McLean
HARVARD MEDICAL SCHOOL AFFILIATE

Pathways Academy Student Information and Consent
2020-2021

Please read and complete the enclosed materials.
Resubmit updated information throughout the school year as necessary.
Permission may be revoked in writing at any time.

Student Information

Name: _____ DOB: _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

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

Primary Language: _____ Preferred Pronoun: _____

Primary Contact

Name: _____ Relationship: _____

Home #: _____ Work #: _____

Cell #: _____ Other #: _____

Email Address: _____

Best way to reach secondary contact during the school day: _____

Secondary Contact

Name: _____ Relationship: _____

Home #: _____ Work #: _____

Cell #: _____ Other #: _____

Email Address: _____

Best way to reach secondary contact during the school day: _____

Guardianship Status

If your child is 18 years of age or older indicate legal guardianship status (please check):

☐ Acting on own behalf _____ ☐ Shared decision making _____

☐ Delegated decision making _____ ☐ Court-appointed guardian_____

Emergency Contact Information

Please provide contact information for **2 additional people,** other than parents or guardians, who do not live with the student, and who are able to promptly pick your child up from school in case of emergency.

Emergency Contact #1

Name: _____ Relationship to Child: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____

Cell #: _____ Other #: _____

Emergency Contact #2

Name: _____ Relationship to Child: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____

Cell #: _____ Other #: _____

Transportation Information

Company Name: _____

Driver's Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Work #: _____ Cell #: _____

Fax #: _____ Other #: _____

____ (Initial) I give Pathways Academy staff permission to transport my child off hospital grounds for field trips.

Student/Family Directory Permission Form

I give permission for the following information about my student to be included in a directory given to the families of current students:

Student name:	☐ Y	☐ N
Student date of birth:	☐ Y	☐ N
Student grade:	☐ Y	☐ N

Contact Information

	Permission to be listed	
Please indicate how you would like your name(s) listed:	☐ Y	☐ N
_____		
_____		
Parent/guardian phone number(s) to be listed:	☐ Y	☐ N
_____		
_____		
Parent/guardian email(s) to be listed:	☐ Y	☐ N

_____ @ _____.____

_____ @ _____.____

_____ _____

Signature of Parent/Guardian/ Student Acting on Own Behalf **Date**

Insurance Contact Information

Please provide copies of insurance cards

Primary Health Insurance

Insurance Carrier: _____

Name on Insurance Card: _____

ID #: _____

Phone # of Insurance Carrier: _____

Secondary Health Insurance

Insurance Carrier: _____

Name on Insurance Card: _____

ID #: _____

Phone # of Insurance Carrier: _____

Dental Insurance

Dental Carrier: _____

Name on Insurance Card: _____

ID #: _____

Phone # of Insurance Carrier: _____

Provider Contact Information

Physician's Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Work #: _____ Fax #: _____

Date of Last Examination: _____

_____ (Initial) I am required to provide Pathways Academy my students' most recent physical and immunization records.

Psychiatrist's (or prescriber's) Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Work #: _____ Fax #: _____

Dentist's Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Work #: _____ Fax #: _____

Date of Last Examination: _____

_____ (Initial) I am required to provide Pathways Academy my child's most recent dental records.

Other Treatment Provider (specify): _____

Street Address: _____

City: _____ State: _____ Zip: _____

Work #: _____ Fax #: _____

PLEASE SEND IN MOST RECENT PHYSICAL, IMMUNIZATION RECORDS AND DENTAL RECORDS W/ THIS FORM OR ASAP.

_____ _____

Signature of Parent/Guardian/ Student Acting on Own Behalf **Date**

Diagnoses/ Medical Concerns/ Allergies

If there are no diagnoses, medical concerns, and/or allergies, please write "None" on the appropriate line

Diagnoses

1. _____
2. _____
3. _____
4. _____

Medical Concerns

1. _____
2. _____
3. _____
4. _____

Allergies - Severe/ Life Threatening (Anaphylaxis)

1. _____
2. _____
3. _____
4. _____

Allergies - Other

1. _____
2. _____
3. _____
4. _____

Over the Counter Medication Policy

Initial all that apply

_____ (Initial) I do not give permission for my child to receive OTC medication at school.

_____ (Initial) I give permission for my child to be administered _____*Acetaminophen*___ subsequent to the assessment of the student by the School Nurse, for the relief of minor pain.

INDICATE DOSAGE _____

_____ (Initial) I give permission for my child to be administered _____*Ibuprofen*_____ subsequent to the assessment of the student by the School Nurse, for the relief of minor pain.

INDICATE DOSAGE _____

_____ (Initial) I give permission for my child to be administered _____*Antacids*_____ subsequent to the assessment of the student by the School Nurse, for the relief of indigestion.

INDICATE DOSAGE _____

_____ (Initial) I understand that I may send in sunscreen with my child to be kept in the nurses' station. Pathways Academy staff may remind my child to apply sunscreen and if needed, can supervise the application of sunscreen. Child's name must be clearly labeled on any products sent in.

_____ (Initial) I understand that I may send in insect repellent with my child to be kept in the nurses' station. Pathways Academy staff may remind my child to apply insect repellent and if needed, can supervise the application of insect repellent. Child's name must be clearly labeled on any products sent in.

Emergency Medical Treatment

Pathways Academy staff members and McLean Hospital Security are trained in First Aid and CPR.

In the event of an emergency, Pathways Academy staff and/or McLean Hospital Security will administer First Aid and/or CPR to a Pathways Academy student if needed. Pathways Academy and/or McLean Hospital Security may also contact emergency responders as deemed appropriate by Pathways/McLean staff and may release information to appropriate medical staff regarding the student as deemed necessary by Pathways/McLean staff.

_____ _____

Signature of Parent/Guardian/ Student Acting on Own Behalf **Date**

School Administered Medication Information

Initial all that apply

_____ (Initial) I understand that these medications will not be administered without a completed Medication Order Form from a Licensed Prescriber. I further understand a separate medication order must be completed & signed by prescriber for each medication and that the medication order must be renewed each academic year. The prescriber must complete and sign a new medication order for changes in medication (change in dose, etc.).

_____ (Initial) I understand the school nurse must follow prescriber's orders for school administered medication (not parental directives).

_____ (Initial) I understand that I may retrieve the medicine from the School at any time and that the medicine will be destroyed if it is not picked up within one week following termination of the order or the termination of placement at Pathways Academy

_____ (Initial) I understand all medication must be delivered to the school in a pharmacy or manufacturer- labeled container.

_____ (Initial) I understand that Pathways Academy is permitted to maintain, at most, a 30-day supply of any medication.

_____ (Initial) I understand the school nurse cannot dispense medications from a container with an expired expiration date on the label

_____ (Initial) I give permission for my child to self-administer medication if the school nurse deems appropriate.

_____ (Initial) I understand that any OTC medication, other than Ibuprofen and Acetaminophen, will not be administered without a completed Medication Order Form from a Licensed Prescriber

_____ (Initial) I give permission for the school nurse (or personnel designated by the school nurse) to administer the following prescription medications to my son/daughter while at school:

Name of medication	dosage	time	side effects
Name of medication	dosage	time	side effects
Name of medication	dosage	time	side effects
Name of medication	dosage	time	side effects
Name of medication	dosage	time	side effects

Medication updates / changes will be shared with the staff at Pathways Academy unless requested in writing to the school nurse not to do so.

_____ _____

Signature of Parent/Guardian/ Student Acting on Own Behalf **Date**

Medications Administered at Home

Name of medication	Indication	Dosage	Time
Name of medication	Indication	Dosage	Time
Name of medication	Indication	Dosage	Time
Name of medication	Indication	Dosage	Time
Name of medication	Indication	Dosage	Time
Name of medication	Indication	Dosage	Time
Name of medication	Indication	Dosage	Time
Name of medication	Indication	Dosage	Time
Name of medication	Indication	Dosage	Time
Name of medication	Indication	Dosage	Time
Name of medication	Indication	Dosage	Time
Name of medication	Indication	Dosage	Time

Medication updates/changes will be shared with the staff at Pathways Academy unless requested in writing to the school nurse not to do so.

_____ (Initial) I understand that it is my responsibility to call the school nurse (617.855.2960) when a medication is added, discontinued, or a dosage is changed.

Signature of Parent/Guardian/ Student Acting on Own Behalf **Date**

Sick Policies and Procedures

Pathways Academy requires that students be kept home/sent home from school for the following, but not limited to, illnesses/symptoms:

a. A cold in the contagious stage (first few days).
b. Sore throat and swollen neck glands accompanied by fever of 100 degrees F or higher.
c. Undiagnosed rash or skin eruptions.
d. Earache, red eyes or drainage from eyes.
e. Fever of 100 degrees F or higher in the past 24 hours. A student must have a temperature below 100 degrees F a full 24 hours without taking a fever reducing medicine before re-entry into school.
f. Vomiting or diarrhea within the past 24 hours. A student must be kept home a full 24 hours post last episode of vomiting or diarrhea before re-entry into school. If a student has an allergy or a condition which regularly causes stool to be characteristic of diarrhea in its consistency, please alert School Nursing.
g. Any communicable diseases. Examples include, but are not limited to: chicken pox, strep throat, scarlet fever, conjunctivitis, ear infection, or fifth disease. Please notify School Nursing in the event of such illness.

In some cases of contagious illness, such as conjunctivitis and strep throat, a child may re-enter school once temperature is below 100 degrees F without fever reducing medicine, per comfort/stamina level and after a full 24 hours of antibiotic therapy has been initiated. This list is a guideline and is not all-inclusive. Pathways Academy School Nursing reserves the right to dismiss students, in nursing professional opinion, that are contagious or too ill to be in school.

_____ (Initial) I have read and understand the above information regarding Sick Policies and Procedures

_____ _____

Signature of Parent/Guardian/ Student Acting on Own Behalf **Date**

Privacy and Confidentiality

Pathways Academy is dedicated to preserving the confidentiality and privacy of all our students. In general, all communication between a student and a clinical staff member are considered confidential and protected by law. There are some exceptions and Pathways Academy is required by Massachusetts law to inform you of the limits on confidentiality. There are a number of rare circumstances in which Pathways Academy cannot maintain confidentiality: These situations rarely arise, but if they do, it is Pathways Academy's policy to discuss these matters with a student's family, head of the school, and/or hospital personnel and legal counsel before taking any action. In all other circumstances, student information will only be shared upon express written consent of the student and/or parent.

h. If a student presents a clear danger to him or herself and refuses to accept appropriate treatment, information is released to protect the student.
i. If a student communicates an actual threat of physical violence to an identifiable victim, information is released to protect the potential victim.
j. If a judge orders Pathways Academy to disclose information or orders a school staff member to testify, information relevant to the legal issue would be provided.
k. If services are being covered by a third-party payor, Pathways Academy may be requested to provide information. Insurance companies claim to keep this information confidential. If you, the parent, request it, we will provide you with any information which we submit to an insurer on your behalf.
l. If a staff member has reasonable cause to believe that a minor child is being abused or neglected, there is a legal mandate to report said abuse to Department of Children and Families.

_____ (Initial) I have read and understand the above information regarding the limits of confidentiality.

Restraint Policy

Pathways Academy staff members and McLean Hospital Security are trained in the Crisis Prevention Institute (CPI) method of crisis intervention and restraint. Pathways Academy will use a CPI taught physical restraint after appropriate verbal interventions and in the event of the following:

a. A student is deemed to be in imminent danger of hurting oneself.
b. A student is deemed to be in imminent danger of hurting someone else.

In the event that the additional clinical care becomes necessary Pathways Academy may transport students the McLean Hospital Clinical Evaluation Center (CEC) for further evaluation.

Pathways Academy invites parents, guardians and students to meet with administration regarding the use of restraints and alternatives to restraints.

_____ (Initial) I have read and understand the above information regarding Pathways Academy restraint policy.

Signature of Parent/Guardian/ Student Acting on Own Behalf **Date**

Sex Education Consent

Initial and check one

_____ (Initial) ☐Yes, I do ☐No, I do not give _____ (student's name) permission to participate in curriculum that involves human sexual education or human sexuality issues as part of the Massachusetts Department of Elementary and Secondary Education (DESE) Health Curriculum.

Media

Initial all that apply

_____ (Initial) I give consent to allow my child's name and photograph to be used in the yearbook.

_____ (Initial) I give consent to allow my child to be photographed during the Pathways Academy program.

_____ (Initial) I give consent to allow my child to be video recorded during the Pathways Academy program.

_____ (Initial) I give consent to allow my child to be audio recorded during the Pathways Academy program

_____ (Initial) I hereby give my consent to Pathways Academy, McLean Hospital, the McLean Hospital Public Affairs Office and the McLean Hospital Webmaster to use my child's photograph, name and/or personal information on the McLean Hospital website. This authorization is granted indefinitely, for the duration of the website, and may be rescinded at any time.

Library Card Policy

_____ (Initial) I understand that I am solely responsible for anything taken out on my child's library card.

Annual Notice on Policy and Procedure Manual

_____ (Initial) I understand that Pathways Academy Policy and Procedure Manuals are available in the main office of Pathways Academy

Annual Notice on Bullying Prevention and Intervention

Pathways Academy faculty and staff are trained annually through the MARC (Massachusetts Aggression Reduction Center). Pathways Academy students learn about bullying prevention and intervention in their Social Pragmatics classes and receive ongoing guidance and social skills training on a daily basis. If you have any questions, concerns, or want to report potential bullying behavior, please contact school administrators at 617.855.2847. Policy and forms can be found on our website: www.mcleanhospital.org/treatment/pathways-academy#forms

_____ _____

Signature of Parent/Guardian/ Student Acting on Own Behalf **Date**

Fitness and Recreation Waiver Use Agreement

The McLean Hospital Fitness and Recreation Center and off-site equivalents ("Fitness Center") are available as a recreational experience for its patients, employees, and on-site school students registered at McLean for inpatient, partial-hospital or residential care. Please read and acknowledge the following before using the Fitness Center.

I certify that I have informed the Fitness Center staff about any medical or physical condition of which I am aware or that my health care provider has told me should limit my use of the Fitness Center. Upon the request of the Fitness Center staff, I will obtain the written approval of my physician for my use of the Fitness Center, including any limits that my physician feels appropriate. I agree that I will use the Fitness Center only to the extent advised or authorized by my physician.

I understand that my use of the Fitness Center, including any of its equipment or facilities, may place me at risk for serious illness or injuries. I agree to take all reasonable steps to minimize my risk of such illness or injuries, and I understand the Fitness Center staff is available for consultation to help me minimize my risks during my use of the Fitness Center.

In the event that I need emergency medical care, my healthcare plan or I am financially responsible for any necessary emergency services.

I agree that the Fitness Center cannot be responsible for personal property left in the Fitness Center or surrounding areas and that McLean Hospital may dispose of unclaimed property left in the Fitness Center for more than 30 days.

I, for myself, my legal representatives, next-of-kin, heirs and assigns, hereby indemnify and hold harmless McLean Hospital, its directors, officers, employees, or agents, from any and all claims, loss, damages, liability, costs, expenses (including reasonable attorneys' fees), judgments, or obligations whatsoever, for or in connection with illness, injury or damage to any person or property arising out of or related to my use of the Fitness Center, except to the extent that such claims, loss, damages, liability, costs, expenses, judgments, or obligations are attributable to the gross negligence or willful misconduct of McLean Hospital, its directors, officers, employees, or agents.

I agree to comply with all applicable rules, policies, and procedures of McLean Hospital and the Fitness Center, including those pertaining to safety, and understand that my failure to comply with such rules, policies, and procedures may result in limitation on and/or ineligibility of use of the Fitness Center. I agree to use the Fitness Center only when a Fitness Center staff member is present. I understand that classes, schedules, staff and hours of operation are subject to change at any time. I will not at any time invite any person to use the Fitness Center as my guest or for any other reason. I will take reasonable steps requested by the Fitness Center to keep clean the equipment I use and to help ensure the general cleanliness of the Fitness Center.

I HAVE READ AND UNDERSTOOD THE FOREGOING, AND HAVE ASKED THE FITNESS CENTER STAFF ANY QUESTIONS THAT I HAVE ABOUT THIS FORM OR MY USE OF THE FITNESS CENTER.

Print Client Name: _____ D.O.B: _____

Signature: _____
(If under the age of 18 years, signature must be by parent/legal guardian)

Date: _____ McLean Program: Pathways Academy

Emergency Contact: _____ Phone Number: _____