Anchor Academy
49 Plymouth Street
Middleboro, MA 02346
Phone: 508-947-0131
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Intake Information

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Information Received By:

_____
Name

_____
Title

Transferred/Reviewed By:

_____
Name

_____
Title

Anchor Academy
Source Document

Funding Source:_____
Admission Date:_____

Student's First Name: _____ Student's Middle Name: _____ Student's Last Name: _____

DOB: _____ Place of Birth: _____ Age: _____ Grade: _____ Sex: _____

Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____

Distinguishing Marks: _____Home Address: _____

Student's Home Phone #:_____ Student's Cell #:_____Primary Language: _____

Resides with: _____Mother _____Father _____Both Caregivers_____ Other Relatives: _____

____Foster Parents Name: _____ Agency Contact Name: _____

____Group Home Name: _____ Case Manager Name: _____

Guardian: ____18+ _____Mother _____Father _____Joint custody _____DCF ____Other:_____

Name of Guardian(s):_____ Email address: _____

Address: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Emergency contact: please notify if parent of guardian cannot be reached: _____

Relationship name and phone number: _____

Is there anyone to whom the student should **NOT** be released to (ex-spouse, etc.):_____

In case of emergency, can student be transported to their place of residence without guardian/staff being present: _____
If no, where can student be transported in case of emergency: Name: _____

Address: _____ Phone: _____ Relationship: _____

_____ DCF Case worker & phone #:_____

_____DMH Case worker & phone #:_____

_____DYS Case worker & phone #:_____

_____Court involved Probation officer name & phone #:_____

_____Psychiatrist and/or Therapist name & phone #:_____

Other: _____

SOURCE DOCUMENT Continued:

Student's Physician, address & phone: _____

Student's Dentist, address & phone: _____

Insurance Co: _____ ID#_____ Group#_____

Medical Information:

Medication: _____

Last physical (date):_____ Significant Medical Conditions: _____

Allergies: _____ Blood type: _____

_____	_____	_____	_____
Caregiver/Guardian Signature	Date	Witness Signature	Date

Student Handbook

I have received a copy of the Student Handbook of Anchor Academy. I understand that Anchor Academy is required to maintain a safe learning environment for all students. Therefore, all rules are under the discretion of the employees at Anchor Academy.

( ) The contents of this handbook have been presented and explained and I have been provided the opportunity to have any and all questions answered.

_____
Caregiver/Guardian Signature

_____
Witness

_____
Date

Student Contract

Justice Resource Institute is determined to provide its students with a safe environment in which individual needs and goals can be met. In order to provide such a place for you, we ask that you in turn agree to terms of the contract below.

I, _____, understand that respect for other people and property makes for a supportive environment for all. I agree to respect staff, other students, and property at Justice Resource Institute and understand that there will be consequences for which I am responsible if I do not.

In addition, I agree to:

1. Follow program rules.
2. Complete class assignments to the best of my ability.
3. Willing to meet with my clinician/teacher weekly to set goals.
4. Attend meetings and conferences.
5. Attend and participate in team meetings.
6. Follow my IEP.

( ) The contents of this contract have been presented and explained and I have been provided with the opportunity to have any and all questions answered.

_____
Student

_____
Witness

_____
Date

Acknowledgement Form
For Receipt of
Admissions Criteria and Interview/Intake Process

STUDENT'S NAME: _____

I have received a Prospective Student Information Folder, which includes the following:

- Admissions Criteria and Interview/Intake Process Policies and Procedures, including information required from the sending district, documentation required upon admission and information about the interview process
- A statement regarding the location of the school's Policy and Procedure Manual and an invitation to view such at any time requested
- The Handbook and Code of Conduct
- Bullying Intervention and Prevention Policy
- Anti-Hazing Policy
- Student Record Keeping and Procedural Safeguards

Additional:

- Statement of Purpose – The school's mission and philosophy
- Type of Services Provided
- Policies related to Student and Parent Rights and student records
- Health Care, including provision for emergency health care and/or hospitalization
- Planning for foreseen and emergency terminations
- Behavior Management/Use of Nonviolent Restraints, BCC, TSS
- Clothing Requirement
- Hours of Operation
- Summer Program Description
- Visiting Policy
- Name and telephone number of school contact
- Complaint Policy
- Approved School Calendar

_____ _____

Signature of Student Date

_____ _____

Signature of Caregiver/Guardian Date

_____ _____

Signature of Witness Date

Activities Release Form

I, _____, being the Caregiver/Guardian of

_____, give permission for my student to participate in all
(Students Name)

activities of Justice Resource Institute. These activities may include transportation to and from sporting events, field trips, academic learning experiences and vocational training, and community service activities. I understand that some of these activities may involve some risk, such as swimming, roller-skating, basketball, skiing, weight lifting, and other sporting events.

_____ yes _____ no

( ) The contents of this release have been presented and explained and I have been provided with the opportunity to have any and all questions answered.

_____	_____	_____
Caregiver/Guardian Signature	Witness	Date

Student Consent for Transportation Services

Student Name: _____ Student SASID:_____

I, _____, give Justice Resource Institute, Inc.

permission to transport me in a company vehicle or a staff's personal vehicle.

I understand that this is a courtesy offered by Justice Resource Institute as part of its treatment services and programs. Furthermore, I understand my consent to this transportation option is voluntary and I recognize that I am not obligated to accept this transportation service.

I hereby release Justice Resource Institute, as well as its staff, clinicians, and Board of Trustees from any claims, rights, demands, causes of action suits, liabilities, damages or other obligations of any kind whatsoever, known or unknown, which may arise from the provision of transportation services. I understand that the Justice Resource Institute Transportation Policy requires that staff operating a vehicle have taken precautions prior to consenting to transport clients.

All passengers must follow the following rules in order that this service can be offered.

1. Seat belts must be worn at all times.
2. No smoking, eating or drinking is allowed in the vehicle.
3. Passengers should behave courteously and in no way be distracting the driver.

( ) The contents of this consent form have been presented and explained and I have been provided with the opportunity to have any and all questions answered.

Caregiver/Guardian Signature:_____ Date: _____

Student Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Inclement Weather Policy

In the event of inclement weather, the school director will make a determination as to whether school will be cancelled or delayed and will notify the transportation companies prior to 6:30 a.m. ***Please note that due to the wide geographic area that we serve, in some cases the student's local district may choose not to transport even if Anchor Academy is open.***

Agility Course Safety Guidelines

These guidelines are to ensure that safety is maintained at all times while students are using the agility equipment. In accordance with our mission and vision, it is the expectation that all students and school employees follow these guidelines to maintain a safe environment.

- Students are not permitted on the agility course without school employees permission and/or direct supervision
- Students must utilize the equipment safely by being careful and showing courtesy to students and school employees
- Students must utilize the equipment safely, sensibly and appropriately at all times
- Students must wear proper clothing attire and skin protection (shoes should be tied, no excessively loose clothing, hats, gloves, suntan lotion, etc.)
- Students are not permitted to utilize the equipment during inclement weather (lightening, severe cold, excessive heat, etc.)
- The equipment must be dried following any wet weather
- During warmer months, students and school employees should be mindful of the temperature of the equipment
- Only one student is permitted to utilize each piece of equipment at a time, unless it's designed otherwise (leg press)
- Students may only use the equipment for its intended use
- Students should be sitting in the center of the swing (no standing or kneeling)
- Jumping off the swings is not permitted
- Students should stay a safe distance from others while equipment is in use- do not to run or walk in front, in back or in between active students
- Only one student can utilize individual pieces of equipment at a time
- Only one student can utilize the monkey bars at a time
- Only one student can utilize the climbing bridge at a time
- Students are to maintain boundaries with students and school employees and should keep their hands and feet to themselves
- Students should leave backpacks and other items that could impact movement in a designated area away from the agility equipment
- Any student who intentionally damages the equipment will immediately be restricted from using the equipment until reviewed and approved by the Director/Dean of Operations
- If any of the above expectations are violated or others behaviors that jeopardize any school rules are demonstrated, a student will be immediately restricted until reviewed and approved by the Director/Dean of Operations

_____ _____

Print Student's Name Date

_____ _____

Print Caregiver/Guardian/School Employee Signature of Caregiver/Guardian/School Employee

Recreational Equipment Expectations
(Bikes, Skateboards, Scooters, Roller Blades)

These guidelines are to ensure that safety is maintained at all times while students are using the agility equipment. In accordance with our mission and vision, it is the expectation that all students and school employees follow these guidelines to maintain a safe environment.

- Students and school employees must wear helmets/protective gear when utilizing recreational equipment at all times.
- Students must participate in an initial competency test to show that they are capable of operating the equipment safely and efficiently.
- Students and school employees must demonstrate safe behaviors while using the recreational equipment (no horse playing, crashing into one another, jumping over objects, wheelies, etc.).
- Only one student is allowed on each piece of recreational equipment at a time (two students are never allowed to be on one bike at a time).
- Each student is in charge of the piece of recreational equipment they use. The equipment must be returned to the bike rack after each use and stored appropriately. The equipment may not be left outside in between activities.
- The recreational equipment is school property. The equipment cannot be tampered with, reconstructed, or manipulated in any way.
- Students need to remain in designated areas assigned by school employees and remain in sight of school employees at all times. Sidewalks and bike paths must be used when they are available.

If these expectations are not followed, students will lose the opportunity to use school equipment for at least 2 school days unless determined otherwise by the Director/Dean of Operations.

_____ _____
Print Student's Name Date

_____ _____
Print Caregiver/Guardian/School Employee Date

_____ _____
Signature of Caregiver/Guardian/School Employee Date

Student Record Policy

It is the policy of Justice Resource Institute to destroy all student records at the time of the student's graduation/termination from the program, with the exception of academic and attendance records. Any information other than academic or attendance required by any of the student's collaterals after graduation or termination must be accessed through the placement school district.

( ) The contents of this policy have been presented and explained and I have been provided with the opportunity to have any and all questions answered.

_____	_____	_____
Caregiver/Guardian Signature	Witness	Date

Annual Statement of Acknowledgement
For Student Groups, Team, and Organizations
Anti-Hazing Law, M.G.L. c. 269 SS 17-19

To: Caregiver/Guardian:

On behalf of_____, I certify that
(Name of Student)

_____have read the policy and
(Name of Student)

have received a copy of An Act Prohibiting the Practice of Hazing, Hazing, M.G.L. c 269, SS 17-19; and that he/she understands and agrees to comply with the law.

Date: _____

Signed: _____
(Caregiver/Guardian Signature)

Signed: _____
(Student Signature)

School Director: _____
(Anchor Academy)

Date Received by Director or Designee: _____

Cc: School Files

Bullying Prevention and Intervention Policy and Procedures Receipt Documentation

I, _____, acknowledge that I have received a written copy of the Anchor Academy's Bullying Prevention and Intervention Plan, as well as notification of how I can tell someone if I am concerned about bullying at the school.

Please check one of the following:

I am a:

_____ Student

_____ Parent/Guardian

_____ Name of Student

_____ Employee/Volunteer

Internet Policy

Anchor Academy is committed to making advanced technology and increased learning opportunities available to our students and school employees. Anchor Academy believes that Internet access can offer a valuable resource for learning and communicating with others. At the same time, Anchor Academy is aware that material in the Internet is uncensored and we can make no guarantees that information found on the Internet will be valuable, reliable, or inoffensive. However, Anchor Academy firmly believes that, with proper supervision, electronic controls, and compliance with State and Federal statutes, the vast amount of information available and the interaction with other people made possible via the Internet will be designed in a manner that points students to those resources that have been reviewed and evaluated prior to student use.

Access to the Internet within school is viewed as a privilege, not a right. That access entails responsibility. Anchor Academy expects all users of the school's technology resources will do so in a responsible manner and will be considerate of all other users. Students utilizing the Internet must have permission of and must be supervised by a Anchor Academy school employee.

Internet use areas will be treated like class work and school lockers in that they are the property of the school's and, as such, their contents may be viewed at any time by a school employee. Network administrators and Anchor Academy employees may view files, communications and sites visited to maintain system integrity and to insure that users are using the system responsibly. Users should not expect that files accessed or stored are private. Anchor Academy will not be held liable for any lost, damaged, or unavailable information because of technical or other difficulties.

Before access is granted to a student, the user must **annually** read and sign the attached agreement for acceptable use of the Internet at the School. Signed student agreement forms will be **signed once** and kept on file.

Student access will also require the signature of a caregiver/guardian. While we realize that accidental access to unsuitable Internet areas may occur on occasion, repeated or intentionally inappropriate Internet use will result in suspension or revocation of that privilege and may result in further disciplinary action.

The following will also apply to Internet use within Anchor Academy:

1. All users of the Internet within Anchor Academy are responsible for appropriate behavior on the Internet, just as they are when involved in any school activity. General school rules and policies apply to all computer activity and communication.

2. The purpose of Internet access at school is to support research and educational goals. Use of the Internet must always support those goals.

3. Unless explicit permission is granted, games and chat lines may not be used.

4. Internet users must never:
    - Reveal personal addresses or phone numbers
    - Send or display offensive messages, data, graphics, or pictures
    - Use inappropriate language
    - Use another person's password or account
    - Share an account or password with anyone
    - Violate copyright law by copying or using unauthorized copies of programs/music
    - Access other people's folders, files, or programs without permission
    - Use information without giving proper credit to the author
    - Harass, insult, or attack other Internet users
    - Use of the Internet for any commercial purposes
    - Willfully destroy or vandalize other people's work, computers, or computer programs

Permission Form for Internet Access

Each student and a caregiver/guardian must read and sign this form prior to accessing school Internet resources.

Student Name: _____

Current Grade: _____ Homeroom: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: _____

I understand and will abide by the terms and conditions for Internet and e-mail access at Anchor Academy. I further understand that any violation of the regulations is unethical and may constitute a criminal offense. If I commit any violation, my access privileges may be limited, suspended or revoked.

User Signature: _____ Date: _____

As a caregiver/guardian of this student, I have read and understand the terms and conditions for Internet access. I understand that this access is designed for educational purposes and that Anchor Academy will take reasonable precautions to restrict access to controversial material. I also recognize that it is impossible to restrict access to all controversial material, and I will not hold the Anchor Academy responsible for materials acquired on the Internet. I hereby give permission to provide Internet access to my child and certify that the information contained on this form is correct.

Caregiver/Guardian's Name (please print): _____

Signature: _____

Date: _____

Electronic Device Procedure

- Electronic devices (including but not limited to- cell phones, iPod's, iPad's, tablets, MP-3 players) must be passed in to an Anchor Academy employee upon entry into the school building.
- Electronic devices will be secured in a locked box only accessible by Anchor Academy employees.
- Students may request to check or utilize their electronic device throughout the school day by completing a check-in note.
- Access to electronic devices will be permitted at the discretion of Anchor Academy employees.
- A designated area for a student to utilize their electronic device will be determined by an Anchor Academy employee.
- Students are not permitted to utilize their electronic devices outside.
- Students must be in a designated area with an Anchor Academy employee when utilizing their electronic devices. No other students are permitted to be in the area.
- Only one student is permitted to access their electronic device at a time during school hours.
- Students are not permitted to utilize the camera function on any electronic device at Anchor Academy.
- Accesses to electronic devices are not permitted during meal times.
- Electronic devices are not permitted off campus during school hours.
- Students understand that checking or accessing electronic devices during school hours is a privilege not a right.
- Constant violations of any of the expectations noted above will result in students being ineligible to check or access an electronic device during school hours. Anchor Academy maintains the right to only return electronic devices to caregivers/guardians if procedure violations occur.

Caregiver/Guardian Signature: _____

Student Signature: _____

Anchor Academy Employee Signature: _____

Date: _____

Public Relations Release Form

I, _____, being the Caregiver/Guardian of

_____, give permission to Justice Resource Institute to use
(Students Name)

photographs or video/audio tapes of my child for the purposes of:

(Please indicate on each line below with a "yes" or "no")

____ Fundraising
____ Public relations
____ Yearbook projects
____ School Newsletter (to be sent to various agencies)
____ Other _____

while he/she is participating in school.

( ) The contents of this release have been presented and explained and I have been provided with the opportunity to have any and all questions answered.

_____
Caregiver/Guardian Signature

_____
Witness

_____
Date

Authorization to Release/Obtain Information

Student Name: _____ DOB: _____

I hereby authorize and request Anchor Academy to:

____ Obtain From: _____

____ Release To: _____

(Typically, counselors may need to share information with the student's therapist, psychiatrist, physician, probation officer, etc., in order to assist the student in the best possible manner while at school.)
The information obtained for the treatment period:

_____ to _____

I understand that the information transmitted is confidential and will be used for the following purpose:

Benefits/Assessment/Treatment/Planning/Other

_____

The specific information to be disclosed is:

____ School Health Record
____ School Records
____ Assessments
____ IEP
____ Lab Reports
____ Info Relevant to Stated Purpose
____ Psychological Testing
____ Other (specify)_____

and may be communicated in the form of records, phone conference, e-mail transmission, etc.

I have carefully read and understand the above statements, and do herein expressly and voluntarily consent to disclosure of the above information about, or medical records of, my condition to those persons or agencies named above. I further release my attending physician and the employees from any liability arising from the release of this information to such persons or agencies provided the said release of information is done substantially in accordance with applicable law.

I understand that my record contains information about my identity, diagnosis and treatment and may reference the following: Psychiatric Information, Drug and/or Alcohol Abuse, HIV (AIDS) Testing/Results and/or other highly sensitive information

I understand that this consent is subject to revocation at any time unless action on it has already begun. This release shall expire one year from the date of:

_____	_____	_____
Date	Caregiver/Guardian Signature	Witness

( ) The contents of this form have been presented and explained and I have been provided the opportunity to have any and all questions answered.

I do not wish you to access the following individuals for information: _____

Medication Policy

The MA Department of Education in conjunction with the MA Department of Public Health require that the following forms must be on file in the student's health record before we begin to give any medication at school, or allow the student to self-administer any medication.

1. "PERMISSION TO ADMINISTER OVER-THE-COUNTER MEDICATION"
   The Over-The-Counter Medication form must by signed by both the student's legal guardian and the student's licensed prescriber in order for school personnel to administer or supervise the self-administration of over-the-counter medications. This form must be reviewed and signed annually.
2. "CAREGIVER/GUARDIAN CONSENT FOR PRESCRIPTION MEDICATION ADMINISTRATION BY SCHOOL PERSONNEL"& MEDICATION PLAN If the student is to be administered prescription medication (this includes PRN or as needed medication as in Albuterol Inhalers or Lactaid) while at school, a consent form and medication plan must be signed for each medication. A new consent and plan must be provided each time there is a change in the medication or administration (dosage, time etc.) and each year.
3. "MEDICATION ORDER" The written medication order form should be taken to the student's licensed prescriber (your child's physician, nurse practitioner, etc.) for each prescription medication that will be administered at school. A new form must be completed each time there is a change in the medication or administration (dosage, time etc.) and each year.

MEDICATION RECEIPT/STORAGE/RETRIEVAL

- Medication must be delivered by a responsible adult.
- Medication must be received in a pharmacy or manufacturer-labeled container.
- The container must reflect the latest date filled.
- No more than a 30-day supply of any one medication will be accepted.
- A responsible adult may retrieve medication stored at school at any time.
- All medication will be destroyed if not picked up within 1 week following discontinuation of the medication or closing of the school.

If you have any questions or concerns, please feel free to contact the school nurse.

( ) The contents of this policy have been presented and explained and I have been provided with the opportunity to have any and all questions answered.

_____ _____

Caregiver/Guardian Signature Date

_____ _____

Witness Date

Permission to Administer Over-The Counter Medications

The Department of Public Health guidelines requires school to have written permission of caregivers/guardians, and specific medical orders to administer over-the-counter medications to students. This consent must be renewed annually. The following list has been developed with specific medications that may be available if needed, along with the circumstances under which the medication may be given. If you have any questions or concerns, please feel free to contact the school nurse.

Students are not allowed to keep any kind of medication with them in school. All medications must be turned into the designated school personnel. A phone call will be made to the caregiver/guardian, group home, or emergency contact should the student require any more than basic first aid.

Physician: By signing below you give designated school personnel permission to administer the listed over-the-counter medication approved by the school and yourself.

Caregiver/Guardian: By signing below you give designated school personnel permission to administer the listed over-the-counter medication approved by the school and Justice Resource Institute's physician. ***Please cross out any medication you do not give permission to be administered***. In addition, you acknowledge that you have had your questions answered by a licensed prescriber or designee.

Caregiver/Guardian Signature: _____Physician Signature: _____

Printed Caregiver/Guardian Name: _____ Printed Physician Name: _____

Drug	Dose	Frequency & Use	Cautions & Contraindications	Potential Side Effects	Assessment needed prior to administration
Sunscreen 30-50 SPF		Topical to exposed skin 15mins prior to outside activity, may reapply as directed by manufacturer to protect from UV burns	Allergies to any ingredients in sunscreen.	Acne or skin irritation.	Be aware of broken or irritated skin prior to application
Insect repellant 0-25% DEET		Topical to exposed skin and clothing prior to outside activity, may reapply as directed by manufacturer to protect from insect bites.	Avoid application to eyes, mouth, broken skin, and use sparingly on ears.	Skin rash, eye irritation DEET may discolor clothing.	Apply after sunscreen Do not apply to areas of broken skin
Petroleum Jelly	Small amount	Topically to chapped lips every 2 hours as needed.	Allergies to Petrolatum.	Allergy to product.	Evaluate skin color, swelling, drainage, redness, heat and pain (location, severity and duration), location of rash and skin integrity. Notify caregiver/guardian as appropriate, document treatment; refer to health care provider as needed and follow-up as needed.

Drug	Dose	Frequency & Use	Cautions & Contraindications	Potential Side Effects	Assessment Needed Prior to Administration
Benadryl	1-2 tablets (25mg per tablet)	Take 1-2 tablets for non-life threatening signs of an allergic reaction (hives, localized itching and/or rash). More serious reactions such as respiratory distress or vomiting requires treatment with Epinephrine. Mild to moderate reactions to an insect sting, drug allergy or food allergy.	Known allergy to Benadryl, lower respiratory tract disease.	Dizziness, drowsiness, poor coordination, fatigue, anxiety, confusion, blurred vision, dry nose, throat and mouth, nausea, diarrhea or chest tightness may occur.	Note respiratory status, rate, rhythm and increase in bronchial secretions, wheezing and chest tightness. Observe skin for alteration in skin integrity, presence of rash or hives. Observe for alleviation of symptoms for which the drug was administered. Notify caregiver/guardian as appropriate, document treatment; refer to health care provider as needed and follow-up as needed.
Antibiotic Ointment	Small amount	May be applied 1 to 3 times daily if appropriate, may be covered with band aid or sterile dressing for prevention of infection in minor lacerations, abrasions and burns if soap and water is not enough.	Allergy to any listed ingredients. Do not use in the eyes or over large areas of the body. In case of deep puncture wounds, animal bites, or serious burns consult a licensed provider. Consult provider if condition persists or becomes inflamed. Do not use longer than 1 week unless directed by a licensed provider.	Allergic reaction	Evaluate skin color, swelling, drainage, redness, heat and pain (location, severity and duration), location of rash and skin integrity. Verify tetanus status if warranted. Notify caregiver/guardian as appropriate, document treatment; refer to health care provider as needed and follow-up as needed.
Cough Drops (Sugar Free)	1-2 drops	May give 1-2 drops for relief of cough or sore throat due to occasional minor irritation.	Choking hazard. Do not give to student with a known swallowing issue. If sore throat is severe, persists more than 2 days, is accompanied by a fever, headache, rash,	Allergic reaction to ingredients, irritation can occur.	Assess upper respiratory tract, obtain temperature and review history of cough symptoms as needed. Notify caregiver/guardian as appropriate, document treatment; refer to health care provider as needed and follow-up as needed.

			swelling or vomiting, consult a physician.		
Drug	**Dose**	**Frequency & Use**	**Cautions & Contraindications**	**Potential Side Effects**	**Assessment Needed Prior to Administration**
Ibuprofen	1-2 tablets (200mg per tablet)	Take 1 tablet every 4-6 hours while symptoms persist, if pain or fever does not respond to 1 tablet, 2 tablets may be used for simple headaches, menstrual cramps, general malaise due to cold/flu or as an antipyretic.	Allergy to ibuprofen, not to be given with other NSAIDS, not to be given with other anti-inflammatories, not to be given 1 week before surgery.	Allergic reaction, upset stomach, mild heartburn, nausea, vomiting, stomach bleeding.	Evaluate pain and pain source, measure temperature if appropriate and contact parent if temperature is >100, check for last dose and administer appropriate dose. Notify caregiver/guardian as appropriate, document treatment; refer to health care provider as needed and follow-up as needed.
Acetaminophen	2 tablets (325mg per tablet)	Take 2 tablets every 4-6 hours while symptoms last for simple headaches, menstrual cramps, and general malaise due to cold/flu or as an antipyretic.	Allergy to acetaminophen, not to be given with any other acetaminophen or aspirin containing products.	Allergic reaction, liver damage can occur if not taken at the recommended dose.	Evaluate pain and pain source, measure temperature if appropriate and contact parent if temperature is >100, check for last dose and administer appropriate dose. Notify caregiver/guardian as appropriate, document treatment; refer to health care provider as needed and follow-up as needed.
Aloe Vera Gel		May apply topically to skin for mild itching, mild pain and discomfort.	Do not use if symptoms worsen.	Very unlikely, but report promptly any rash or irritation and cleanse area thoroughly.	Evaluate skin color, swelling, drainage, redness, heat and pain (location, severity and duration), location of rash and skin integrity. Notify caregiver/guardian as appropriate, document treatment; refer to health care provider as needed and follow-up as needed.
Aquaphor	Small amount	Topically to dry or irritated skin every 4 hours as needed.	Allergies to Mineral Oil or Petrolatum	Allergic reaction	Evaluate skin color, swelling, drainage, redness, heat and pain (location, severity and duration), location of rash and skin integrity. Notify caregiver/guardian as appropriate, document treatment; refer to health care provider as needed and follow-up as needed.
Antacid	2-4 tablets (750mg per tablet)	Chew 2-4 tablets as symptoms occur for relief of acid indigestion, heartburn, sour stomach and upset stomach.	Do not take more than 6 tablets per day. Antacids may interact with certain prescription drugs.	May have a laxative or constipating effect.	Assess for location, duration, quality, character of discomfort and how often discomfort occurs. Notify caregiver/guardian as appropriate, document treatment; refer to health care provider as needed and follow-up as needed.

Pediculosis (Head Lice) Procedure

- Upon admission to Anchor Academy, each student will be screened by the School Nurse or trained designee for head lice and nits (egg cases attached to the strand of hair).
- On a quarterly basis, the School Nurse or trained designee will screen each student for head lice and nits.
- Any time a student requires an inpatient (medical/psychiatric) hospitalization and/or visit to the emergency room, the student must be screened for head lice and nits by the School Nurse or trained designee upon return to Anchor Academy.
- If an Anchor Academy student has been in the vicinity of someone with head lice or nits, the School Nurse or trained designee must be notified so proper screening can be completed.
- If it is determined that a student at Anchor Academy has active head lice or nits, the student will be dismissed and the caregiver/guardian will be instructed on the proper treatment. Additionally, a notification will be made to caregivers/guardians of all students enrolled within the school. This notification will include instructions on how to assess and treat head lice or nits.
- The student may not return to Anchor Academy until the student is clear from lice and nits. In addition, the School Nurse or trained designee will screen the student upon return.
- Protection of the student's confidentiality and emotional sensitivity is a PRIORITY and discretion will be used.

_____
Print Student's Name

_____
Print Caregiver/Guardian's Name

_____
Signature of Caregiver/Guardian

_____
Date

Curriculum Primarily Involving Human Sexual Education Or Human Sexuality Issues

In accordance with Chapter 71, Section 32A, schools are responsible for notifying parents if curriculum that primarily involves human sexual education or human sexuality issues will be presented.

Topics are sometimes discussed and presented at Anchor Academy. These issues are discussed in the context of human biology, sexual reproduction, health and healthy choices. If you would not like your child to participate in such discussions or classroom presentations, you have the right to exclude your child.

Please indicate your choice below and return this to Anchor Academy.

____ My child,_____, has my permission to participate in class discussions and presentations concerning human sexual education or human sexuality issues.

____ My child, _____, does not have my permission to participate in class discussions and presentations concerning human sexual education or human sexuality issues.

_____ _____
Caregiver/Guardian Signature Date

_____ _____
Witness Date

49 Plymouth St Middleboro, MA 02346 **PHONE** (508) 947-0131 **FAX** (508) 947-1569 www.jri.org/anchor

Consent for Emergency Treatment

I, _____, being the Caregiver/Legal Guardian of

_____, provide consent for an emergency
(Students Name)
medical/psychiatric/dental evaluation when recommended by a qualified medical technician. I also provide consent for the administration of medical treatment in the event of a life-threatening condition or illness, if I or my designated emergency contact is unable to be reached. I understand that every effort will be made to locate myself or my designated emergency contact before treatment is administered unless my child's safety is at risk without immediate treatment.
I understand and provide consent for Anchor Academy to release pertinent demographic and medical information as it pertains to the emergency illness, injury or condition unless otherwise indicated below:
_____

( ) The contents of this policy have been presented and explained and I have been provided with the opportunity to have any and all questions answered.

_____
Caregiver/Guardian Signature

_____
Witness

_____
Date

Authorization to Release Medical Information

I, _____, being the Caregiver/Guardian of

_____, hereby authorize Anchor Academy to release the
(Students Name)

following information to the **Director, Dean of Operations, Administrative Assistant, School Counselors, Teachers and Classroom Counselors.** This information may be necessary to know in order to assist the student throughout the day, or, should the student require medical assistance either in the building or outside of school (i.e. gym, field trip, internship, etc.).

- Allergies
- Diagnosis (medical/psychiatric)
- Medication/Treatments
- Immunization records

Caregiver/Guardian Signature: _____

Witness: _____

Date: _____

Release of Medical Information

Primary Physician: _____

Address: _____

Telephone: _____

RE: _____ DOB: _____

Dear Physician:

The above named student has been referred to our school. We require a complete physical exam for **new students** within the past six (6) months, or since the onset of any current problems. Annual physicals are required for all **returning students.** This is to ensure that we can provide the best possible academic services and/or make any necessary modifications or adaptations. This signed consent form for the release of information has been provided for your convenience and is required annually.

1. Date of last physical: _____
2. Physical condition as of last exam: _____
3. Any past major illness, accidents, hospitalizations, or surgeries:

   _____

4. Medication history - Allergies: _____

   _____

   Current medications: ___ yes (see attached OTC form) ___ no

   _____

   Adverse drug effects: _____

   _____

5. Impressions of patient: _____

Please attach a copy of the student's current physical and immunization record

I give permission to this student's physician to share with appropriate school personnel the information provided above as deemed necessary for the student's health and safety.

_____ yes _____ no

( ) The contents of this form have been explained to me and I have been provided with the opportunity to have any and all questions answered.

_____ _____

Caregiver/Guardian Signature Date

_____ _____

Physician Signature Date

_____ _____

Witness Signature Date

Release of Medical Information

Licensed Prescriber: _____ Therapist: _____
Address: _____ Telephone: _____
RE: _____ DOB: _____

Dear Licensed Prescriber:
The above named student has been referred to our school. We require this release of medical information, signed by the student's legal guardian, be reviewed, filled out, and signed annually. Please return to the school to be kept on file for the current school year. This will enhance the ability of school counselors in meeting the individual needs of the student and in providing the best academic services possible with modifications and/or adaptations, as needed.
Signatures of all parties will also provide for the opportunity to share information as deemed appropriate and necessary for the provision of education and to maintain the health and safety of the student.

1. Date of last visit: _____
2. Frequency of visits: _____
3. Past hospitalizations or inpatient treatment:

   _____ _____
   _____ _____
   _____ _____

4. Diagnosis:

   Axis I: _____
   Axis II: _____
   Axis III: _____
   Axis IV: _____

5. Medication history: Allergies: _____

Current medication	Dosage	Time	Diagnosis
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Noteworthy ineffective medications: _____
_____
Adverse drug effects: _____
_____

( ) The contents of this consent form have been presented and explained to me and I have been provided with the opportunity to have any and all questions answered.

_____ _____
Caregiver/Guardian Signature Date

_____ _____
Licensed Prescriber Signature Date

Release of Dental Information

Dentist: _____

Address: _____

_____

Telephone: _____

RE: _____ DOB: _____

Dear Dentist:

The above named student attends our school. The MA Department of Elementary and Secondary Education requires that we acquire and keep on file a copy of each student's comprehensive dental exam. This signed consent form for the release of information has been provided for your convenience and is required annually.

Date of Exam: _____

Prophy: _____

Fluoride: _____

X-Rays: _____

Caries: _____

Caries Free: _____

I give permission to this student's dentist to share with appropriate school personnel the information provided above as deemed necessary for the student's health and safety.

_____ yes _____ no

_____ _____

Caregiver/Guardian Signature Date

_____ _____

Dentist Signature Date

_____ _____

Witness Signature Date

Consent for Prescription Medication Administration by School Personnel

GENERAL INFORMATION
Name of Student: _____ DOB: _____

Name of Caregiver/Guardian: _____

Address: _____

Home/Cell Telephone #:_____Work Telephone #: _____

CONSENT

1. As Caregiver/Guardian, I give permission to have the school personnel designated by the school, give the following medicine _____(Name of Medication) prescribed by _____(Licensed Prescriber) to _____(Student).

_____ yes _____ no

2. When applicable, as Caregiver/Guardian I give permission for the student to self-administer their prescription medication under supervision (provided the school nurse deems this safe and appropriate).

_____ yes _____no

( ) The contents of this form have been presented and explained and I have been provided with the opportunity to have any and all questions answered.

_____ _____
Caregiver/Guardian Signature Date

_____ _____
Witness Signature Date

Medication Order

To be completed by a Licensed Prescriber:
Physician, Nurse Practitioner, or others authorized by Chapter 94C

Name of Student: _____ Date of Birth: _____

Address: _____ Grade: _____
(Street) (City/Town)

Name of Licensed Prescriber:_____ Title: _____

Business Telephone #: _____ Emergency Telephone #: _____

Medication: _____

Route of Administration: _____ Dosage: _____

Frequency: _____Time(s) of Administration: _____

Please note: Whenever possible, medication should be scheduled at times other than school hours.

Specific Directions or Information for Administration: _____

Date of Order: _____ Discontinuation Date: _____

*Diagnosis: _____

*Any Other Medical Condition(s): _____

Optional Information

1. Special side effects, contraindications, or possible adverse reactions to be observed:_____
2. Other medication being taken by the student: _____
   _____
3. The date of the next scheduled visit or when advised to return to prescriber: _____
4. Consent for self-administration, under supervision, (provided the school nurse determines it is safe and appropriate): Yes _____ No _____

_____

* If not in violation of confidentiality Signature of Licensed Prescriber

Medication Plan

Name of student_____ Date of Birth _____ Caregiver/Guardian name _____

School _____ Grade _____ Home telephone _____

Name of Licensed Prescriber _____ Business telephone _____

Business telephone _____ Emergency telephone _____

Food/Drug Allergies _____ Diagnoses: _____
(if not a violation of confidentiality)

Name of Medication: _____ Date Ordered _____ Duration of Order _____

Dosage _____ Frequency _____ Route of Administration _____ Expiration Date of Medications Received _____

Specific Directions, e.g. times to be given: _____

Possible Side Effects, Adverse Reactions: _____

Quantity of Medication Received by School and Date: _____

Required Storage Conditions: _____

Delegated to (if applicable): _____ Back-up Plans (if delegatee unavailable): _____

Plan for Field Trips: _____

Plans for teaching self-administration, if applicable: _____

Other persons to be notified of medication administration (with parental permission): _____

Other medications being taken by the student (if not in violation of confidentiality): _____

Location where medication administration will occur: Health Room ____ Other (specify) _____

Plan for monitoring medication, if needed: _____

School Nurse Signature _____ Date _____

Caregiver/Guardian Signature _____ Date _____

Student's Signature, if appropriate _____ Date _____

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Prescription Medication

- The following forms are to be completed (check mark and signed where applicable) by the caregiver/legal guardian or student if over the age of 18 years only if the student is to receive prescription medication on a daily or as needed basis during school/Summer program hours.

_____Consent for Prescription Medication Administration by School Personnel

_____Medication Plan

_____Medication Order: To be completed by student's physician