Welcome

Dear Parent/Guardian:

Thank you for taking the time to explore the opportunities available for your child at the West Virginia Schools for the Deaf and the Blind (WVSDB) and to seek admission to one of our unique programs.

Within this packet you will find information for the application process.

WHERE IS THE SCHOOL LOCATED?
The School's 70-acre campus is located in the Potomac Highlands in the small town of Romney, West Virginia. The school is located in town affording students the convenience of local business yet away from the many concerns associated with living in larger cities.

WHO IS ELIGIBLE TO ATTEND THE WEST VIRGINIA SCHOOLS FOR THE DEAF AND THE BLIND
Your child must be between the ages of 3 years – 23 years. In addition he or she must be identified as a student who is deaf, hard of hearing, blind, low vision or deaf blind. That identification is typically made by your local school. If that has not occurred or if there is a question about the identification, staff at WVSDB may conduct the evaluations.

The identification is made after considering all evaluations and the criteria established by the WV Department of Education. The criteria are shown below:

WHAT DOES IT COST TO ATTEND THE WEST VIRGINIA SCHOOLS FOR THE DEAF AND THE BLIND?
WV Code §18-17-3 provides all deaf and blind pupils who are residents of the state of West Virginia are admitted to the schools without charge for board and tuition.

Children from out of state may also attend the West Virginia Schools for the Deaf and the Blind provided a space is not needed for a resident of West Virginia and the WV Board of Education must by law approve that enrollment. The cost for a student who is not a resident of West Virginia is not the responsibility of the West Virginia Schools for the Deaf and the Blind.
Admissions Application Checklist

Student Name __________________________________________    Date__________________________

The following is a brief description of records, forms, and procedures that need to be completed as part of the application to The West Virginia Schools for the Deaf and the Blind.

______ 1. Copy of current school records including the current Individualized Education Plan (IEP) if the student has one.

______ 2. Copy of prospective student's original birth record (certificate). Must be a copy of the State Registrar of Vital Statistics certificate.

______ 3. Notarized Suspension/Expulsion Form


______ 5. Copy of child's insurance or medical card.

______ 6. An Administration of Medication Form signed by a physician and parent for each medication to be given at school.

______ 7. Completed Physical Examination Form by a physician or pediatrician. Must include a Tuberculin Test for students not currently enrolled in a WV public school system and a copy of immunization records.


______ 9. SCHOOL FOR BLIND PROSPECTIVE STUDENT – Current (within the last year) ophthalmological evaluation or low vision report.

______ 10. SCHOOL FOR DEAF PROSPECTIVE STUDENT – Current (within the last year) audiological evaluation report

- Please note, the above is the minimum required information for enrollment at the West Virginia Schools for the Deaf and the Blind. When special medical, behavioral, or emotional problems are present, additional information may be requested.
Admission Application

Circle the program(s) for which you would like information? Deaf Blind Date ____________________________

STUDENT INFORMATION

<table>
<thead>
<tr>
<th>Full Name</th>
<th>DOB MM/DD/YYYY</th>
</tr>
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<tbody>
<tr>
<td>Last</td>
<td>First Middle</td>
</tr>
</tbody>
</table>

Gender: M  F  Social Security Number ____________________________

PARENT OR GUARDIAN INFORMATION

Mother or Guardian

<table>
<thead>
<tr>
<th>First</th>
<th>Middle</th>
<th>Last</th>
<th>Maiden</th>
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</thead>
</table>

Home Address:

City: State: Zip Code:

Home Phone: Mobile Phone: Work Phone:

Email Address:

Father or Guardian

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<tr>
<th>First</th>
<th>Middle</th>
<th>Last</th>
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</thead>
</table>

Home Address:

City: State: Zip Code:

Home Phone: Mobile Phone: Work Phone:

Email Address:

- Are parents currently living together? YES  NO
- If NO, who has custody and is the legal guardian? Please provide documentation.
  Joint  Mother  Father  Other _________________________________________________________
- If over 18, is student his or her own guardian? YES  NO  Not Applicable

SIBLING INFORMATION

<table>
<thead>
<tr>
<th>Full Name</th>
<th>DOB</th>
<th>Gender</th>
<th>Other Information</th>
<th>Does sibling currently attend WVSDB?</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td>Yes  No</td>
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<td>Yes  No</td>
</tr>
</tbody>
</table>

For Office:  Bus Number:  Special Equipment:  Department:  __________
MEDICAL HISTORY

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

_____ Asthma  _____ Seizures  _____ Allergic Reactions  _____ Diabetes

Does your child have any special dietary requirements?

Altered Food Consistency:  (pureed, mechanical soft, chopped meats, etc.)

_____  _____  _____  Nutritional Supplement

Thickened Liquids  Food Tolerance or Allergy (list below)

Other diagnoses, illnesses, and operations:

________________________________________________________________________

ALLERGIES

<table>
<thead>
<tr>
<th>Food Name</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Allergies</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
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</table>

EMERGENCY INFORMATION

<table>
<thead>
<tr>
<th>Name</th>
<th>Relation to Child</th>
<th>Home Phone</th>
<th>Mobile Phone</th>
<th>Can Pick-Up at Bus Stop</th>
</tr>
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<tbody>
<tr>
<td></td>
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<td></td>
<td>Yes  No</td>
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<td>Yes  No</td>
</tr>
</tbody>
</table>

Is child on regular medication?  Yes  No

Please list all medications your 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.
Authorization for the Administration of Medication

PHYSICIAN SIGNATURE REQUIRED

Student’s Name: ___________________________ Date: ________________

Date of Birth: ___________________________ Parent’s Phone Number: ___________________________

Parent’s Request/Approval for Administration of Medication at School

Signature: ____________________________________________________________

An authorization of medication form must be completed at the beginning of each school year. If changes in medication or dosage occur, a new form must be completed. Please use one form for each medication.

Diagnosis: ___________________________

Name of Medication: ___________________________ Dosage: ___________________________

Frequency of Administration: ___________________________ Method of Administration: ___________________________

Side Effects: ___________________________

Comments and/or other instructions, permission to carry inhaler: ___________________________

_________________________ ___________________________ ___________________________
PHYSICIAN’S INFORMATION

Physician’s Name Printed: ____________________________________________

Physician’s Signature: ____________________________________________ Date: ___________________________

Physician’s Address: ____________________________________________

City: ___________________________ State: _______ Zip Code: ___________________________

TUBERCULOSIS QUESTIONNAIRE - New Student

Child’s Name _____________________________

Date ___________

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.

_____________________________  _______________________________________
(Print Name of Parent/Guardian)   (Parent/Guardian Signature)

__________________
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)
Physical Examination Form

NAME OF STUDENT APPLICANT

- 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: ________________________________

CURRENT DIAGNOSES AND HEALTH HISTORY

____________________________________________________
____________________________________________________
____________________________________________________
____________________________________________________

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
Release of Information

I, _________________________________ (name of Parent or Guardian), hereby give permission to _________________________________ (Doctor, 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 Majority Student  Date

RELEASING PARTY INFORMATION

Physician, Agency, Individual’s Address

City: ___________________________  State: ________  Zip Code: ______________

<table>
<thead>
<tr>
<th>History &amp; Physical Examination Request</th>
<th>Laboratory Reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Evaluation</td>
<td>X-Ray</td>
</tr>
<tr>
<td>Psychological Evaluation</td>
<td>EEG</td>
</tr>
<tr>
<td>Social Service Summary</td>
<td>EKG</td>
</tr>
<tr>
<td>Discharge Summary</td>
<td>EST</td>
</tr>
<tr>
<td>Audiological Report</td>
<td>Ophthalmological Report</td>
</tr>
<tr>
<td>Educational Report</td>
<td>Other:</td>
</tr>
</tbody>
</table>
Medical Consent Form

Child's Name: ____________________________________________

MEDICAL CONSENT

- I (we) certify that child named above has insurance or a medical card in force to cover injuries/illnesses, which may occur to my child while attending the West Virginia Schools for the Deaf and the Blind. If child does not have insurance or medical card, I recognize that I will be liable for any and all medical expenses incurred by my child while attending the schools. The West Virginia Schools for the Deaf and the Blind will not be responsible for medical expenses as a result of an illness or accident incurred while my child is a student at WVSDB. Cost for any medications prescribed by school physicians will be the responsibility of the parent if health insurance does not cover the cost or child does not have insurance or medical card.

- I (we), the undersigned, give consent for the designated staff of the West Virginia Schools for the Deaf and the Blind to administer my child prescribed medication or over-the-counter medicines to be dispensed according to the printed directions on the medication label or medications as may be recommended by the school’s medical staff. We also give designated members of the staff permission to administer necessary test, which, in the opinion of the physician, are deemed advisable.

- I (we) consent to allow the West Virginia Schools for the Deaf and the Blind to give proper medical attention to my child. Also, any hospital, offices, personnel, and physician providing medical or surgical services to the above named child may rely on the consent or authorization executed by the West Virginia Schools for the Deaf and the Blind with the same force and effect as if personally executed by me at the same time that such consent or authorization is obtained. I understand that I will be notified as soon as possible should such medical attention be needed. In case of extreme emergency, this consent extends to authorizing major surgical operations. Please note: as has always been our policy, parents will be contacted as soon as emergency arises and every effort will be made until the parent is contacted.

- The West Virginia Schools for the Deaf and the Blind have my permission to correspond with my child's family doctor if a need is indicated.

- I consent for designated staff of the West Virginia Schools for the Deaf and the Blind to accompany my child to medical clinics held on or off campus and give/receive information concerning my child to medical staff of said clinics.

- I consent for the West Virginia Schools for the Deaf and the Blind to receive copies of any medical reports from my child’s appointments at medical clinics held on the WVSDB campus.

- I hereby release the West Virginia Schools for the Deaf and the Blind and its administration, directors, employees, agents, and subcontractors, from any and all liability for bodily injury or cost of medical treatment, therefore, or injury incurred as a result of the administration of emergency medical treatment.

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 __________
Press and Participation Consent Form

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, age, and address 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.

PARTICIPATION IN SCHOOL ACTIVITIES

- I (we) do hereby give permission for my child to participate in any school or dormitory trip, activity, and program held during current school year unless otherwise noted. This permission includes all school and dormitory activities including field trips to off-campus sites and any other special program and projects conducted as part of the schools program.

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 __________
Suspension/Expulsion Form

I, _______________________________ (Parent of Guardian Name), hereby swear/affirm that _______________________________ (Name of Student) is not, at this time, under suspension or expulsion from attendance at a private or public school in West Virginia or any other state.

____________________________ [Parent or Guardian Signature]

STATE OF WEST VIRGINIA
County of ________________________________, to wit:

The foregoing instrument was acknowledged before me this ________________ day of ________________________________, 20____, by

______________________________.

My commission expires ________________________________.

(SEAL)

______________________________ Notary Public
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.

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.

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 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 _______________