



HOPETREE

FAMILY SERVICES

EST. 1890

860 MOUNT VERNON LANE, SALEM, VA 24153
540-389-5468 | HOPETREEFS.ORG



HOPETREE

ACADEMY

862 Mount Vernon Lane, Salem, VA 24153
P: 540-389-4941 F: 540-444-7309

SCHOOL INFORMATION

Date of Referral:		Date School Placement is needed:	
Name of Referral Representative: (Parent/Guardian, LEA Representative (School District), or other Agency:			
Representative's Name:	Representative's Phone:	Representative's Email:	Representative's Fax:
Relationship to Student:			
Student's Current Local Education Agency (School District):			
Home School Name:	Home School Address:	Home School Phone:	Home School Fax:
Student's Current Placement (If different from home school)			
Current School Name:	Current School Address:	Current School Phone:	Current School Fax:
Student's Last Name:	Student's First Name:	Student's Middle Name:	Current Grade Level:
Race:	Sex:	Preferred Pronoun:	DOB:
SSN:			
Student's Testing Identification Number (STI):			
Student's Primary Disability:			
Provide a brief description of the Youth's current educational situation and why an educational placement is needed at HopeTree Academy:			

DOCUMENTS

In order to complete the application process, the following items must be completed and attached in order for HopeTree Academy to consider acceptance:

Current IEP and Addendums
Most recent Eligibility
Behavior Intervention Plan (BIP)
Functional Behavioral Assessment (FBA)
Most Recent Psychological Report
Most Recent Report Card

Most Recent Transcript
SOL Score records
Most Recent Class Schedule
Discipline Records
Available Discharge Summaries.
Comprehensive Physical and Immunization Records
Other:

After all items of the application are submitted, HopeTree Academy's School Social Worker will reach out to schedule an admissions meeting.

Please attach copies of the records and reports specified above and send to:

**HopeTree Academy
ATTN: HopeTree Academy School Social Worker
862 Mount Vernon Lane
P.O. Box 849
Salem Virginia 24153
Fax (540) 444 - 7309**

PARENT / LEGAL GUARDIAN INFORMATION

Mother / Legal Guardian's Name:			
Mother / Legal Guardian's Address:			
Home Number:	Cell Number:	Work Number:	Email Address:
Father / Legal Guardian's Name:			
Father / Legal Guardian's Address:			
Home Number:	Cell Number:	Work Number:	Email Address:
Insurance Provider:			
Insurance Policy Number:			
Emergency Contacts:			
Name:	Relationship:	Phone Number:	
Name:	Relationship:	Phone Number:	
Name:	Relationship:	Phone Number:	

Current/Past Agency Involvement if applicable:	
Social Services:	Name of Contact:
Mental Health Services:	Name of Contact:
Youth Services:	Name of Contact:
Other:	Name of Contact:

HOPETREE ACADEMY RELEASE OF RECORDS

HOPETREE ACADEMY – HOPETREE FAMILY SERVICES

AUTHORIZATION FOR RELEASE OF SCHOOL RECORDS AND PROTECTED HEALTH INFORMATION (PHI) TO HOPETREE ACADEMY

Section A: This section must be completed for ALL Authorizations		
Student Name:	Birth Date:	Social Security No. (optional):
Name and Address:	Release to: Hope Tree Academy PO Box 849 Salem, VA 24153 Phone: (540)389-4941 Fax: (540)444-7309	
This authorization will expire on the following: (Fill in the Date or the Event, but not both.)		
Date:	Event:	
Purpose of Disclosure:	<input type="checkbox"/> Admission <input type="checkbox"/> Evaluation of current and future needs <input type="checkbox"/> Recent review of file revealed the following records to be missing	
DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED		
HopeTree Family Academy may check as many items below as needed.		
Description:	Notes:	
<input type="checkbox"/> Current IEP and Addendums <input type="checkbox"/> Most recent Eligibility <input type="checkbox"/> Behavior Intervention Plan (BIP) <input type="checkbox"/> Functional Behavioral Assessment (FBA) <input type="checkbox"/> Most Recent Psychological Report <input type="checkbox"/> Most Recent Report Card <input type="checkbox"/> Most Recent Transcript <input type="checkbox"/> Most Recent Class Schedule <input type="checkbox"/> Discipline Records <input type="checkbox"/> Available Discharge Summaries. <input type="checkbox"/> Comprehensive Physical and Immunization Records <input type="checkbox"/> Other:		
I understand that:		
1. I may see and obtain a copy of the information described on this form by requesting it in writing. Under Virginia law this information will be provided to me within 15 days of my request. 2. I may revoke this authorization at any time by notifying HopeTree Academy , in writing, of my intent to do so. This will not affect any actions taken prior to receiving the revocation. 3. If the requester or receiver is not a health plan, health care clearinghouse, or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed. 4. I acknowledge that I have the right to a copy of this authorization after I have signed it.		
Section B: This Request for the PHI is NOT for the purpose of marketing.		
HopeTree Academy will not receive financial or in-kind compensation in exchange for using or disclosing this information.		
Section C: Signatures		
I have read the above and authorize the disclosure of School Records and Protected Health Information as described on this form, and I believe that such consent is in the best interests of all concerned.		
Signature of Student's Legal Guardian/Adult Student	Date:	
Legal Guardian's Relationship to Student:		

MEDIA RELEASE

2020-2021 School Year

HopeTree Family Services would like to share HopeTree Academy experiences with our community. By consenting to have your child’s name, photo, or voice used in our online and printed publications, you are helping us share student successes and experiences.

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

The undersigned student and guardian each consent to the use of the following information in HopeTree Family Services promotional materials. Please place an “x” on the lines that apply.

	Yes	No
Full Name		
First Name Only		
Photograph		
Film/Video		
Voice		

Promotional materials include, but are not limited to, printed or electronic publications, websites, social media, such as HopeTree Family Services Facebook, Twitter, and all other electronic or printed communications of HopeTree Family Services.

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 remain property of HopeTree Family Services. The student and guardian may receive a copy of any printed materials using their name, photograph, or identifiable interview content. Lastly, the student and guardian acknowledge that they will not receive any monetary compensation.

Date: _____ Signature: _____
Student

Date: _____ Signature: _____
Parent or Legal Guardian

ACADEMIC YEAR 2020 - 2021

HEALTH INFORMATION FORM

Student's Name				
Physician's Name		Physician's Phone		
Preferred Hospital				
Medicaid	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Medicaid #	
Other Insurance	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Other Insurance Name	Policy #		Phone #	

PAST AND PRESENT HISTORY - STUDENT HEALTH PROBLEMS (please check and provide explanation below)

<input type="checkbox"/> ADD / ADHD	<input type="checkbox"/> Ear problem / hearing	<input type="checkbox"/> Muscular Dystrophy
<input type="checkbox"/> Bleeding disorder / hemophilia	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Neurological disorders
<input type="checkbox"/> blood pressure disorder	<input type="checkbox"/> Eczema	<input type="checkbox"/> Orthopedic disorders
<input type="checkbox"/> Cancer	<input type="checkbox"/> Emotional disorders	<input type="checkbox"/> Scoliosis Seizures
<input type="checkbox"/> Catheterization	<input type="checkbox"/> Feeding tube G tube	<input type="checkbox"/> Sickle cell anemia
<input type="checkbox"/> Cerebral palsy	<input type="checkbox"/> Headaches	<input type="checkbox"/> Spina bifida
<input type="checkbox"/> Cochlear implant	<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Stomach spasms / ulcers
<input type="checkbox"/> Colostomy	<input type="checkbox"/> Hyperventilates	<input type="checkbox"/> Thyroid condition
<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Menstrual Disorder	<input type="checkbox"/> Tracheostomy
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Vision

Explanation(s):

Other Health Concerns:

Allergies:

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

Medications:

All medication that need s 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 HopeTree Academy's handbook for further information.

Is your child currently taking any medications (prescription and over the counter at home or at school	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If yes, please describe below:

Name of Drug	Dosage	How Often	School or Home

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

Signature of Parent/ Guardian

Date

MEDICAL ORDERS FOR SPECIAL HEALTH CARE NEEDS

Student's Name				
Student's Grade				
Student's DOB				
Effective Date		Plan in effect for one academic school year including ESY.		

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

HEALTH STATUS
Diagnosis and description of medical concern:
List of relevant medical history (surgery, hospitalizations, allergies, ect.):

ACTIVITY

Are there any health related absences expected?

Yes

No

Comment:

Level of participation in Physical Education

Full

Restricted

Partial

Comment:

EMERGENCY PLAN

Are there any emergency medical interventions needed?

Yes

No

Comment:

PROCEDURES

Are procedures required for this student to attend school?

Yes

No

Comment:

Does the student require assistance from additional staff?

Yes

No

PRN Unskilled (non-licensed)

PRN Skilled (RN or LPN)

Full-time

Part-time

Comment:

MEDICATIONS

Please list relevant medications:

Medication / Dosage	Time	Directions	School	Home
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>

AUTHORIZATION OF MEDICAL PROVIDER

M.D. Printed Name	
M.D. Signature	
M.D. Phone	
M.D. Date of Authorization.	

PARENT / GUARDIAN CONSENT

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

Parent / Guardian Printed Name	
Parent / Guardian Signature	
Parent / Guardian Phone	
Date of Authorization	

HEALTH INFORMATION ACKNOWLEDGEMENT FORM

Student's Name	
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Please check the boxes and sign at the bottom of the form indicating that you understand each of the following:

<input type="checkbox"/>	The information provided on the Health Information Sheet is correct to the best of my knowledge.					
<input type="checkbox"/>	I give permission for the school to contact my child's physician when necessary.					
<input type="checkbox"/>	All medication (over-the-counter and prescribed) must be provided by the parent in the original container and the parent must provide written permission before any medication may be administered.					
<input type="checkbox"/>	<p>Keep your child home if he/she has any of the following symptoms</p> <table border="1" style="margin-left: 20px;"> <tr><td>A temperature greater than 99.1°F</td></tr> <tr><td>Vomiting</td></tr> <tr><td>Diarrhea</td></tr> <tr><td>Rash with fever</td></tr> <tr><td>appears severely ill</td></tr> </table>	A temperature greater than 99.1°F	Vomiting	Diarrhea	Rash with fever	appears severely ill
A temperature greater than 99.1°F						
Vomiting						
Diarrhea						
Rash with fever						
appears severely ill						
<input type="checkbox"/>	Please call the school if your child is sick.					
<input type="checkbox"/>	Update the school of any changes to your child's medications.					
<input type="checkbox"/>	Keep school immunization records up-to-date. If your child receives immunizations after the initial enrollment in the school, please give a copy to the school.					

Signature of Parent / Guardian

Date

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

I, _____ Parent/Legal Guardian, hereby give any paid staff of HopeTree Academy 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 for the on-going medical, dental, psychiatric needs pertaining to _____.

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

_____ Signature of Mother	Date _____
_____ Signature of Father	Date _____
_____ Signature of Legal Guardian	Date _____

PERMISSION TO TRANSPORT

ACADEMIC YEAR _____ - _____

My child has permission to be transported by HopeTree Family Services. 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 / Guardian Signature

Date

PERMISSION TO ADMINISTER MEDICATION FORM

Dear Parents/Guardians:

Please complete the "Permission to Administer Medication form for your child who may need prescribed or over-the-counter medication (Tylenol, Acetaminophen, or Ibuprofen, etc.) administered during the school day. All medication forms must be filled out by the physician prescribing the medication and signed by both the prescribing physician and parent/guardian. We will not be allowed to administer any medication to the student during the school day if we do not have a form filled out by the student's physician and/or prescriber for each medication.

The form must be returned to Hope Tree Academy preferably by parent/guardian or faxed to (540) 444-7309 from the doctor's office. The Academy cannot legally call the parent/guardian for verbal permission to administer any medication. All permissions must be listed on the written form to be adhered to. If the student is on a prescribed medication (Inhaler, Epi-pen, etc.) the prescription and over-the-counter medication must be brought in by Parent Guardian in its original container (box, plastic container, prescription bottle, etc.) with the prescription clearly displayed. All prescribed and over-the-counter medication in pill form will be counted by the parent/guardian and the office assistant at the time of delivery and both parties will sign off on the number of pills delivered and counted.

Each medication requires its own Permission to Administer Medication form signed by the prescriber. For example, if a student takes three prescription medications, then they will need to have three Permission to Administer Medication forms. Also, any changes to dosage or instructions will require a new form signed by the prescriber.

Thank you for your cooperation. If you have any questions, feel free to call (540) 389-4941.

Permission to Administer Medication

This form must be completed fully in order for HopeTree Academy Staff to administer required medication both prescription and over-the-counter. A New medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of medication.

- Medication must be labeled by physician or pharmacist and be in the original container
- Non-prescription medication must be in the original container with the label intact
- A legal guardian must bring the medication to school
- All medications brought to the school must be checked and verified by Hope Tree Academy Staff
- At the end of the school year, all remaining medication must be picked up by the guardian within two weeks of the child's last day of school. Medications that are not picked up will be disposed of.

This order is only valid for the _____ - _____ school year(including summer session).

Student's Name	
Student's Date of Birth	
Date of Prescription	
Medication	
Medication Strength	
Medication Dose	
Medication Route	
Time/Frequency of Administration	
If PRN, Frequency	
Condition or Allergy for which medication is being administered	
What is the intended effect of the medication	
Relevant Side Effects	

ASTHMA and ALLERGIES ONLY: Please check Yes or No

	Yes	No
May student self-administer medication under the supervision of HopeTree Academy Staff?		
Does Severity of asthma necessitate that the student carry an inhale on their person while in school?		
Does the severity of allergy(s) require the student to carry an EpiPen on his/her person while in school?		
Should an additional EPI-Pen be kept in the Medication room for this student.		

Consent of Parent Guardian for above Administration of Prescription OTC medications

_____ Parent Signature	_____ Physician Signature
_____ Printed Name	_____ Printed Name (Physician)
_____ Emergency Phone Number	_____ Physician's Phone Number
_____ Date	_____ Date

Parental Waiver of Liability

I herewith acknowledge that I am primarily responsible for administering medication to my child. However, in my absence, I hereby authorize HopeTree Academy/HopeTree Family Services and its medically training employees to administer to my child the above noted medication. I further acknowledge and agree that when the above medication is administered, I waive any/all claims I may have against HopeTree Academy/HopeTree Family Services and its employees arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the HopeTree Academy/ HopeTree Family services and its employees either jointly or severally, from and against all claims, damages, causes of action or injuries incurred or resulting from the administration of said medication.

Parent Signature
Date

STUDENT INFORMATION AND PERMISSION FOR COUNSELING

ACADEMIC YEAR _____ - _____

Student's Name			
Date			
Parent Guardian Name		Relationship to Student	
Home Phone Number		Work Phone Number	
Cell Phone Number			

Presenting Behaviors (please check all that apply):

<input type="checkbox"/> Threatened to run away	<input type="checkbox"/> Number of runaways __	<input type="checkbox"/> Skipping School
<input type="checkbox"/> Threatened suicide	<input type="checkbox"/> Attempted suicide	<input type="checkbox"/> Currently suicidal
<input type="checkbox"/> Family conflicts	<input type="checkbox"/> Substance abuse	<input type="checkbox"/> Anger Problems
<input type="checkbox"/> Depressed mood	<input type="checkbox"/> Grief or loss	<input type="checkbox"/> Lying
<input type="checkbox"/> Negative attitude	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Sexual abuse
<input type="checkbox"/> Physical Abuse	<input type="checkbox"/> Family Substance Abuse	<input type="checkbox"/>

Has the student been exposed to a traumatic event? If so, please Specify:

I, _____, Parent/guardian of _____ give my permission for my child to participate in counseling services at school. I understand that information shared in individual and group counseling will remain confidential. As mandated reporters, HopeTree Academy 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: _____

HopeTree Academy Technology Access Survey

Student's Name _____

Date _____

What type of technology do you have available for your child to use for school work at home?	<input type="checkbox"/> Desktop PC <input type="checkbox"/> Laptop PC <input type="checkbox"/> iPad <input type="checkbox"/> Android Tablet <input type="checkbox"/> Chromebook <input type="checkbox"/> Other _____
Would you allow your child to use a device that the school issued for schoolwork at home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
How many devices are being used in the household?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 5+
Do you have internet access at home?	
What type of Internet do you have at home?	<input type="checkbox"/> Broadband <input type="checkbox"/> DSL <input type="checkbox"/> Dial-up <input type="checkbox"/> Satellite <input type="checkbox"/> Cellular Service <input type="checkbox"/> We do not have internet access
Do you have an alternate method for accessing the internet if not available at home?	<input type="checkbox"/> No, We cannot access the internet <input type="checkbox"/> Yes, We have access at a local restaurant or business. <input type="checkbox"/> Yes, We have access at the local library. <input type="checkbox"/> Yes, we have access at a friend's or family member's house.

HOPETREE ACADEMY COMPUTER USAGE AND INTERNET POLICY

Internet access has been established for a limited educational purpose that shall be consistent with the school's curriculum and the State Standards. The term "educational purpose" includes academic activities, career development, and approved limited, high-quality, activities. All students and parents/guardians must sign a copy of this policy and return it to their teacher prior to being allowed to use a computer.

- Under no circumstances should a student provide their password or user names to other students or allow anyone to use their login and password.
- Students are not authorized to load any software on a computer system.
- Our internet access is limited to an approved white list. Under no circumstances is a student permitted to access a website that is not approved by the classroom teacher for academic purposes.
- Students are not allowed to play personal media or use personal peripherals on the school's computers.
- Students are not permitted to use obscene, profane, lewd, vulgar, rude, threatening, or disrespectful language while using the school's computers.
- Students are not permitted to change the default set-up of HopeTree computers.
- There is no food or beverages allowed around the computers.
- Students are responsible to report any problems they see with the computers immediately to a teacher.
- All student accounts are monitored by HopeTree Academy staff. HopeTree Academy will have open access to all student accounts at all times.

Failure to follow these rules and standards can result in the suspension and/or deletion of the student's computer account and/or other disciplinary action. Please sign that you have read and understand the Computer Usage and Internet Policy and that you have discussed it with your child.

I have read and understand the above policy and agree to follow all the rules as stated. I understand that if I don't follow these policies, then I will have to face the consequences explained to me.

Student Signature

Date

Parent / Guardian Signature

Date