Application for Admission

PARENT PACKET

Please send to: WVSDB
wvsdb@k12.wv.us
301 East Main Street
Romney, WV 26757
(P) 304.822.4810 (F) 304.461.8005

PARENT

Admission Application

Student Name _____ Date_____

The following is a brief description of components that need to be completed by the parent as part of the application to the West Virginia Schools for the Deaf and the Blind. The application will not be considered until all documentation is provided.

Only students whose primary exceptionality is Deaf, Hard of Hearing, Blind, Low Vision, or Deaf/Blind will be considered for enrollment. Application does not guarantee admission. Students must have a basic level of independance and daily living skills.

STUDENT COMPONENTS – Parent

____ Student Information, Parent/guardian Information, Emergency Contacts
____ Press Consent Form
____ WVSDB Educational Purpose And Acceptable Use of Electronic Resources, Technologies, And The Internet Student Agreement
____ Release of Information
____ Copy of student's Social Security Card
____ Parent Information Report
____ Guardianship documentation (if applicable)
____ Copy of prospective student's original birth record (certificate). Must be a copy of the State Registrar of Vital Statistics certificate.

MEDICAL COMPONENTS - Parent

____ Medical Questionnaire
____ Medical Consent Form (permission for emergency/routine medical care)
____ FERPA/HIPPA Consent
____ Copy of Immunization Records
____ Copy of student's Insurance or Medical Card
____ Copy of most recent Dental Exam (within one year of the application)
____ Physical Examination Form completed by a physician or pediatrician.
____ Authorization for the Administration of Medication/Treatment (complete form for each medication to be given at school, signed by a physician and parent)

Please submit Application for Admission along with required Student Components to:

Special Education
West Virginia Schools for the Deaf and the Blind
301 E. Main St.
Romney, WV 26757

West Virginia Schools for the Deaf and the Blind

PARENT

Admission Application

Date_____

STUDENT INFORMATION

Full Name _____ DOB _____
Last First Middle MM DD YYYY

Gender: M F Social Security Number _____

Race: ____White ____Black/African American ____Hispanic ____Asian ____American Indian ____Pacific

Current Grade_____ Current District of Enrollment _____

Will your child be a day student or residential student?_____

PARENT OR GUARDIAN INFORMATION

Student lives with: (Check all that apply) ____Both Parents ____Mother only ____Father only ____Grandparents
____ Other (Please specify) _____

Student's Home Phone:_____

Alternate Phone Number:_____

Guardian Name:_____
Last First Middle Relationship

____Not Military ____Air Force ____Army ____Coast Guard ____Marines ____Navy
____Active Duty ____National Guard ____ Reserve ____Active Guard Reserve ____Standby Reserve ____Retiree/Veteran

Guardian Name:_____
Last First Middle Relationship

____Not Military ____Air Force ____Army ____Coast Guard ____Marines ____Navy
____Active Duty ____National Guard ____ Reserve ____Active Guard Reserve ____Standby Reserve ____Retiree/Veteran

Physical Home Address: _____
House Number Street Name

_____
City State Zip Code

Mailing Address (If different than physical address):_____
House Number Street Name

_____
City State Zip Code

- Who has custody and is the legal guardian? ***Please provide documentation***.
  Joint Mother Father Other_____
- If 18 or over, is student his or her own guardian? ***If no, please provide documentation*** YES NO Not Applicable

Does your child speak a language other than English? ___Yes ___No If yes, which language? _____

Does either parent speak a language other than English in the home? ___Yes ___No If yes, Which language?_____

What is the main language used in the home? _____What language did the student speak first? _____

What language is most often spoken by the student? _____

EMERGENCY INFORMATION

Name	Relation to Child	Home Phone	Mobile Phone	Can Pick-Up at School/Bus Stop ?
				Yes No
				Yes No
				Yes No

West Virginia Schools for the Deaf and the Blind

Admission Application

Press Consent

Child's Name:_____

PRESS RELEASE AND DATA COLLECTION

- I (we) hereby grant the West Virginia Schools for the Deaf and the Blind permission to photograph, videotape, or otherwise depict my child, and to publish any such depiction along with his/her name and age in connection with any publicity program or professional activity.
- I (we) understand that any depiction may be used in connection with newspapers, television, website, radio program, motion pictures, school publications, professional journals, and in other proper circumstances.
- Consent for photographing and video may be used for medical purposes for documentation of accident or injury. I (we) give permission for the West Virginia Schools for the Deaf and the Blind to collect and submit data concerning my child which is required by deferral and state agencies for reporting purposes.

SPECIAL INSTRUCTIONS

Please include any special instructions below

_____

_____

_____

_____

Your signature below indicates consent for all sections above unless section(s) is/are otherwise initialed.

_____ _____

Parent or Guardian Signature Date Parent or Guardian Signature Date

WEST VIRGINIA SCHOOLS FOR THE DEAF AND THE BLIND
EDUCATIONAL PURPOSE AND ACCEPTABLE USE OF ELECTRONIC RESOURCES, TECHNOLOGIES AND THE INTERNET
STUDENT AGREEMENT

It is the belief of WVSDB that the educational benefits to students through access to the Internet far exceed any potential disadvantages of such access. Access to the Internet is given as a privilege to students who agree to act in a responsible manner. We require that students and their parents/guardians read and accept the following rules established by Policy 2460 and WVSDB:

As a responsible technology user:

I will use all technology only for educational purposes and objectives established by my teachers. I understand that my technology use will be monitored.

I will only access programs and equipment I am authorized to use.

I understand that I may access email at school only through my state given email account. I may not access my personal email account while using WVSDB technology.

I understand that information obtained online is, unless specified, private property; therefore, I will not plagiarize information received and will adhere to copyright laws.

I will respect and not attempt to bypass the network security measures put into place by WVSDB and the WV Department of Education.

I will not divulge personal information of others or myself.

I will not install or add any device to the school computer or network. I will only use my usernames and passwords. I will not share this information with others.

I will not log on to a computer using another person's username or password.

I will not participate in direct electronic communications such as but not limited to blogs, wikis, text messaging, chat rooms and instant messaging unless assigned for a specific educational purpose and under the direct supervision of a teacher.

I understand that these guidelines include personal devices such as cell phones, video cameras and other electronic technologies. I will not use such devices for cheating, taking inappropriate pictures, copying of materials that could be used for cheating, text messages, engaging in cyber bullying or any inappropriate communication. I further understand that, if I receive any of the above-mentioned items, I am required to report it to a teacher immediately.

I understand that I, as the technology user, am personally responsible for my actions in accessing and utilizing the schools' technology resources. I understand that if I lose, steal, neglect to return or intentionally break a device, my parents can be held financially responsible for the replacement cost of the device.

WEST VIRGINIA SCHOOLS FOR THE DEAF AND THE BLIND
EDUCATIONAL PURPOSE AND ACCEPTABLE USE OF ELECTRONIC RESOURCES, TECHNOLOGIES AND THE INTERNET
STUDENT AGREEMENT

I understand that the use of technology at WVSDB is a privilege, not a right. I further understand that violations of these rules can result in the loss of technology access at WVSDB.

I understand and agree to the Student Responsibilities listed on page 11 of the policy.

As a user of the WVSDB computer network, I agree to comply with Policy 2460 and the above policy. Should I commit any violation, I accept responsibility for my conduct and understand that I will lose technology access privileges at my school.

 STUDENT'S NAME (print) _____

STUDENT'S SIGNATURE _____
(If student is unable to sign please write N/A)

DATE _____

FOR PARENTS/GUARDIANS OF MINORS:

As a parent or legal guardian of the above signed student, I have read and discussed these regulations with my child. I understand that WVSDB and the WV Department of Education have taken precautions to minimize objectionable material. However, I recognize it is impossible to restrict access to all controversial materials. I understand that it is the responsibility of my child to restrict his/her use to the set guidelines.

I have read and agree to the Parent Responsibilities listed on page 12 of the policy. I also understand that if my child is to lose, steal, neglect to return or intentionally break a device, I can be held financially responsible for the replacement cost of the device.

 PARENT/GUARDIAN'S NAME (PRINT) _____

PARENT SIGNATURE _____

DATE _____

** Policy 2460 can be found on the WVSDB website: https://www.wvsdb2.state.k12.wv.us/

PARENT

Admission Application

West Virginia Schools for the Deaf and the Blind
301 East Main Street
Romney, WV 26757
(304)-822-4800

Release of Information

I, _____ ***(name of Parent or Guardian)***, hereby give permission to _____ ***(Agency, Individual)*** to release any records concerning my child, _____ ***(Child's Name and Date of Birth)***, to the West Virginia Schools for the Deaf and the Blind. The purpose of the request is as follows:

_____

_____

_____

_____ _____

Signature of Parent, Guardian, or Age of Majority Student — Date

RELEASING PARTY INFORMATION

Physician, Agency, Individual's Address _____

City: _____ State: _____ Zip Code: _____

_____ History & Physical Examination Request
_____ Psychiatric Evaluation
_____ Psychological Evaluation
_____ Social Service Summary
_____ Ophthalmological Report
_____ Audiological Report
_____ Educational Report
_____ Current Grades for all classes
_____ Other:_____

PARENT

Admission Application

West Virginia Schools for the Deaf and the Blind

FERPA/HIPAA CONSENT

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION BETWEEN DENTAL/MEDICAL PROVIDERS AND SCHOOL DISTRICTS

Completion of this document authorizes the disclosure and/or use of individually identifiable health information as set forth below, consistent with Federal laws (including HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name: _____ _____

Last First MI Date of Birth

I, the undersigned, do hereby authorize (name of agency, dental, and/or health care providers):

(1)_____ (2)_____

(3) _____ (4) _____

To provide health information from the above-named child's dental and/or medical record to and from:

WVSDB 301 East Main St. Romney, WV, 26757

School District to which Disclosure is Made **Address/City and State/ Zip Code**

Health Services at WVSDB 304-822-4831

Contact Person at School **Telephone Number**

This disclosure of Health information is required for the following purpose:

_____

Requested information shall be limited to the following:

____ All minimum necessary Health Information: or disease specific information as described:

_____

____ Other: _____

(Please Specify)

DURATION:

This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for one year from the date of signature, if no date entered.

RESTRICTIONS:

Law prohibits that Requester from making further disclosure of my health information unless the Requester obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:

I understand that I have the following rights with respect to this Authorization: I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the school district/ health care agencies/persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the Requester or others have acted in reliance to this Authorization.

RE-DISCLOSURE:

I understand the Requester (School District) will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the Schools District for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs.

I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

APPROVAL:

_____ _____

Printed Name Parent/Guardian/ Student Signature Date

_____ _____

Relationship Telephone

West Virginia Schools for the Deaf and the Blind

Admission Application

Medical Consent Form

I, _____, parent/legal guardian of _____, do hereby consent to give proper medical attention to my child by West Virginia Schools for the Deaf and the Blind's Health Services, contracted medical provider, or emergency services as indicated below:

INSTRUCTIONS: If you have read and consent to each statement below, please initial on the line. Otherwise, leave blank

1. ____ I give consent that WVSDB's Health Services and appropriately trained staff administer medication and provide treatments that the contracted medical provider deems necessary. I understand that staff will make at least three (3) attempts to contact me to get verbal permission to administer medication or treatment as ordered by the contracted medical provider. I understand in the event that I am unreachable, that this consent or authorization give executive consent so that there is no delay in treatment.

2. ____With the exception of an extreme emergency, I give consent for WVSDB staff to consent to care that is necessary for the welfare of my child in an emergency if I am not reasonably available by telephone to give consent. I understand every attempt will be made for me to be contacted prior to and after the situation. I understand that after three (3) attempts, this is considered a sufficient number of calls that has been made in good faith.

3. ____ I give consent for WVSDB staff to accompany my child to medical clinics held on- or off-campus and give/receive information concerning my child to medical staff of said clinic, during my absence.

4. ____ I understand that there may be costs associated with treatments and medication prescribed by the contracted physician are the responsibility that of the parents/ guardian.

5. ____ I consent that when WVSDB staff is attempting to make contact me and are unsuccessful, that emergency contacts be contacted.

_____

Print Name Parent/Guardian Signature Date

PARENT

West Virginia Schools for the Deaf and the Blind

Admission Application

MEDICAL QUESTIONNAIRE- Confidential to Health Services

Child's Name _____

PART I: Criteria

Read the list of criteria below:

- Has your child been in contact with a case of TB?
- Is your family homeless?
- Was your child born or has the child lived in a TB endemic country?
- Has your child visited a TB endemic country for more than 2 months?

Check one:

_____ My child meets at least one of the criteria above.

_____ My child does not meet any of the above criteria.

PART II: Medical Conditions

Read the list of medical conditions below:

- Does your child have diabetes mellitus?
- Is your child HIV positive?
- Does your child have any lung diseases?
- Does your child have an autoimmune disorder?
- Is your child immunocompromised?
- Is your child on or using immune-compromising therapies?

Check one:

_____ My child meets at least one of the medical conditions above.

_____ My child does not have any of the above medical conditions.

PART III: Mental Health

Check one:

_____ My child participates in ongoing mental health counseling.

_____ My child does not participate in ongoing mental health counseling.

_____

(Print Name of Parent/Guardian) Signature (Parent/Guardian) Date

FOR OFFICE USE ONLY

_____ Referred to School Nurse (if child meets any of the above criteria)

_____ Cleared for school entry (if child does not meet any criteria. **Place in student file**)

PARENT

West Virginia Schools for the Deaf and the Blind

Admission Application

Physical Examination Form (to be completed by a physician)

Full Name _____ (Last) _____ (First) _____ (Middle) DOB ____ (MM) ____ (DD) ____ (YYYY)

Date of Examination: _____

VITAL STATISTICS

Height: _____ Weight: _____ Blood Pressure: _____

Heart: _____

Lungs: _____

Abdomen: _____

Extremities: _____

Skin: _____

Ears: _____

Nervous System: _____

Other _____

Medical History

Does the child have a diagnosis of any of the following: (Mark all that apply)

_____ **Asthma** _____ **Seizures** _____ **Allergic Reactions** _____ **Diabetes**

Does the child have any special dietary requirements?

_____ **Altered Food Consistency:** ***(pureed, mechanical soft, chopped meats, etc.)*** _____ **Thickened Liquids** _____ **Food Tolerance or Allergy (list below)** _____ **Nutritional Supplement**

Other diagnoses, illnesses, and operations: _____

_____

_____

_____

Current level of nursing care _____

West Virginia Schools for the Deaf and the Blind

Admission Application

Physical Examination Form (to be completed by a physician)

ALLERGIES

Food Name	Reaction
Medication Name	Reaction
Other Allergies	Reaction

Medications

Is child on regular medication? Yes No

Please list all medications the child is currently taking:

_____

_____

_____

_____

Note: If YES, **Administration of Medication Form must be filled out by a physician for EACH medication.** This is a state requirement and the completion of the form allows the **school to administer** the prescribed medication. Parents must sign the form and a physician must complete the top of the form. A medication form must be completed for any prescription or long term over the counter medication during the school year. If a child is to carry their own inhaler and use as needed, a physician must authorize the self-administration of that medication. **Medication must be in the original prescription bottle**. Most pharmacies will give a second prescription bottle upon request to be sent to school.

Please inform the Infirmary staff of any change in the child's health so that they are better able to care for the student. The Health Services staff can be reached at 304-822-4831.

PHYSICIAN'S INFORMATION

Physician's Name Printed: _____

Physician's Signature: _____ Date: _____

Physician's Address _____

City: _____ State: _____ Zip Code: _____

A COPY OF THE CHILD'S IMMUNIZATION RECORD IS REQUIRED FOR ADMISSIONS. PLEASE ATTACH TO THE EXAMINATION FORM

West Virginia Schools for the Deaf and the Blind

Admission Application

Authorization for the Administration of Medication/Treatment

PHYSICIAN SIGNATURE REQUIRED

Student's Name: _____ Date of Birth: _____

Allergies: _____

Parent/Guardian Name: _____ Phone: _____

ONLY ONE MEDICATION/TREATMENT PER FORM

Diagnosis: _____

Medication/Treatment: _____

Dose: _____ Mode of Administration: _____

Frequency: _____

Comments (Side-effects, Special Instructions, Reactions, etc.):

_____

_____

_____

Physician Name: _____

Address: _____

_____

Phone: _____ Fax: _____

PARENTS/GUARDIANS:By Signing this form you are giving permission to administer/perform the above medication/treatment while student is at school/on campus. A physician's signature is required for all medications, even over the counter.

_____ _____

PHYSICIAN SIGNATURE/DATE PARENT/GUARDIAN SIGNATURE/DATE

PLEASE NOTE: FORMS ARE ONLY GOOD FOR ONE SCHOOL YEAR. AFTER JUNE 30 OF EACH YEAR AUTHORIZATION FORMS ARE NO LONGER VALID.

West Virginia Schools for the Deaf and the Blind

Parent Information Report

STUDENT NAME _____
Last

_____ _____
First **Middle**

Birth Date _____ **Age** _____
School _____ **Grade** _____
Initial Evaluation ☐ **Reevaluation** ☐

Parents: To help develop the best educational plan for your child, it is required that the parent/guardian provide written information about the child. If you need help completing this form, please contact the Special Education Office.

1. Please list your child's special interests and hobbies.

2. Please list the names of all individuals who live in your home and their relationship to the student.

3. Has your child had any health problems, accidents and/or medical/mental health diagnoses that might affect school performance?

4. Please list any medications your child takes on a regularly scheduled basis. Is the medication taken at school?

5. Please describe your child's behavior at home and in the community. Name his/her behavioral strengths and weaknesses.

6. As your child has grown, what concerns have you had about his/her emotional development?

7. Please list your child's academic strengths and weaknesses. What do you feel would help your child in school?

8. How does your child get along with other children and adults?

9. Are there any special conditions at home or elsewhere that might be affecting your child's ability to function at school?

Thank you for completing this confidential report.

_____ _____
Signature of person completing form Relationship to child

_____
Date