## Inspirationz, LLC

## ADMISSION INFORMATION

Inspirationz, LLC (IGH) requires a complete admission study to assure that all placements meet the needs of and the interest of each applicant and their parents, as well as other legal guardians and/or referring agency representatives. The following information is required for the admission study and/or admission to program.

1. Complete application form (including ALL requested signatures)
2. Social History
3. Psychological evaluation within past year (and other reports available)
4. Pertinent records of last several placements
5. History of court involvements
6. Copy of Birth Certificate
7. Copy of court order if in custody of DSS or other guardian
8. Physical examination (within 6 months prior to application)
9. Social Security card
10. Current IEP
11. Medical History/Medical Records/Doctor's Order Forms/Medication Education Information (on prescription drugs)
12. Medicaid Card (Upon Admission)
13. High Risk Intervention Orders
14. Discharge Summaries, if applicable
15. Progress summaries, if applicable
16. Educational Summaries/Placements

20. Diagnosis
21. Valid treatment plan addressing contractual services and signed by the client and/or/guardian/parent
22. Valid consent form to exchange information between agency and area authority.
23. Admission Assessment
24. Treatment Orders signed and dated prior to service provisions
25. Service Documentation
26. Service Notes

# Inspirationz, LLC

**CLIENT**: ________________________ **RECORD NO**: ______________

**Medical Agreement**

In the event that I (we) cannot be reached, I hereby give my consent and authorization to the staff of IGH to provided and/or consent to the administration of any drugs and medical, dental, or surgical treatment which, in the opinion of the physician selected by IGH is deemed necessary for the well being of my child. I further agree to be responsible for any cost that is incurred in securing these services. If necessary, I will furnish directly to a physician or hospital documented financial information utilized for computation of fees.

I give permission to take my child to Forsyth Medical Center, NC Baptist Hospital or other medical facilities selected by IGH for emergency medical attention.

______________________________________________ ___________________
**Legal Responsible Person** **Date**

______________________________________________ ___________________
**Legal Responsible Person** **Date**

______________________________________________ ___________________
**Witness/Title** **Date**

## Medical Insurance Information

Name of Participant: ____________________________________________________________

Name of Policy Holder: __________________________________________________________

Address: _______________________________________________________________________

_______________________________________________________________________________

Phone #: _______________________________________________________________________

Insurance Co.: __________________________________

Address: _______________________________________

Phone #: _______________________________________

Policy #: _______________________________________

If the participant is covered by Medicaid, please note the number _________________________ and the County of Issuance _____________________________. If participant is not covered by either family insurance or Medicaid, who will pay for any medical/dental expenses? ___________

Provider: _______________________________________

**Inspirationz, LLC**

## CONSENT FOR TREATMENT

**Client Name**: ________________________________________

**Date of Birth**: ________________________________________

**Social Security No.**: ___________________________________

**Record No.**: ___________________________________________

I have received the Resident Handbook for INSPIRATIONZ,LLCand understand the terms and conditions explained therein.

I___________________________(specify relationship to client) consent for this resident to be admitted to this program. In doing so, I also agree that this resident will abide by the terms stated in the Resident Handbook.

I agree to allow INSPIRATIONZ,LLCstaff to implement regular and accepted therapeutic interventions in meeting the treatment goals and plans mutually agreed upon by the members of the treatment team.

I have received a full explanation regarding the use of restrictive interventions (physical and otherwise) by staff of this agency. This procedure may be used if the resident's behavior warrants such an intervention. I understand that restrictive intervention is defined as an intervention procedure which presents a significant risk of mental or physical restraint, excluding protective devices, or isolation time-out; or any combination thereof. The goal of restrictive intervention shall be to prevent the resident from doing harm to themselves, other residents, staff or property. Restrictive intervention is not a punishment, therefore no excessive force or mechanical device shall be used to restrain this resident.

_____By initialing this section of the consent, I am indicating a preference to be noticed when restrictive restraint (physical or otherwise) is used on this resident. Failure to initial this section indicates my preference not be notified.

_____By initialing this section, I am indicating a preference that another source other than myself should be notified when restrictive restraint is used on this resident. NOTE: Indicate the name of contact phone(s) of the person who should be notified.________________________________

I grant permission for this resident to participate in all INSPIRATIONZ,LLCouting and independent living programs. I am aware that some of these outings will involve the resident being transported away from the facility. It is my understanding that INSPIRATIONZ,LLCwill inform me in advance if the outing requires overnight stay or travel out of state. Based on this understanding, I agree not to hold INSPIRATIONZ,LLClegally or financially liable in the event that an accident or injury occurs to this resident.

I authorize INSPIRATIONZ,LLCto transport this resident to and from medical, dental, mental health and related appointments, home visits, etc. if the need arises. I understand that I will be notified of any serious medical or related illness affecting the resident.

I understand that I will be notified if a change in the resident's treatment regime and medications.
I understand that prescription medications will be administered to this resident only if ordered by a licensed physician whose care for the resident has been recognized by the resident's parent or legal guardian.

I agree to provide INSPIRATIONZ,LLCany and all medications prescribed for this resident. In addition, I agree to provide this agency with a written prescription from a physician for each medication that I supply this agency for the resident.

# Inspirationz, LLC

I agree that during tours of this facility by professional and related organizations, they may be allowed to have brief discussions with this resident, and with the understanding that INSPIRATIONZ,LLC will take all measures to ensure the resident's confidentiality.

I agree to allow this resident to be photographed, audiotaped, or videotaped for training purposes strictly for INSPIRATIONZ, LLC staff. These items may be used for security purposes in the event of a runaway or accident to serve as a means of identification.

I grant INSPIRATIONZ, LLC permission to obtain emergency care for this resident, if needed, until at such time that I can be contacted to authorize further care.

I authorize INSPIRATIONZ, LLC to provide educational assistance to this resident, including issues such as human sexuality, abstinence, contraception, drug and alcohol abuse, sexually transmitted disease prevention, housing issues and other discussions relevant to obtaining basic life skills leading to independent and interdependent living.

I have been provided the INSPIRATIONZ, LLC Resident Rights Brochure, and Client Grievance Procedure. I understand that the resident or his/her guardian may use the grievance procedure to notify the agency or other public agencies to file a grievance in the event they disagree with services rendered or decisions reached by the agency regarding the resident's care.

I would like the following exceptions or additions made to this consent:

______________________________________________________________

**NOTE**: I agree that this consent and document referred to herein may be amended on an as needed basis, and information required while in the performance of treatment may be released without client's consent.
This agreement will expire one year after the date it is signed. When this agreement expires, a new admission agreement will be provided.

**Signatures**:

_________________________________ _________________________
Legally Responsible Person Date

_________________________________ _________________________
Witness Date

_________________________________ _________________________
INSPIRATIONZ, LLC Staff/Title Date

LEVEL III: 607 Hillhaven Drive, Winston-Salem, NC 27107 PH: 336-788-8579
LEVEL II: 5089 Baux Mountain, Winston-Salem, NC 27105 PH: 336-245-8143
LEVEL II: 216 Hedgecock Avenue, Winston-Salem, NC 27104 PH: 336-293-6705
FAX: (336) 217-8716 EMAIL: contactus@inspirationzllc.org WEBSITE: www.inspirationzllc.org

**Inspirationz, LLC**

## CONSENT FOR RELEASE OF CLIENT INFORMATION

**CLIENT**: ________________________ **RECORD NO**: ______________

I, the above named, hereby authorize _______________________________________________
[Name of Center/Program to Release Information]

to release specified information to __________________________________________________
[Name of Person/Agency to Receive Information]

and in addition authorize ________________________________________________ to release
[Name of Center/Program to Release Information]
specific information to __________________________________________________________.
[Name of Person/Agency to Receive Information]

This information shall include only that of the nature and to the extent which is specified below:

[ ] Reason for Referral;

[ ] Psychiatric, Psychological, Social, Medical Information Affection CURRENT Functioning

[ ] CURRENT Medications;

[ ] History of Psychotropic Drugs Prescribed;

[ ] School Academic Achievement and Behavior,

[ ] ______________________________________________________________________

This information will be used for SUPPORT OF THE NEED FOR SERVICES, TO FACILITATE AND COORDINATE DELIVERY OF SERVICES IN BEST INTEREST OF CLIENT.

Other Information: ______________________________________________________________

I understand the contents to be released, the need for the information, and that there are state and federal regulations protecting the confidentiality of authorized information, and cannot be released without my written consent unless otherwise provided for in the regulations. I herby acknowledge that this consent is truly voluntary and is valid for a period not to exceed one year. I further acknowledge that I may revoke this consent at any time except to the extent that action based on this consent has been taken. Any revocation of consent must be in writing. This data shall include only that of the nature and to the extent which is specified above. NOTE: The records release may include psychiatric, drug abuse, alcohol abuse, HIV and/or AIDS information (if applicable).

_____________________________________ OR __________________________________
Client Signature Parent/Guardian/Legally Responsible Party

_____________________________________ __________________________________
Witness Signature Date

LEVEL III: 607 Hillhaven Drive, Winston-Salem, NC 27107 PH: 336-788-8579
LEVEL II: 5089 Baux Mountain, Winston-Salem, NC 27105 PH: 336-245-8143
LEVEL II: 216 Hedgecock Avenue, Winston-Salem, NC 27104 PH: 336-293-6705
FAX: (336) 217-8716 EMAIL: contactus@inspirationzllc.org WEBSITE: www.inspirationzllc.org

**Inspirationz, LLC**

**CLIENT**: ________________________ **RECORD NO**: ______________

## MEDICATION ADMINISTRATION (CONSENT)

I, the parent or legal responsible person of _____________________give my consent and authorization for the admission of medication in the IGH program as prescribed by a physician. This includes my permission for the administration of the following non-prescription drugs:

_____________________________ ______________________
Legally Responsible Person Date

_____________________________ ______________________
Legally Responsible Person Date

I____________________________, do hereby recommend that it is medically safe for to receive the following prescribed or non-prescribed medication(s) and I have advised patient of side effects, reactions, effectiveness, etc. of these medications.

_______________________________ ___________________
Physicians Date

Note: If child is on any prescription medication, education information including warnings, cautions, side effects, what to do if dosage is missed, etc. must be included with this form. Information can be obtained through physician and/or pharmacy.

**Inspirationz, LLC**

**Residential Treatment Application**

**Date of Application:** __________________ **Date of Service Needed:** __________________

**Type of referral Needed/CFT Recommendation:**
☐ Residential Treatment Level 2
☐ Residential Treatment Level 3

**Section I: Consumer Information**

Consumer's Name: ________________________ Nickname: ________________________________
Social Security Number: ____________________ Date of Birth:__________Age:_____ Sex:_____
Medicaid Number:__________________ County: ____________________Weight:_____ Height:_____
Consumer's Current Address:_______________________________________________________________
Consumer's Phone Number: ________________________Current Living Arrangement :_______________
Place of Birth:__________________________________Primary Language: __________________________
Distinguishing Features (i.e., scars, tattoos, birthmarks, etc.): __________________________________
_________________________________________________________________________________________

**Section II: Guardian Information**

Legal Guardian: __________________________________________________________________________
Relationship: ___________________________ County of Legal Custody: _________________________
Guardian's Address: ______________________________________________________________________
Guardian's Phone Number: ________________________ Cell:______________________________
If a Guardian ad Litem has Been Appointed Please List Name and Contact Number:
_________________________________________________________________________________________

**Section III: Consumer Primary Referral Source Information:**

Referring Agency: Support ☐ DJJ ☐ DSS ☐ County: _______________________________________
Other: ___________________________________________________________________________________
Provider Agency: ________________________________ Phone #: _______________________________
Agency Contact Person: ___________________________ Phone #: ______________________________
Address: _________________________________________________________________________________
City: __________________________ State: ________________ Zip Code: _____________________
Emergency Contact: ______________________________ Relationship to Consumer: ______________
Contact #: _____________________ Fax#: _________________ Pager/Cell#: __________________
Address: _________________________________________________________________________________

**Section IV: Clinical/Diagnostic Information:**

**DSM IV-TR Multi-Axial Diagnosis**

| Diagnoses: | Effective Date: | Source: |
|---|---|---|
| Axis I:______,________,________,______ | | |
| Axis II: | | |
| Axis III: | | |
| Axis IV: ____________________________<br>____________________________________<br>____________________________________ | | |
| Axis V: | | |

**CALOCUS Score: _______**

IQ: _____________ Verbal: ________ Performance: ____________ Full Scale: _________

Examiner: ____________________________________ Date: __________________________

**History of Abuse**

☐ Victim of Neglect: ______________________________________________________________

☐ Victim of Physical Abuse: ________________________________________________________

☐ Victim of Sexual Abuse: __________________________________________________________

☐ Victim of Emotional Abuse: _______________________________________________________

☐ None

***If checked please provide a written description. If DSS involvement please attach documentation.***

| Medications | Prescribing Physician | Dosage/Frequency | Date Started / Compliant |
|---|---|---|---|
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**Section V: Medical Information**

Allergies: ______________________________________________________________

Special Dietary Needs: ______________________________________________________

**Medical Conditions (past and present):** ***Please note most recent occurrence***

| | | |
|---|---|---|
| ☐ **Lice** | ☐ **Bulimia** | ☐ **Eczema** |
| ☐ **Anemia** | ☐ **Anorexia** | ☐ **Asthma** |
| ☐ **Drug/Alcohol Abuse** | ☐ **Measles** | ☐ **Hay Fever** |
| ☐ **HIV/AIDS** | ☐ **Mumps** | ☐ **Convulsions** |
| ☐ **Sexually Transmitted Disease** | ☐ **Chicken Pox** | ☐ **Sinus Problems** |
| ☐ **Ringworm** | ☐ **Sickle Cell Anemia** | ☐ **Diabetes** |
| ☐ **Tuberculosis** | ☐ **Migraine Headaches** | ☐ **Hepatitis** |
| ☐ **Chronic Urinary/Bowel Problems** | ☐ **Rubella** | ☐ **TBI** |

Other: ________________ Other: ________________ Other: ____________________

Name and Address of Pediatrician: ______________________________________________

Name and Address of Dentist: __________________________________________________

Date of Last Phys. Exam: __________ Last Dental Exam:__________ Last Eye Exam: _________

Dental Appliances: ☐ Yes ☐ No Contacts/Glasses: ☐ Yes ☐ No

Medical Insurance Company: ☐ Medicaid______________ ☐ NC Health Choice _____________

Private Ins.(Agency): _________________________________________________________

Insurance Policy Number: _____________________________________________________

Insurance is in Whose Name? ___________________________________________________

Any Other Third Party Insurance? _______________________________________________

**Section VI: Strengths/Abilities/Preferences**

Strengths/Capabilities: ______

Friendships/Social/Peer Support: ______

Religion/Spirituality: ______

Cultural/Ethnic Concerns: ______

Meaningful Activities (community involvement, volunteer activities, leisure recreation, other interests): ______

Goals for Independent Living: ______

**Section VII: Presenting Problems/Concerns, Reason for Referral (specify)**

______

**Section VIII: Previous Treatment Interventions**

| Outpatient | Date | Effectiveness |
|---|---|---|
| | | |
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| | | |

Consumer Name: Medicaid Number: Record Number:

**Section IX: Placement History**

| Placement (Begin w/Current Placement) | Dates (From – To) | Reason for Discharge |
|---|---|---|
| | | |
| | | |
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| | | |

**Section X: Current Emotional/Behavioral Problems**

Please describe behavior and date of the last incident.

| | | |
|---|---|---|
| ☐ Abandonment Issues | ☐ Anxiety | ☐ Arson |
| ☐ Alcohol/Drug Abuse | ☐ Antisocial Behavior | ☐ Stool/Feces smearing |
| ☐ Assaultive (Physical) | ☐ Assaultive (Sexual) | ☐ Assaultive (Verbal) |
| ☐ Bedwetting | ☐ Eating Disorder | ☐ Depression |
| ☐ Property Destroying | ☐ Fire Setter | ☐ Developmental Disability |
| ☐ Homeless | ☐ Hyperactive | ☐ Impulsive |
| ☐ Lying | ☐ Low Self-Esteem | ☐ Loss/Grief Difficulties |
| ☐ Physical Impairment | ☐ Mental Retardation | ☐ Parent Neglect Issues |
| ☐ Perception of Reality | ☐ Phobic Behavior | ☐ Physical Disability |
| ☐ Self-Destructive Behavior | ☐ Sibling Related Difficulty | ☐ Oppositional |
| ☐ Social Immaturity | ☐ Sexually Inappropriate Behavior | ☐Stealing |
| ☐ Suicidal | ☐ Running Away | ☐ Truancy |
| ☐ Unruly/Ungovernable | ☐ Cruelty to Animals | ☐ Hygiene/Cleanliness Issues |
| ☐ Problems with Sleep | ☐ Gang Related Activity | ☐ History w/ Weapons |

Other: ______________________________________________

**Aggressive or Violent Behavior Alert**

**Please describe the nature of the acting out behaviors:**

☐ Verbally Aggressive, Frequency: ______________________________

Description: ______________________________

______________________________

______________________________

☐ Physically Aggressive, Frequency: ______________________________

Description: ______________________________

______________________________

______________________________

☐ Property Destruction, Frequency: ______________________________

Description: ______________________________

______________________________

______________________________

Has the Behavior Resulted in Injury to Others? ☐ Criminal Charges? Please describe:

______________________________

______________________________

______________________________

______________________________

Aggression is: ☐ Impulsive ☐ Planned ☐ Instrumental ☐ Triggered by Fearfulness

Where is the Client Aggressive:

______________________________

______________________________

Known Triggers, Please Describe:

______________________________

______________________________

Main Targets of Aggression: ☐ Peers ☐ Authority Figures ☐ Family Members (Please be specific)

______________________________

______________________________

______________________________

______________________________

Please Describe the Most Recent Episode of Aggression

______________________________

______________________________

______________________________

______________________________

______________________________

______________________________

| History of Self-Injurious/ Risky Behaviors | |
|---|---|
| Self-Injury | **Check all that apply:**<br>☐ Cuts on Body<br>☐ Conceals Cutting- Indicated Area<br>☐ Other Forms of Self-Injury (please describe): ______<br>Has Self-Injury ever Required Medical Attention? ☐ Yes ☐ No (Please explain):<br>______ |
| Suicidal<br><br>Characteristics | **Check all that apply:**<br>☐ Suicidal Thoughts ☐ Past Suicide Attempts<br>☐ Suicidal Plans (describe): ______<br>Methods Used in Previous Attempts (describe): ______<br>Were Attempts Planned: ☐ Yes ☐ No ☐ Sometimes ☐ Don't know |
| Homicidal<br><br>Characteristics | **Check all that apply:**<br>☐ Homicidal Thoughts ☐ Past Attempts to Harm Others<br>☐ Homicidal Plans (describe): ______<br>Methods Used in Previous Attempts (please describe): ______<br>Were Attempts Planned: ☐ Yes ☐ No ☐ Sometimes ☐ Don't know<br>Does Consumer have Access to Weapons? ☐ Yes ☐ No<br>Please Explain: ______ |
| History of AWOL | Runs Away from Home: ☐ Yes ☐ No<br>Has Run from Previous Placements: ☐ Yes ☐ No<br>In the Past Year how Many Times has Consumer Run? ______<br>Where Does He/She Go? ______<br>How Long is Consumer Typically AWOL? ______ |
| Substance Abuse History | **Check all that apply:**<br>☐ Marijuana Frequency: ______- Last Used: ______<br>☐ Cocaine Frequency: ______ -Last Used: ______<br>☐ Heroin/Opiates Frequency: ______- Last Used: ______<br>☐ Amphetamines Frequency: ______- Last Used: ______<br>☐ Inhalants Frequency: ______- Last Used: ______<br>☐ Hallucinogens Frequency: ______- Last Used: ______<br>☐ Alcohol Frequency: ______- Last Used: ______<br>☐ Other: Frequency: ______- Last Used: ______<br>Explain: ______ |
| Sexual Behaviors | Describe any Sexualized Behaviors Exhibited by Consumer (i.e. peeping, sexual acting out, predatory behaviors, prostitution): ______<br>______<br>______<br>______ |
| Psychotic Behaviors | Please Describe any Past/Present History of Psychosis: ______<br>______<br>______<br>______ |

**Section XI: Family Information**

**Biological Mother's Name**: ____________________

Address: ____________________

Telephone Number: Home: __________ Work:__________ Cell:__________

Ethnicity: ________ Education Level: __________ (Unknown ☐)

Criminal Record: ☐Yes ☐No ☐Unknown

**Biological Father's Name**: ____________________

Address: ____________________

Telephone Number: Home: __________ Work: Cell: __________

Ethnicity: ________ Education Level: __________ (Unknown ☐)

Criminal Record: ☐Yes ☐No ☐Unknown

**Check all that apply:**

Are Parents: ☐ Married ☐Separated ☐ Divorced ☐Never Married ☐Deceased Mother ☐Deceased Father

Have Parental Rights Been Terminated: ☐Yes ☐No

If so, Who and When?

____________________

____________________

Siblings:

| Name | Age | Gender |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Are Siblings in Out-of-Home Placements? ☐ Yes ☐ No

If yes, please specify: ☐ DSS Foster Care ☐ Relatives ☐ Incarcerated ☐ Group Home ☐ Other:

Explain: ____________________

**Section XII: Family Social History**

**Include description of social history, and significant family events leading up to referral, and living arrangement prior to referral. If checked please explain.**

| ☐ Criminal Activity | ☐ Child Abuse |
|---|---|
| ☐ Inappropriate Sexual Behavior | ☐ Treatment Disruption |
| ☐ Psychiatric Illness | ☐ Substance Abuse |
| ☐ Suicide | ☐ Other: |

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**If other pertinent family history please document separately and attach.**

## Section XIII: Authorized Contacts/Resources

| Name | Relationship | Address | Telephone Number | Types of Contact (supervised, letter, etc.) | Date of Release of Information |
|---|---|---|---|---|---|
| | | | | | |
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**Special Conditions/Restrictions for HomeVisits?**______________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

## Section XIV: School Information

Last School Enrolled: ____________________________ District: __________________________________

Grade: ______ Special Classes: ☐EH ☐LD ☐Resource ☐BEH ☐Homebound ☐Other: ___________

Any History of Truancy? ☐ Yes ☐ No Grade(s) Repeated: _______ Current IEP? ☐ Yes ☐ No

Suspensions/Expulsions: ____________________________________________________________________

## Section XV: Agency/Provider Involvement

Indicate all agencies currently involved:

☐ DSS______________ ☐ Mental Health Provider ________________ ☐ DJJ______________

☐ Vocational Rehabilitation_______________ ☐ Other: ________________

**Section XVI: Court History**

Does Consumer Have a Criminal Record? ☐ Yes ☐ No

| Offenses | Conviction Dates | Tried as Juvenile or Adult |
|---|---|---|
| | | |
| | | |
| | | |

Pending Charges: ______________________________

Is Consumer on Probation? ☐ Yes ☐ No Name and Contact: ______________________________

Is Placement Court Ordered? ☐ Yes ☐ No **(If "Yes, attach court order)**

**Section XVII: Final Comments**

Estimated Length of Stay: ☐ 90 Days ☐ 180 Days ☐ 270 Days ☐ 360 Days

**Check All That Apply**

Anticipated Discharge Plan: ☐ Return Home ☐ Step Down Placement ☐ Community Supports

______________________________
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**Signatures:**

| | | |
|---|---|---|
| **Legal Guardian** | **Print Name** | **Date** |
| **Social Worker** | **Print Name** | **Date** |
| **Case Manager** | **Print Name** | **Date** |
| **CC/DJJ** | **Print Name** | **Date** |
| **Care Coordinator** | **Print Name** | **Date** |

Article 4.
Consent to Health Care for Minor.

**§ 32A-28. Purpose.**

(a) The General Assembly recognizes as a matter of public policy the fundamental right of a parent to delegate decisions relating to health care for the parent's minor child where the parent is unavailable for a period of time by reason of travel or otherwise.

(b) The purpose of this Article is to establish a nonexclusive method for a parent to authorize in the parent's absence consent to health care for the parent's minor child. This Article is not intended to be in derogation of the common law or of Article 1A of Chapter 90 of the General Statutes. (1993, c. 150, s. 1.)

**§ 32A-29. Definitions.**

As used in this Article, unless the context clearly requires otherwise, the term:

(1) "Agent" means the person authorized pursuant to this Article to consent to and authorize health care for a minor child.

(2) "Authorization to consent to health care for minor" means a written instrument, signed by the custodial parent and acknowledged before a notary public, pursuant to which the custodial parent authorizes an agent to authorize and consent to health care for the minor child of the custodial parent, and which substantially meets the requirements of this Article.

(3) "Custodial parent" means a parent having sole or joint legal custody of that parent's minor child.

(4) "Health care" means any care, treatment, service or procedure to maintain, diagnose, treat, or provide for a minor child's physical or mental or personal care and comfort, including life sustaining procedures and dental care.

(5) "Life sustaining procedures" are those forms of care or treatment which only serve to artificially prolong life and may include mechanical ventilation, dialysis, antibiotics, artificial nutrition and hydration, and other forms of treatment which sustain, restore, or supplant vital bodily functions, but do not include care necessary to provide comfort or to alleviate pain.

(6) "Minor or minor child" means an individual who has not attained the age of 18 years and who has not been emancipated. (1993, c. 150.)

**§ 32A-30. Who may make an authorization to consent to health care for minor.**

Any custodial parent having understanding and capacity to make and communicate health care decisions who is 18 years of age or older or who is emancipated may make an authorization to consent to health care for the parent's minor child. (1993, c. 150, s. 1.)

**§ 32A-31. Extent and limitations of authority.**

(a) A custodial parent of a minor child, pursuant to an authorization to consent to health care for minor, may grant an agent full power and authority to consent to and authorize health care for the minor child to the same extent that a custodial parent could give such consent and authorization.

(b) An authorization to consent to health care for minor may contain, and the authority of the agent designated shall be subject to, any specific limitations or restrictions as the custodial parent deems appropriate.

(c) A custodial parent may not, pursuant to an authorization to consent to health care for minor, authorize an agent to consent to the withholding or withdrawal of life sustaining procedures. (1993, c. 150, s. 1.)

**§ 32A-32. Duration of authorization; revocation.**

(a) An authorization to consent to health care for minor shall be automatically revoked as follows:

(1) If the authorization to consent to health care for minor specifies a date after which it shall not be effective, then the authorization shall be automatically revoked upon such date.

(2) An authorization to consent to health care for minor shall be revoked upon the minor child's attainment of the age of 18 years or upon the minor child's emancipation.

(3) An authorization to consent to health care for minor executed by a custodial parent shall be revoked upon the termination of such custodial parent's rights to custody of the minor child.

(b) An authorization to consent to health care for minor may be revoked at any time by the custodial parent making such authorization. The custodial parent may exercise such right of revocation by executing and acknowledging an instrument of revocation, by executing and acknowledging a subsequent authorization to consent to health care for the minor, or in any other manner in which the custodial parent is able to communicate the parent's intent to revoke. Such revocation shall become effective only upon communication by the custodial parent to the agent named in the revoked authorization.

(c) In the event of a disagreement regarding the health care for a minor child between two or more agents authorized pursuant to this Article to consent to and authorize health care for a minor, or between any such agent and a parent of the minor, whether or not the parent is a custodial parent, then any authorization to consent to health care for minor designating any person as an agent shall be revoked during the period of such disagreement, and the provisions of health care for the minor during such period shall be governed by the common law, the provisions of Article 1A of Chapter 90, and other provisions of law, as if no authorization to consent to health care for minor had been executed.

(d) An authorization to consent to health care for minor shall not be affected by the subsequent incapacity or mental incompetence of the custodial parent making such authorization. (1993, c. 150, s. 1.)

**§ 32A-33. Reliance on authorization to consent to health care for minor.**

(a) Any physician, dentist, or other health care provider involved in the health care of a minor child may rely upon the authority of the agent named in a signed and acknowledged authorization to consent to health care for minor in the absence of actual knowledge that the authorization has been revoked or is otherwise invalid.

(b) Any consent to health care for a minor child given by an agent pursuant to an authorization to consent to health care for minor shall have the same effect as if the custodial parent making the authorization were present and acting on behalf of the parent's minor child. Any physician, dentist, or other health care provider relying in good faith on the authority of an agent shall be protected to the full extent of the power conferred upon the agent, and no person so relying on the authority of the agent shall be liable, by reason of reliance, for actions taken pursuant to a consent of the agent. (1993, c. 150, s. 1.)

**§ 32A-34. Statutory form authorization to consent to health care for minor.**

The use of the following form in the creation of any authorization to consent to health care for minor is lawful and, when used, it shall meet the requirements and be construed in accordance with the provisions of this Article.

**"AUTHORIZATION TO CONSENT<br>TO HEALTH CARE FOR MINOR."**

I, ____________, of ____________ County, ____________, am the custodial parent having legal custody of____________, a minor child, age______, born________, ____ . I authorize____________, an adult in whose care the minor child has been entrusted, and who resides at____________, to do any acts which may be necessary or proper to provide for the health care of the minor child, including, but not limited to, the power (i) to provide for such health care at any hospital or other institution, or the employing of any physician, dentist, nurse, or other person whose services may be needed for such health care, and (ii) to consent to and authorize any health care, including administration of anesthesia, X-ray examination, performance of operations, and other procedures by physicians, dentists, and other medical personnel except the withholding or withdrawal of life sustaining procedures.

[Optional: This consent shall be effective from the date of execution to and including____________,_____].

By signing here, I indicate that I have the understanding and capacity to communicate health care decisions and that I am fully informed as to the contents of this document and understand the full import of this grant of powers to the agent named herein.

(SEAL)

Custodial Parent                                        Date

STATE OF NORTH CAROLINA

COUNTY OF

On this ________ day of__________, ____, personally appeared before me the named_________, to me known and known to me to be the person described in and who executed the foregoing instrument and he (or she) acknowledges that he (or she) executed the same and being duly sworn by me, made oath that the statements in the foregoing instrument are true.

Notary Public

My Commission Expires:

(OFFICIAL SEAL). (1993, c. 150, s. 1; 1999-456, s. 59.)

**§ 32A-35. Reserved for future codification purposes.**

**§ 32A-36. Reserved for future codification purposes.**

**§ 32A-37. Reserved for future codification purposes.**

**§ 32A-38. Reserved for future codification purposes.**

**§ 32A-39. Reserved for future codification purposes.**

# Admission of Students to WS/FCS Who Are Not Domiciled in Forsyth County.
# Instructions for use and completion of Caretaker Affidavits.

A student who is not living with a parent, a legal guardian appointed by the court or a custodian parent as a result of a court order or child custody agreement may attend WS/FCS if the student resides with an adult who is a domiciliary of (has a home in) Forsyth County, if one of the following specific conditions exists and is verified as set forth below[1].

**This form may only be used if one of these conditions exists.** If it is found that the information contained in this affidavit is false, WS/FCS may remove the student from school. If a student is removed from school, the parent/caretaker may appeal the removal under Policy 5117 and P5145, "Parent and Student Grievance Procedure."

**IF IT IS FOUND THAT A PARENT OR CARETAKER WILLFULLY AND KNOWINGLY PROVIDED FALSE INFORMATION IN THIS AFFIDAVIT, HE/SHE MAY BE FOUND GUILTY OF A CLASS I MISDEMEANOR AND MAY BE REQUIRED TO PAY TO WINSTON-SALEM/FORSYTH COUNTY SCHOOLS AN AMOUNT EQUAL TO THE COST OF EDUCATING THE CHILD OR CHILDREN DURING THE PERIOD OF ENROLLMENT.**

**Conditions that must exist to enroll a student using the Caretaker Affidavit forms.**

- **The death or incarceration of a parent or legal guardian**. To verify the condition described in the Caretaker Affidavit, the caretaker and/or parent is asked to provide a death certificate or a copy of the court order placing the parent in the NC Department of Correction or some other prison.
- **The abandonment by a parent or legal guardian** of the complete control of the student as evidenced by the failure to provide substantial financial support and parental guidance. **Abandonment** means any willful or intentional conduct on the part of the parent which evinces a settled purpose to forego all parental duties and relinquish all parental claims to the **child**. "**Abandonment"** has also been defined as willful neglect and refusal to perform the natural and legal obligations of parental care and support. It has been held that if a parent withholds his presence, his love, his care, the opportunity to display filial affection, and willfully neglects to lend support and maintenance; such parent relinquishes all parental claims and abandons the **child**.
- **Abuse or neglect by the parent or legal guardian**. To verify this condition, the caretaker must show evidence that the parent has been reported to the Child Protective Services Division of the Department of Social Services or a similar agency in some other state.
- **The serious illness, physical or mental condition of the parent or legal guardian** is such that he or she cannot provide adequate care and supervision of the student. To verify this condition in the Caretaker Affidavit, the parent and/or caretaker is asked to provide a statement from the parent's physician or mental health professional verifying that the parent is too ill to care for is/her child/children.
- **Assignment to or Placement in Group or Foster Home.** The relinquishment of physical custody and control of the student by the student's parent or legal guardian upon the recommendation of the Department of Social Services or the Division of Mental Health. To verify this condition, the parent or caretaker is asked to provide documentation of the assignment or placement.
- **The loss or uninhabitability of the student's home as the result of a natural disaster**. To verify this condition, the parents are asked to provide documentation that their home has been seriously damaged or destroyed by a natural disaster.
- **If a student's parent/legal guardian is on active military duty** and is (1) deployed out of the local school administrative unit in which the student resides; or (2) the student comes to Forsyth County to reside during the deployment of the parent/legal guardian. Additionally, a student may be admitted if the parent/legal guardian is (1) a member or veteran of the uniformed services and was severely injured/medically discharged or retired with in the past year; or (2) a member the uniformed services who died within the past year while on active duty or as a result of injuries sustained while on active duty. For purposes of this provision, the term "active duty" does not include periods of active duty for training for less than thirty (30) calendar days. A student may be admitted pursuant to this provision only with presentation of some evidence of the deployment.
- **The Temporary relocation or the parent who lives in Forsyth County, NC**. To verify this condition, the parent is asked to provide documentation from an employer that he/she has been asked to leave his/her home for some work related reason or some other documentation of the reason for and length of time that the parent will be away from home.

[1] NCGS § 115C-366(a3), P5117, Pupil Assignment

| STATE OF:________________________<br>COUNTY OF:________________________ | **AFFIDAVIT OF PARENT OR GUARDIAN**<br>**For School Admission** |
|---|---|
| Parent Name(s): | Caretaker(s) name(s): |
| Street Address: | Street Address: |
| City: State: Zip: | City: State: Zip: |
| Home phone: Work Phone: Email: | Home phone: Work phone: Email: |

| Child's name: DOB: | Child's name: DOB: | Child's name: DOB: |
|---|---|---|

1. I am the [ ] parent [ ] legal guardian (as checked) of the child/children listed above.

2. Caretaker's relation to me is:

3. The child or children is/are qualified to attend school in Forsyth County because (**check one**):

- ☐ I am incarcerated for a term of up to ____ months or ___ years.
- ☐ I have abandoned the complete control of the student as evidenced by my failure to provide substantial financial support and parental guidance.
- ☐ I/we admit that I/we have abused or neglected my child/children.
- ☐ Due to a serious illness or a physical or mental condition, I/we am/are unable to provide adequate care and supervision of the child/children.
- ☐ I/We have relinquishment physical custody and control of the student upon the recommendation of the Department of Social Services or the Division of Mental Health or a similar agency (if I live in another state);
- ☐ My/our home is lost or uninhabitable as the result of a natural disaster.
- ☐ I am assigned to active military duty and deployed outside of Forsyth County; my student comes to Forsyth County to reside during the period of my active duty; or I am a member or veteran of the uniformed services and was severely injured/medically discharged or retired with in the past year.
- ☐ I live in Forsyth County, NC and am leaving the County temporarily and intend to return within ____ months.

4. The child/children is/are not currently under a term of suspension or expulsion from a school for conduct that could have led to a suspension or an expulsion from Winston-Salem/Forsyth County Schools.

5. The child's/children's claim of residency with the caretaker named above is not primarily related to attendance at a particular school within Winston-Salem/Forsyth County Schools.

6. I (we) give the caretaker the responsibility and authority to make educational decisions for and in behalf of the child/children, including receiving notices of discipline under G.S. §115C-391, attending conferences with school personnel, granting permission for school-related activities, and taking appropriate action in connection with student records. I understand that I retain liability for the student's acts.

7. I/we understand that if it is found that the information contained in this affidavit is false, WS/FCS may, unless the student(s) is/are otherwise eligible for school attendance, remove the student from school. I/we understand that if a student is removed from school, I/we may appeal the removal under Policy 5117 and P5145, "Parent and Student Grievance Procedure. These policies may be found at WS/FCS website: wsfcs.k12.nc.us. **I/WE UNDERSTAND THAT IF IT IS FOUND THAT I/WE WILLFULLY AND KNOWINGLY PROVIDED FALSE INFORMATION IN THIS AFFIDAVIT, I/WE MAY BE FOUND GUILTY OF A CLASS I MISDEMEANOR AND MAY BE REQUIRED TO PAY TO WINSTON-SALEM/FORSYTH COUNTY SCHOOLS AN AMOUNT EQUAL TO THE COST OF EDUCATING THE CHILD OR CHILDREN DURING THE PERIOD OF ENROLLMENT.**

| Signature: | Signature: |
|---|---|

I, ______________________, a Notary Public of the County of ________________, State of ____________________ certify that ______________________personally appeared before me this day, being duly sworn, acknowledge the execution of this Affidavit. Witness my hand and official stamp or seal, the ___ day of ______________, 200__.

_____________________________________________Notary Public

My Commission Expires: (NOTARY SEAL)