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 Student Support Specialist** **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:
☐Admission
☐Evaluation of current and future needs
☐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:
☐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 ☐Most Recent Class Schedule ☐Discipline Records ☐Available Discharge Summaries. ☐Comprehensive Physical and Immunization Records ☐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

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 _____

HEALTH INFORMATION FORM

Student's Name				
Physician's Name		**Physician's Phone**		
Preferred Hospital				
Medicaid	❑ **Yes**	❑ **No**	**Medicaid #**	
Other Insurance	❑ **Yes**	❑ **No**		
Other Insurance Name	**Policy #**		**Phone #**	

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

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

Explanation(s):

Other Health Concerns:

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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 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 HopeTree Academy's handbook for further information.

Is your child currently taking any medications (prescription and over the counter at home or at school	❑ **Yes**	❑ **No**

If yes, please describe below:

Name of Drug	**Dosage**	**How Often**	**School or Home**

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

_____ _____
Signature of Parent/ Guardian **Date**

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, etc.):

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
			❑	❑
			❑	❑
			❑	❑
			❑	❑
			❑	❑

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	
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.
❑	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.
❑	Keep your child home if he/she has any of the following symptoms A temperature greater than 99.1°F Vomiting Diarrhea Rash with fever 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 the initial enrollment in the school, please give a copy to the school.

_____ _____

Signature of Parent / Guardian Date

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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.

_____ Date_____
Signature of Mother

_____ Date_____
Signature of Father

_____ Date_____
Signature of Legal Guardian

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PERMISSION TO TRANSPORT

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

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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.

HopeTree Academy

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HopeTreeAcademy.org
A Ministry of HopeTree Family Services

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
- An adult must bring the medication to the school
- All medications brought to the school must be checked in and verified by HopeTree Academy Staff
- At the end of the school year, all remaining medications must be picked up by parent/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 valid only for school year (current): _____ including Summer session.

Student's Name: _____ Birthdate: _____

Date of Prescription: _____

Medication: _____ Strength: _____ Dose: _____ Route: _____

Time/Frequency of Administration: _____ If PRN, frequency: _____

Condition for which medication is being administered: _____

What is the intended effect of the medication? _____

Relevant Side Effects: ☐None Expected ☐Explain: _____

ASTHMA & ALLERGIES only: (Please check Yes or No)

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

Consent of Parent/ Guardian for above Administration of Prescription/OTC medications:

_____ _____
Parent Signature Physician Signature

_____ _____
Printed Name (Parent) Printed Name (Physician)

_____ _____
Emergency Phone# Physician's Phone#

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 trained 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 any and 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):

❑ Threatened to run away	❑ Number of runaways __	❑ 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	❑

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 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

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HopeTree Academy

HopeTree Academy

In collaboration with HopeTree Family Services Clinical Department, HopeTree Academy provides various behavioral health services and supportive educational interventions to your student. Services offered include:

Individual Counseling

Group Counseling

Family Counseling

Case Management

Family Activities/Events

Classroom Presentations/Activities

School-wide Activities

Classroom Behavior Support

Teacher/School Staff Consultation

Behavioral Health Screening and Assessment

Home Visits (as needed)

Psychiatric Consultation

Advocacy

Attendance and Support at Team Meetings

Resource Sharing

Consent for Behavioral Health Services

I give consent for my child,_____, to receive behavioral health services through HopeTree Family Services at HopeTree Academy. I understand that these services may include individual, group, and/or family sessions, teacher/staff consultation, as well as other services and activities (see attached). I understand that youth, teacher, and caregiver assessments will be collected as part of the school behavioral health program. These assessments will be used to inform treatment and to ensure the quality of the services provided. Results of these assessments will only be shared as a group report, without any identifying student information. All records pertaining to the school mental health services are the property of the school behavioral health program and will be kept confidential (i.e. they will not be released without parental/legal guardian permission). Please sign below to indicate your consent for your child to receive school behavioral health services from the HopeTree Family Services.

Signature of parent/legal guardian	**Date**
Printed Name of parent/legal guardian	**Phone Number**
Address	**Work Number**
Staff	**Date**

☐ **Please check if the student is over 14 years of age.**

☐ **Please check if the student is 18 years of age or older.**

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