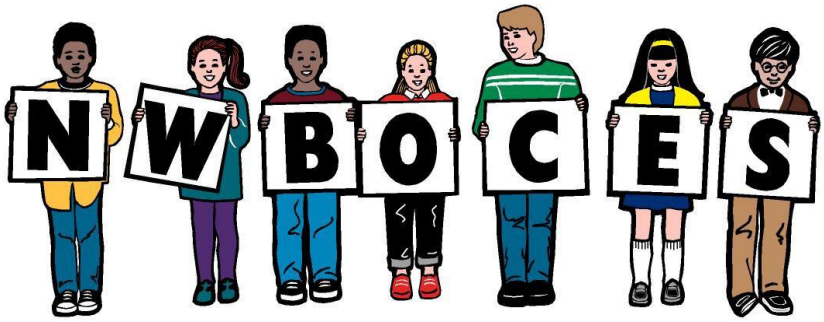
Northwest Wyoming Board of Cooperative Educational Services



Northwest Wyoming Board of
Cooperative Educational Services

Admission Packet

2019-2020

Big Horn Basin Children's Center

P.O. Box 112
250 E. Arapahoe
Thermopolis, Wyoming

307-864-2171/2100
800-928-2171
307-864-9463 Fax
nwboces@rtconnect.net
http://www.nwboces.com

New Student Enrollment Forms Needed

NW BOCES / Big Horn Basin Children's Center

Student Name:_____ DOB:_____ Entry Date: _____

Please remit the following items, as they are mandatory for admittance to NW BOCES. Admissions Packet forms are to be filled out and signed by parent/guardian.

Forms to be provided by Parent/Agency

_____ Individual Education Program (IEP)

_____ 3-Year Evaluation

_____ Immunization Record

_____ Psychological Evaluations

_____ Transcripts/Last Report Card

_____ Social Security Number

_____ Title 19/Ins. (Copy of card and/or no.)

_____ Court Order (if applicable)

_____ Discipline Reports/Records

Forms (to be filled out by Parent/Agency)

_____ Student Information Form

_____ Student Inventory

_____ Admission Application/Consent and Authorization

_____ Special Treatment Intervention

_____ Permission Form for pictures, activities, contests, etc.

_____ Social/Sexual Program Permission

_____ Religious Attendance Permission

_____ Computer Use Policy

_____ Home Language Survey/English Language Learner

_____ Haircut Permission

_____ Camera/Recording Notification

_____ Climbing Wall Permission

_____ Notice of Destruction of Sped. Files

NWBOCES Medical Forms (to be filled out by Parent/Agency)

_____ Health & Safety Documentation

_____ Student Nursing Release

_____ Psychiatric Evaluation Permission

_____ Consent for Administration of OTC Meds

_____ Psychotropic Medication Permission/ Medications List

_____ Special Meals

_____ 1 month of any prescriptions in RX bottles

_____ 1 month written prescription for any controlled meds

NWBOCES Forms (to be filled out by student and staff after admission)

_____ Student Orientation Rights

_____ School & Cottage Rules

_____ Student Handbook Signature Page

_____ Referral

_____ Student Intake

_____ Treatment Plan

Revised July 2019

ED Front of Binder

Student Information

Student's Name: _____

Address: _____

City: _____ State _____ Zip _____

Home Phone: _____ Student's SS #_____

Birthdate: _____ Birthplace: _____

Gender: ___ male ___ female Religion (optional): _____

Ethnicity: _____

Household Members (Names and Relationship, Age of Children)

_____

_____

_____

Father's Name (Stepfather or Guardian): _____

Address: _____

Occupation: _____ *Employer:* _____

Home Phone: _____ *Work Phone:* _____ *Cell Phone:* _____

Mother's Name (Stepmother or Guardian): _____

Address: _____

Occupation: _____ *Employer:* _____

Home Phone: _____ *Work Phone:* _____ *Cell Phone:* _____

Preference for receiving weekly, monthly, & quarterly reports on your child (check one):

_____*e-mail* _____*regular mail* *e-mail address:*_____

Person to notify in case of emergency, other than parent. MUST HAVE 2 PHONE NUMBERS AVAILABLE.

1. Name: _____ Relationship: _____
   Address: _____ Phone: _____ Phone: _____
2. Name: _____ Relationship: _____
   Address: _____ Phone: _____ Phone: _____

Family Physician (home): _____ Phone: _____

Insurance:_____ Policy Number: _____
(A copy of the insurance card is required)
Title XIX:_____ Medicare: _____

Referring Agency:_____ Contact Person:_____ Phone:_____

Court District:_____Judge: _____

Guardian Ad Litem/Attorney:_____ Phone: _____

Schoo lDistrict: _____Contac tPerson: _____ Phone: _____

Current grade: _____

Operations (and dates): _____

Diseases (and dates):_____

Healh Problems:_____

Bleeding or Clotting Problems: _____

Please write any special instructions about your child you think we should know:

_____

_____

_____

Emergency Medical Attention:

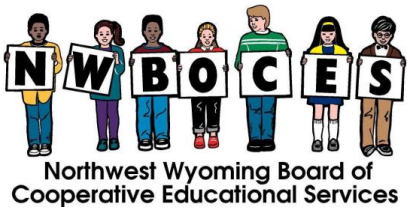
In the event that emergency medical, dental, and/or psychological care is deemed necessary by the Big Horn Basin Children's Center staff, I hereby give my permission to the Big Horn Basin Children's Center staff to seek and carry out appropriate actions.

I understand that I will be notified should such an event occur and be notified of action taken or to be taken.

I understand that Big Horn Basin Children's Center, its agents and employees shall not be liable in the event an accident should occur in connection with any activities.

_____ _____
Parent/Guardian Signature Date

Revised 7/2019
ED #1



ADMISSION APPLICATION
CONSENT AND AUTHORIZATION

The undersigned authorize placement of _____ at Big Horn Basin
(Child's Name)
Children's Center and consent to the following conditions:

1. Provide assessment and/or treatment for psychiatric, psychological, emotional, social/sexual program, and behavioral methodologies, which are normal and customary practice.
2. Allow student to participate in online educational programs and activities following compliance with Children's Online Privacy Protection Act (COPPA).
3. Allow physical intervention and/or placement in a seclusion room when used in accord with Big Horn Basin Children's Center's policies and procedures for crisis intervention to prevent harm to student or others.
4. Allow a physical examination upon admission and medical care by a local physician, periodic blood work, emergency care, and other curative or preventive procedures.
5. Allow Big Horn Basin Children's Center to authorize emergency medical services.
6. Transport the resident within the state or across state lines for program and/or other treatment purposes.
7. Allow the resident to be recorded/filmed for the purpose of internal security, staff training and resident treatment ONLY.
8. Consent to NWBOCES to submit medical claims for court ordered youth for psychological counseling and evaluation, occupational therapy, physical therapy, and speech language therapy per the student's IEP goals.

Signature Instructions:

1. *If placement is by a social agency or Court Order, a representative from the agency that has legal custody must sign below.*
2. *If the placement is through a school district, parent or legal guardian AND a representative from school district must sign.*

I hereby attest that I am the parent/legal guardian/official representative of the student and possess full/legal rights to sign the above Consent and Authorization.

Signature _____ Title/relationship: _____ Date: _____

Name of Agency (If applicable): _____

Signature _____ Title/relationship: _____ Date: _____

Name of Agency (If applicable): _____

ED #11
Revised 7/1/16

40a.

Northwest Wyoming Board of Cooperative Educational Services

Northwest Wyoming Board of Cooperative Educational Services

Big Horn Basin Children's Center

STUDENT : _____

SPECIAL TREATMENT INTERVENTION (STI)

The Big Horn Basin Children's Center recognizes the importance and the responsibility for providing a therapeutic and safe environment for all children. Students will sometimes engage in behavior that places themselves and others in a situation that threatens their safety. Eminent threats or attempts to hurt themselves, threats or attempts to hurt others, and intense behavior that incite others to engage in threatening unsafe behavior may require physical intervention by the staff.

A STI may be necessary to place the child in a physical hold until they are able to manage their behavior. If unsuccessful, it also may be necessary to place the child away from other students in a safe room where they are isolated until they have better management of their behavior. It may be necessary to lock the safe room to maintain this isolation.

Students are encouraged to utilize a quiet area or room on a voluntary basis to assist with regaining self-control as a preventative measure. If the student is unwilling to take this responsibility, it may be necessary for staff to intervene.

When a STI is necessary, the use and procedures are closely monitored and reviewed.

If the child requires more than 45 minutes to regain self-control, a treatment team member is required to be called. If the child has been isolated in a safe room, every effort is made to help the child end the need for the isolation and rejoin the community as soon as there is no longer imminent danger to self or others. All staff are extensively trained in the use of de-escalation techniques and the administering of holds that have a minimum risk of hurting the child.

Every effort will be made to prevent physical or psychological injury to the child in the event that a STI is required. The safety of the child and others are of primary importance. Past abuse and physical limitations are considered to ensure minimum risk for physical or psychological trauma.

The parent/legal guardian will be notified of the time, reason, and outcome in a timely manner when a restraint and/or seclusion placement is initiated. Whenever prudent, family members may be involved in helping to reduce or eliminate the need for STI procedures.

I have been informed of the philosophy and use of STIs by the Big Horn Basin Children's Center and concur with the interventions when required under the circumstances stated above.

_____	_____	_____
Parent/Legal Guardian (please print)	**Signature**	**Date**

STUDENT INVENTORY

Student Name: _____ Date: _____
The following items are requested for each student when enrolled in the NW BOCES ED Program:

CLOTHING

5 prs. jeans	2 prs. shoes	1 heavy coat
5 prs. shorts	1 pr. slippers	1 pr. snow boots
5 T-shirts	1 bathrobe	1 winter hat
3 sweatshirts	3 prs. pajamas	1 light jacket
3 sweatpants	10 prs. socks	
2 athletic shorts	1 belt	
7 underpants/underwear	1 swim suit	
1 dress outfit	1 pr. gloves	4 bras (girls)
1 dress shirt	1 pr. snow pants	

These items may not have drug/alcohol/sexual/violence/death/skulls/snake connotations (this includes day students). Clothing must be machine washable and dryer safe. All items need to be labeled with the child's name/initials. Clothing to meet the needs of the season.

PERSONAL HYGIENE

2 toothbrushes	1 bottle shampoo	2 combs
1 tube toothpaste	1 bottle conditioner	1 hair brush
1 deodorant	1 styling product	2 pkg sanitary pads(girls)

Parents/guardians will be requested to supply these items and re-stock as needed. You may bring in items on visits. Please do not leave/bring money for your child.

OPTIONAL ITEMS

1 hair dryer	1 pillow
1 favorite stuffed animal	1 blanket
Family photos	3 favorite toys (valued at $20 or less)

Please Do Not Send the following items:

Knives, scissors, tools, and other sharp objects
Radio/CD Player, Cell Phones, Ipads, Ipods, Computers
Alcohol and alcohol containing products, e.g. mouthwash, body sprays, cologne, aftershave
Any over the counter or prescription medications should be given to a staff person

Drug paraphernalia	Aerosols sprays of any kind
Nail polish, remover, files, or clippers	Tobacco products/paraphernalia
Butane lighters or other flammable objects	Pornographic materials

Tapes, CDs, or videos with inappropriate language/content (E, G, & PG ratings only)
No Boots/Cowboy Boots allowed until Level 3 and 4
No Muscle Shirts or Spaghetti Straps (this includes day students also)

Please do not send more items than are listed due to limited space and program restrictions. If there are more items than requested or if any items are found to be inappropriate, they will be returned home. Inventories will be updated on a monthly basis. Thank you again for your cooperation.

Updated 6/2019

ED#1

BIG HORN BASIN CHILDREN'S CENTER PERMISSION FORMS

STUDENT'S NAME: _____ DATE: _____

PICTURES & INFORMATION: I hereby give permission to NWBOCES to use pictures/video and any accompanying audio of me and/or my child recorded by NWBOCES to be used with educational, training, or promotional materials and publications..
Yes _____ No _____

ACTIVITIES: I give my permission for my child to attend school sanctioned activities whether in Thermopolis or elsewhere; to go on any field trips planned by his/her teacher or the cottage staff; to be involved in any extracurricular activities such as attending local concerts, basketball games, parties, movies, swimming, leisurely walking, etc. during the school year. Yes _____ No _____
List any activity you do not give permission to participate in:
_____

CONTESTS: I give my permission for my child to enter contests which are approved by BHBCC.
Yes _____ No _____

TELEPHONE PRIVILEGES: As privileges are earned (Level III /Level IV), my child has my permission to make long distance calls and charge them to my home phone, or by a phone card provided by the parent/guardian.
Yes _____ No _____ and to receive telephone calls. Yes _____ No _____

Calls to:		Calls from:	
Name	**Relationship**	**Name**	**Relationship**

VISITATION PRIVILEGES: Please write the names of persons who may visit your child at the cottage or school.

Name	Relationship

CORRESPONDENCE FROM/TO: Please write the names of persons who may receive/send correspondence from/to your child at the cottage or school.

Correspondence to:		Correspondece from:	
Name	**Relationship**	**Name**	**Relationship**

_____ _____

Date ***Parent/Guardian Signature***

ENGLISH LANGUAGE LEARNER

Policy:

Northwest Wyoming Board of Cooperative Educational Services recognizes the special requirements of students who do not have the English language as their primary language. All English Language Learners will acquire sufficient competency in areas of listening, speaking, reading and writing of English to facilitate their success in grade-level appropriate classes and according to their Individualized Educational Program.

Procedure:

NW BOCES will provide a differentiated curriculum for English Language Learners appropriate to their Individualized Educational Program. Students will be integrated into NW BOCES programs in a manner that facilitates their language needs and leads to the fulfillment of their Individualized Education goals.

NW BOCES will identify English Language Learner students upon enrollment and continuing through grade 12, using multiple sources of data and information.

NW BOCES will continue to research and implement best practices in English Language Learners involved in special education programs. This research will be used to implement and support instructional strategies.

English Language Learner students' progress will be monitored and re-evaluated on an annual basis and as part of their annual review of their Individualized Education Program.

NW BOCES will provide time, support, and staff development in the field of English Language Learner instruction to personnel. Personnel with specific education and/or skill will be assigned to support English Language Learners as appropriate.

As part of their therapeutic plan, English Language Learners will receive educational, social, and emotional support from appropriately trained staff.

Northwest Wyoming Board of
Cooperative Educational Services
Thermopolis, Wyoming

Parent/Guardian Home Language Survey

Student Name: _____

Relationship of Person Completing Survey: ☐ **Mother** ☐ **Father** ☐ **Guardian**

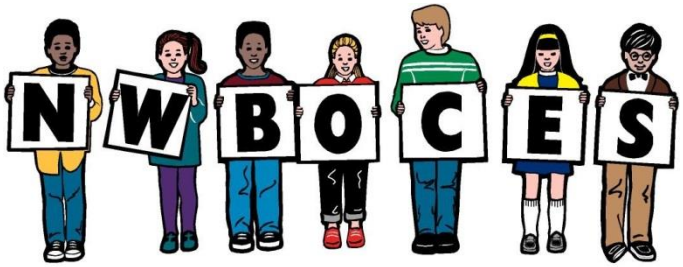
Circle the correct response for each of the following questions concerning your child.

1. What language did the child learn when he/she first began to talk?	**English**	**Other (specify)_____**
2. What language does the family speak in the home most of the time?	**English**	**Other (specify)_____**
3. What language does the mother speak to her child most of the time?	**English**	**Other (specify)_____**
4. What language does the father speak to his child most of the time?	**English**	**Other (specify)_____**
5. What language does the child speak to his/her mother most of the time?	**English**	**Other (specify)_____**
6. What language does the child speak to his/her father most of the time?	**English**	**Other (specify)_____**
7. What language does your child speak to his/her brothers and sisters most of the time?	**English**	**Other (specify)_____**
8. What language does your child speak to his/her friends most of the time?	**English**	**Other (specify)_____**

_____ _____

Signature of person completing survey **Date**

ED #11



Northwest Wyoming Board of
Cooperative Educational Services

HAIRCUT PERMISSION

I give permission for _____ to receive periodic haircuts while in residence at NW BOCES.

- NW BOCES Staff Person – free; a buzz/crew cut for boys
- Local Licensed Cosmetologist (payment must be made in advance)
- Haircuts only by Parent/Guardian

_____ _____

Signature Date

ED #11

Big Horn Basin Children's Center
Attendance at Religious Services
Permission Form

I, _____, desire to have my child, _____attend religious services at _____ church, Thermopolis, Wyoming.

I understand that all the following rules apply:

1. NW BOCES Administrative Director will check with staff to determine if any NW BOCES staff members attend the selected church and if they want to volunteer to take student to Sunday services
2. A NW BOCES staff person must accompany student to Sunday Services.
3. NW BOCES volunteer staff person will transport student in his/her personal vehicle.
4. NW BOCES staff person's driving record and vehicle insurance will be on file at NW BOCES.
5. My child will earn this outing consistent with privileges identified on the Behavioral Level System.
6. If earned, a maximum of one religious outing per week will be allowed at Level 2, 3, and 4.
7. My child may lose this privilege based on inappropriate behavior while on the religious outing, at the cottage, or in the classroom.
8. NW BOCES is relieved of all liability for the safety of my child during transportation to and from the service and supervision during the service.

_____ _____

Parent/s Signature Date

NW BOCES staff person to provide transportation and supervision:

(name) _____

(phone no.) _____

This form must be completed and on file at NW BOCES prior to the child being allowed to attend services.

ED #11

Northwest Wyoming Board of Cooperative Educational Services

Notification of Recording/Filming Audio & Visual At NW BOCES School & Residences

NW BOCES/ Big Horn Basin Children's Center notification to staff, parents, students, and visitors regarding installation of surveillance cameras at each of the NW BOCES facilities:

Please be aware that when you are at NW BOCES facilities there will be visual and audio recordings occurring except in the bedrooms at the cottages and bathrooms at the school and cottages. Please be aware that communications in any other area of the facility may be recorded.

The recordings will be used for internal security, staff training, and resident treatment program planning purposes.

I hereby attest that I have been notified that the installation of this recording/video equipment is intended to be permanent and that this may be the only notice I will receive. I understand the purpose for the installation and acknowledge that I have been given notice thereof.

For (student's initials if applicable):_____

Signature _____ Title/relationship: _____ Date: _____

Name of Agency (If applicable): _____

If signing as a parent/guardian/DFS caseworker, I am also signing on behalf of _____,child/student.

ED #11
Revised 3/19/2019

Northwest Wyoming Board of Cooperative Educational Services

CLIMBING WALL NOTIFICATION LETTER/PERMISSION TO PARTICIPATE

Dear Parents/Guardians,

Beginning when the signed Permission to Participate letter is received, your child has the opportunity to participate in a climbing wall unit as a part of our physical education program.

We are using a traverse climbing wall to host many exciting activities. At its highest point, the wall measures eight/ten feet and is approximately 12 feet long. Participants climb horizontally (traverse) across the wall and their feet should never be higher than three/three-and-a-half feet off the ground. Your child will be informed of safety rules and will climb under the careful supervision of an adult instructor at all times.

Indoor rock climbing is one of the fastest growing activities today. It simultaneously develops coordination, strength, flexibility and cardiovascular fitness. Additionally, important life skills like problem-solving, goal-setting, perseverance, inner confidence and patience will be learned in this unit.

In order for your child to participate in our climbing wall unit, we must have a signed permission slip. Should you have any questions regarding this exciting educational opportunity, please do not hesitate to call NW BOCES at 307-864-2171.

Sincerely,

Carolyn Conner

Carolyn Conner
Administrative Director, NW BOCES

PERMISSION TO PARTICIPATE

_____(student name) has my permission to participate in the climbing wall unit at NW BOCES. I understand that this activity involves some risk of injury and I will stress the importance of following the class safety rules when we discuss this activity at home.

_____ _____
(Signature of parent/guardian) (Date)

Northwest Wyoming Board of
Cooperative Educational Services

Social/Sexual Program Permission Form

We are seeking your permission to include your child, _____, in a Social/Sexual Program specifically designed for students in 5th to 8th grade. Each child involved will work one-on-one with the teacher and will be included in small group discussion on appropriate living behaviors.

If you have any questions about the curriculum, please feel free to call us at 307-864-2171 and we can discuss the program in detail.

We would like your signature of approval of _____ being included in this program. Your child will not be included until we have your permission. If you do not give permission we will assume you will take care of this area of education. If we become aware of areas of concern, we will pass these concerns on to you.

I, _____ give my permission for my child, _____ to participate in a Social/Sexual Education Program especially designed for students with disabilities.

_____
Date Signed

ED #11

Computer Security

Access to computer data stored within all computer systems may need to be carefully monitored for security purposes.

Disposal of reports and/or other information after it is no longer being used or when the information has been removed to a central back-up system shall be done with the consent and knowledge and in accordance with any procedure established by the supervisor responsible for the department utilizing the information

The Administrative Director and/or designated members of the administrative staff shall have responsibility for determining who will have on-line access to information and who will have access to information stored on the computers personally utilized by individual staff members.

To the extent passwords are issued to individual users, such passwords are not to be recorded in any location accessible to any other staff or students except such administrative staff as are responsible for issuing the passwords and/or their specific designee.

No user shall be permitted to utilize the computer for any illegal, inappropriate, or offensive purpose. Any employee who becomes aware that this policy is being violated shall immediately notify his/her supervisor of the violation.

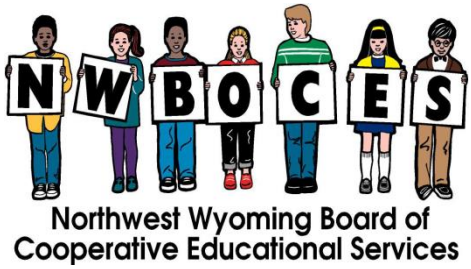
Information other than general educational/program information intended to be available for all staff should be carefully secured by all staff members working with the information in order to avoid divulging confidential information to students or other staff except as may be appropriate and on a need-to-know basis. Access to and maintenance of data should be strictly limited. Accessing data for which there is no need to know is forbidden. Disclosure of information should not occur either by intent or inadvertence except as is necessary to carry out the staff member's assigned duties. All confidential and secure information should be safeguarded to the extent possible. If it is copied onto disks, the disks and/or other backup information should be secured in a locked location so that they cannot be accessed by persons who are not intended to have the information.

Computer-generated reports or displays are not to be released outside of NWBOCES except as provided for in NWBOCES policies, regulations or procedures or by approval of the Administrative Director and/or his/her designee.

All computers utilized within NWBOCES shall be utilized solely for educational/program purposes unless specific consent is otherwise given by the Administrative Director or his/her designee. No employee working for NWBOCES shall have any expectation of privacy regarding the information stored on the computer utilized by the employee. In order for the employee to utilize the computer for educational/program purposes, the employee must consent to allowing his/her supervisor, as well as other persons the supervisor and/or Administrative Director may designate to access the information stored on the employee's computer and/or any other floppy drives or backup system.

Policy 4022

Adopted 7-24-13
Reviewed 7-22-15
Reviewed 3-22-17



Acknowledgement of Receipt and Consent to Comply With Electronic Devices Policies and Guidelines 4021; 4021a-R to 4021e-R; and 4022

The undersigned acknowledges having received a copy of Board Policies and Procedures 4021; 4021a-R to 4021e-R; and 4022 and states that he/she has read and understands the policy regulation and agrees to comply therewith. The undersigned does further acknowledge that there is no expectation of privacy as to the computer information stored on the computer utilized by the undersigned and the undersigned does consent to allow his/her supervisor and other persons designated by the Administrative Director to have access to all information stored on the computer or any disk.

Date: _____ _____

Employee/Parent

Policy 4022-R

Adopted 7-24-13
Reviewed 7-22-15
Revised 10-26-16
Reviewed 3-22-17

Northwest Wyoming BOCES
Big Horn Basin Children's Center
250 E. Arapahoe PO Box 112
Thermopolis, Wyoming 82443
(307) 864-2171

NOTICE OF DESTRUCTION OF SPECIAL EDUCATION RECORDS

Student Name:_____ Student ID Number:_____

Northwest Wyoming shall destroy records of students with disabilities when personally identifiable information collected or maintained is no longer needed to provide educational services to the student.

Each student's records will be maintained for the longest period of time that any portion of that record is required by the state to be maintained. If NW BOCES determines that a specific file needs to be permanently maintained, that file may be sent to the State Archives or microfilmed and destroyed.

A parent/guardian or student who has reached the age of majority and is otherwise competent, may request a copy of the records at any time prior to the destruction of the records.

This shall serve as notice of the intent to destroy records to the parent/guardian or student having reached the age of majority. Notice of intent to destroy records will also be placed in the local newspaper prior to the destruction of records.

This notification of destruction of records was given to parent/guardian or student having reached the age of majority.

Signature:_____
Parent/Guardian or Student having reached the age of majority

Date:_____

ED #3

Northwest Wyoming Board of
Cooperative Educational Services

HEALTH AND SAFETY DOCUMENTATION

Please fill out the following questionnaire and return to NW BOCES before your child/student is admitted: If information can be found in reports received by NW BOCES simply reference those reports.

Student: _____

1. Allergies – (what reactions he/she has) including food and medications and the environment:

2. Medications – (medication names, dosage, and why he/she is taking them):

3. Immunization history: please include form

4. Hospitalizations: (when and why)

5. Medical diagnoses:

6. Medical problems that run in the family:

7. Complications of pregnancy, if applicable:

8. Special dietary needs: (we don't allow caffeine products except for Special occasions)

9. Illnesses:

10. Injuries:

11. Dental and eye –
    A. Dental: Dental problems and when was last appointment
    B. Eye: Does he/or she wear glasses and when was his/her last appointment?

12. Mental health issues:

13. Emotional problems:

14. Ongoing medical care needs:

15. History of aggressive or violent behavior: (describe please)

16. Substance abuse history:

17. Sexual history or behavior patterns that may place the child or other children at risk:

18. Known or suspected suicide or self-injury attempts or gestures:

19. Emotional history which may indicate a predisposition for self injury or suicide:

20. History of fire setting:

21. Homicidal thinking:

22. Animal cruelty or mutilation:

_____ _____

Parent/Guardian Date

Red Rock Family Practice

Patient Registration Form

Primary Care Dr: _____

PATIENT INFORMATION

Patient Full Name _____

Date of Birth _____/_____/_____ Social Security Number _____-_____-_____

Sex: Male / Female Ethnicity: Hispanic / Non-Hispanic Race _____ Primary Language _____

Marital Status: Single / Separated / Married / Widowed / Divorced

Mailing and Street Address _____

City _____ State _____ Zip Code _____

Home Phone ( ) _____ Cell Phone ( ) _____ Work Phone ( ) _____

May we send you a text message? Yes/No

Employer _____ Address _____

Email Address _____ **Pharmacy** VICKLUND PHARMACY _____

RESPONSIBLE PARTY INFORMATION *(Person responsible for bill – Not insurance)*

- Same as above, otherwise, please fill out below:

Responsible Party's Full Name _____

Date of Birth _____/_____/_____ Social Security Number _____-_____-_____

Sex: Male / Female Marital Status: Single / Separated / Married / Widowed / Divorced

Mailing and Street Address _____

City _____ State _____ Zip Code _____

Home Phone ( ) _____ Cell Phone ( ) _____ Work Phone ( ) _____

INSURANCE INFORMATION

Please Note: We will file your insurance as a courtesy if we have current and necessary information. All charges incurred are your responsibility regardless of insurance coverage.

Primary Insurance Carrier _____

Policy Number _____ Group Number _____

Secondary Insurance Carrier _____

Policy Number _____ Group Number _____

Worker's Compensation Number *(if applicable)* _____

Employer's Telephone Number ( ) _____ Date of Injury _____/_____/_____

EMERGENCY CONTACTS

In Case of Emergency Notify _____

Relationship _____ Phone Number _____

Address _____

SOMEONE NOT LIVING IN HOUSEHOLD _____

Relationship _____ Phone Number _____

Address _____

Red Rock Family Practice

120 North C Avenue
Thermopolis WY

Phone 307-864-5534
Fax 307-864-5226

Travis Bomengen, MD
Linsey Brooks, FNP-C

Jason Weyer, DO

Hallie Bischoff, DO
Ellen Reynolds, PA-C

AUTHORIZATION TO DISCUSS YOUR HEALTH INFORMATION

Please assist us in managing your health information. You may wish to discuss your medical condition or bill with a relative or friend. In order to protect the privacy of your health information, we cannot do this without your permission.

Please check and specify with whom we may discuss your health information:

- ☐ Your spouse, specify name: _____
- ☐ Your mother, specify name: _____
- ☐ Your father, specify name: _____
- ☐ Your child, specify name: _____
- ☐ A step-parent, specify name: _____
- ☐ A friend, specify name: _____
- ☑ Other, specify name and relation: **NW BOCES RES. TREATMENT**

_____

Patient Name (please print): _____

Patient Signature: _____

Parent or Legal Guardian Name (please print): _____

Parent or Legal Guardian Signature: _____

Date: _____/_____/_____

This authorization will remain in effect unless revoked in writing.

Red Rock Family Practice

120 North C Avenue
Thermopolis WY

Phone 307-864-5534
Fax 307-864-5226

Travis Bomengen, MD
Linsey Brooks, FNP-C

Jason Weyer, DO

Hallie Bischoff, DO
Ellen Reynolds, PA-C

AUTHORIZATIONS AND SIGNATURES

Printed Patient Name_____ Date of Birth _____/_____/_____

NOTICE: Do not sign this agreement before you read and agree to the conditions set forth. You are entitled to a copy of the agreement at the time you sign. Keep it to protect your legal rights.

1. CONSENT FOR TREATMENT

I voluntarily consent to treatment for myself/child/dependent from the healthcare providers at Red Rock Family Practice, which include physicians, physician assistants and/or nurse practitioners who are under the supervision of the physicians.

_____ _____/_____/_____
Signature of Patient/Parent/Guardian Relationship Date

2. HIPAA PRIVACY

My signature below acknowledges that I have received Red Rock Family Practice's Notice of Privacy Practices.

_____ _____/_____/_____
Signature of Patient/Parent/Guardian Relationship Date

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3. FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment regardless of insurance. I agree to pay the New Patient fee today unless otherwise noted. I agree to pay all charges for me and members of my family shown by statements promptly upon presentment thereof, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of the billing date.

Should the account be turned over for collections, a 25% interest charge will be added to all services. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without them assuming responsibility for the collection thereof. You may also be billed for missed appointments. (A copy of this assignment is as valid as the original.)

I give permission to this office, its service providers, collection agencies, successors and assigns to dial (including auto-dialed calls) any phone number (including cell phones) provided by or otherwise owned by me or my spouse.

I give permission to this office, its service providers, collection agencies, successors and assigns to leave a message (including automated messages) on the voicemail of any phone number (including cell phones) provided by or otherwise owned by me or my spouse which may include the name of the company dialing the call.

I give permission to this office, its service providers, collection agencies, successors and assigns to communicate with me by email at any email address provided by me or my spouse regarding services provided and my financial obligations regarding those services.

I hereby acknowledge that I have read and received a copy of this form.

_____ _____ _____/_____/_____

Signature of Patient/Parent/Guardian Relationship Date

Wyoming Department of Health

IMMUNIZATION AGREEMENT BETWEEN PARENT/GUARDIAN AND SCHOOL

To ensure the Wyoming Department of Health is aligning with the Health Insurance Portability and Accountability Act (HIPAA), Wyoming schools must obtain parent/guardian agreement before accessing a student's immunization record within the Wyoming Immunization Registry (WyIR) for proof of immunization.

Parent/guardian agreement must be maintained in the student's school file and made available to the Wyoming Department of Health upon request.

I, _____, am the parent/guardian of _____. I
(Parent/Guardian Name) (Child's Name)

agree that the designated administrative official, such as the school nurse, representing

NW BOCES has my permission to access this student's immunization
(Name of School)

record in the WyIR to obtain proof of immunization in order to meet the school entry

requirements in accordance with Wyo. Stat. Ann. § 21-4-309.

_____ _____
Parent/Guardian Signature Date

Northwest Wyoming Board of
Cooperative Educational Services

TO: Parents and Guardians
FROM: Dawn Davis, RN
RE: STUDENT NURSING RELEASE

It is mutually agreed by the Central Wyoming College Nursing Program and the Northwest Community College Nursing Program and NW BOCES that clinical experience will be provided at the NW BOCES for nursing students in the colleges' nursing programs.

Nursing students will be given information on the rules of confidentiality, bloodborne pathogens, universal precautions, seizure precautions, CPR, medications, behavior management and crisis intervention strategies.

I hereby give / do not give (please circle one) my permission for my child,

_____**, to participate in this**
(Student's name)
program and that treatment and medical records may be viewed by assigned nursing students.

_____ _____
Parent/Guardian signature **Date**

Northwest Wyoming Board of
Cooperative Educational Services

Permission for Psychiatric/Psychiatric Nurse Practitioner
Evaluation and Follow-up (If applicable)

Admit Date: _____

As the guardian of _____, I hereby give permission for him/her to be evaluated by the consulting Psychiatrist/Psychiatric Nurse Practitioner who visits NW BOCES on an as needed basis, for purposes of medication evaluation and consultation. I further give permission for periodic follow-up visits and blood-test workups as deemed necessary by the Psychiatrist/Psychiatric Nurse Practitioner. I realize I am responsible for paying for all visits and medications unless otherwise specified.

Signature of Guardian: _____

Date: _____

MD #3

CONSENT FOR ADMINISTRATION OF OVER THE COUNTER MEDICINES

In an effort to meet your child's needs, a limited number of over the counter remedies are available for common complaints. These medicines are dispensed under the direction of a registered nurse.

As parent/legal guardian of NW BOCES Student _____, I hereby grant permission for the administration of the following over the counter medications if needed for minor symptoms:

_____ Acetaminophen (Tylenol)

_____ Ibuprofen (Advil/Motrin)

_____ Dimetapp (decongestant)

_____ Sudafed (decongestant)

_____ Diphenhydramine (Benadryl)

_____ Dramamine (anti-nausea)

_____ Robitussin DM (cough med)

_____ Cortisporin Cream (for rash, skin irritation)

_____ Bacitracin Ointment (antibacterial ointment for minor wounds)

_____ Chloraseptic Spray (sore throat treatment)

_____ Tums (antacid)

_____ Pepto-bismol (stomach upset)

_____ Pepcid (acid indigestion)

_____ Throat lozenges

_____ Blistex (lip ointment)

_____ Oragel (mouth pain)

_____ Normal Saline Spray (nose)

These do not replace medical care. For any persistent symptoms or serious injuries, your child will receive professional medical care, with your consent.

Name
(Printed) _____ *Relationship* _____
Parent/Guardian

Signature _____ *Date* _____
Parent/Guardian

Name
(Printed) _____ *Date* _____
Physician

Signature _____
Physician

MD #3

Big Horn Basin Children's Center
P.O. Box 112
Thermopolis, WY 82443
864-2171

NAME: _____ DATE: _____

DRUG, DOSAGE, TIME	REASON ORDERED	HOW LONG ON MEDICATION	PRESCRIBING PHYSICIAN

THE ABOVE MEDICATIONS WERE ORDERED BEFORE _____
WAS ADMITTED TO NW BOCES

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____

PHYSICIAN'S SIGNATURE: _____

DATE: _____

CONSENT TO TREAT WITH PSYCHOACTIVE MEDICATION

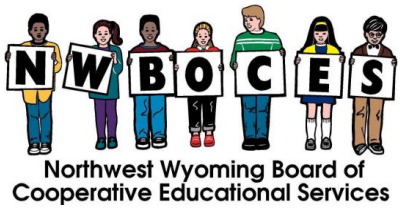
	Y/N
1. The explanation was given in simple, non-technical language and included all checked items.	
2. The patient (or guardian/parent) is competent to provide informed consent.	
3. The nature of his/her mental/physical disorder or change in status was explained.	
4. The expected beneficial effects on his/her condition as a result of treatment with or change in medication(s) were explained.	
5. The probable health and mental consequences of not taking medication, including the occurrence, increase or recurrence of symptoms of mental disorder were explained.	
6. A detailed explanation was given regarding the existence of generally accepted alternative forms of treatment, if any, that could reasonably be expected to achieve some benefits of the medication(s) and why the physician recommends this medication.	
7. Expected method of medication administration and expected duration of treatment were described.	
8. It was explained that side effects of varying degrees of severity are a risk of all medications, and an explanation was provided concerning relevant side effects, including: A. Frequently occurring side effects. B. Side effects to which the individual may be predisposed. C. With neuroleptic (antipsychotic) medication, the nature of tardive dystkinesia risk factors.	
9. Opportunity was given to object, respond or ask questions.	

 I have read this form and hereby consent to treatment with the medications recommended. I understand that I may withdraw consent at any time.

 I specifically refuse consent for recommended treatment, though the expected benefit has been explained to me.

Parent/Guardian Signature: _____

MD#3



42.

Section 504 of the Rehabilitation Act of 1973 assures students access to school meal service, even if special meals are needed because of the disability.

If special meals are needed and requested, certification from a medical doctor must (1) verify that special meals are needed because of the disability, and (2) prescribe the alternate foods and forms needed, *specify any foods that are to be omitted.*

Completion of the following, by a student's doctor, will provide the necessary certification:

Name of student for whom special meals are requested: _____

Foods Prescribed	Form Allowed *(e.g., fresh, baked, ground, blended, etc.)*
Meat and Meat Alternates	
Milk and Milk Products	
Bread/Cereal	
Fruits and Vegetables	

Any instructions: _____

_____

_____

Are there any particular foods that should be omitted from the diet? _____

_____

The substitute for this would be: _____

_____

_____ _____
Physician's Signature *Date*

_____ _____
Parent's Signature *Date*

43. STUDENT ORIENTATION/RIGHTS

There is a Secluded Timeout Room that will be used for your safety in a crisis situation. There is a calm-down Safe Room which we hope you will use if needed. You will receive an orientation to this room by staff. Usually, if you are having a problem, and become upset, you will be asked to take a sitting time out, or a standing time out. If you cannot calm down, or if you become a danger to yourself or to other people, you may be directed to go to the environmental time out area to calm down. We hope you will make a good decision, and walk in on your own. After you are calm, you will be asked to problem-solve. Then you can return to your regular activities.

You have many rights and responsibilities as a student at BHBCC.

Some of your rights include:

1. You have the right to maintain contact with your guardian through mail and telephone.
2. You have the right to be treated with respect.
3. You have the right to participate in I.E.P. and other planning meetings.
4. You have the right to look at your records, as long as you are accompanied by your therapist.
5. You have the right to file a student grievance.
6. You have the right to wear your own clothing and to keep personal possessions, at the appropriate level unless the articles may be used to endanger yourself or others.
7. You have the right to be free from physical restraints and isolation except for emergency situations or when isolation or restraint is a part of a treatment program.
8. You have the right to be free from unnecessary to excessive medication.
9. You have the right to seek family planning services.
10. You have the right to be informed orally and in writing of the above rights at the time of admission.
11. You have the right to the legal system, legal counsel, and spiritual access.

Some of your responsibilities include:

1. You have the responsibility to attend school and complete all assignments.
2. You have the responsibility to attend therapy sessions: individual, group, family, social skills training, etc.
3. You have the responsibility to be safe.
4. You will be expected to take responsibility for your actions.
5. You have the responsibility to treat others with respect.

If you should come to BHBCC, this letter will be part of your orientation. You will be asked to read it and sign it within 48 hours of admission to BHBCC.

I have read (or have had read to me) this orientation information within 48 hours of admission to BHBCC, and I have received orientation to the sequence of time out options.

Student Signature _____ Date_____

Witness Signature _____ Date _____

School & Cottage Rules

1. Listen and Learn

2. Follow Directions

3. Make Good Choices

4. Learn From Mistakes

5. Show Respect of Self and Others

_____ _____

Signature **Date**

_____ _____

Witness Signature **Date**

ED #11

TREATMENT PLAN & DISCHARGE PLAN
NW BOCES – Thermopolis, WY

Name _____ DOB _____ IEP Meeting Date _____ Reviewed _____

1. Client will be admitted to NW BOCES in the school and/or residential program through district or court ordered placement.
2. NW BOCES will provide close observation, an individualized education plan, and safety precautions.
3. Client will attend scheduled classes as identified in the IEP and following the NW BOCES school calendar.
4. Client will have a psychiatric evaluation for diagnosis and psychiatric monitoring as recommended.
5. Client will follow the psychopharmacological interventions recommended.
6. Client will have an annual physical and eye exam, and a dental check up every 6 months while attending NW BOCES.
7. Client will attend psychological counseling, family therapy/training, recreational therapy, and social skills as recommended by the IEP team.
8. Treatment of the client's Mental Health diagnosis of: _____ will be addressed through counseling, the treatment program, family counseling, and other interventions as identified by the treatment team.
9. Daily Behavior Rating Data (DBR) Four Main Goals & Individual Treatment Plan Goals

   A. Limits, Feelings, Getting Along, & Trust Data is included on quarterly graph reports
   B. _____
   Progress: May ____ June ____ July____ Aug. ____ Sept. ____ Oct. ____
   C. _____
   Progress: May ____ June ____ July____ Aug. ____ Sept. ____ Oct. ____
   D. _____
   Progress: May ____ June ____ July____ Aug. ____ Sept. ____ Oct. ____
   E. _____
   Progress: May ____ June ____ July____ Aug. ____ Sept. ____ Oct. ____

10. Client will follow the NW BOCES behavioral management program through the transition phase of Level IV.

11. Client transition will be according to the NW BOCES level system with IEP team and MDT team member's participation.

12. Parent/ Guardian:
    a) Parent/foster parent/legal guardian will participate in family counseling/training as offered as part of NW BOCES treatment-program;
    b) Parent/foster parent/legal guardian will call and visit on a regular basis as scheduled.

13. IEP Meetings will be held at least annually with parent/legal guardian/foster parent, referring agency and NW BOCES staff participating to coordinate services.

14. MDT Meetings will be held as scheduled by the DFS case manager.

15. **DISCHARGE PLANNING** by parent/legal guardian/foster parent and referring agency will include but not be limited to providing appropriate continuity of care and promote success for the client after successfully completing the program. Please note this is a dynamic timetable which is subject to the client's individual achievement.

    A. Level I = _____

    B. Level II three consecutive weeks of 80% weekly average @ school & cottages (earliest achievement date)_____

    C. Level III three consecutive weeks of 90% weekly average @ school & cottages (earliest achievement date)_____

    D. Level IV four Consecutive weeks of 95% weekly average @ school & cottage (earliest achievement date)_____

    E. Discharge per individual student transition plan and court order (if applicable).

16. Exit reports and recommendations will be completed within 30 days of discharge. Reports to include:
    a) Services received while at NW BOCES;
    b) Goal progress during placement;
    c) Where student is discharged to;
    d) Service recommendations and follow-up services as part of the after-care program.
    e) In the case of an emergency/unplanned discharge, reports regarding circumstance and action taken.

17. Transition components following discharge to include:

    A. Resides_____
    Responsible/determining party_____

    B. Education_____
    Responsible/determining party_____

    C. Medical care through_____
    Responsible/determining party_____

    D. Psychiatrist/Psychiatric Nurse Practitioner _____
    Responsible/determining party_____

    E. Couseling_____
    Responsible/determining party _____