appropriate state or local authorities.

VI. Family Involvement

The Student and/or Sponsor signing below understand that family involvement, cooperation, follow-through, and support are important components of the Student's emotional and academic success. Sponsor agrees to make every reasonable effort to attend conferences scheduled for the Student. Sponsor is encouraged to develop a strong relationship with the Student's teacher and behavioral specialist and to take an active interest in the student's progress.

VII. Consent to Follow-Up After Enrollment

The Student and Sponsor agree to receive follow-up contact, by telephone, mail, or electronic mail, from the School for the purpose of monitoring progress after the Student has left Bear Creek Academy.

VIII. Student Handbook & Standards of Student Conduct

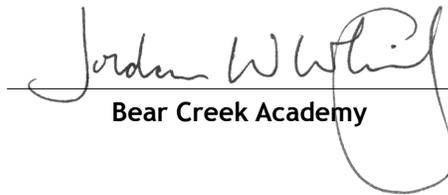
Sponsor and Student acknowledge the receipt of the Bear Creek Academy Student Handbook and the Standards of Student Conduct and have been provided the opportunity to ask questions and seek clarification on any matters of concern to me.

IX. Legal Representative

If this Agreement is signed by someone other than the Student on the Student's behalf, the person signing this Agreement confirms that he/she is the legal guardian (or representative of the legal guardian, if a state custody child) of the Student.

By signing below, the Student and/or Sponsor hereby confirms that he/she has read this **Student Enrollment Agreement** and understands and agrees to the terms and conditions set forth above.

Accepted:



Parent/Guardian

Date

Bear Creek Academy

Date



Parental Consent & Authorization

A. I authorize and give permission: (please check all that apply)

- Five checkboxes for authorizing various school activities: off-campus field trips, off-campus adventure-based activities, family life education programs, intramural recreational activities, and off-campus community service work projects.

B. Please list all individuals who have permission to pick up your child from school:

Form for listing individuals with permission to pick up the child, including fields for Name, Address, Relationship, and Telephone for up to three individuals.

C. Please list any individuals who, through legal action, are not allowed to have contact with your child or to pick up your child from school:

Form for listing individuals not allowed to have contact with the child, including fields for Name, Address, Relationship, and Telephone for up to three individuals.

If possible, please attach a recent photograph of any individuals listed above.

Signature and date lines for the parent/guardian.



Medication Release Form

Should a student need to take medicine during the school day, the parent/guardian must send a doctor's order regarding dosage and time of administration. Prescription medication must be sent to school in their original containers and be clearly labeled by the pharmacist. No expired medication will be administered.

The parent/guardian is responsible for submitting doctor's orders to the school each time there is a change of medication, dosage, or time of administration. Under no circumstances may a school staff member administer a prescribed medication without a doctor's order. Over-the-counter oral medications (e.g. Tylenol, Motrin, Benadryl, Sudafed) may be given if allowed by the parent/guardian as indicated on the form below.

Please indicate ONLY the items, which when necessary, may be used for your child:

I authorize the Bear Creek Academy staff to use the following items as part of basic first-aid care for my child, _____.

Check (✓) only those that apply.

- | | |
|---|---|
| <input type="checkbox"/> Hydrogen Peroxide | <input type="checkbox"/> First Aid Spray |
| <input type="checkbox"/> First Aid Antibiotic Ointment | <input type="checkbox"/> Hydrocortisone Cream |
| <input type="checkbox"/> Anti-itch Cream | <input type="checkbox"/> Sore Throat/ Cough Drops |
| <input type="checkbox"/> Chewable Antacid Tablets | <input type="checkbox"/> Isopropyl Alcohol |
| <input type="checkbox"/> Tylenol (Acetaminophen) | <input type="checkbox"/> Motrin (Ibuprofen) |
| <input type="checkbox"/> Benadryl (Allergy Relief) | <input type="checkbox"/> Sudafed |
| <input type="checkbox"/> Visine (Allergy Relief Eye Drop) | <input type="checkbox"/> Pepto-Bismul |
| <input type="checkbox"/> Cold & Flu Caplets | <input type="checkbox"/> Tussin DM (Cough & Chest Congestion) |

Parent/Guardian Signature: _____ Date: _____

***"Bear Creek Academy, along with all public school students, have the permission to use undesignated epinephrine for use with any student believed to be having an anaphylactic reaction (systematic allergic reaction)."*

Please sign below giving consent for the use of Epinephrine (Epi Pen) in the event of an anaphylactic reaction.

Parent/Guardian Signature: _____ Date: _____



Health Information and Emergency Release

Student's Name: _____ Social Security #: _____

Gender: M F Height: _____ Weight: _____ Eyes: _____ Hair: _____

Parent/Guardian's Name(s): _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Parent/Guardian Work Phone: _____

EMERGENCY CONTACTS - Please provide 2 emergency contacts other than parents

Name: _____ Address: _____

Home Phone: _____ Work Phone: _____

Name: _____ Address: _____

Home Phone: _____ Work Phone: _____

MEDICAL INFORMATION

Family Physician: _____ Telephone: _____

Date of last physical exam: _____ Any problems? YES NO

If "yes", please explain: _____

Family Dentist: _____ Telephone: _____

Please list all regularly used medications. Include times they are given: _____

Please list all allergies and/or drug sensitivities: _____

Please list any complications from childhood diseases: _____

Please list any mental/emotional conditions: _____

HEALTH INSURANCE INFORMATION

Health Insurance Company: _____

Group #: _____ Subscriber ID #: _____

As parents/guardians of the above child, we attest that the information provided on this form is true and accurate. We grant Bear Creek Academy permission to secure necessary medical attention for our child in case of an emergency in our absence. We further agree to pay any expense incurred.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

School Health Entrance Form (2007) Instructions

Part I

Part I is to be completed by the parent or guardian.

Please note that there are three signature lines at the bottom of the page. The first two signatures are required.

1. Inside the box -- signature of the legal guardian or parent: notes authorization for information sharing only.
2. Signature of the person completing the form: this may or may not be the parent or legal guardian; this signature is separate from that authorizing sharing of information.
3. Signature of the Interpreter: needed only if the form was completed with the assistance of an interpreter.

Part II

Instructions for the immunization records are included on the form.

For current immunization requirements consult the Division of Immunization web site at <http://www.vdh.virginia.gov/epidemiology/immunization>

Part III

The Code of Virginia requires documentation of a comprehensive physical examination upon entry to public kindergarten or elementary school. The physical examination must be done by a licensed physician, nurse practitioner, or physician assistant, and must be completed no longer than one year before school entry. The physical examination is required to protect the public from communicable disease, and to identify physical, social-emotional, or developmental needs the child has so that (1) the school can begin to prepare to assist those needs, and (2) necessary interventions can be initiated to maximize the child's school readiness. **For these reasons, in order for a child to be admitted to school without delay, Part I, Part II and -- at minimum -- the *Recommendations to (Pre) School, Child Care, or Early Intervention Personnel on Part III* must be completed in full.** Local school divisions may require other components. The School Health Entrance Form is also widely used by providers of child care, Head Start, Virginia Preschool Initiative (VPI), and Infant and Toddler Connection (Part C Early Intervention) services. School or other program personnel will contact health care professionals about forms where required sections are incomplete.

The content of the examination is based on *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents*. Wherever possible, the documentation meets expectations for Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements. Web-based continuing education modules on **current** Bright Futures and EPSDT standards are accessible at www.vcu-cme.org/bf. Revisions to the content of this training are in process to accommodate the new release of Bright Futures later in 2007.

Health Assessment/Physical Examination

Refer to Part I as completed by the parent to assist in taking or clarifying the child's history. Checking the boxes for "age/gender appropriate history" and "anticipatory guidance provided" indicates that you have completed these tasks.

Check the appropriate box for each body system examined using the following guide:

1= Within normal limits

2= Abnormal finding

3= Referred for evaluation or treatment (this indicates the provider has made a direct referral to another provider, or advised the parent to follow up with another provider)

Use the *Recommendations to (Pre) School, Child Care, or Early Intervention Personnel* section to summarize any diagnoses, abnormal findings, or concerns from the physical examination that are of significance.

Perform a risk screen for tuberculosis considering the following risk factors:

- Exposure to TB or to high risk adults
- TB-like symptoms
- Lived in high prevalence country or extensive travel in areas of high prevalence
- Homelessness or resident in congregate living
- Medically underserved
- HIV infection or receiving immunosuppressive therapy
- Other medical risk factors (i.e., malignancy, diabetes)

If the child is not at risk according to one of these factors, check the box for TB Risk Screen Negative. If the child is at risk, check the box for TB Risk Screen Positive; if you then administer a Mantoux test, document the results in the space provided. Some localities *may require* TB tests on all children for school or other program entry.

Note: If completing this form for use in Head Start, EPSDT screening and diagnostic tests apply. This includes: blood lead (test at age 1 and 2, or age 3 if not previously done) and a screen for anemia (hemoglobin or hematocrit annually at ages 2 - 5). Record the specific results and the date of each in the spaces provided. For other children, EPSDT lead or anemia screen, or any significant history of abnormal test results, **may** be noted in this section as information to the personnel reviewing the form.

Developmental Screen

Screening for age appropriate development is a critical component of well child care and is integral to identifying children who may need assistance in the school or other structured environment. The established standard of well child care recognizes the use of a tool for assessing development. Examples of tools that have been validated and found to be efficient for use in provider offices include: Parent's Evaluation of Developmental Skills (PEDS), Ages and Sages Questionnaires (ASQ), and Child Development Inventories (CDI). Bright Futures milestones are also used in such screening.

Assessment Method: Indicate the tool or method used to evaluate the child. Note the results:

- Check in the column if findings are within the normal range
- Specify any/all concerns identified in the appropriate row/column

- Check if you referred the child for further evaluation (either made a direct referral to another provider, or advised the parent to follow up)

Hearing Screen

Check the box for the screening method used and indicate the results for each method. Pure tone audiometer should be screened at 20 dB HL in each ear.

Check the boxes as applicable:

- Referred to audiologist/ENT (if child does not pass at the 20 dB level)
- Permanent hearing loss previously identified
- Hearing aid or other assistive device (such as cochlear implant)
- If you are unable to complete a hearing screen check the box “unable to test – needs rescreen”; this will alert school personnel to conduct a hearing screen.

Vision Screen

Check the box indicated if the test was performed with the child wearing corrective lenses.

Indicate the results of a stereopsis screen, if conducted (up to age 9); check the appropriate box if not.

Indicate the results of the distance acuity screen and note the test used; examples include Snellen letters, Snellen numbers, tumbling E chart, Picture tests, Allen figures. Distance testing at 10 feet is recommended.

Check the boxes as applicable:

- Pass
- Referred to eye doctor (worse than 20/40 with either eye if child is 3 – 5 years old, or 20/30 is 6 years or older, or if there is a two-line difference between the eyes even in the passing range)
- If you are unable to complete a vision screen check the box “unable to test – needs rescreen”; this will alert school personnel to conduct a vision screen.

Dental Screen

Dental caries (tooth decay) is the most common chronic disease in children. By the time of school entry, all children should be receiving routine preventive care in a dental office (dental home). Perform a visual examination of the mouth, lifting the lip to observe the condition of the gums. Based on your exam, check the appropriate box:

- Problem Identified: Referred for treatment (there are signs of caries, periodontal disease, soft tissue pathology, or a significant abnormal orthodontic condition requiring additional evaluation or corrective intervention in a dental office)
- No Problem: Referred for prevention (there is no evidence of pathology and the mouth appears normal, but the child is not currently receiving routine preventive dental care)
- No Referral: Already receiving care in a dental home (the mouth appears normal, and the child receives regular dental care as reported by the parent). **Note:** the child may have had a single or recent dental visit for an acute problem such as a broken tooth; this alone does not constitute a dental home.

Recommendations to (Pre) School, Child Care, or Early Intervention Personnel

This box communicates specific information about the child to the school or other program he/she will be entering. It is your opportunity to inform the school/program about this child’s health status, special needs or considerations, and raise any concerns that may help the school/program prepare for the child. ***This box must be completed in order for the form to be accepted by (pre) school personnel.***

Summary of Findings: Check the box “Well child; no conditions identified of concern to school program activities” if the findings from your examination and screening are all within normal range, or not significant to the child’s school entry, e.g., an acute upper respiratory infection. Check the box “Conditions identified that are important to schooling or physical activity” if there were any diagnoses or substantive abnormal findings on your examination or screening that should be flagged for school personnel, e.g., asthma, eczema, heart murmur. Use the space provided to summarize such findings from your exam or screenings.

- **Allergy:** Check the type of allergy, specify the allergen, the type of reaction, and the response required.
- **Individualized Health Care Plan Needed:** Note if a Care Plan is needed for any identified condition such as asthma, diabetes, seizure disorder, severe allergy, etc. The parent will need to collaborate with the child’s health care practitioner and provide a Care Plan to school personnel. The Care Plan does not need to accompany this form at the time of enrollment.
- **Restricted Activity:** Indicate any restrictions to physical activity, required assistive devices, or any limitations the child has, of which school personnel need to be aware.
- **Developmental Evaluation:** Note if the child already has an individualized education plan (IEP), or specify any further evaluation needs.
- **Medication:** Note if the child takes medicine, and further note if that medicine must be given or available at school. If this is the case, parents will need to provide the school with authorization. The parent should check with the school for the appropriate form and documentation needed. Authorization does not need to accompany this form at the time of enrollment.
- **Special Diet:** Note special dietary needs that have medical implications, e.g., metabolic restrictions, tube feedings. The parent will need to communicate any special dietary requests to school nutrition services.
- **Special Needs:** Summarize any special health care needs (not otherwise addressed here) of which school personnel should be aware, i.e., oxygen, treatments, etc.
- **Other Comments:** Note any other findings or recommendations that will help school or other program personnel prepare for the child, or assist the child’s family.

Health Care Professional’s Certification:

Provide the requested information about the provider who completed the exam and practice location contact information. ***The signature line must be completed;*** a signature stamp is allowed.

Helpful Web Addresses:

<http://www.vahealth.org/schoolhealth/publications.asp>

<http://www.pen.k12.va.us/VDOE/Instruction/Health/home.html>

http://www.dss.virginia.gov/facility/child_care/licensed/child_day_centers/ -- Virginia Child Day Center regulations

<http://www.headstartva.org/resources/index.htm> -- Additional resources and links, including federal regulations for Head Start

<http://www.vdh.virginia.gov/epidemiology/immunization> -- Immunization schedule/requirements

www.vcu-cme.org/bf -- Bright Futures and EPSDT requirements (under revision 2007)

**COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM
Health Information Form/Comprehensive Physical Examination Report/Certification of Immunization**

Part I – HEALTH INFORMATION FORM

State law (Ref. Code of Virginia § 22.1-270) requires that your child is immunized and receives a comprehensive physical examination before entering public kindergarten or elementary school. **The parent or guardian completes this page (Part I) of the form.** The Medical Provider completes Part II and Part III of the form. This form must be completed no longer than one year before your child's entry into school.

Name of School: _____ Current Grade: _____
 Student's Name: _____
 Student's Date of Birth: _____/_____/_____ Sex: _____ State or Country of Birth: _____ Middle Main Language Spoken: _____
 Student's Address: _____ City: _____ State: _____ Zip: _____
 Name of Mother or Legal Guardian: _____ Phone: _____ - _____ - _____ Work or Cell: _____ - _____ - _____
 Name of Father or Legal Guardian: _____ Phone: _____ - _____ - _____ Work or Cell: _____ - _____ - _____
 Emergency Contact: _____ Phone: _____ - _____ - _____ Work or Cell: _____ - _____ - _____

Condition	Yes	Comments	Condition	Yes	Comments
Allergies (food, insects, drugs, latex)			Diabetes		
Allergies (seasonal)			Head or spinal injury		
Asthma or breathing problems			Hearing problems or deafness		
Attention-Deficit/Hyperactivity Disorder			Heart problems		
Behavioral problems			Hospitalizations		
Developmental problems			Lead poisoning		
Bladder problem			Muscle problems		
Bleeding problem			Seizures		
Bowel problem			Sickle Cell Disease (not trait)		
Cerebral Palsy			Speech problems		
Cystic fibrosis			Surgery		
Dental problems			Vision problems		

Describe any other important health-related information about your child (for example, feeding tube, oxygen support, hearing aid, etc.):

List all prescription, over-the-counter, and herbal medications your child takes regularly:

Check here if you want to discuss confidential information with the school nurse or other school authority. Yes No

Please provide the following information:

	Name	Phone	Date of Last Appointment
Pediatrician/primary care provider			
Specialist			
Dentist			
Case Worker (if applicable)			

Child's Health Insurance: None FAMIS Plus (Medicaid) FAMIS Private/Commercial/Employer sponsored

I, _____ (do ___) (do not ___) authorize my child's health care provider and designated provider of health care in the school setting to discuss my child's health concerns and/or exchange information pertaining to this form. This authorization will be in place until or unless you withdraw it. You may withdraw your authorization at any time by contacting your child's school. When information is released from your child's record, documentation of the disclosure is maintained in your child's health or scholastic record.

Signature of Parent or Legal Guardian: _____ Date: _____/_____/_____

Signature of person completing this form: _____ Date: _____/_____/_____

Signature of Interpreter: _____ Date: _____/_____/_____

**COMMONWEALTH OF VIRGINIA
SCHOOL ENTRANCE HEALTH FORM**

Part II - Certification of Immunization

Section I

**To be completed by a physician, registered nurse, or health department official.
See Section II for conditional enrollment and exemptions.**

(A copy of the immunization record signed or stamped by a physician or designee indicating the dates of administration including month, day, and year of the required vaccines shall be acceptable in lieu of recording these dates on this form as long as the record is attached to this form.)

Only vaccines marked with an asterisk are currently required for school entry. Form must be signed and dated by the Medical Provider or Health Department Official in the appropriate box.

Student's Name: _____ Date of Birth:

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IMMUNIZATION	RECORD COMPLETE DATES (month, day, year) OF VACCINE DOSES GIVEN				
*Diphtheria, Tetanus, Pertussis (DTP, DTaP)	1	2	3	4	5
*Diphtheria, Tetanus (DT) or Td (given after 7 years of age)	1	2	3	4	5
*Tdap booster (6 th grade entry)	1				
*Poliomyelitis (IPV, OPV)	1	2	3	4	
*Haemophilus influenzae Type b (Hib conjugate) *only for children <60 months of age	1	2	3	4	
*Pneumococcal (PCV conjugate) *only for children <2 years of age	1	2	3	4	
Measles, Mumps, Rubella (MMR vaccine)	1	2			
*Measles (Rubeola)	1	2	Serological Confirmation of Measles Immunity:		
*Rubella	1		Serological Confirmation of Rubella Immunity:		
*Mumps	1	2			
*Hepatitis B Vaccine (HBV) <input type="checkbox"/> Merck adult formulation used	1	2	3		
*Varicella Vaccine	1	2	Date of Varicella Disease OR Serological Confirmation of Varicella Immunity:		
Hepatitis A Vaccine	1	2			
Meningococcal Vaccine	1				
Human Papillomavirus Vaccine	1	2	3		
Other	1	2	3	4	5
Other	1	2	3	4	5

I certify that this child is **ADEQUATELY OR AGE APPROPRIATELY IMMUNIZED** in accordance with the MINIMUM requirements for attending school, child care or preschool prescribed by the State Board of Health's *Regulations for the Immunization of School Children* (Minimum requirements are listed in Section III).

Signature of Medical Provider or Health Department Official: _____ **Date (Mo., Day, Yr.):** ___ / ___ / ___

Part III -- COMPREHENSIVE PHYSICAL EXAMINATION REPORT

A qualified licensed physician, nurse practitioner, or physician assistant must complete Part III. The exam must be done no longer than one year before entry into kindergarten or elementary school (Ref. Code of Virginia § 22.1-270). Instructions for completing this form can be found at www.vahealth.org/schoolhealth

Student's Name: _____ Date of Birth: ____/____/____ Sex: M F

Health Assessment	Date of Assessment: ____/____/____ Weight: _____ lbs. Height: _____ ft. ____ in. Body Mass Index (BMI): _____ BP _____ <input type="checkbox"/> Age / gender appropriate history completed <input type="checkbox"/> Anticipatory guidance provided TB Risk Assessment: <input type="checkbox"/> No Risk <input type="checkbox"/> Positive/Referred Mantoux results: _____ mm	Physical Examination 1 = Within normal 2 = Abnormal finding 3 = Referred for evaluation or treatment <table style="width:100%; border:none;"> <tr> <td></td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> <td style="text-align:center;">3</td> <td></td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> <td style="text-align:center;">3</td> <td></td> <td style="text-align:center;">1</td> <td style="text-align:center;">2</td> <td style="text-align:center;">3</td> </tr> <tr> <td>HEENT</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Neurological</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Skin</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>Lungs</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Abdomen</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Genital</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> <tr> <td>Heart</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Extremities</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td>Urinary</td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> <td style="text-align:center;"><input type="checkbox"/></td> </tr> </table>		1	2	3		1	2	3		1	2	3	HEENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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EPSDT Screens <u>Required</u> for Head Start – include specific results and date: Blood Lead: _____ Hct/Hgb _____																																																		

Developmental Screen	Assessed for:	Assessment Method:	Within normal	Concern identified:	Referred for Evaluation	
	Emotional/Social					
	Problem Solving					
	Language/Communication					
	Fine Motor Skills					
	Gross Motor Skills					

Hearing Screen	<input type="checkbox"/> Screened at 20dB: Indicate Pass (P) or Refer (R) in each box.				<input type="checkbox"/> Referred to Audiologist/ENT <input type="checkbox"/> Unable to test – needs rescreen <input type="checkbox"/> Permanent Hearing Loss Previously identified: ___Left ___Right <input type="checkbox"/> Hearing aid or other assistive device
		1000	2000	4000	
	R				
L					
<input type="checkbox"/> Screened by OAE (Otoacoustic Emissions): <input type="checkbox"/> Pass <input type="checkbox"/> Refer					

Vision Screen	<input type="checkbox"/> With Corrective Lenses (check if yes)				
	Stereopsis	<input type="checkbox"/> Pass <input type="checkbox"/> Fail		<input type="checkbox"/> Not tested	
	Distance	Both	R	L	Test used:
		20/	20/	20/	
<input type="checkbox"/> Pass <input type="checkbox"/> Referred to eye doctor <input type="checkbox"/> Unable to test – needs rescreen					

Dental Screen	<input type="checkbox"/> Problem Identified: Referred for treatment <input type="checkbox"/> No Problem: Referred for prevention <input type="checkbox"/> No Referral: Already receiving dental care
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Recommendations to (Pre) School, Child Care, or Early Intervention Personnel	Summary of Findings (check one): <input type="checkbox"/> Well child; no conditions identified of concern to school program activities <input type="checkbox"/> Conditions identified that are important to schooling or physical activity (complete sections below and/or explain here): _____ _____ _____ _____
	___ Allergy <input type="checkbox"/> food: _____ <input type="checkbox"/> insect: _____ <input type="checkbox"/> medicine: _____ <input type="checkbox"/> other: _____ Type of allergic reaction: <input type="checkbox"/> anaphylaxis <input type="checkbox"/> local reaction Response required: <input type="checkbox"/> none <input type="checkbox"/> epi pen <input type="checkbox"/> other: _____
	___ Individualized Health Care Plan needed (e.g., asthma, diabetes, seizure disorder, severe allergy, etc)
	___ Restricted Activity Specify: _____
	___ Developmental Evaluation <input type="checkbox"/> Has IEP <input type="checkbox"/> Further evaluation needed for: _____
	___ Medication. Child takes medicine for specific health condition(s). <input type="checkbox"/> Medication must be given and/or available at school.
	___ Special Diet Specify: _____
	___ Special Needs Specify: _____
	___ Other Comments: _____

Health Care Professional's Certification (Write legibly or stamp):			
Name : _____	Signature: _____	Date: ____/____/____	
Practice/Clinic Name: _____	Address: _____		
Phone: _____ - _____ - _____	Fax: _____ - _____ - _____	Email: _____	



Consent & Authorization - Behavior Management Program

Formal Behavior Management Program

In order to protect the Student from harming himself/herself or others and/or destroying property, the use of physical containments may be necessary. The use of containments with students is limited to those situations where, in the best judgment of the involved staff, a student is acting in a manner that puts the student, other persons, or staff at risk of harm. While non-physical interventions are the preferred actions to be taken, occasionally these actions are unsuccessful or the immediate seriousness of the situation precludes such utilization. In such situations, school staff members are trained in Satori Alternatives to Managing Aggression (SAMA), and empowered to implement containments to maintain the safety of the student, other persons, or staff.

Containments will not be used as a substitute for alternative behavioral management practices which would provide for less restrictive control. They are to be used only as a last resort in dealing with behavior. The staff member will maintain the containment until such time as they feel the youth has regained their composure and is able to control themselves. When the problem has passed the physical stage and anger has subsided, the staff member and student should work out the problem by talking about it.

Should the use of containments become necessary, the Student and Sponsor indemnify the School and its employees from any loss due to injury that may occur as a result of such containment. The Student and/or parent/guardian shall reimburse the School for any damage caused by the Student to School property and shall reimburse any other party for any damage caused to that party's property while either on School grounds or participating in a school-sponsored activity.

By signing this document, the student, parent/guardian, and placing school division consent to the use of the aforementioned formal behavior management program by trained Bear Creek Academy staff.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____



Parental Consent - Photo Release Form

I authorize and give permission: (please check all that apply)

- For my child's photograph to be taken by employees of Bear Creek Academy while in class, on outings, on field trips, or at other special events.
- For Bear Creek Academy to use such photographs of my child for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content.
- For my child's photograph to be taken as part of newspaper or television coverage of Bear Creek Academy or its participation in an event.

I have read and understand the above.

Parent/Guardian Signature: _____ Date: _____
Parent/Guardian Signature: _____ Date: _____

- This form must be completed in English.
- One form must be completed for each medication. **Multiple medications cannot be listed on one consent form.**
- **This form is not required for over-the-counter diaper cream, sunscreen, insect repellent, lotion, lip balm or Vaseline.**
- **Parent MUST complete #1-#17 and #19-#22 for medication to be administered 10 working days or less.** Parent may omit #16 and #17 for over-the-counter medications, sunscreen & topically applied insect repellent.
- **Health care provider MUST complete #1-18 for prescription or OTC medication to be given more than 10 working days, nebulizer or epinephrine auto-injector medication, and when dosage directions state “consult a physician”. Parent must also complete #19-22 in these cases. Health care providers do not need to complete this form for over-the-counter medications/products applied to the skin.**

1. <u>CHILD’s first and last name:</u>	2. Date of birth:	3. Child’s known allergies:
4. <u>Name of MEDICATION</u> (including strength):	5. <u>Amount/DOSAGE to be given:</u>	6. <u>ROUTE of administration:</u>
7A. <u>FREQUENCY:</u> _____ <u>Specific TIME(s)</u> (e.g. 1p.m.): _____ <u>to administer</u> <p style="text-align: center;">OR</p> 7B. Identify the <u>symptoms that will necessitate administration</u> of medication: (signs and symptoms must be observable and, when possible, measurable parameters).		
8. Possible side effects: <input type="checkbox"/> See package insert (parent must supply) <i>AND/OR</i> additional side effects:		
9. What action should the child care provider take if side effects are noted: <input type="checkbox"/> Contact parent <input type="checkbox"/> Contact prescriber at phone number provided below <input type="checkbox"/> Other (describe):		
10. Special instructions: <input type="checkbox"/> See package insert (parent must supply) <i>AND/OR</i> Additional special instructions: (Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child’s age, allergies or any pre-existing conditions. Also describe situations when medication should not be administered.) _____		
11. Reason the child is taking the medication (unless confidential by law): _____		
12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and require health and related services of a type or amount beyond that required by children generally? <input type="checkbox"/> No <input type="checkbox"/> Yes If you checked yes, complete #25 and #27 on the back of this form.		
13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered? <input type="checkbox"/> No <input type="checkbox"/> Yes If you checked yes, complete #26 and #27 on the back of this form.		
14. <u>Date consent form completed:</u>	15. <u>Date to be discontinued or length of time in days to be given</u> (this date cannot exceed 12 months from the date authorized or this order will not be valid):	
16. Prescriber’s name (please print):	17. Prescriber’s telephone number:	
18. Licensed authorized prescriber’s signature:		
Required for long-term (more than 10 working days) prescription medications, nebulizer or epinephrine auto-injector medications and when dosage directions state “consult a physician”. Not required for over-the-counter medications/products applied to the skin.		

PARENT/GUARDIAN MUST COMPLETE THIS SECTION

19. I, parent/legal guardian, authorize the day care program to administer the medication as specified on this form to _____ (child's name) _____.	
20. Parent or legal guardian's name (please print):	21. Date authorized:
22. Parent or legal guardian's signature:	

PARENT/GUARDIAN: ONLY COMPLETE THIS SECTION IF YOU REQUEST TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN #15

23. I, parent/legal guardian, request that the medication indicated on this consent form be discontinued on _____ (date) _____. Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.
24. Parent or Legal Guardian's Signature:

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED

25. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.
26. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date by which you expect the pharmacy to fill the updated order. DATE: _____ By completing this section the day care program will follow the written instruction on this form and <i>not</i> follow the pharmacy label until the new prescription has been filled.
27. Licensed Authorized Prescriber's Signature:

CHILD DAY PROGRAM TO COMPLETE THIS SECTION

28. Provider/Facility name:	29. Facility Phone Number:
I have verified that #1-#22 and, if applicable, #25-#27 are complete. My signature indicates that all information needed to give this medication has been given to the day care program.	
30. Authorized child care provider's name (please print):	31. Date received from parent:
32. Authorized child care provider's signature:	

Virginia Asthma Action Plan

School:

Effective Dates:

Name		Date of Birth
Health Care Provider	Emergency Contact	Emergency Contact
Provider Phone #	Phone: area code + number	Phone: area code + number
Fax #	Contact by text? <input type="checkbox"/> YES <input type="checkbox"/> NO	Contact by text? <input type="checkbox"/> YES <input type="checkbox"/> NO

▼ Medical provider complete from here down ▼

Asthma Triggers (Things that make your asthma)

<input type="checkbox"/> Colds	<input type="checkbox"/> Dust	<input type="checkbox"/> Animals: _____	<input type="checkbox"/> Strong odors	Season	
<input type="checkbox"/> Smoke (tobacco, incense)	<input type="checkbox"/> Acid reflux	<input type="checkbox"/> Pests (rodents, cockroaches)	<input type="checkbox"/> Mold/moisture		<input type="checkbox"/> Fall <input type="checkbox"/> Spring
<input type="checkbox"/> Pollen	<input type="checkbox"/> Exercise	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Stress/Emotions		<input type="checkbox"/> Winter <input type="checkbox"/> Summer

Asthma Severity: Intermittent Persistent: Mild Moderate Severe

Green Zone: Go! Take these CONTROL Medicines every day at home

<p>You have ALL of these:</p> <ul style="list-style-type: none"> Breathing is easy No cough or wheeze Can work and play Can sleep all night <p>Peak flow: _____ to _____ (More than 80% of Personal Best)</p> <p>Personal best peak flow: _____</p>	<p>Always rinse your mouth after using your inhaler. Remember to use a spacer with your MDI when possible. <input type="checkbox"/> No control medicines</p> <p><input type="checkbox"/> Advair _____, <input type="checkbox"/> Alvesco _____, <input type="checkbox"/> Arnuity _____, <input type="checkbox"/> Asmanex _____</p> <p><input type="checkbox"/> Breo _____, <input type="checkbox"/> Budesonide _____, <input type="checkbox"/> Dulera _____, <input type="checkbox"/> Flovent _____, <input type="checkbox"/> Pulmicort _____</p> <p><input type="checkbox"/> QVAR Redihaler _____, <input type="checkbox"/> Symbicort _____, <input type="checkbox"/> Other: _____</p> <p>MDI: _____ puff (s) _____ times per day <u>or</u> Nebulizer Treatment: _____ times per day</p> <p>Singular/Montelukast take _____mg by mouth once daily</p>
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For Asthma with exercise/sports add: MDI w/spacer 2 puffs, 15 minutes prior to exercise:
 Albuterol Xopenex Ipratropium *If asymptomatic not < than every 6 hours*

Yellow Zone: Caution! Continue CONTROL Medicines and ADD RESCUE Medicines

<p>You have ANY of these:</p> <ul style="list-style-type: none"> Cough or mild wheeze First sign of cold Tight chest Problems sleeping, working, or playing <p>Peak flow: _____ to _____ (60% - 80% of Personal Best)</p>	<p><input type="checkbox"/> Albuterol <input type="checkbox"/> Levalbuterol (Xopenex) <input type="checkbox"/> Ipratropium (Atrovent)</p> <p>MDI: _____ puffs with spacer every _____ hours as needed</p> <p><input type="checkbox"/> Albuterol 2.5 mg/3m1 <input type="checkbox"/> Levalbuterol (Xopenex) <input type="checkbox"/> Ipratropium (Atrovent) 2.5mg/3m1</p> <p>Nebulizer Treatment: one treatment every _____ Hours as needed</p> <p style="text-align: center;">Call your Healthcare Provider if you need rescue medicine for more than 24 hours <u>or</u> two times a week <u>or</u> if your rescue medicine does not work.</p>
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Red Zone: DANGER! Continue CONTROL & RESCUE Medicines and GET HELP!

<p>You have ANY of these:</p> <ul style="list-style-type: none"> Can't talk, eat, or walk well Medicine is not helping Breathing hard and fast Blue lips and fingernails Tired or lethargic Ribs show <p>Peak flow: < _____ (Less than 60% of Personal Best)</p>	<p><input type="checkbox"/> Albuterol <input type="checkbox"/> Levalbuterol (Xopenex) <input type="checkbox"/> Ipratropium (Atrovent)</p> <p>MDI: _____ puffs with spacer <u>every 15 minutes</u>, for THREE treatments</p> <p><input type="checkbox"/> Albuterol 2.5 mg/3m1 <input type="checkbox"/> Levalbuterol (Xopenex) <input type="checkbox"/> Ipratropium (Atrovent)</p> <p>Nebulizer Treatment: one nebulizer treatment <u>every 15 minutes</u>, for THREE treatments</p> <p style="text-align: center;">Call 911 or go directly to the Emergency Department NOW!</p>
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I give permission for school personnel to follow this plan, administer medication and care for my child, and contact my provider if necessary. I assume full responsibility for providing the school with prescribed medication and delivery/ monitoring devices. I approve this Asthma Management Plan for my child. With HCP authorization & parent consent inhaler will be located in clinic or with student (self-carry)

PARENT/Guardian _____ Date _____

SCHOOL MEDICATION CONSENT & HEALTH CARE PROVIDER ORDER

CHECK ALL THAT APPLY

Student may carry and self-administer inhaler at school.

Student needs supervision/assistance & should not carry the inhaler in school.

MD/NP/PA SIGNATURE: _____ DATE _____

- CC: Principal Parent/guardian School Nurse or clinic Bus Driver Coach/PE
 Office Staff School Staff Cafeteria Mgr
- Transportation**

Virginia Asthma Action Plan approved by the Virginia Asthma Coalition (VAC) 03/2019

Blank copies of this form may be reproduced or downloaded from www.virginiaasthmacoalition.org

Bear Creek Academy
Parent/Student Agreement for Permission to Carry an Inhaler

If your child must use an inhaler for his/her asthma, please complete and return this form with your application packet.

Parent:

- I give my consent for my student to carry and self-administer his/her inhaler.
- I understand that the school and / or its employees cannot be held responsible for negative outcomes resulting from self-administration of the inhaled asthma medication.
- This permission to possess and self-administer asthma medication may be revoked by school staff if it is determined that your student is not safely and effectively self-administering the medication.
- A new Parent/Student Agreement for Permission to Carry an Inhaler must be submitted each school year.

Parent/Guardian's Signature Required

Date

Student:

- I have demonstrated the correct use of the inhaler to the school administration.
- I agree never to share my inhaler with another person or use it in an unsafe manner.
- I agree that if there is no improvement after self-administering, I will report to the school administration or other responsible adult for assistance.

Student's Signature Required

Date



BEAR CREEK ACADEMY

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Name: _____ SSN: _____ DOB: _____

This authorizes Bear Creek Academy, Inc. to ___ send to; ___ receive from:

The following information:

_____ Discharge Summary	_____ Treatment Plan	_____ Diagnosis
_____ Educational Testing	_____ Quarterly Reviews	_____ Grade Reports
_____ Other (please specify): _____		

For the purpose of:

_____ Assessment/Evaluation	_____ Service Coordination	_____ Referral
_____ Determination of Eligibility	_____ Treatment Planning	_____ Case Management
_____ Other (please specify): _____		

Limitations or Restrictions: _____

I understand that, if not previously revoked, this consent will expire **one year** after the date of my signature unless otherwise specified here: Authorization expires _____ (not to exceed one year). I may cancel this consent at any time by submitting a written statement to this effect to Bear Creek Academy, Inc.

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____



Request for Student Records

To the Parent or Guardian:

To complete the application process, please sign the following release statement and deliver to the Guidance Office at the applicant's current school. This will give Bear Creek Academy access to the applicant's official transcripts, records, and confidential files. If you have any questions or difficulties in having materials sent to Bear Creek Academy, contact the School Administrator.

Applicant's Name: _____

I hereby authorize my child's school to release transcripts, test scores, and health information (including immunization records) and any confidential files to Bear Creek Academy.

Parent/Guardian Signature: _____ Date: _____

To the Counselor/Principal:

The above-named student has applied for admission to Bear Creek Academy. Thank you for assisting us in the admission process by forwarding the requested records to:

Director of Education
Bear Creek Academy
P.O. Box 192
Cumberland, VA 23040
Fax: 804-492-9942

- Academic transcripts, including courses and final grades
- Standardized test data, including SOL test scores
- Records or evaluations pertaining to any placement in special education programs, including:
 1. Eligibility Committee Minutes
 2. Most recent IEP
 3. Behavior Intervention Plans
 4. Functional Behavior Assessments
- Health/immunization records