THE CLEAR VIEW SCHOOL DAY TREATMENT CENTER **2017 - 2018**
BRIARCLIFF MANOR, NEW YORK 10510

Parent Orientation
Part II

All medical forms, releases and permission slips which must be filled out or signed at the start of the school year are contained in this second part of the Orientation Letter. The following check list may help you to keep track of them and to be sure that you have taken care of all of them. Please bring these forms with you, as well as the requested change of clothing, when you bring your child in at the appointed time during Orientation Week.

Check list of forms and releases:

- ☐ Registration Form
- ☐ School Records
- ☐ Emergency Information
- ☐ Activity Permission
- ☐ Field Trip Permission
- ☐ Sunscreen/Insect Spray Permission
- ☐ Funding for Education & Treatment (Release)
- ☐ Photograph Permission
- ☐ Medicaid Insurance Information Sheet
- ☐ Electronic Device Agreement
- ☐ Emergency Medical Treatment (Release)
- ☐ Allergies and Medication (filled out by parents)
- ☐ Medication After School Hours Form
- ☐ Pesticide Notification
- ☐ Acknowledgment of School Policies
  - CIPA
  - HIPAA
  - FERPA
- ☐ Annual Health Examination and History (Second page - filled out by physician)
- ☐ Over the Counter Medication Permission Form (filled out by physician)
- ☐ Immunization Record (filled out by physician)
- ☐ Annual Dental Examination (filled out by Dentist)

Check list of clothing required for all children:

- ☐ Pair of sneakers
- ☐ Change of outer clothing
- ☐ Pair of socks
- ☐ Suit of underwear
- ☐ Sweater or sweatshirt

Please note that the forms pertaining to physical examinations and other health matters are contained in the section of this Manual pertaining to those topics.

2017 - 2018

REGISTRATION FORM

In registering my child, _____at The Clear View School Day Treatment Center, I hereby consent to his/her participation in the special education and mental health treatment services provided by the Center.

I understand that the Association for Mentally Ill Children cannot be held responsible for any damages my child might cause to any person(s) or property while in the care of the Association and I further exonerate the Association completely from any responsibility for such damages.

Preparatory to registering my child at The Clear View School for the school year, I have received, read through, and made myself familiar with the contents of the current Orientation Letter. I have provided the requested clothing to be kept in School and have taken care of the other pre-registration requirements.

_____

Signature of Self
(Age 18 or older)

_____

Signature of Parent or Guardian

_____

Date

2017 - 2018

Child's Name: _____

Child's Cell # *(if applicable)*: _____

SCHOOL RECORDS

So that we can keep our records up to date, will you please fill out and return this page to us? It is most important that we have business addresses and telephone numbers.

Parents/Guardian: _____

Home Address: _____

_____

Phone: _____

(If parents are separated, list both addresses and telephone)

Email Address: _____

Do you have a computer _____ if yes, do you have access to a printer _____

We are developing an email listing that will be used to keep parents/guardians informed about upcoming events and activities (i.e., future newsletters, dinner dance, topics of interest, etc.). Email address will only be used by Clear View/AMIC and will not be shared with any external sources.

Mother's Business: _____

Phone: _____ Cell: _____

Father's Business:_____

Phone: _____ Cell: _____

Doctor's name and address to be called in the event of emergency:

_____

_____ Telephone: _____

Name, address, phone of person to be called in event of emergency and parents cannot be reached.

Name: _____

Address: _____

Phone numbers: _____

Relationship to child: (Grandmother, Neighbor, etc.): _____

2017 - 2018

EMERGENCY INFORMATION

Child's Name: _____

In the event that my child is absent from school and I cannot be reached, please call:

Name	Relationship	Phone

In the event that my child must be brought home early and I cannot be reached, please call the following, who can provide for my child in my absence:

Name	Address	Phone	Relationship

_____ _____

Signature of Self (Age 18 or older) | Parent/Guardian Signature

****

If your child has a key and is used to being home alone, you may indicate your permission by signing below:

I hereby give permission for my child _____ to be sent home from school, in the event of an early dismissal, even if I am unable to be reached by telephone.

_____ _____

Signature of Self (Age 18 or older) | Parent/Guardian Signature

2017 - 2018

ACTIVITY PERMISSION

(Please Sign and Return)

I hereby give permission for my child _____to participate in any and all activities of The Clear View School Day Treatment Center program.

When photographs, videotaping, stage productions, art projects and the like are created and used within the program, I understand that my child's image, artwork, voice, musical production, etc., may be used for program purposes and may be displayed within Clear View's buildings and grounds with my child's name as the subject and/or creator of the image, and give permission for such activities and display.

Further, I give permission for my child to take trips or walks away from the school premises when the staff deems such trips or walks to be of benefit to my child.

Further, I give permission for my child to take part in playground and other physical activities during the hours that he/she attends The Clear View School and generally to participate in all of the activities which the School's center involves, unless I have given specific, written instructions that such participation not be permitted.

_____
Signature of Self
(Age 18 or older)

_____
Signature of Parent or Guardian

_____
Date

2017 - 2018

FIELD TRIP PERMISSION

(Please Sign and Return)

I hereby give permission to The Clear View School of Westchester to take my child _____ on field trips away from the school premises when the staff deems such field trips to be of benefit to my child.

I understand that the purpose of field trips is basic education and/or enrichment, and will generally include recreation and socialization activity. The duration of such field trips may be all or part of a school day. Transportation methods may include public transportation, school vehicle, staff cars and hired vehicle, depending on the nature of the trip.

I further understand that my child will generally bring home a field trip notice a few days before the trip, and that I can revoke permission for any particular trip to which I object by giving specific, written instructions that such participation not be permitted.

_____
Signature of Self
(Age 18 or older)

_____
Signature of Parent or Guardian

_____
Date

SUNSCREEN / INSECT SPRAY PERMISSION

Weather permitting, outdoor activity is an integral part of The Clear View program, resulting in the children's exposure to the sun and to insects.

Of course, we routinely take ordinary precautions to avoid sunburn and insect bites during regular outdoor activities. For those times when the children will be outdoors for a prolonged period of time, we have sunscreen and insect repellant available. Would you please sign and return the consent form below if you give permission for your child to use the products described? You may want to check with your pediatrician about the use of these products.

I hereby consent to the use of Sunscreen SPF #15 or above for my child.

_____
Child's Name

_____ _____
Parent Date

I hereby consent to the use of Insect Repellant for my child.

_____
Child's Name

_____ _____
Parent Date

2017 - 2018

FUNDING FOR EDUCATION AND TREATMENT SERVICES

(Release)

I hereby authorize The Clear View School Day Treatment Center and The Association for Mentally Ill Children of Westchester, Inc. (AMIC), to obtain funding for any and all special education and or treatment services provided for my child and family from all sources allowed by Federal or New York State Law and Regulation. I further consent to the release of any and all information required to obtain such finding.

This release includes, but is not limited to information and billing:

- To receive tuition funds from the State Department of Education, from my local Board of Education or from any other source of public funding for educational purposes.
- To receive payment from Medicaid or Medicare Insurance.
- To bill private medical insurance when necessary.

_____ _____

Child's Name

Signature of Self
(Age 18 or older)

_____

Signature of Parent or Guardian

_____

Date

2017 - 2018

PHOTOGRAPH PERMISSION

I hereby give the Association for Mentally Ill Children of Westchester, Inc. and The Clear View School or their designated agents, permission to take photographs of my child for publicity or professional purposes and to use such photographs at the discretion of the above named Association and School.

_____ _____

Child's Name

Signature of Self
(Age 18 or older)

_____

Signature of Parent or Guardian

_____

Date

THE CLEAR VIEW SCHOOL DAY TREATMENT CENTER
BRIARCLIFF MANOR, NEW YORK 10510

2017 - 2018

MEDICAID/INSURANCE INFORMATION SHEET

Child's Name: _____

Date of Birth: _____

MEDICAID:

_☐_ My child does not have a medicaid card.

_☐_ My child does have a medicaid card.

My child's medicaid number is _____
(Please attach copy of current medicaid card)

My child's social security number is _____

If your child does NOT have a medicaid card, please fill in the section below.

_☐_ I have checked with Westchester DDS to determine if my child can receive a medicaid card.

_☐_ I have not as yet checked with Westchester DDS to determine if my child can receive a medicaid card.

PRIVATE INSURANCE:

Carrier: _____

ID Number: _____

Group: _____

Address: _____

_____

Phone: _____

_____ _____ _____
Signature of Self (parent or guardian) Date
(Age 18 or older)

THE CLEAR VIEW SCHOOL DAY TREATMENT CENTER **2017 - 2018**
BRIARCLIFF MANOR, NEW YORK 10510

ELECTRONIC DEVICE AGREEMENT

We understand that The Clear View School cannot assume responsibility for the protection of personal property brought from home. Electronic devices, including cell phones, are attractive targets for theft and are easily broken pieces of equipment. The undersigned acknowledge that there is a high probability that any electronic device brought to school will become damaged or stolen, and agree that neither the staff nor the students nor the agency itself will be held responsible for damage or theft, either in school or on the school bus. The undersigned further agree that the use of any electronic device in the classroom will be governed by the rules, restrictions and teachers' directions of the particular classroom.

Electronic device(s) covered by this agreement:

_____
Student's Name

_____ _____
Student's Signature Parent's Signature

EMERGENCY MEDICAL TREATMENT

(Release)

In the event of an emergency, I hereby give permission to The Clear View School of Westchester to obtain medical and surgical treatment of my child_____. I authorize transportation to a hospital, where required, and treatment by a physician or surgeon selected by the School in the event that should be deemed necessary. I agree to assume responsibility for all charges so incurred.

Please indicate any information that should be available to an emergency physician (allergies, medication, etc.).

Medical Insurance Carrier: _____

Policy Number: _____

Medicaid Number: _____

Social Security Number: _____

_____
Signature of Self
(Age 18 or older)

_____
(Parent or Guardian)

_____
Date

2017 - 2018

ALLERGIES AND MEDICATION
(To be filled out by parent)

Name: _____ Date: _____

Food Allergies:

Is child allergic to any foods? If so, please name and describe allergic reaction. Be specific about child's age when reaction occurred.

Medical Allergies:

Is child allergic to any medicines? If so, please name and describe allergic reaction. Be specific about child's age when reaction occurred.

Has child ever received penicillin? Yes No

Has child ever had allergic reaction to penicillin? Yes No

Date: _____

Describe:

Current Medical Status

Does child have any important medical problems?

Please describe:

Please name doctor caring for this: _____

Is child receiving medication of any sort? Yes No

If yes, name of drug(s): _____

Amount of dosage: _____ Frequency of administration: _____

Reason for use: _____

Possible reaction to medication: _____

Name of doctor managing medication: _____

THE CLEAR VIEW SCHOOL DAY TREATMENT CENTER
BRIARCLIFF MANOR, NEW YORK 10510

2017 - 2018

IF YOUR CHILD TAKES ANY MEDICATION OUTSIDE OF SCHOOL HOURS

If your child takes any medication before or after regular school hours, please list the medications, dose and time below.

Child's Name: _____

Medication (s)_____dose_____time_____

Medication (s)_____dose_____time_____

Medication (s)_____dose_____time_____

Medication (s)_____dose_____time_____

_____
Signature of Parent or Guardian

_____
Date

THE CLEAR VIEW SCHOOL DAY TREATMENT CENTER
BRIARCLIFF MANOR, NEW YORK 10510

2017 - 2018

PESTICIDE APPLICATION NOTIFICATION

New York State Education Law now requires written notification to parents, guardians and staff members regarding the potential use of pesticide periodically throughout the school year.

The Clear View School is required to maintain a list of persons in parental relation, faculty, and staff who wish to receive 48-hour prior written notification of certain pesticide applications. The following pesticide applications are not subject to prior notification requirements:

- a school remains unoccupied for a continuous 72 hours following an application;
- anti-microbial products;
- nonvolatile rodenticides in tamper resistant bait stations in areas inaccessible to children;
- nonvolatile insecticidal baits in tamper resistant bait stations in areas inaccessible to children;
- silica gels and other nonvolatile ready-to-use pastes, foams, or gels in areas inaccessible to children;
- boric acid and disodium octaborate tetrahydrate;
- the application of EPA designated biopesticides;
- the application of EPA designated exempt materials under 40CFR152.25;
- the use of aerosol products with a directed spray in containers of 18 fluid ounces or less when used to protect individuals from an imminent threat from stinging and biting insects including venomous spiders, bees, wasps, and hornets.

In the event of an emergency application necessary to protect against an imminent threat to human health, a good faith effort will be made to supply written notification to those on the 48-hour prior notification list.

Since The Clear View School is committed to an Integrated Pest Management approach, which involves infrequent use of the least toxic pesticides possible, with application during time when school is closed, it is unlikely that we would use pesticides which fall under the 48-hour notification provisions of this law.

However, in the event that we must use such a pesticide at any time in the future, please return the attached form.

Please feel free to contact George Pagnotta at the school, 941-9513, for further information on these requirements.

Updated 8/01

THE CLEAR VIEW SCHOOL DAY TREATMENT CENTER
BRIARCLIFF MANOR, NEW YORK 10510

2017 - 2018

REQUEST FOR PESTICIDE APPLICATION NOTIFICATION

I would like to receive 48-hour prior notification of pesticide applications that are scheduled to occur, as provided for in New York State Education Law.

Name: _____

_____

Address: _____

_____

_____

_____

Day Phone: _____

Evening Phone: _____

Updated 8/01

EXECUTIVE DIRECTOR
Charles F. Devlin

SCHOOL DIRECTOR
Jackie Hastings, SAS, LMHC

CLINICAL DIRECTOR
Elaine K. Haagen, M.D.

DIRECTOR, PSYCHOLOGICAL SERVICES
Laurie Wolkin, Ph.D.

ACKNOWLEDGMENT OF SCHOOL POLICIES

I,_____, (parent/legal guardian of _____) acknowledge that I have received notice of the following policies of The Clear View School Day Treatment Center (**2017-2018**), which are posted on The Clear View website:

- Children's Internet Protection Act (CIPA) Policy
- The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule
- Notice of Parents' Bill of Rights for Data Privacy and Security Under FERPA and NYS Education Law §2-D.

_____
Signature

_____
Date

480 Albany Post Road
Briarcliff Manor, New York
10510-2436

Phone (914) 941-9513
Fax (914) 941-1649
www.clearviewschool.org

Sponsored by AMIC, Inc.
A Voluntary Non-Profit Agency

THE CLEAR VIEW SCHOOL DAY TREATMENT CENTER
BRIARCLIFF MANOR, NEW YORK 10510

ANNUAL HEALTH EXAMINATION
(To be filled out by physician)

Date of Exam: _____

Child's Name: _____ Date of Birth: _____

Physical

Height _____ Weight _____ Blood Pressure _____

BMI (Body/Mass Index) _____ Pulse _____

EYES Ophthalmic _____

Vision without glasses: R. _____ L. _____ B. _____

Vision with glasses: R. _____ L. _____ B. _____

EARS Otoscope _____

Has an audiometric examination ever been done: Yes No

Date of last examination _____

TEETH AND GUMS _____

HEAD AND NECK _____

HEART _____

LUNGS _____

ABDOMEN _____

SKIN _____

SKELETAL (scoliosis)
_____

NERVOUS SYSTEM _____

Medical History

Describe history of:

Seizures _____

Asthma _____

Ear condition _____

Frequent colds or sore throats _____

Operations _____

Serious injuries _____

Child's Name: _____

ANY HISTORY OF ALLERGY TO FOOD OR MEDICATION (Please include reactions):

How long have you known this child? _____

Is this child receiving medication of ANY sort? yes no

If YES: Name of drug(s) _____

Amount of dosage _____

Frequency of administration _____

Reason for use _____

Possible reaction to medication _____

Is this child subject to any significant physical defect or physical condition which the school should take into consideration when planning for this child?

yes no

If YES, please explain: _____

COMMENTS OR RECOMMENDATIONS:

This child is free from contagious illness and is cleared for full physical activities.

There are NO contraindications to his/her competing in competitive sports.

We would be pleased to consult with you about your patient's condition and progress at any time.

Physician Signature: _____

Address: _____

Telephone: _____

Date: _____

THE CLEAR VIEW DAY TREATMENT CENTER **2017 - 2018**
BRIARCLIFF MANOR, NY 10510

IMMUNIZATION POLICY

The Clear View School Day Treatment Center program requires immunization records from all students prior to admission. We comply with yearly reporting requirements to the New York State Department of Health. All students are required to be immunized according to the most current New York State Department of Health schedules. Exceptions may be evaluated for students presenting requests for medical or religious exemption.

In accordance with New York State Department of Health recommendations for control measures related to disease outbreaks, unvaccinated students will be excluded from program until 25 days after isolation of known disease cases in the school community. A student may return to program after one dose of the appropriate immunization and a schedule for full immunization.

_____

Child's Name

_____ _____

Signature of Parent or Guardian Date

Immunization Record

Child's Name:_____ **DOB:** _____**Age:** _____

Today's Date: _____

Fill in the age and date for each immunization child has received:

Hepatitis B	**#1**	**#2**	**#3**		
Age					
Date					
DTaP (Tetanus)	**#1**	**#2**	**#3**	**#4**	**#5**
Age					
Date					
Tdap	**#1**				
Age					
Date					
Hib	**#1**	**#2**	**#3**		
Age					
Date					
IPV (OPV)	**#1**	**#2**	**#3**	**#4**	
Age					
Date					
MMR	**#1**	**#2**			
Age					
Date					
Varicella	**#1**	**#2**			
Age					
Date					
Pneumonia PCV	**#1**	**#2**	**#3**	**#4**	
Age					
Date					
Meningitis MCV4	**#1**	**#2**			
Age					
Date					
Influenza	**#1**				
Age					
Date					
H1N1	**#1**				
Age					
Date					
HPV	**#1**				
Age					
Date					
PPD	**#1**				
Age					
Date					
Other	**#1**				
Age					
Date					

THE CLEAR VIEW SCHOOL DAY TREATMENT CENTER
BRIARCLIFF MANOR, NEW YORK 10510

OVER THE COUNTER MEDICATION PERMISSION FORM

Student's name:_____ Date: _____

Allergies:_____ Date of Birth: _____

The following medications will be provided by The Clear View School if they have been approved by the child's physician/provider (signature is required) and requested by the guardian; please indicate by checking Yes or No next to medication.

Yes/No	Drug Name	Route	Dosage & Schedule	Indications	Comments
Yes☐ No☐	Tylenol (or generic) acetaminophen	PO (chewable, elixir, or tabs)	Per label instruction by age/weight	Pain or Fever	Call parent/guardian event of fever
Yes☐ No☐	Advil (or generic) ibuprofen	PO (chewable, elixir, or tabs)	Per label instruction by age/weight	Pain or Fever	Call parent/guardian event of fever
Yes☐ No☐	Benadryl (or generic)	PO (elixir, or tabs)	Per label instruction by age/weight	Allergic reactions (hives, insect bites)	Call if allergic reaction, respiratory problems
Yes☐ No☐	Cepacol lozenges or (generic) (contains benzocaine)	PO	Per label instruction by age/weight	Sore throat	Check allergy history
Yes☐ No☐	Tums or (generic) calcium carbonate	PO (chewable)	Per label instruction by age/weight	Indigestion, heart burn	
Yes☐ No☐	Pepto Bismol	PO (chewable, elixir, or tabs)	Per label instruction by age/weight	Upset stomach, nausea, diarrhea, indigestion	
Yes☐ No☐	Oragel/ Anbesol (or generic, contains benzocaine)	PO	Per label instruction by age/weight	Toothache, sore gums canker sore	Check allergy history
Yes☐ No☐	Hydrocortisone Cream 1%	Topical	Per label instruction by age/weight	Allergic reactions (contact dermatitis, insect bites	
Yes☐ No☐	Calagel	Topical	Per label instruction by age/weight	Poison oak, poison ivy	
Yes☐ No☐	Medicaine Sting Swabs (contains benzocaine)	Topical	Per label instruction by age/weight	Insect bites, bee stings	
Yes☐ No☐	Antibiotic Ointment	Topical	Per label instruction by age/weight	Superficial cut/ abrasion	Check allergy history
Yes☐ No☐	Silvadene 1%	Topical	Per label instruction by age/weight	Burns	Check allergy history / sulfa antibiotic

Physician/Provider Signature:_____ Date:_____
Physician/Provider Stamp: (required):

Parent/Guardian Signature_____ Date:_____

ANNUAL DENTAL EXAMINATION

STUDENT'S NAME _____ BIRTHDATE _____

ADDRESS_____

TEETH: General Condition _____

Temporary _____

Permanent _____

Carious _____

GUMS: General Condition _____

THIS PATIENT: requires no dental treatment at this time

is under dental treatment at this time

will begin dental treatment at this time

has completed all current dental treatment

REMARKS OR RECOMMENDATIONS:_____

Dentist Signature _____

Address _____

Telephone _____

DATE OF EXAMINATION: _____