2022-2023 STUDENT INFORMATION FORM

Full Name: _____ DOB: _____ Sex: _____
Student Address: _____ City: _____ Zip: _____
Home Phone: _____Social Security Number: _____ Ethnicity: _____
Diagnoses:_____
_____

PARENT/GUARDIAN INFORMATION

1st Guardian's Name: _____ Phone (Home/Cell): _____
Relationship: _____ Email Address: _____
Address (if different from student): _____
Employer: _____ Title: _____ Work Phone: _____

2nd Guardian's Name: _____ Phone (Home/Cell): _____
Relationship: _____ Email Address: _____
Address (if different from student): _____
Employer: _____ Title: _____ Work Phone: _____

Do parents share custody, or is there a custody agreement in place that the school should know about? In addition to noting here, please provide school with court ordered documentation. (Choose one) ☐ **Y** ☐ **N**

IT IS THE PARENT'S/GUARDIAN'S RESPONSIBILITY TO KEEP THE SCHOOL INFORMED OF CHANGES IN CUSTODY BY PROVIDING THE OFFICE WITH CURRENT AND COMPLETE LEGAL DOCUMENTS EACH YEAR AND AFTER ANY CHANGES.

EMERGENCY CONTACTS

Please list 2 emergency contacts to be called in the event a parent/guardian cannot be reached:
Name _____Relationship _____Phone Number _____
Name _____Relationship _____Phone Number _____

HEALTH INFORMATION

I AUTHORIZE THE SCHOOL PERSONNEL TO TAKE RESPONSIBLE EMERGENCY MEASURES, INCLUDING CALLING 911, ON BEHALF OF MY CHILD AND AGREE TO HOLD THEM HARMLESS FOR ANY TREATMENT RENDERED.

Parent Signature _____ Date: _____

Insurance Company: _____ Policy #: _____Group #: _____
Physician: _____ Phone: _____ Hospital: _____

I VERIFY THAT THE INFORMATION IN THIS DOCUMENT IN ITS ENTIRETY IS CURRENT AND THAT I WILL IMMEDIATELY INFORM THE SCHOOL OF ANY CHANGES IN THIS INFORMATION. I AM RESPONSIBLE FOR TUITION, FINES, PENALTIES, ATTORNEY'S FEES, AND COURT COSTS RESULTING FROM A FALSIFIED DOCUMENT.

Parent Signature _____ Date: _____

2022-2023 BILLING AUTHORIZATION FORM

Parent Name_____
Student Name_____

BILLING AGREEMENT

Billing Frequency (Choose one) ☐ **MONTHLY** ☐ **QUARTERLY** ☐ **SEMI-ANNUALLY** ☐ **ANNUALLY** ☐ **OTHER**

Payment Type (Choose one) ☐ **CREDIT CARD** ☐ **PERSONAL CHECK** ☐ **BANK CHECK** ☐ **MONEY ORDER** ☐ **OTHER**

I UNDERSTAND THE FOLLOWING (Initial):

_____If I have chosen the monthly plan, I am required to keep an active credit card on file at the school.

_____Using a credit card for any purposes at Mainspring Academy will result in a 3% convenience fee being added to the transaction.

_____Mainspring Academy will not accept cash payments for tuition, registration fees, parent participation opt-out fees, Intersession, the Extended School Day Program, or Extended School Year Program.

_____If the school has not received payment close of business on the 1st of the month or a monthly date otherwise agreed upon by Mainspring Administration; OR by close of business on the quarterly, semi-annual, or annual due dates, this credit card information will be used to process my tuition payment.

_____I am responsible for a $50.00 fee for any bounced check penalties should I pay with a check returned due to insufficient funds. Repeated bounced checks maybe grounds for dismissal from the program.

_____After a second incident of a bounced personal check, I will be required to use bank checks, money orders, or an active credit card.

_____Late payments will result in a fee of 10% of my payment due, for each week late.

_____I am responsible for promptly notifying the School before any payment due dates and completing a change in payment request form if my payment information changes due to loss, fraud, insufficient funds, and any other circumstances.

_____Unpaid obligations may result in the suspension of my child from the school or its programs until payments are fulfilled.

_____I am responsible for unpaid obligations due to scholarship delays or related issues. Unpaid obligations or failure to arrange for timely payment to the school on my child's state scholarship accounts may result in late fees and/or the suspension of my child from the school or its programs until payments are fulfilled.

_____Regardless of who is the actual payer of any amount owed, I remain solely responsible for all tuition, fees, and additional programming costs for my child.

CREDIT CARD INFORMATION

Name on Card _____

Cardholder Street Address_____
City _____ State _____ Zip _____

Credit Card Type (Choose One) ☐ **VISA** ☐ **MASTERCARD** ☐ **AMERICAN EXPRESS** ☐ **OTHER**

Credit Card Number _____

Expiration Date_____CVV_____
Address (if different from student): _____

BY SIGNING THIS DOCUMENT, I HEREBY AUTHORIZE MAINSPRING ACADEMY INC. TO BILL MY CREDIT CARD FOR TUITION, SCHOOL REGISTRATION FEES, PARENT PARTICIPATION OPT-OUT FEES, INTERSESSIONS, EXTENDED CARE SERVICES, AND/OR EXTENDED SCHOOL YEAR SERVICES.

Signature _____Date_____ Printed Name _____

2022-2023 PICK UP/ DROP OFF AUTHORIZATION FORM

Parent Name _____

Student Name _____

PICK UP/ DROP OFF AGREEMENT

I HEREBY AUTHORIZE THE FOLLOWING INDIVIDUAL(S) TO PICK UP/DROP OFF MY CHILD IN MY ABSENCE:

1. Name_____Relationship_____Phone_____
2. Name _____Relationship_____Phone_____
3. Name _____Relationship_____Phone_____
4. Name _____Relationship_____Phone_____
5. Name _____Relationship_____Phone_____
6. Name _____Relationship_____Phone_____

I <u>DO NOT</u> ALLOW THE FOLLOWING INDIVIDUAL(S) TO PICK UP/DROP OFF MY CHILD IN MY ABSENCE:

1. Name_____
2. Name_____
3. Name_____
4. Name_____
5. Name_____
6. Name_____

I UNDERSTAND THE FOLLOWING (Initial):

_____Mainspring Academy requires written parent authorization through an Add/Change Request Form in order to make changes to the student's pick up/drop off list. The school will not accept verbal or text message authorizations.

_____Mainspring Academy requires photo identification for any individuals I authorize to pick up/ drop off my child in my absence.

_____School drop-off begins at 8:25am unless students are enrolled in the Extended School Day Program. I will be responsible for Extended School Day Program fees if my child is dropped off by any authorized individuals during morning Extended Care hours. If I have not filled out an Extended School Day Release packet, my child will not be allowed into the building.

_____I will be responsible for late pickups of any individuals I authorize to pick up/ drop off my child in my absence at a rate of $1.00 per minute late after 2:50pm and $60 for the Extended School Day Drop-In fee after 3:00pm. After 2:50pm, I may not contact my child's teacher to keep my child in the classroom until pickup. Students will be placed in the Extended School Day Program.

_____ It is my responsibility to keep the school informed of changes in parent/guardian custody by providing the office with current and complete legal documents each year and after any changes.

Parent Signature_____Date_____

2022-2023 PARENT PARTICIPATION REQUIREMENT FORM

Parent Name _____
Student Name _____

PARENT PARTICIPATION AGREEMENT

I UNDERSTAND THE FOLLOWING (Initial):

_____ I must volunteer a *minimum* of 10 hours per school year between the dates of July 1, 2022 and June 1, 2023. These volunteer hours can be served in a variety of ways, including but not limited to: quarterly Saturday Service Days; school events/ holiday celebrations; Special Olympics; classroom projects; membership in the Parent Action Committee (PAC); monetary donations; in-kind donations of listed school, classroom, and event needs; as well as personal fundraisers. Opportunities will be posted on the school's monthly newsletter.

_____ All families are required to complete their volunteer obligation unless they have been exempt in writing by the Head of School. My full participation is a condition of my child's future enrollment at Mainspring. However, if I do not wish to give my time this school year, I may choose to pay a one-time $500.00 opt-out fee.

_____ If I fail to meet any portion of the annual 10 hour requirement, I will be billed at a rate of $50 per hour not completed. *Example: The Jones family volunteers 7 of the 10 required hours during the school year. At the end of the school year, the School will invoice the Jones family $150 (3 hours x $50 per hour).* I will be notified 30 days in advance prior to being billed.

_____ Attendance as a chaperone to school field trips or visitation to school events does not constitute as parent participation hours.

_____ Participation hours will not be given for required school-wide supplies such as the beginning-of-year school supplies, Halloween event candy, and the Val Pal Valentine's Day Exchange.

_____ Event, supply, or monetary donations will be logged for every $50 spent in funds or items.

I HAVE READ THE 2022-2023 PARENT PARTICIPATION AGREEMENT IN ITS ENTIRETY AND I UNDERSTAND I MUST FULFILL THE TEN-HOUR REQUIREMENT BY JUNE 1, 2023.

Parent Signature_____Date_____

I HAVE READ THE 2022-2023 PARENT PARTICIPATION AGREEMENT IN ITS ENTIRETY, BUT I AM UNABLE TO FULFILL THE PARENT PARTICIPATION REQUIREMENT, SO I ELECT TO PAY THE $500 OPT-OUT FEE BY JUNE 1, 2023.

Parent Signature_____Date_____

2022-2023 ILLNESS POLICY FORM

Parent Name _____

Student Name _____

ILLNESS POLICY AGREEMENT

I UNDERSTAND THAT FOR ANY OF THE FOLLOWING SYMPTOMS, THE STUDENT SHOULD NOT ATTEND SCHOOL (Initial):

_____ Fever of 100.4 or higher
_____ Colored discharge from nose
_____ Discharge and redness in eyes
_____ Shortness of breath, wheezing, or difficulty breathing
_____ Sore throat
_____ Loss of smell or taste
_____ Muscle aches
_____ Vomiting or diarrhea
_____ Currently-awaiting COVID-19 test result
_____ Living in the same household as someone who has tested positive for COVID-19
_____ In close vicinity with an unvaccinated person in the past 10 days who has tested positive for COVID-19
_____ General malaise/lethargy that impacts student participation

I UNDERSTAND THAT STUDENTS MUST BE FREE OF ALL SYMPTOMS FOR 48 HOURS OR PROVIDE A (Initial):

_____ Doctor's note clearing them to attend school
_____ If COVID-19 is suspected, a negative test

IF THE STUDENT DISPLAYS THESE SYMPTOMS DURING THE SCHOOL DAY, I WILL BE CONTACTED TO PICK MY CHILD UP. I AM EXPECTED TO PICK MY CHILD UP WITHIN ONE HOUR OF NOTIFICATION. I UNDERSTAND THAT FAILURE TO RESPOND TO THE SCHOOL'S COMMUNICATIONS OR PICK UP MY CHILD MAY RESULT IN THE SCHOOL'S COMMUNICATION WITH THE DEPARTMENT OF CHILDREN AND FAMILIES OR LOCAL AUTHORITIES.

Parent Signature_____Date_____

2022-2023 PHOTO AND VIDEO POLICY FORM

Parent Name _____
Student Name _____

PHOTO AND VIDEO POLICY AGREEMENT

I CONSENT FOR MY CHILD TO BE PHOTOGRAPHED OR FILMED BY MAINSPRING ACADEMY AND THEIR IMAGE/LIKENESS TO BE SHARED FOR THE FOLLOWING (Initial):

_____ School website
_____ Staff training
_____ School social media
_____ Fundraisers or Board-sponsored events
_____ Print materials such as flyers, brochures, posters, and displays
_____ **I DO NOT CONSENT TO ANY OF THE ABOVE.**

MEDIA AGREEMENT

IN THE EVENT OF MEDIA COVERAGE, I CONSENT FOR MY CHILD TO BE PHOTOGRAPHED OR FILMED BY LOCAL NEWS OUTLETS REGARDING SCHOOL FUNDRAISERS, EVENTS, AND NEWS; AND FOR THEIR IMAGE/LIKENESS TO BE SHARED IN PRINT OR DIGITAL MEDIA.

Parent Signature_____Date_____

-OR-

IN THE EVENT OF MEDIA COVERAGE, I DO NOT CONSENT FOR MY CHILD TO BE PHOTOGRAPHED OR FILMED BY LOCAL NEWS OUTLETS REGARDING SCHOOL FUNDRAISERS, EVENTS, AND NEWS, NOR FOR THEIR IMAGE/LIKENESS TO BE SHARED IN PRINT OR DIGITAL MEDIA.

Parent Signature_____Date_____

VENDOR AGREEMENT

I CONSENT FOR MY CHILD TO BE PHOTOGRAPHED OR FILMED BY THIRD PARTY ORGANIZATIONS, FOUNDATIONS, VENDORS, OR PROVIDERS WHILE AT MAINSPRING ACADEMY OR RELATED SCHOOL FUNCTIONS. I CONSENT FOR THEIR IMAGE/LIKENESS TO BE SHARED BY THIRD PARTY PRINT OR DIGITAL MEDIA.

Parent Signature_____Date_____

-OR-

I DO NOT CONSENT FOR MY CHILD TO BE PHOTOGRAPHED OR FILMED BY THIRD PARTY ORGANIZATIONS, FOUNDATIONS, VENDORS, OR PROVIDERS WHILE AT MAINSPRING ACADEMY OR RELATED SCHOOL FUNCTIONS; AND FOR THEIR IMAGE/LIKENESS TO BE SHARED BY THIRD PARTY PRINT OR DIGITAL MEDIA.

Parent Signature_____Date_____

2022-2023 LOSS, THEFT, AND DAMAGE OF SCHOOL PROPERTY FORM

Parent Name _____
Student Name _____

LOSS, THEFT, AND DAMAGE OF SCHOOL PROPERTY AGREEMENT

I UNDERSTAND THAT I SHALL BE RESPONSIBLE FOR THE COST OF REPLACING/REPAIRING MATERIALS OR PROPERTY WHICH ARE LOST, STOLEN, OR DAMAGED DUE TO ANY MALICE, NEGLIGENCE, OR INTENTIONAL ACTS OF MY CHILD. FOR NOTIFICATION TO PARENTS STAFF WILL COMPLETE A PROPERTY DAMAGE REPORT. I UNDERSTAND THE FOLLOWING (Initial):

_____ I am responsible for the loss, theft, or damage of school property caused by my child's conduct.

_____ I will be issued a copy of a Property Damage Report upon any instance of my child's loss, theft, or damage of school property. Property Damage Reports must be signed and returned to the school within 72 hours.

_____ I will be issued a warning upon my child's first instance of loss, theft, or damage of school property. Upon the second instance, I will be billed at a fee of 10% of the value of the item or its repair/replacement cost. Upon the third instance, I will be billed the total value of the item or its repair/replacement cost.

Parent Signature_____Date_____

2022-2023 CONSENT FORM FOR EDUCATIONAL AND PSYCHOLOGICAL ASSESSMENT

Parent Name _____

Student Name _____

ASSESSMENT AGREEMENT

I UNDERSTAND THAT IN ORDER TO MAINTAIN ACADEMIC AND BEHAVIORAL TREATMENT INTEGRITY FOR MY CHILD, EDUCATIONAL AND PSYCHOLOGICAL ASSESSMENTS MAY BE RECOMMENDED AND PROVIDED TO MY CHILD THROUGHOUT THE SCHOOL YEAR. ASSESSMENTS ARE USED AS PART OF A COMPREHENSIVE /PLAN DESIGNED TO MAINTAIN APPROPRIATE INSTRUCTIONS AND GOALS FOR STUDENTS. THESE ASSESSMENTS ARE CLASSIFIED INTO TWO CATEGORIES. I UNDERSTAND AND CONSENT TO THE FOLLOWING (Initial):

1. **Educational assessments:** Ongoing skill assessments are necessary to document learning. These assessments will be conducted by our staff using a variety of measures, including standardized assessments.

   _____ Students will be assessed at least twice annually on overall curriculum, and will be assessed regularly as part of progress monitoring. I understand that this is routine practice, and I may not be notified of an assessment taking place. Assessment results and progress will be presented at the annual ILP meeting.

   _____As a result of my child's disability, norm referenced and standardized assessments may not be appropriate to use a measure of progress. If I have questions on my child's progress or how they are being assessed I will set an appointment with my teacher and the Director of Programming.

2. **Psychological assessments**: Psychological assessments are a comprehensive evaluation of a student's cognitive (e.g., I.Q.), academic, adaptive behavior, social/emotional, and behavioral functioning. These evaluations are conducted under the supervision of a psychologist, at the parent's expense.

   _____ All students at Mainspring are required to have received a comprehensive psychological evaluation and that evaluation or any updated evaluations should be provided to the school.

   _____ In cases of extreme changes in my child's behavior, learning profile, or the school's suspicion that a student is improperly diagnosed, the school reserves the right to request a new psychological evaluation be completed. In this case the parent may use a psychologist of their choosing, and should provide the updated report within 90 days

   _____ The school will always support the family in obtaining additional psychological testing by providing feedback in the form of questionnaires, letters, or other student related documentation. I agree to provide 2-weeks-notice when this type of feedback is required.

Parent Signature_____Date_____

2022-2023 PARENT COMMUNICATION FORM

Parent Name _____

Student Name _____

PARENT COMMUNICATION AGREEMENT

I UNDERSTAND THE FOLLOWING (Initial):

_____ Mainspring Academy staff members are not expected to return communications after work hours, during the weekend, during periods of school closure; or at any time via their private phone number, social media, or any other private forms of communication. Should an emergency circumstance arise, I will communicate with Mainspring administration via email during these times.

_____ Mainspring Academy maintains consistent communications regarding school and classroom matters. I am responsible for regularly checking my email, Class Dojo, as well as my child's backpack and home folder.

_____ I am responsible for communicating with my child's teacher and/or Mainspring Academy administration regarding any major changes which might affect my child's behavior or attendance at the school, including: general information about changes in family situations, medical issues, illnesses, safety issues, family emergencies, sleep difficulties, and any other ongoing/pervasive problems outside of the school environment.

_____ I am responsible for communicating with my child's teacher and/or Mainspring Academy administration regarding any cancellations of my scheduled obligations.

_____ I am responsible for communicating with my child's teacher and Mainspring Academy administration regarding any changes to my child's allergies, health, medication, emergency PRN, as well as any additions/removals of people I have authorized to pick up my child.

_____ I am responsible for communicating with my child's teacher and/or Mainspring Academy administration regarding the provision or delivery of my child's food, snacks, and drinks. I am responsible for providing adequate lunch, beverage, and snacks for my child prior to the times indicated by Mainspring teachers and staff. I understand I must also provide adequate snacks and drinks for the school day, as well as for before and aftercare. I understand that I must provide my child's teacher a labelled, refillable water bottle to be kept in the classroom. Mainspring Academy staff is not responsible for providing lunch, snacks, or beverages for my child.

_____ I am responsible for communicating with my child's teacher and/or Mainspring Academy administration regarding my provision or delivery of my child's changes of clothing. I understand that, regardless of my child's age, grade, or level of independence, I must provide a minimum of 2 changes of clothing to be kept in my child's classroom, including tops, bottoms, socks, underwear, and pull-ups (if applicable). I am responsible for replacing/replenishing any extra clothing that is used. I must drop off the necessary clothing or pick up my child within 45 minutes of communication from Mainspring Academy staff due to lack of extra changes of clothing. Mainspring Academy staff is not responsible for providing changes of clothing for my child.

_____ I am responsible for communicating with my child's teacher regarding any payments or important documents I have placed in my child's backpack or home folder.

_____ All meetings with staff must be prescheduled, unless it is an emergency. Communications should be respectful and not interfere with teaching, learning, and school-day operations.

_____ Mainspring Academy administration and staff are the most reliable personnel with whom to address any school-related concerns. I will discuss any school-related issues or concerns directly with administration or staff.

Parent Signature_____Date_____

2022-2023 TRANSPORTATION CONSENT FORM

Parent Name _____

Student Name _____

TRANSPORTATION AGREEMENT

I CONSENT FOR MY CHILD TO BE TRANSPORTED BY A TRANSPORTATION SERVICE (SCHOOL BUS SERVICE) CONTRACTED BY MAINSPRING ACADEMY.

Parent Signature_____Date_____

-OR-

I <u>DO NOT</u> CONSENT FOR MY CHILD TO BE TRANSPORTED BY A TRANSPORTATION SERVICE (SCHOOL BUS SERVICE) CONTRACTED BY MAINSPRING ACADEMY.

Parent Signature_____Date_____

I CONSENT FOR MY CHILD TO BE TRANSPORTED IN THE MAINSPRING ACADEMY PASSENGER VAN.

Parent Signature_____Date_____

-OR-

I <u>DO NOT</u> CONSENT FOR MY CHILD TO BE TRANSPORTED IN THE MAINSPRING ACADEMY PASSENGER VAN.

Parent Signature_____Date_____

I CONSENT FOR MY CHILD TO BE TRANSPORTED BY MAINSPRING ACADEMY STAFF IN THEIR PERSONAL VEHICLES. THESE INSTANCES WILL BE VERY RARE IN OCCURANCE AND ALWAYS WITH 2 STAFF MEMBERS IN THE VEHICLE.

Parent Signature_____Date_____

-OR-

I <u>DO NOT</u> CONSENT FOR MY CHILD TO BE TRANSPORTED BY MAINSPRING ACADEMY STAFF IN THEIR PERSONAL VEHICLES.

Parent Signature_____Date_____

I UNDERSTAND THAT IF MY CHILD'S CLASS OR SCHOOL WILL BE ATTENDING A FIELD TRIP AND THEY WILL NOT BE RIDING WITH MAINSPRING ACADEMY EMPLOYEES OR A TRANSPORTATION SERVICE CONTRACTED BY MAINSPRING ACADEMY, I WILL BE RESPONSIBLE FOR TRANSPORTING THEM TO AND FROM THE FIELD TRIP, PICKING THEM UP FROM SCHOOL PRIOR TO THE FIELD TRIP, TAKING THEM TO SCHOOL AFTER THE STUDENTS RETURN, OR KEEPING THEM AT HOME FOR THE DAY.

Parent Signature_____Date_____

2022-2023 CONSENT FORM FOR CRISIS INTERVENTION PROCEDURES

Parent Name _____

Student Name _____

CRISIS INTERVENTION AGREEMENT

I UNDERSTAND THAT IN ORDER TO MAINTAIN A SAFE SCHOOL ENVIRONMENT IT MAY BE NECESSARY TO USE CRISIS PREVENTION PROCEDURES USING THE CRISIS PREVENTION INSTITUTES (CPI) NON-VIOLENT CRISIS INTERVENTION PROGRAM. THIS MAY REQUIRE PHYSICAL CONTACT WITH MY CHILD. THE PHILOSOPHY OF CPI IS *"CARE, WELFARE, AND SECURITY"* WHICH WILL BE AT THE FOREFRONT OF ALL CRISIS INTERVENTION AT MAINSPRING ACADEMY. I UNDERSTAND THE FOLLOWING (Initial):

_____**CPI Procedures are classified into 3 categories:** Ongoing skill assessments are necessary to document learning. These assessments will be conducted by our staff using a variety of measures, including standardized assessments.

- **SUPPORTIVE APPROACHES:** Prior to staff using physical intervention, all attempts will be made by staff to deescalate the student by modeling of coping procedures, providing options for replacement behaviors, or offering other alternatives.

- **DIRECTIVE APPROACHES:** If supportive approaches are unsuccessful, the student will be given compliance options. This may present as a "first/then" or "if/then" statement, through gestural or verbal prompting, or by other means supported in the student's behavior plan.

- **SAFETY INTERVENTION:** If both supportive and directive approaches have been unsuccessful in deescalating the student and they are a danger to themselves or others, staff will use one of several CPI approved physical restraints to manage their risk behavior. Staff will always implement the least restrictive procedure appropriate for the given situation.

- **THERAPEUTIC RAPPORT:** After all crisis situations, staff will focus on rebuilding the relationship between the student and the staff. In doing so, the staff will help the student recognize why they were considered to be in crisis, and how they can avoid this in the future. In addition to debriefing with the student, staff involved will debrief to determine how the situation can be avoided in the future.

_____ **Mainspring Academy takes great care to ensure student dignity and safety**. Any time that crisis intervention is needed, the parent will be sent an incident report. If a parent would like additional information specific to the incident, they may set a meeting with administration. At no time will Mainspring provide personal information regarding another student involved in a crisis.

I HEREBY CONSENT FOR CPI PROCEDURES TO BE USED AS SPECIFIED ABOVE. I UNDERSTAND THAT IF I HAVE ANY QUESTIONS OR CONCERNS ABOUT CPI, I MAY SCHEDULE A MEETING WITH THE CERTIFIED CPI INSTRUCTOR ON SITE.

Parent Signature_____Date_____

2022-2023 EMERGENCY CARE PLAN

Parent Name _____

Student Name _____

STUDENT EMERGENCY CARE INFORMATION

Student Date of Birth_____Height_____Weight_____

Diagnoses_____

_____

ALLERGIES

1. Please list any food intolerances_____
2. If applicable, describe your child's food intolerance symptoms? _____

_____

_____

3. Please list any allergies _____
4. If applicable, describe your child's allergy exposure symptoms? _____

_____

_____

5. Does your child use an allergy treatment or medication? (Choose one) ☐ **YES** ☐ **NO**
6. If yes, please describe _____

_____

7. Will your child be keeping a supply of this emergency allergy treatment at the school*? (Choose one) ☐ **YES** ☐ **NO**

***IF YES, PLEASE COMPLETE A MEDICATION PROFILE AND PERMISSION FORM**

8. Please list the criteria in which staff should administer the emergency treatment? (e.g. If the seizure lasts more than 5 minutes, If the child is having difficulty breathing, If the child begins wheezing) _____

_____

_____

_____

ASTHMA

1. Does your child have asthma or issues with breathing?(Choose one) ☐ **YES** ☐ **NO**
2. If applicable, what are your child's asthma symptoms? _____

_____

_____

3. Does your child use an asthma treatment or medication? (Choose one) ☐ **YES** ☐ **NO**
4. If yes, please describe _____

_____

5. Will your child be keeping a supply of this emergency asthma treatment at the school*? (Choose one) ☐ **YES** ☐ **NO**

***IF YES, PLEASE COMPLETE A MEDICATION PERMISSION FORM.**

6. Please list the criteria in which staff should administer the emergency treatment? (e.g. If the seizure lasts more than 5 minutes, If the child is having difficulty breathing, If the child begins wheezing) _____

_____

_____

_____

SEIZURES

1. Does your child have a history of seizures?(Choose one) ☐ **YES** ☐ **NO**
2. Please indicate the estimated date of your child's last seizure_____
3. How often does your child experience seizures? _____
4. How long do your child's seizures typically last? _____
5. If applicable, what are some of the symptoms and behaviors your child exhibits *prior* to having a seizure? _____

_____

_____

6. Does your child use seizure treatment or medication? (Choose one) ☐ **YES** ☐ **NO**
7. If yes, please describe _____

_____

8. Will your child be keeping a supply of this emergency seizure treatment at the school*? (Choose one) ☐ **YES** ☐ **NO**

***IF YES, PLEASE COMPLETE A MEDICATION PERMISSION FORM.**

9. Please list the criteria in which staff should administer the emergency treatment? (e.g. If the seizure lasts more than 5 minutes, If the child is having difficulty breathing, If the child begins wheezing) _____

_____

_____

OTHER EMERGENCY DISORDERS

1. Please list any other emergency disorders you'd like Mainspring Academy to be aware of _____

_____

2. If applicable, describe your child's symptoms? _____

_____

_____

3. Does your child use an emergency treatment or medication for this disorder? (Choose one) ☐ **YES** ☐ **NO**
4. If yes, please describe _____

_____

5. Will your child be keeping a supply of this emergency treatment at the school*?(Choose one) ☐ **YES** ☐ **NO**

***IF YES, PLEASE COMPLETE A MEDICATION PROFILE AND PERMISSION FORM.**

6. Please list the criteria in which staff should administer the emergency treatment? (e.g. If the seizure lasts more than 5 minutes, If the child is having difficulty breathing, If the child begins wheezing) _____

_____

_____

I UNDERSTAND MAINSPRING ACADEMY WILL NOTIFY ME IMMEDIATELY IN THE EVENT OF EMERGENCIES, OR IN THE EVENT THAT STAFF MUST USE MY CHILD'S EMERGENCY TREATMENT. THE SCHOOL WILL NOTIFY LOCAL EMERGENCY SERVICES IF PARENTS ARE NOT RESPONDING TO THE SCHOOL'S COMMUNICATIONS, SYMPTOMS ARE SEVERE, TREATMENTS ARE INEFFECTIVE, OR IF SYMPTOMS PERSIST.

MY PREFERRED HOSPITAL IN CASE OF AN EMERGENCY IS _____. HOWEVER, IN THE EVENT A HOSPITAL OR FACILITY IS NOT INDICATED AND I CANNOT BE REACHED, I GIVE PERMISSION TO THE PHYSICIAN OR HOSPITAL SELECTED BY THE SCHOOL TO SECURE PROPER TREATMENT AND MEDICAL CARE (E.G. MEDICATION, ANESTHESIA, SURGERY, ETC.) FOR MY CHILD.

I AM RESPONSIBLE FOR REPLENISHING MY CHILD'S SUPPLY OF THEIR EMERGENCY TREATMENT AT THE SCHOOL. DEPENDING ON THE SEVERITY OF THE DISORDER/EMERGENCY, MY CHILD MAY NOT RETURN TO SCHOOL UNTIL I PROVIDE A NEW SUPPLY. IF I DO NOT HAVE AN EMERGENCY PROTOCOL, MAINSPRING ACADEMY RESERVES THE RIGHT TO POSTPONE MY CHILD'S RETURN UNTIL MY CHILD HAS SEEN A PHYSICIAN OR UNTIL I CAN PROVIDE A NEW EMERGENCY TREATMENT TO BE KEPT AT THE SCHOOL. I AM RESPONSIBLE FOR PROMPTLY COMMUNICATING WITH MAINSPRING ACADEMY'S MEDICATION ADMINISTRATION TEAM ABOUT ANY CHANGES REGARDING MY CHILD'S SYMPTOMS, CRITERIA, AND TREATMENT.

I UNDERSTAND THAT, I MUST PICK UP MY CHILD AFTER AN EMERGENCY HEALTH INCIDENT TO ALLOW FOR MY FURTHER MONITORING AND A PROPER REST PERIOD FOR THE REMAINDER OF THE DAY.

Parent Signature_____Date_____

2022-2023 MEDICAL HISTORY FORM

Parent Name _____

Student Name _____

STUDENT EMERGENCY CARE INFORMATION

PLEASE CHECK YES OR NO FOR THE FOLLOWING HEALTH INFORMATION CONCERNING YOUR CHILD. BE SURE TO INCLUDE ANY RECENT (PAST 6-12 MONTHS) INJURIES, ILLNESSES, OR SURGERY THAT IS IN THE STUDENT'S HEALTH HISTORY WHICH COULD INFLUENCE PARTICIPATION IN ACTIVITIES OR OTHER NEEDS.

		DESCRIPTION
Arthritis/joint or bone condition	□ Yes □ No	_____
Asthma/Reactive Airway Disease	□ Yes □ No	_____
Bleeding/blood disorder (e.g. anemia, hemophilia, sickle cell disease, etc)	□ Yes □ No	_____
Developmental condition/consideration	□ Yes □ No	_____
Diabetes	□ Yes □ No	_____
Digestive/stomach condition	□ Yes □ No	_____
Dental/orthodontic appliance or other prosthesis	□ Yes □ No	_____
Eyeglasses/contacts/vision	□ Yes □ No	_____
Fainting/lightheaded episodes/heat sensitivity	□ Yes □ No	_____
Hearing loss	□ Yes □ No	_____
Heart condition or chest pain with exercise	□ Yes □ No	_____
High blood pressure	□ Yes □ No	_____
Seizure disorder	□ Yes □ No	_____
Immune system disorder (e.g. mono, chronic fatigue syndrome, chemotherapy, etc.)	□ Yes □ No	_____
Menstrual disorder/difficulties	□ Yes □ No	_____

Significant fears/phobias	□ Yes □ No	_____
Sleepwalking or sleep time difficulties	□ Yes □ No	_____
Toileting consideration	□ Yes □ No	_____
Orthopedic condition, recent injury, back pain	□ Yes □ No	_____
Other (please specify)	□ Yes □ No	_____

Please specify any dietary restriction/needs:

□ Vegetarian □ No milk/dairy □ Soy □ Casein □ Whey □Other

_____

Please specify any injuries/surgeries/major illness in the past 6 to 12 months:

Type Date

_____ _____

_____ _____

I ATTEST THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. IN CASE OF EMERGENCY AND I CANNOT BE REACHED, I GIVE PERMISSION TO THE PHYSICIAN OR HOSPITAL SELECTED BY THE SCHOOL REPRESENTED TO SECURE PROPER TREATMENT AND MEDICAL CARE (E.G. MEDICATION, ANESTHESIA, SURGERY, ETC.) IN CASE OF EMERGENCY OR AS SPECIFIED ABOVE FOR MY CHILD.

Parent Signature_____Date_____

2022-2023 PRESCRIBED AND OVER-THE-COUNTER MEDICATION PROFILE

Parent Name _____

Student Name _____

MEDICATION INFORMATION

Please complete this form if your child will require prescription, over-the-counter, or emergency medications/treatments at any time while at Mainspring Academy.

MEDICATION 1

Name of medication _____

Purpose of medication _____

Medication dose _____

Medication Type (Choose One): ☐ **Prescription** ☐ **Over-the-counter** ☐ **Emergency**

Medication Frequency (Choose One): ☐ **Daily** ☐ **As needed** ☐ **Emergency**

If daily, preferred time to administer (Choose One) ☐ **9:30am** ☐ **10:30am** ☐ **11:30am** ☐ **12:30pm** ☐ **1:30pm** ☐ **Before Meal**

Does the medicine need to be taken with food or water? List _____

How long will your child need to take this medication? _____

Please list any additional directions, if applicable _____

_____

_____

MEDICATION 2

Name of medication _____

Purpose of medication _____

Medication dose _____

Medication Type (Choose One): ☐ **Prescription** ☐ **Over-the-counter** ☐ **Emergency**

Medication Frequency (Choose One): ☐ **Daily** ☐ **As needed** ☐ **Emergency**

If daily, preferred time to administer (Choose One) ☐ **9:30am** ☐ **10:30am** ☐ **11:30am** ☐ **12:30pm** ☐ **1:30pm** ☐ **Before Meal**

Does the medicine need to be taken with food or water? List _____

How long will your child need to take this medication? _____

Please list any additional directions, if applicable _____

_____

_____

2022-2023 MEDICATION PERMISSION FORM

Parent Name _____
Student Name _____

MEDICATION AGREEMENT

I UNDERSTAND IF MY CHILD REQUIRES PRESCRIPTION, OVER-THE-COUNTER, OR EMERGENCY MEDICATION/TREATMENT DURING THEIR TIME AT MAINSPRING ACADEMY, THE FOLLOWING RULES MUST BE OBSERVED (Initial):

_____ A medication profile must be completed for each treatment to be administered. This form serves as my consent for Mainspring Academy to administer the medication to my child.
_____Med-certified staff at Mainspring Academy must be notified regarding any changes to my child's treatment.
_____All medication must be transported from home to school directly to med-certified staff. It cannot be transported via the student's backpack or given to a non-certified staff member during car line.
_____Medication must be given to med-certified staff in its original form, affixed with a pharmacy label which includes medication, pharmacy, and clinic details.
_____ Med-certified staff can only administer treatment as specified on the pharmacy label.
_____ Medication must be stored in the locked nurse's station. It may not be stored in the classroom.
_____ If my child's medication is to be discontinued, I must complete a take-home consent form.
_____ I am responsible for refilling my child's medication in a timely manner and ensuring the school has an adequate supply.
_____ If my child takes his/her medication with pudding, applesauce, flavored drinks, or via any other alternative method, I am responsible for providing a supply for the school and promptly refilling it as needed.
_____ I am responsible for collecting my child's medication prior to breaks, intersessions, and long school closures.
_____ I am responsible for replacing expired medications.
_____ Medication will be disposed of if med-certified staff do not receive a response to 3 repeated communications to collect my child's medication.
_____ If staff has to use my child's emergency medication, depending on the severity of the related emergency, my child may not return to school until I can provide a replacement for the treatment.
_____There shall be no liability for civil damages as a result of the administration of such medication when the person administering such medication acts as a reasonable prudent person would act under the same circumstances.

I HEREBY CONSENT FOR MY CHILD TO TAKE THE MEDICATION THAT I AM PROVIDING, AUTHORIZE THE SCHOOL TO STORE THESE MEDICATIONS ACCORDING TO SCHOOL POLICIES, AND ADMINISTER THE MEDICATION TO MY CHILD AS DIRECTED. I FURTHER AGREE TO INFORM MAINSPRING ACADEMY OF ANY CHANGES IN TREATMENT, INCLUDING ANY REACTION TO THE MEDICATION. I UNDERSTAND THAT THIS CONSENT APPLIES TO ALL MEDICATION, WHETHER IT IS PRESCRIBED OR PURCHASED OVER THE COUNTER WITHOUT A PRESCRIPTION. I UNDERSTAND THAT THIS CONSENT IS VALID FOR ONE YEAR FROM THE SIGNED DATE.

Parent Signature_____Date_____