













INTAKE PACKAGE INFORMATION

THE FOLLOWING INFORMATION IS REQUIRED PRIOR TO OR AT THE TIME OF ADMISSION:

-  consent for child's routine medical and dental care (must be signed by parents)
-  health services package (to be completed by parents)
-  consent for release of information (signed by parents)
-  authorizations

ADDITIONAL INFORMATION NEEDED AT THE TIME OF PLACEMENT:

-  Court Order
-  Social Security Number
-  Day 1 (UCR Timeline)
-  Client Identification Number (CIN)
-  Birth certificate
-  Request for Consent to Evaluate Form
-  Immunizations
-  30-Day supply of medication and a copy of the prescription and/or recent order

Mary Beth Carman, CSW
Intake Coordinator

CONSENT FOR CHILD'S ROUTINE MEDICAL AND DENTAL CARE
(By Parents or Guardian)

I, _____, hereby give my consent for medical and dental care to the child listed below while under the care of Vanderheyden Hall, Inc., or any person or agency acting as the agent of Vanderheyden Hall, Inc.

This medical care includes, but is not limited to, physical examinations, administration of medications, immunizations against communicable diseases (including Hep B, Chicken Pox), vaccinations, and any necessary tests and emergency room treatment which in the opinion of the physician, dentist or psychiatrist treating the child listed are deemed necessary or advisable and/or is prescribed by such physician, dentist or psychiatrist.

This includes the right, in the case of an emergency, to admit for hospitalization and to administer necessary treatment, including surgery whenever such treatment is deemed medically necessary.

NAME

BIRTHDATE

RELIGION

Signature _____

Address _____

Home Phone _____

Work Phone _____

Relationship _____

Witness _____

Date _____

2/99

(NAME)

(D.O.B.)

I, _____, hereby
give permission to Vanderheyden Hall, Inc. to request medical or dental information
from any of the physician's or dentists who have cared for _____
_____, in regard to the above named child, when deemed
necessary by the Health Services Staff.

Signature: _____

Relationship: _____

Date: _____











Witness: _____

Date: _____

CONSENT FOR RELEASE OF EDUCATION RECORDS

I hereby consent that Vanderheyden Hall Campus School may have access to the education records of _____.
(Student's Name)

The following records are being requested.

-  Report Cards/Transcripts
-  Birth Certificate
-  Academic achievement test results
-  Current grade level information
-  Special Education classification and placement information
-  Psychoeducational Evaluation
-  Attendance records for present year
-  Teacher reports
-  Health
-  Miscellaneous material

These records will not be released by this person or agency to other persons without my further consent.

(Date)

Signature of Parent/Guardian

REQUEST FOR CONSENT TO EVALUATE

In an effort to provide appropriate educational services to your child, the Committee on Special Education requesting permission to evaluate your child if it becomes necessary to do so. If the testing is not indicated by your child's performance, it will not be conducted. This consent in no way causes you to waive or relinquish any rights for your child, and may be revoked by you at any time in writing.

Please check the box below and sign.

_____ I hereby grant consent for my child to be evaluated by the
Committee on Special Education.

(Student Name)

(Signature of Parent/Guardian)

(Date)

I, _____, hereby grant permission for my son
(please print)

son/daughter _____ to have their photograph appear
(please print)

in public relations brochure, pamphlets, video tapes and exhibits of Vanderheyden
Hall. The identity of the child will not be disclosed, but may be identified as
a resident of Vanderheyden Hall.

SIGNED: _____

RELATIONSHIP: _____

DATE: _____

CONSENT FOR RELEASE OF INFORMATION TO VANDERHEYDEN HALL

I hereby consent that Vanderheyden Hall may have access

to _____ records, (academic,
(NAME OF CHILD)

standardized testing, attendance, psychological/psychiatric, health, immunizations)

with the understanding that such records will not be released by this person or agency
to other persons without my further consent.

Dated: _____

Signature of Parent*

*Person must be over 18 years of age to give consent for self.

Witness: _____

HEALTH PACKAGE

Introduction:

The purpose of the health services package is to enable our program to organize the health information of each child. This will help us to identify health problems and establish a plan to meet these needs. It is understood that the information requested on the forms will not always be available. However, every effort should be made so that the forms are as complete as possible.

While completing the forms please feel free to call the Health Services Office if you have any questions. We will be glad to assist you in any way we can.

VANDERHEYDEN HALL

HEALTH HISTORY

Name of Client

Date of Birth

Place of Birth

Signature of person completing form

FAMILY HEALTH HISTORY:

FAMILY MEMBERS: Please not any special relationships such as step-parent, foster child, adopted, etc. If deceased include date and cause of death.

Relationship	Age	Name	State of Health	Occupation School	Grade reached/school
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Mother

Father

Siblings:

FAMILY HEALTH HISTORY - Circle any of the following that this child or his parents, grandparents, brothers, sisters, etc. have had.

<u>CONDITION</u>	<u>RELATIONSHIP TO CHILD</u>
1. Allergy	1.
2. Asthma	2.
3. Arthritis (Rheumatoid or Osteo)	3.
4. Alcoholism	4.
5. Cancer	5.
6. Drug Addiction	6.
7. Diabetes (Sugar)	7.
8. Epilepsy (Convulsions)	8.
9. Gout	9.
10. High Blood Pressure	10.
11. Heart Disease	11.
12. Hemorrhagic Problems (Bleeding)	12.
13. Kidney Problems	13.
14. Liver Problems	14.
15. Migraine	15.
16. Mental Illness (Psychiatric problems)	16.
17. Mental Retardation	17.
18. Nervous Breakdown	18.
19. Obesity	19.
20. Rheumatic Fever	20.
21. Sickle Cell Problems	21.

Name

D.O.B.

DEVELOPMENTAL HISTORY:

I. Pregnancy History - Mother

- a. What number pregnancy was this? _____
- b. What number live birth? _____
- c. Was mother under a doctor's care during pregnancy? _____
Doctor's name _____
What month did care begin? _____
- d. Were there any complications:

- e. Did the baby arrive on time? _____
 - 1. If premature or over due - how long _____
 - 2. Birth weight _____
- f. Were there any complications with labor and delivery? _____
Explain _____

II. Infancy - did this child have any problems - rolling over, sitting up, crawling feeding, standing or walking etc.? Explain: _____

III. Toddler - did this child have any problems with speech, behavior, toileting, etc.? Explain _____

IV. Pre-School: (3-5yr.) Did this child attend pre-school? Any problems with bed wetting, soiling behavior, socialization, etc.

V. School Age (5-present): Did this child have problems with school, peers, clumsiness, behavior etc. Explain

VI. Present: Problem that brought this child into Vanderheyden Hall for placement:

Completed by _____

Date _____

Name

D.O.B.

ALLERGIES: _____

CURRENT MEDICAL PROBLEMS: _____

ILLNESSES/INJURIES/SURGERY (without being admitted to hospital) _____

HOSPITALIZATIONS: (include medical/surgical/psychiatric): _____

CHILDHOOD DISEASES: (fill in the circle)

	<u>Age</u>		<u>Age</u>
<input type="checkbox"/> German Measles (Rubella)	_____	<input type="checkbox"/> Rheumatic Fever	_____
<input type="checkbox"/> Chicken Pox	_____	<input type="checkbox"/> Hepatitis	_____
<input type="checkbox"/> Mumps	_____	<input type="checkbox"/> Mononucleosis	_____
<input type="checkbox"/> Whooping Cough	_____	<input type="checkbox"/> T.B.	_____
<input type="checkbox"/> Scarlet Fever	_____	<input type="checkbox"/> Meningitis	_____

Completed by _____

Date _____

IMMUNIZATION RECORD

Name _____

Specific Dates must be included to comply with Public Health Regulations.

Vaccine	#1	#2	#3	#4	#5	#6
D.P.T (Diphtheria-Pertussis- Tetanus)						
O.P.V. (Oral Polio Vaccine)						
MEASLES						
MUMPS						
RUBELLA (german measles)						

Completed by _____

Date _____

Name

County: _____

D.O.B

DENTAL INFORMATION:

Dentist:

Name: _____

Address: _____

Phone: _____

Please give dates for the following questions.

Has this child been seen by a dentist during the past six months? **Yes** **No**

Has this child had dental x-rays? **Yes** **No**

Has this child had Fluoride treatments? **Yes** **No**

Has all necessary dental work been completed? **Yes** **No**

Do you have dental insurance coverage? (please enclose a form)

Insurance Co. _____

ID Number _____

Completed by _____

Date _____

Name _____

MEDICAL INFORMATION:

Family Doctor - Pediatrician - Clinic:

Name: _____

Address: _____

Phone: _____

Date of Last appointment: _____

Reason for appointment: _____

Specialist: Reason for appointment (Eye-Ear-Nose-Throat-Skin, etc.)

Do you have medical/health insurance coverage?

Insurance Company _____

Employer _____

ID# _____

Group# _____ Plan: _____

Is coverage a managed care policy provided by Medicaid.

Yes ____ No ____

MEDICAID # _____

Completed by _____

Date _____

Name

D.O.B:

MEDICATION HISTORY:

Please list any medication the child is currently receiving and the reason he is receiving it. A Doctor's prescription and a one week supply of medication must be presented to Vanderheyden Hall when the child is admitted.

Below please list to the best of your recollection any medications the child has received in the past.

MEDICATION	AGE WHEN GIVEN	REASON	EFFECT OF MEDICATION

