Application for Admission
West Virginia Schools for the Deaf and the Blind

Return to: Director of Outreach
Melanie Hesse
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301 East Main Street
Romney, WV 26757
(P) 304.822.4843 (F) 304.461.8005
Admissions Application Checklist

Student Name _____________________________________________ Date __________________________

The following is a brief description of components that need to be completed 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.

- Completed Admissions Application pages:
  - Student Information, Parent/guardian Information, Emergency contacts
  - Press Consent Form
  - Suspension/Expulsion/Change of Placement form (completed by the current school administrator or counselor)
  - Signed Acceptable Use Policy for Technology
  - Release of Information
  - Medical documentation:
    - FERPA/HIPAA Consent
    - Medical Consent Form
    - Medical Questionnaire
    - 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.
    - Administration of Medication Forms for each medication to be given at school, signed by a physician and parent

- It is your responsibility to provide WVSDB with the following:
  - Copy of current school records including: the current Individualized Education Plan (IEP), Academic, medical, psychiatric, discipline and behavior records, Behavior Intervention Plan, Functional Behavioral Assessment,
  - Eligibility Committee Report and Reevaluation Determination Plan (RDP)
  - Copy of prospective student’s original birth record (certificate). Must be a copy of the State Registrar of Vital Statistics certificate.
  - Immunization Records
  - Copy of child’s Social Security Card.
  - Copy of child’s insurance or medical card.
  - Copy of most recent Dental Exam (within one year of application)
  - SCHOOL FOR THE DEAF PROSPECTIVE STUDENT – Current (within the last year) audiological report. Audiological history from date of diagnosis to present, if possible.
  - SCHOOL FOR THE BLIND PROSPECTIVE STUDENT--Current (within the last year) ophthalmological evaluation or low vision report.
  - Guardianship documentation (if applicable)
Admission Application

STUDENT INFORMATION

Full Name ___________________________ DOB 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 Name First Name Middle Name Relationship ___________________________

Not Military ___Active Duty ___Not Military ___Active Duty

Air Force ___Army ___Coast Guard ___National Guard ___Reserve ___Active Guard Reserve

Marines ___Standby Reserve ___Retiree/Veteran

Guardian Name: ___________________________________________

Last Name First Name Middle Name Relationship ___________________________

Not Military ___Active Duty ___Not Military ___Active Duty

Air Force ___Army ___Coast Guard ___National Guard ___Reserve ___Active Guard Reserve

Marines ___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

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

I, _________________________________ (current school administrator/counselor), hereby confirm 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.

___________________________________________________________
Current School Administrator/Counselor Signature

Date

Educational Change of Placement

Has educational placement for the student been changed due to any of the following high risk behaviors?

___ Mental health episodes
___ Incidents of behavior disruptions that violate the Safe Schools Policy 4373
___ Self-harm or harm to others
___ Hospitalizations or crises relating to mental health care

If so, please provide documentation supporting the student's return to school.

___________________________________________________________
Current School Administrator/Counselor Signature

Date
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.

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/
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 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: ____________________________________________
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: ____________________________________________

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<tr>
<th>Last</th>
<th>First</th>
<th>MI</th>
<th>Date of Birth</th>
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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

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 ________________________________
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
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)
Physical Examination Form (to be completed by a physician)

Full Name ___________________________ DOB ________________

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: ___________________________
**Admission Application**

**Physical Examination Form** *(to be completed by a physician)*

**ALLERGIES**

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<tr>
<th>Food Name</th>
<th>Reaction</th>
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<th>Medication Name</th>
<th>Reaction</th>
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<tr>
<th>Other Allergies</th>
<th>Reaction</th>
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**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**
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.

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

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