

Inspirationz, LLC

CONSENT FOR TREATMENT

Client Name: _____

Date of Birth: _____

Social Security No.: _____

Record No.: _____

I have received the Resident Handbook for INSPIRATIONZ,LLC and 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,LLC staff 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 notified 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,LLC outing 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,LLC will 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,LLC legally or financially liable in the event that an accident or injury occurs to this resident.

I authorize INSPIRATIONZ,LLC to 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,LLC any 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.

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 hereby 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).

Client Signature OR 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

Consumer Name: _____

Medicaid Number: _____

Record Number: _____



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 V: Medical Information

Allergies: _____

Special Dietary Needs: _____

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

- | | | |
|---|---|---|
| <input type="checkbox"/> Lice | <input type="checkbox"/> Bulimia | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Anorexia | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Measles | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Mumps | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Ringworm | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Chronic Urinary/Bowel Problems | <input type="checkbox"/> Rubella | <input type="checkbox"/> 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? _____

Consumer Name:

Medicaid Number:

Record Number:

Section IX: Placement History		
Placement (Begin w/Current Placement)	Dates (From – To)	Reason for Discharge

Section X: Current Emotional/Behavioral Problems		
Please describe behavior and date of the last incident.		
<input type="checkbox"/> Abandonment Issues	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Arson
<input type="checkbox"/> Alcohol/Drug Abuse	<input type="checkbox"/> Antisocial Behavior	<input type="checkbox"/> Stool/Feces smearing
<input type="checkbox"/> Assaultive (Physical)	<input type="checkbox"/> Assaultive (Sexual)	<input type="checkbox"/> Assaultive (Verbal)
<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Depression
<input type="checkbox"/> Property Destroying	<input type="checkbox"/> Fire Setter	<input type="checkbox"/> Developmental Disability
<input type="checkbox"/> Homeless	<input type="checkbox"/> Hyperactive	<input type="checkbox"/> Impulsive
<input type="checkbox"/> Lying	<input type="checkbox"/> Low Self-Esteem	<input type="checkbox"/> Loss/Grief Difficulties
<input type="checkbox"/> Physical Impairment	<input type="checkbox"/> Mental Retardation	<input type="checkbox"/> Parent Neglect Issues
<input type="checkbox"/> Perception of Reality	<input type="checkbox"/> Phobic Behavior	<input type="checkbox"/> Physical Disability
<input type="checkbox"/> Self-Destructive Behavior	<input type="checkbox"/> Sibling Related Difficulty	<input type="checkbox"/> Oppositional
<input type="checkbox"/> Social Immaturity	<input type="checkbox"/> Sexually Inappropriate Behavior	<input type="checkbox"/> Stealing
<input type="checkbox"/> Suicidal	<input type="checkbox"/> Running Away	<input type="checkbox"/> Truancy
<input type="checkbox"/> Unruly/Ungovernable	<input type="checkbox"/> Cruelty to Animals	<input type="checkbox"/> Hygiene/Cleanliness Issues
<input type="checkbox"/> Problems with Sleep	<input type="checkbox"/> Gang Related Activity	<input type="checkbox"/> 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	<p>Check all that apply:</p> <input type="checkbox"/> Cuts on Body <input type="checkbox"/> Conceals Cutting- Indicated Area <input type="checkbox"/> Other Forms of Self-Injury (please describe): _____ Has Self-Injury ever Required Medical Attention? <input type="checkbox"/> Yes <input type="checkbox"/> No (Please explain): _____ _____
Suicidal Characteristics	<p>Check all that apply:</p> <input type="checkbox"/> Suicidal Thoughts <input type="checkbox"/> Past Suicide Attempts <input type="checkbox"/> Suicidal Plans (describe): _____ Methods Used in Previous Attempts (describe): _____ Were Attempts Planned: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Don't know
Homicidal Characteristics	<p>Check all that apply:</p> <input type="checkbox"/> Homicidal Thoughts <input type="checkbox"/> Past Attempts to Harm Others <input type="checkbox"/> Homicidal Plans (describe): _____ Methods Used in Previous Attempts (please describe): _____ Were Attempts Planned: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Don't know Does Consumer have Access to Weapons? <input type="checkbox"/> Yes <input type="checkbox"/> No Please Explain: _____
History of AWOL	Runs Away from Home: <input type="checkbox"/> Yes <input type="checkbox"/> No Has Run from Previous Placements: <input type="checkbox"/> Yes <input type="checkbox"/> No In the Past Year how Many Times has Consumer Run? _____ Where Does He/She Go? _____ How Long is Consumer Typically AWOL? _____
Substance Abuse History	<p>Check all that apply:</p> <input type="checkbox"/> Marijuana Frequency: _____ - Last Used: _____ <input type="checkbox"/> Cocaine Frequency: _____ - Last Used: _____ <input type="checkbox"/> Heroin/Opiates Frequency: _____ - Last Used: _____ <input type="checkbox"/> Amphetamines Frequency: _____ - Last Used: _____ <input type="checkbox"/> Inhalants Frequency: _____ - Last Used: _____ <input type="checkbox"/> Hallucinogens Frequency: _____ - Last Used: _____ <input type="checkbox"/> Alcohol Frequency: _____ - Last Used: _____ <input type="checkbox"/> Other: Frequency: _____ - Last Used: _____ Explain: _____
Sexual Behaviors	Describe any Sexualized Behaviors Exhibited by Consumer (i.e. peeping, sexual acting out, predatory behaviors, prostitution): _____ _____ _____ _____
Psychotic Behaviors	Please Describe any Past/Present History of Psychosis: _____ _____ _____ _____

Consumer Name:

Medicaid Number:

Record Number:

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.

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
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 below¹.

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: _____ COUNTY OF: _____			AFFIDAVIT OF PARENT OR GUARDIAN For School Admission		
Parent Name(s):			Caretaker(s) name(s):		
Street Address:			Street Address:		
City:		State:	City:		State:
Zip:			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):					
<input type="checkbox"/> I am incarcerated for a term of up to ____ months or ____ years.					
<input type="checkbox"/> I have abandoned the complete control of the student as evidenced by my failure to provide substantial financial support and parental guidance.					
<input type="checkbox"/> I/we admit that I/we have abused or neglected my child/children.					
<input type="checkbox"/> 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.					
<input type="checkbox"/> 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);					
<input type="checkbox"/> My/our home is lost or uninhabitable as the result of a natural disaster.					
<input type="checkbox"/> 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.					
<input type="checkbox"/> 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)		