Please confirm that the STUDENT INFORMATION below is correct, any additional information or corrections that need to be made can be written in.

Student Information

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

Birth Date: ___/___/___ **Social Security #:** _____ ☐ **Male** ☐ **Female** **Grade:** _____

ADDRESS INFORMATION	**PHONE INFORMATION**
Street Address **Apt. #**	**HOME PHONE:** ( ) -
	PARENT/GUARDIAN WORK: ( ) -
	PARENT/GUARDIAN MOBILE: ( ) -
City **State** **Zip Code**	**STUDENT MOBILE:** ( ) -

Parent/Guardian Information

Parent/Guardian: _____ _____ _____
Last Name **First Name** **Relationship To Student**

Address:
☐ **Check here if same as above**

Street Address **Apt. #**

City **State** **Zip Code**

Best Parent/Guardian Contact Number & Email Address:	
HOME PHONE:	( ) -
PARENT/GUARDIAN WORK:	( ) -
PARENT/GUARDIAN MOBILE:	( ) -
EMAIL ADDRESS:	

Emergency Contact Information

Emergency Contact: _____ _____ _____
Last Name **First Name** **Relationship To Student**

Address:

Street Address **Apt. #**

City **State** **Zip Code**

Best Emergency Contact Number:	
Emergency Contact HOME PHONE:	( ) -
Emergency Contact WORK/other:	( ) -
Emergency Contact MOBILE:	( ) -
Please check if you authorize this person to release your child from school.	☐ **Yes, I authorize this person to release my child from school.**
	☐ **No, I DO NOT authorize to release my child from school.**

Please sign and date below indicating that the information stated on this form is the most current information for your child. Thank you.

Parent/Guardian Signature:_____ **Date:**_____

Please confirm that the STUDENT MEDICAL INFORMATION below is correct and provide your signature as authorization of this information as well as for emergency medical treatment. Any additional information or corrections that need to be made can be written in. Also, please be sure to complete the Important Allergy Information.

STUDENT MEDICAL INFORMATION

Physician's Name or GROUP: _____

Phone Number: ( ) - **Address:** _____

MEDICAL INFORMATION

List below chronic conditions the student may have (i.e. asthma, diabetes, epilepsy, allergies, etc.):

Please fill out the form below regarding the Administration of both non-prescription and prescription medications. This information is necessary for our files to ensure that we have the most up to date medical information when providing medical treatment to your student. Students will not be provided medication without completion of this form.

Parent Permission for Over-the-Counter Medical Administration

Our School Medical Inspector, Daniel Greenfield, MD has authorized the administration of the following medication by the School Nurse in the School Health Office. However, parental/guardian permission is required before a student can receive any of the listed medication. If you would like your child to be able to receive any of the listed medication in school if needed, please complete the following and return it to the Health Office. **If medication is requested in excess, a recommendation will be sent home to have the student visit their Health Care Provider for evaluation.**

Please check off if your student will be using either of the following products while in school. These products must be supplied by the parent/guardian and will be kept in the Health Office for the assigned student's use only.

_____ contact lens solution _____ sunscreen

The following medications will be supplied by the school district with your authorization:

- Acetaminophen dosed according to weight and product label
- Ibuprofen dosed according to weight and product label
- TUMS® dosed according to product label
- Cough Drops dosed according to product label
- Claritin D® (Loratadine)

Note: if you do NOT wish to have your student receive any one of the above medications, please list it here:

_____

_____ **Yes, I authorize the school nurse to administer the above medications to my child as needed.**

_____ **No, I do not authorize the school nurse to administer the above medications to my child.**

Parent/Guardian Signature: _____ **Date:** _____ **Date:**

Student's Current Medications

Please list ALL medications that the student is currently prescribed, even if they are not administered in school. If this does not apply to your student, please indicate below by writing n/a:

Medication	Dose	Time

We would appreciate if you could keep us updated during the school your if ANY medications, dosage or frequencies change so that we can be observant for any side effects. Please call the School Nurse, Mrs. Bartiromo, at (732) 469-5892 ext. 30 to report these changes or if you have any questions or concerns. I hereby authorize that the above information I have provided is accurate.

Parent/Guardian Signature: _____ **Date:** _____

Permission for Emergency Medical Treatment

I hereby authorize the physicians and/or their designated associates or assistants, or their covering physicians, or in the event these persons cannot be contacted, the emergency physician on duty at Somerset Medical Center in Somerville, New Jersey or the nearest emergency facility to provide emergency treatment to my child for the following:

- Any laceration, fracture or other traumatic injury or;
- Any symptom, diseases or injury which in the judgment of the attending physician, if untreated, reasonably may be expected to increase the risk or threaten the health or life of such child, or threaten disfigurement of impairment of his faculties. No major surgery or life threatening procedure may be performed upon my child and no general anesthesia may be administered unless:
  - The Life and Health of my child is in danger; or delaying such treatment to obtain consent would create a threat of serious injury to the health of my child; and
  - The attending physician and one other physician consult and agree that such treatment is necessary for the health of my child.
- I hereby give my consent for admission of my child if in the judgment of the attending physician, it is necessary for any treatment authorized herein.
- This consent is to be effective only after reasonable efforts have been made to contact and obtain specific consent to any emergency treatment.
- This consent is also to be used in conjunction with the hospital's procedure for documented Administrative Authorization.
-

INSURANCE CARD INFORMATION: (PLEASE PROVIDE INFO BELOW OR SUBMIT A COPY OF YOUR CURRENT INSURANCE CARD.

Insurance Carrier: _____ Policy #: _____

Primary Care Provider (PCP) Name: _____ Phone #: _____

I hereby authorize EMERGENCY MEDICAL TREATMENT for my child.

Parent/Guardian Signature: _____ **Date:** _____

IMPORTANT ALLERGY INFORMATION (If this does not apply to student, please write N/A)

Please list all food allergies: _____

Please list any drug allergies and the reaction: _____

Please list seasonal allergies (i.e. bee stings): _____

Does the student have asthma? ____ **YES** ____ **NO**

If yes, please have your physician complete the Prescribed Medication Authorization form attached and send the inhaler to the health office OR have the physician complete the Self-Medication by pupil form. Students may NOT carry an inhaler without a physician order on file.

Does the student have an Epipen for his/her allergies? ____ **YES** ____ **NO**

If yes, please have your physician complete the Prescribed Medication Authorization Form attached and send medication with label to the health office.

Please read the following medical permissions carefully. It is important that we have these permissions on file in the event Brook Academy Staff believes a student is under the influence of drugs or alcohol.

Substance Abuse Screening Program

Attention: Parents/Guardians

Green Brook Academy has adopted a substance abuse screening program. Random drug/alcohol screenings will not be conducted. Drug/Alcohol screenings will be conducted if Green Brook Academy Staff strongly believe a student is under the influence of an illicit drug/alcohol.

The Substance Abuse Screening Program was established in order to determine if a student needs an evaluation, counseling or treatment due to substance abuse.

Testing your child to determine whether there is drug/alcohol use can only be conducted under the following conditions:

1. The student voluntarily agrees to test.
2. We have your permission to test your child.

Green Brook Academy will use every precaution to protect your child's rights and keep information confidential. The required urine sample will be handled only by designated staff member(s). The identity of your child and the results of the test will be held in strictest confidence.

Test results will be discussed with you. Should the screening reveal that there is drug/alcohol use, you will be informed of the alternatives available to your child for evaluation, counseling and/or treatment. Information concerning the test results will not be released to any unauthorized agency.

If you wish to cooperate with our Substance Abuse Screening Program, please sign the Substance Abuse Screening permission form below and return it. We are earnestly trying to combat the spread of substance abuse. If you do not sign this form, we may not be able to effectively help your child. Your support in this program is truly appreciated.

If you have any questions or concerns regarding our Substance Abuse Screening Program, please contact the school at 732-469-8677.

I hereby give permission to Green Brook Academy to conduct substance abuse screening tests for my child.

I understand that a screening will only be done if there is strong suspicion or evidence of drug/alcohol use. The test results will be used as a therapeutic tool to determine the course of treatment to be followed for my child.

I further understand that every precaution will be taken to protect the rights of my child, and to keep his/her identity and results of this screening confidential.

Student's Name (Please Print):_____

Student Signature:_____**Date:**_____
(required if student is 18 years old or older)

Parent/Guardian Signature:_____**Date:**_____

Witness Signature:_____**Date:**_____

Please Note: This form is valid through the completion of student's educational placement at Green Brook Academy.

Please initial in the box next to the selection for the permissions required for each student. Please provide signatures where needed.

Permission for Activities Outside of School — Initial

I give my permission for my child to participate in class trips and other activities that are held away from the Green Brook Academy Campus. _____

I do NOT give permission for my child to participate in any activity that is off the Green Brook Academy Campus. _____

Permission for School Photography/Video/Website — Initial

I give my permission for my child to be interviewed, photographed and/ or videotaped in school related settings for use in school publications (e.g. newspaper, yearbook, website), school productions, or for use by the general news media for print or broadcast purposes. Videotapes will be used to assist in providing the most appropriate educational programming. I understand that an effort will be made to notify me prior to my student being videotaped. _____

I do NOT give permission for my child to be interviewed, photographed and/or videotaped. _____

Green Brook Academy iPad/Chromebook Agreement

Student Agreement for iPad & Chromebook Use

1. I will take good care of my iPad/Chromebook.
2. I will not leave the iPad/Chromebook unattended.
3. I will never loan out my iPad/Chromebook to other individuals.
4. I will know where my iPad/Chromebook is at all times.
5. I will keep food and beverages away from my iPad/Chromebook since they may cause damage to the device.
6. I will not disassemble any part of my iPad/Chromebook or attempt any repairs.
7. I will protect my iPad/Chromebook by keeping it in its protective case.
8. I will use my iPad/Chromebook in ways that are appropriate and are educational in nature.
9. I will not place decorations (such as stickers, markers, etc.) on the iPad/Chromebook. I will not deface the serial number.
10. I understand that my iPad/Chromebook is subject to inspection at any time without notice and remains the property of the Green Brook Academy.
11. I will follow the policies outlined in the Student Handbook.
12. **I will be responsible for all damage or loss caused by neglect or abuse.**
    a. **Note: Any iPad in need of replacement due to negligence or abuse or mistreatment will be billed to the parent/guardian in the amount of $499. Any Chromebook in need of replacement due to negligence or abuse or mistreatment will be bill to the parent/guardian in the amount of $299.**
13. I will not utilize photos, video, and/or audio recordings of any myself or any other person in an inappropriate manner.
14. I will not attempt to reset or change any passwords or restrictions placed on the iPad/Chromebook by school staff.
15. I understand that ALL iPads/Chromebooks can be tracked, if they are missing.
16. Individual school iPads/Chromebooks and accessories must be returned to the school at the end of each school day.

I agree to the stipulations set forth in the Student Agreement for iPad/Chromebook use.

Student Name (Please Print):_____**Grade:**_____

Student Signature:_____**Date:**_____

Parent/Guardian Name (Please Print):_____

Parent/Guardian Signature:_____**Date:**_____

I have read and completed the above form for the 2017-2018 school year and understand that providing permissions for my student will be for the duration of the current school year. In the event that something changes in regards for the permissions I have provided for my student, I understand that it is my responsibility to contact Green Brook Academy accordingly. In addition, I understand that privileges for my student may be restricted at any time.

_____ _____

Signature of Parent/Guardian **Date**

Please Note: This form is valid through the completion of student's educational placement at Green Brook Academy.

Please complete the following form. This form should be completed with the most current information for your student so that Green Brook Academy may communicate with relevant service providers regarding your student. Please note that this form will remain in effect for as long as the student is enrolled at Green Brook Academy. Any changes to the Consent of Release form must be provided by written notice to Green Brook Academy Administration.

Consent for Release of Information

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

I authorize Green Brook Academy to send and/or receive information regarding my child for the purpose of educational, vocational, mental health, community and/or drug treatment planning.

The following represents a list of professionals presently servicing my child. PLEASE LIST ALL THAT APPLY.

Physician _____ **Phone Number:** ( ) -

Psychiatrist _____ **Phone Number:** ( ) -

Psychologist _____ **Phone Number:** ( ) -

Counselor _____ **Phone Number:** ( ) -

Hospital Staff (Please list Hospital) _____ **Phone Number:** ( ) -

Agency Staff (Please list agency- FACT, CMO, DCP&P, etc.) _____ **Phone Number:** ( ) -

Probation Officer (Please include County) _____ **Phone Number:** ( ) -

Other (Please specify agency) _____ **Phone Number:** ( ) -

Other (Please specify agency) _____ **Phone Number:** ( ) -

I understand that this list is not exhaustive and may change during the course of my child's enrollment. I consent that Green Brook Academy Staff may add/delete professionals from this list as a means of maintaining communication with relevant service providers. I understand that this consent will remain in effect as long as my child is enrolled at Green Brook Academy. Further, I am aware that I may revoke this consent at any time by providing written notice to Green Brook Academy Administration.

Parent/Guardian Signature:_____**Date:**_____

Student Signature:_____**Date:**_____
(Required if student is 18 years old or older)

Witness Signature:_____**Date:**_____

Please Note: This form is valid through the completion of student's educational placement at Green Brook Academy.

Prescribed Medical Authorization Form

Students' Name:

Last Name	First Name	Middle Name

I hereby request the school nurse to administer medication to my child as directed by the physician's orders below. I release Green Brook Academy from any liability concerning administration of medication to my child.

Parent/Guardian Signature:_____ **Date:**_____

Medication must be in the original pharmacy labeled bottle and be delivered to the school nurse by the parent/guardian.

PHYSICIAN PERMISSION FOR ADMINISTRATION OF PRESCRIBED MEDICATION DURING SCHOOL DAY

Physicians Orders: (To be completed by Child's Physician)

Please administer the following medication(s) to above stated student as detailed below:

1. _____

Dosage: _____ Time of administration:_____
Duration of administration: (i.e.: 10 days, school year, etc.)

_____

2. _____

Dosage: _____ Time of administration:_____
Duration of administration: (i.e.: 10 days, school year, etc.)

_____

3. _____

Dosage: _____ Time of administration:_____

Duration of administration: (i.e.: 10 days, school year, etc.)

_____

Diagnosis:

_____

Possible side effects:

_____

Physician's Signature (Required): **Date:**

Physician Stamp

PLEASE NOTE:

Requests are effective for one school year only and must be renewed annually. Parent must notify the school nurse in writing when medication is no longer required. If there is a change in dosage a physician's order is required.

Self-Medication by Pupils- Asthma

P.L. 2001 Chapter 61, Authorizes Parents/Guardians to allow their children to self-medicate for Asthma

Students' Name:

Last Name	**First Name**	**Middle Name**

To: Parent/Guardians

Re: Signed Authorization for Self-Medication

I authorized my son/daughter to self-administer the necessary medication for his/her asthma condition. He/she shall be permitted to carry an inhaler. I understand the school shall not incur any liability as a result of any injury arising from the self-administration of medication. I hold harmless the school and its employees against any claims arising out of self-medication by my child.

Parent/Guardian Signature:_____ **Date:**_____

P.L. 2001 CHAPTER 61, WRITTEN CERTIFICATION FROM PHYSICIAN ALLOWING SELF-MEDICATION - ASTHMA

To: Student's Physician

Re: Self-Medication by a Pupil with Asthma

Please be advised that the student stated above has asthma and is capable of, and has been instructed in the proper use and administration of his/her medication.

The student ___ may ___ may not carry the inhaler with him/her at all times.

Please indicate severity of asthmatic condition: _____ Mild _____ Moderate _____ Severe

Physician Signature:_____ **Date:**_____

Physician Stamp: