



## Minnick Schools

Main Office: 2609 McVitty Rd., Roanoke, VA 24018 • Phone (540) 774 – 7100 • Fax (540) 774 – 1084

Bristol: 150 Janie Hammitt Drive, Bristol, VA 24201 • Phone (276) 494 - 0539 • Fax (276) 494 - 0538

Harrisonburg: 1661 Virginia Ave., Harrisonburg, VA 22802 • (540) 437 – 1814 • Fax (540) 615-5412

Roanoke: 775 Dent Rd., Roanoke, VA 24019 • Phone (540) 265 – 4281 • Fax (540) 265 – 4287

Roanoke Vocational: 6405 Merriman Road, Roanoke, VA 24018 • Phone (540) 206-3270, ext. 3401 • Fax (540) 265 – 4287

Wise: P.O. Box 828, 515 Hurricane Rd., Building N, Wise, VA 24293 • Phone (276) 328 – 7181 • Fax (276) 328 – 9362

Wise Adapted Program: 6408 Glamorgan Chapel Road, Wise VA 24293 • Phone (276) 321 – 7768

Wytheville: 425 Grayson Rd., Building 6, Wytheville, VA 24308 • Phone (276) 228 – 8088 • Fax (276) 228 – 9087

---

Dear Colleague,

Thank you for your interest in Minnick Schools. To complete the application process, please provide the following information:

- Completed Minnick Application Packet
- Signed FAPT release listing Minnick Schools
- Most recent eligibility components to include minutes
- Current IEP
- CANS Assessment (Child and Adolescent Needs and Strengths)
- Immunization Record
- Functional Behavioral Assessment, Behavior Intervention Plan, or other behavioral documentation
- Most recent physical
- SOL score records
- Other standardized testing records
- Transcript and/or grade reports
- Most recent report card (please include grade summary if student is admitted mid-grading period)
- Transcript analysis signed by guidance counselor indicating courses taken and coursework needed to graduate (including verified credit analysis)

**\*Please note that we cannot enroll a student until all components have been submitted.**

Please coordinate times for the parents/guardians to visit the school and meet with the staff during the admissions procedure. We require that the student also attend the visit. If it is not appropriate for the student to attend the initial visit, we will schedule a visit for the student prior to the enrollment date.

Please contact me if you have any questions or require clarification.

Sincerely yours,

Terri Lockhart Webber  
Director of Education



---

**PUBLIC SCHOOL REFERRAL TO MINNICK SCHOOLS**

Minnick School Location: \_\_\_\_\_

Date of Referral: \_\_\_\_\_

Student's Full Name: \_\_\_\_\_

Race/Ethnicity: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Birth Place: \_\_\_\_\_

Referring School System: \_\_\_\_\_

Director of Special Education: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone Number: \_\_\_\_\_

Mother/Legal Guardian: \_\_\_\_\_ Occupation/Employer: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

Father/Legal Guardian: \_\_\_\_\_ Occupation/Employer: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_



**PUBLIC SCHOOL REFERRAL TO MINNICK SCHOOLS**

School Student Currently Attending: \_\_\_\_\_

State Testing Identifier: \_\_\_\_\_

Primary Disability: \_\_\_\_\_

Current Grade Level (as of referral date): \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**School Contact Person(s)**

(Please list case manager and any other school personnel that will need to receive student updates. Include title, address, phone and other contact information for each.)

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_



**MINNICK SCHOOLS  
CONSENT TO EXCHANGE INFORMATION**

*I understand that different agencies provide different services and benefits. Each agency must have specific information in order to provide services and benefits. By signing this form, I am allowing agencies to exchange certain information so it will be easier for them to work together effectively to provide or coordinate these services or benefits.*

I, \_\_\_\_\_ am signing this form for

(Full Printed Name of Consenting Person(s))

\_\_\_\_\_  
(Full Printed Name of Student) (Street Address of Student)

\_\_\_\_\_  
(City, State, Zip) (Student's Date of Birth)

Phone: (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ (Work) \_\_\_\_\_

My Relationship to the student is \_\_\_\_\_ Self \_\_\_\_\_ Parent \_\_\_\_\_ Guardian

I want the following confidential information about the student (*except drug or alcohol abuse diagnoses or treatment information*) to be exchanged.

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Medical Records         | <input type="checkbox"/> Psychological Records | <input type="checkbox"/> Assessment Information |
| <input type="checkbox"/> Medical Diagnosis       | <input type="checkbox"/> Educational Records   | <input type="checkbox"/> Discharge Summaries    |
| <input type="checkbox"/> Mental Health Diagnosis | <input type="checkbox"/> Psychiatric Records   | <input type="checkbox"/> Other (specify) _____  |

I want the following: Minnick Schools Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
and the following agencies to be able to exchange this information:

- |   |  |
|---|--|
| <input type="checkbox"/> Social Services _____      | <input type="checkbox"/> Department of Rehabilitative Services _____ |
| <input type="checkbox"/> Health Department _____    | <input type="checkbox"/> LEA _____                                   |
| <input type="checkbox"/> Physician _____            | <input type="checkbox"/> Court Service Unit _____                    |
| <input type="checkbox"/> Residential Facility _____ | <input type="checkbox"/> Family Education Services _____             |
| <input type="checkbox"/> Psychiatrist _____         | <input type="checkbox"/> Foster Care Agency _____                    |
| <input type="checkbox"/> Detention Facility _____   | <input type="checkbox"/> FAPT _____                                  |
| <input type="checkbox"/> Other _____                |  |

his consent is good until: \_\_\_\_\_ I can withdraw this consent at any time by telling the referring agency. This will stop the listed agencies from sharing information after they know my consent has been withdrawn. I have the right to know what information about me has been shared, and why, when, and with whom it was shared. If I ask, each agency will show me this information. I want all the agencies to accept a copy of this form as a valid consent to share information.

*If I do not sign this form, information will not be shared and I will have to contact each agency individually to provide the information that they need.*

Signature(s) \_\_\_\_\_ Date: \_\_\_\_\_

(Consenting Person or Persons)

Person Explaining Form: \_\_\_\_\_

(Name) (Title) (Phone Number)



## **Permission for Promotional Materials**

The purpose of this form is to make sure that your personal information is shared with your understanding and consent. Please review the following statements before signing this form so you have full knowledge. When this form is fully and properly filled out, it protects your right to privacy and makes sure that we have your consent to share your information.

### **What does “information” mean?**

EnCircle will often ask people who receive our services if they would be willing to share their story so that others may be inspired and in-formed about what we do. This information may be your photo, a video containing your image and voice, or a combination and be used on social media (Facebook, Twitter, Instagram, LinkedIn), a blog post on our website, a feature story, or in a video.

### **How will it be used?**

Published uses could include annual reports, print newsletters, brochures, advertisement, fact sheet, and signs.

### **What if I change my mind?**

If you decide that you do not want us to use your information, please let us know in writing. As soon as we receive your request, we will stop using your information. Please understand that in some cases published material that has already been distributed cannot be retrieved. However, we will immediately stop disseminating your information outside of existing contracts.

# Information Permission for Promotional Materials



The undersigned person is (check one):

a consumer of enCircle services                       a foster parent or family care provider  
 other affiliation, please describe: \_\_\_\_\_

Participant full legal name: \_\_\_\_\_

Participant Date of Birth: \_\_\_\_\_

Legal Guardian or Authorized Representative name and relationship, if applicable: \_\_\_\_\_  
\_\_\_\_\_

I authorize enCircle to use the following personal information (check all that apply):

Photograph                       Film/Video                       Voice/sound recording

Name, please list name as it should appear: \_\_\_\_\_

*(note: for consumers of enCircle services full names will not be used)*

Other: \_\_\_\_\_

The information being utilized is being taken from the following date/dates: \_\_\_\_\_ and was gathered in the following context/event/activity \_\_\_\_\_.

I authorize enCircle to use the above information in communication materials in the following format/platforms:

Brochures or written publications                       Facebook                       Yammer  
 Commercials or video productions                       LinkedIn                       Instagram  
 Audio advertisements or sound bites                       enCircle website                       Twitter  
 Billboard or other photo displays                       Other: \_\_\_\_\_

This authorization expires on the following date: \_\_\_\_\_ (not to exceed one year.) Note: Images may still be used to create future projects and current items may still be in circulation following the date unless consent is revoked.

\_\_\_\_\_  
Signature of Participant                      Date                      Signature of Witness                      Date

\_\_\_\_\_  
Signature of Legal Guardian/  
Authorized Representative                      Date                      Signature of Witness of Guardian/  
Authorized Representative                      Date

The guardian represents and warrants to enCircle that s/he has full power and authority to sign this document and give consent to the use of the designated information and supporting paper-work of the designation is in the file of the person served.

**MEDICAL ORDERS FOR SPECIAL HEALTHCARE NEEDS**

**Student Name:** \_\_\_\_\_

**Grade:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Effective Date:** \_\_\_\_\_ (plan in effect for one academic year – may extend through ESY)

Form to be completed by diagnosing/treating physician as needed. Parent/guardian must provide all necessary medical supplies to the school.

<b>HEALTH STATUS</b>
<b>Diagnosis and description of medical concern:</b>          <b>List relevant medical history (surgery, hospitalizations, allergies, etc.):</b>          
<b>ACTIVITY</b>
<b>Are there health related absences expected?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>Comment:</b>          <b>Level of participation in PE and/or recess:</b> <input type="checkbox"/> Full <input type="checkbox"/> Restricted <input type="checkbox"/> Partial  <b>Comment:</b>          
<b>EMERGENCY PLAN</b>
<b>Are there any emergency medical interventions needed?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  <b>Comment:</b>          

**PROCEDURES**

**Are procedures required for this student to attend school?**  Yes  No

**Does the student require assistance from additional staff?**  Yes  No

PRN Unskilled (non-licensed)  PRN Skilled (RN or LPN)

Full-time  Part-time

**Describe medical procedures that are required for this student to attend school** (equipment, time intervals, positioning, etc.):

**MEDICATIONS**

**Please list relevant medications** (dosage, time given, how given, and if it will be administered at home or at school):

**AUTHORIZATION OF MEDICAL PROVIDER**

**M.D. Print Name:**

**Phone:**

**M.D. Signature:**

**Date:**

**PARENT/GUARDIAN CONSENT**

I agree with this plan of care and I give permission for the school to contact the above provider.

**Parent/Guardian Print Name:**

**Phone:**

**Parent/Guardian Signature:**

**Date:**





**ACADEMIC YEAR 2022 - 2023**

---

**HEALTH INFORMATION ACKNOWLEDGEMENT FORM**

**STUDENT NAME:** \_\_\_\_\_

**PLEASE CHECK THE BOXES AND SIGN AT THE BOTTOM OF THE FORM INDICATING THAT YOU UNDERSTAND EACH OF THE FOLLOWING:**

The information provided on the Health Information Sheet is correct to the best of my knowledge.

I give permission for the school to contact my child's physician when necessary.

**Yes**     **No**

All medication (over-the-counter and prescribed) must be provided by the parent and must have written permission before any medication may be administered.

Keep your child home if he/she has any of the following symptoms:

A) a temperature greater than 100°

B) vomiting

C) diarrhea

D) rash with fever

E) appears severely ill

Please call the school if your child is sick.

Update the school of any changes to your child's medications.

Keep school immunization records up-to-date. If your child receives immunizations after initial enrollment in the school, please give a copy to the school.

---

**SIGNATURE OF PARENT/GUARDIAN**

**DATE**



ACADEMIC YEAR 2022 - 2023

HEALTH INFORMATION FORM

Dear Parent: Please provide a current health history so we can help your child benefit from his/her school experience.

Student Name: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Physician's Phone #: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_

Medicaid:  Yes  No Medicaid # \_\_\_\_\_

Other Insurance:  Yes  No Policy # \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Phone Number: \_\_\_\_\_

(Please continue on next page)

PAST AND PRESENT HISTORY – STUDENT HEALTH PROBLEMS (please check and explain below)

- ADD/ADHD, Allergies, Food Allergies, Bee sting allergies, Arthritis, Asthma, Bleeding disorder/hemophilia, Blood pressure disorder, Cancer, Catheterization, Cerebral palsy, Cochlear implant, Other: (please describe), Colostomy, Cystic Fibrosis, Diabetes, Ear problem/hearing, Eating disorder, Eczema, Emotional disorders, Feeding tube/ G tube, Headaches, Heart Condition, Hyperventilates, Menstrual Disorders, Migraine Headaches, Muscular Dystrophy, Orthopedic disorders, Scoliosis, Seizures, Sickle-cell anemia, Spina bifida, Stomach spasms/ulcers, Thyroid condition, Tracheostomy, Vision, Neurological disorders

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

HEALTH PROBLEMS: Please explain any problems checked above.

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

**ALLERGIES:** List known allergies to food, environment, medication, or other. Describe reaction and treatment.  
**\*If student has allergies, please provide medical documentation so an appropriate health care plan can be written for your student.**

---



---



---



---



---

**MEDICATIONS:** All medication that needs to be administered during the school day must be provided to the designated medication management personnel by the parent/guardian. Written parent permission and/or doctor's order is required before medication will be administered at school. See the Minnick handbook for further information.

Is your child currently taking any medications (prescription and over-the-counter) at home or at school?

Yes If yes, please describe below.  No

Name of Drug	Dosage	How Often	School or Home

**\*Please inform the school of any changes to your child's medications.**

---

**SIGNATURE OF PARENT/GUARDIAN**

**DATE**



**ACADEMIC YEAR 2022 - 2023**

---

**AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT**

I, \_\_\_\_\_, hereby give any paid staff and/or designated volunteer of Minnick Schools bearing this notification, full permission to seek the services and carry out the recommendations of medical and/or dental and/or psychological/psychiatric professionals to provide on-going medical, dental, psychiatric needs pertaining to my child, \_\_\_\_\_.

It is understood that in the case of a crisis or emergency situation when immediate care is necessary, the parent/guardian of the above-name youth will be notified immediately. However, in the event all efforts to contact the parent/guardian have proven unsuccessful, I further authorize Minnick Schools to seek immediate medical, dental, mental health care. I understand this care will not include any surgical procedure or any experimental procedure without written informed consent.

---

Signature of Mother/Guardian

Date

---

Signature of Father/Guardian

Date



ACADEMIC YEAR 2022 - 2023

---

**Application**

**CONFIDENTIAL – FOR PROFESSIONAL USE ONLY**

Student Name: \_\_\_\_\_ Current Grade Level: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Sex: Male  Female

Address: \_\_\_\_\_

**Mother or Guardian**

Name: \_\_\_\_\_

Address:( If different from that student): \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Secondary Phone : \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

**Father or Guardian**

Name: \_\_\_\_\_

Address:( If different from that student): \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Secondary Phone : \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

**Child is in custody of:**  Both  Mother  Father  Other (please list) \_\_\_\_\_

**Does this student have a Medicaid Waiver?**  YES  NO

Person to call in case of emergency if parent/guardian is not available: **(Must be able to pick child up from school)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

*For Office Use:*

Date Enrolled: \_\_\_\_\_ Processed by: \_\_\_\_\_



ACADEMIC YEAR 2022 – 2023

Student Data

CONFIDENTIAL – FOR PROFESSIONAL USE ONLY

Date: \_\_\_\_\_

Student Name: \_\_\_\_\_ Current Grade Level: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Sex: Male  Female  Social Security No: \_\_\_\_\_

Address: \_\_\_\_\_

Parent or Guardian:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Email address: \_\_\_\_\_

Parent or Guardian:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Email address: \_\_\_\_\_

Child is in custody of:  Both  Mother  Father  Other (please list) \_\_\_\_\_

Person to call in case of emergency if parent/guardian is not available:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_



**ACADEMIC YEAR 2022 - 2023**

---

**Permission to Transport**

My child has permission to be transported by MINNICK SCHOOL vehicles and/or staff personal vehicles. I understand off campus activities may include educational or recreation field trips as well as earned special activities. I further understand my child may be transported home or to an agreed upon supervised destination because of illness, injury, or serious disciplinary action.

---

Parent Signature

Date



**ACADEMIC YEAR 2022 - 2023**

---

**PARENTAL CONSENT FORM FOR THE ADMINISTRATION OF ACETAMINOPHEN**

To Minnick School Staff:

I, \_\_\_\_\_, parent/guardian of \_\_\_\_\_, a student at Minnick, hereby (please check one)

**Give Permission**

**Do Not Give Permission**

to the staff of Minnick Schools to administer Acetaminophen (Tylenol) to my child, according to the dosage and frequency recommended by the manufacturer of this non-prescription medication. I further understand that I will be notified of the administration of the non-prescription medication via telephone and documentation on my child's daily behavior sheet.

---

Signature of Parent/Guardian

Date





**ACADEMIC YEAR 2022- 2023**

---

**STATEMENT OF STUDENT RIGHTS**

Having been enrolled at Minnick Schools, I, \_\_\_\_\_,

parent of \_\_\_\_\_ verify that:

- A. I have read or have read to me the Parent/Student Handbook.
- B. I have had an opportunity to ask questions regarding the Parent/Student Handbook and these questions have been answered to my satisfaction.
- C. I understand my rights as a parent/student at Minnick Schools.
- D. I understand staff will maintain confidentiality unless information conveys the potential for self-harm, harm to others, or any type of physical, sexual, or emotional abuse.
- E. I understand the staffs of Minnick Schools have a legal obligation to report all incidents of physical, sexual, or emotional abuse to the proper authorities.
- F. I agree to support the behavior management procedures at Minnick by being an active participant in on-going communications with Minnick via school notes, daily behavior reports, parent/teacher conferences, annual and triennial reviews, and by supporting the consistency of my child’s program while he/she is at home.
- G. I accept responsibility for the financial obligations incurred by my child through his/her vandalism or excessive destruction of school property. I understand these charges will be billed separately and are not part of the regular financial terms.
- H. I understand that regardless of the reason for the absences, Minnick staff will report absences to the home school and/or the LEA’s Director of Special Education. I understand that if my child is absent from school 15 days in a row, he/she will be discharged from the program on the 16<sup>th</sup> day.

By initialing the following statements, I give my permission for:

Yes \_\_\_\_\_ No \_\_\_\_\_ My child to be transported in Minnick School vehicles.

Yes \_\_\_\_\_ No \_\_\_\_\_ My child to be photographed for educational purposes.

Yes \_\_\_\_\_ No \_\_\_\_\_ My child to participate in the behavior management system as described in the Parent/Student Handbook – including the use of Safety-Care and/or time-out.

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent

\_\_\_\_\_  
Date



ACADEMIC YEAR 2022 - 2023

---

**PARENT/PHYSICIAN CONSENT FORM FOR THE ADMINISTRATION OF MEDICATION**

**POLICY STATEMENT:** No youth is permitted to have in his/her possession either prescription or non-prescription medication. Non-prescription medication will not be administered without written permission from a physician. When a youth must take medication, whenever possible, it should be administered before or after school hours. However, when it is necessary for a youth to take prescription or non-prescription medication during school hours, it is to be given to and administered by staff if the following procedures are followed: (If a youth is taking more than one medication, additional forms must be completed for each medication.)

I, \_\_\_\_\_, parent/guardian of \_\_\_\_\_ do hereby request that Minnick School personnel administer the following medication to my child:

Medication Name: \_\_\_\_\_

Description of Medication (color, capsule, tablet, or liquid, dosage): \_\_\_\_\_

Time to be given: \_\_\_\_\_ Amount to be given: \_\_\_\_\_

Date to be given: (beginning) \_\_\_\_\_ (ending) \_\_\_\_\_

Reason for giving medication: \_\_\_\_\_

Physician who prescribed medication: \_\_\_\_\_

**Please note: Prescribed medication must be in the pharmacy issued container with the name of the prescription, the dosage, and the means of administration, etc. printed clearly on the label. Non-prescription medications must be in the original package or bottle with direction clearly indicated. Please do not send medications in any other type of container.**

Additional comments or instructions: \_\_\_\_\_

**Signature of Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physician's Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_

*Please return completed form to:*

- \_\_\_\_\_ Bristol Minnick: 150 Janie Hammitt Drive, Bristol, VA 24201 • Phone (276) 494 - 0539 • Fax (276) 494 - 0538
  - \_\_\_\_\_ Harrisonburg Minnick: 1661 Virginia Ave., Harrisonburg, VA 22802 • (540) 437 - 1814 • Fax (540) 615-5412
  - \_\_\_\_\_ Roanoke Minnick: 775 Dent Rd., Roanoke, VA 24019 • Phone (540) 265 - 4281 • Fax (540) 265 - 4287
  - \_\_\_\_\_ Roanoke Vocational: 6405 Merriman Road, Roanoke, VA 24018 • Phone (540) 206-3270, ext. 3401 • Fax (540) 265 - 4287
  - \_\_\_\_\_ Wise Minnick: P.O. Box 828, 515 Hurricane Rd., Building N, Wise, VA 24293 • Phone (276) 328 - 7181 • Fax (276) 328 - 9362
  - \_\_\_\_\_ Wise Adapted Program: 6408 Glamorgan Chapel Road, Wise VA 24293 • Phone (276) 321 - 7768
  - \_\_\_\_\_ Wytheville Minnick: 425 Grayson Rd., Building 6, Wytheville, VA 24308 • Phone (276) 228 - 8088 • Fax (276) 228 - 9087
-



**ACADEMIC YEAR 2022 - 2023**

---

**STUDENT INFORMATION AND PERMISSION FOR COUNSELING**

Date: \_\_\_\_\_

Student's Name: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

Presenting Behaviors (please check all that apply):

- Threatened to run away
- Past runaway - # of times \_\_\_\_\_
- Skipping school
- Threatened suicide
- Attempted suicide
- Currently suicidal
- Family conflicts
- Substance abuse
- Anger problems
- Depressed mood
- Grief or loss
- Lying
- Negative attitude
- Anxiety
- Sexual Abuse
- Physical abuse
- Family Substance Abuse
- Exposed to traumatic event - Specify: \_\_\_\_\_

**ADDITIONAL INFORMATION/CONCERNS:**

I, \_\_\_\_\_, parent/guardian of \_\_\_\_\_, give my permission for my child to participate in counseling services at school. I understand that the information shared in individual and group counseling will remain confidential. As mandated reporters, Minnick Schools is required to report any information which indicates abuse or neglect of a child and any information regarding suicidal or homicidal behaviors to the appropriate person or agency. I understand that I can contact the counseling department at any time regarding the services provided to my child or to request additional services. I understand I may withdraw this consent to participate in individual or group counseling at any time.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

**Minnick Schools Technology Access Survey**  
**2022 - 2023 School Year (August 1, 2022, to July 31, 2023)**

Student(s) First name \_\_\_\_\_ Last (Family) Name \_\_\_\_\_

<p>What type of technology do you have available for your child to use for schoolwork at home? (Check all that apply)</p>	<input type="checkbox"/> Desktop PC <input type="checkbox"/> Laptop PC <input type="checkbox"/> iPad <input type="checkbox"/> Android Tablet <input type="checkbox"/> Kindle or Nook <input type="checkbox"/> Chromebook <input type="checkbox"/> Smart Phone <input type="checkbox"/> None <input type="checkbox"/> Other (please specify)
<p>Would you allow your child to use a device that the school issued for schoolwork at home?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>How many devices are being used in the household?</p>	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5+
<p>What type of Internet do you have at home?</p>	<input type="checkbox"/> Broadband (via cable vendor hotspot) <input type="checkbox"/> DSL (through phone company) <input type="checkbox"/> Dial-Up (must connect via phone dial) <input type="checkbox"/> Satellite (via a satellite dish) <input type="checkbox"/> Cellular service <input type="checkbox"/> I do not know <input type="checkbox"/> We do not have internet access <input type="checkbox"/> We do not want internet access
<p>What is the connection speed of the internet at your home?</p>	<input type="checkbox"/> No Internet  <input type="checkbox"/> Slow (0–5 Mbps): Stream music, email, and basic web browsing.  <input type="checkbox"/> Moderate (5–40 Mbps): Skype and Facetime calls, play online video games (single player), stream video from Netflix on a single device.  <input type="checkbox"/> Fast (40 – 100 Mbps): Stream video from Netflix or YouTube on multiple devices, download large files.  <input type="checkbox"/> Lightning speeds (100-500Mbps): Download large files quickly, enjoy 4K Netflix on multiple devices
<p>If you do not have Internet access at home, do you have an alternate method for accessing the internet?</p>	<input type="checkbox"/> No, we cannot access the internet <input type="checkbox"/> Yes. Access at a local restaurant or business <input type="checkbox"/> Yes. Access at the local library <input type="checkbox"/> Yes. Access at a friend’s or family member’s house.

# Educational Technology Policy

Minnick Schools, A division of enCircle

## I. Purpose

enCircle recognizes that access to and use of technology has become a powerful tool for promoting educational excellence. Minnick Schools encourages the responsible use of computers, computer networks, the internet, and other electronic resources in support of the mission and goals of enCircle. While these tools have become vital to communication and information access not all material is suited for the K-12 environment. The division expects that Administration and Instructional Staff will blend thoughtful use of the school's telecommunication systems and the Internet throughout the curriculum and will provide guidance and instruction to students on their safe and appropriate use.

## II. Unacceptable Uses.

- A. The use of enCircle Network resources is provided to Minnick Schools solely for educational purposes. Any use not directly related to education or school business is considered an unacceptable use unless directly addressed in this policy.
- B. Unacceptable Activities
  1. Violation of any local, state, or federal law.
  2. Sharing of personal network login information or passwords or allowing others to use your login or password or to log in and let your computer be used by others;
  3. Posting or sending personally identifiable information about another person without current signed release of information (including, but not limited to, home address, telephone numbers, identification numbers, account numbers, access codes or passwords, photographs, height, weight);
  4. Sending threatening or harassing messages;
  5. Making or transmitting any false, defamatory, or libelous statements about another person, group, or organization;
  6. Accessing or sharing of any pornographic, sexually explicit, obscene, or otherwise harmful or inappropriate for educational setting;
  7. Gaining or attempting to gain unauthorized access to enCircle or MinnickSchools computer or telecommunications systems;
  8. Intercepting communications intended for another person without prior authorization;
  9. Engaging in any commercial or fundraising purpose without prior authorization from the appropriate school official;
  10. Engaging in any political activity;
  11. Downloading, uploading, or distributing any files, software, or other material in violation of federal copyright laws;
  12. Violating software usage or licensing agreements;
  13. Installing any software, applications, or computer program without express permission of the Technology Department;

- C. If a user accidentally accesses unacceptable materials or an unacceptable Internet site, the user shall immediately inform the appropriate school official of the accidental access. Doing so may serve as a defense against an allegation that the user has intentionally violated this policy.

### **III. Filtering Internet Access**

- A. enCircle will monitor and may record the online activities of minors, employees, and guests. The Schools will employ technology protection measures during the use of any computers using school internet or networking resources by minors and adults. Those protection measures include, but are not limited to firewalls, filters, bandwidth monitoring, antivirus software, and anti-spyware software. The technology protection measures will be used to protect enCircle networking resources and preventing access to material deemed obscene, inappropriate for an educational setting or pornographic. It is the expectation that all employees monitor and supervise students engaged in computer usage, as the most immediate filter is the instructional staff.
- B. The term “for an educational setting” means any picture, image, graphic image, file, video, or other media that; depicts, describes, or represents in any way, an actual or simulated sexual act, sexual contact, nudity or excretion with no serious literary, artistic, or scientific value to minors.
- C. Filtering will be disabled only for bona fide research or other lawful purposes.

### **IV. Limited Expectation of Privacy**

- A. By authorizing use of the school division’s telecommunication systems enCircle does not relinquish control over materials on the system or contained in files on the system. Users should expect only limited privacy in the contents of personal data or files on the school division equipment or systems.
- B. Routine maintenance and monitoring of the school division systems may lead to a discovery that a user has violated this policy, another school division policy, or law.
- C. An individual investigation or search will be conducted if school authorities have a reasonable suspicion that the search will uncover a violation of law or school division policy.
- D. Except when doing so would interfere with law enforcement investigation, parents have the right at any time to investigate or review the contents of their child’s files and e-mail files. Parents have the right to request the termination of their child’s individual accounts at any time.
- E. School division employees should be aware that data and other materials in files maintained on the school division systems may be subject to review, disclosure, or discovery under federal and state statutes, Family Educational Rights and Privacy Act of 1974 (FERPA), §2.1-342 Code of Virginia (Inspection of Official Records).

## **V. Limitations of Liability**

Use of enCircle's telecommunication systems including the intranet and Internet is at the user's own risk. The system is provided on an "as is, as available" basis. enCircle will not be responsible for any damage users may suffer, including but not limited to loss, damage or unavailability of data stored on school division storage media, including but not limited to diskettes, tapes, hard drives, jump drives, or servers, or for delays or changes in or interruptions of service or mis-deliveries or non-deliveries of data, information or materials, regardless of the cause. The school division is not responsible for the accuracy or quality of any advice or information obtained through or stored on the school division's systems. The school division will not be responsible for financial obligations arising through unauthorized use of the school division's systems including the intranet and Internet.

## **VI. Internet Use Agreement Form**

- A. The safe use of the Internet and the educational value to be gained from its use is the joint responsibility of students, parents, and employees of Minnick Schools.
- B. This policy requires all students must have the permission of and supervision by the school's designated professional staff before and during internet use.
- C. The Internet Use Agreement form must be read and signed by the student (If able to sign), the parent or guardian and staff. The form must then be filed at the school office (students and school staff) or at the user's respective department office (non-school based employees).

## **VII. Minnick Schools Online Safety Program**

The students at Minnick Schools are provided network and online safety instruction and guidelines on an ongoing basis. This training is provided as part of the standard curriculum that each school will follow. This course is located on the Minnick online training site.

**Minnick Schools**  
**Acceptable Use Policy Statement – User Form**  
**2022 - 2023 School Year (August 1, 2022, to July 31, 2023)**

**User Agreement** (to be signed by all adult users and student users)

I have read or had read to me, understand, and will abide by the above Acceptable Use Policy when using computer and other electronic resources owned, leased, or operated by Minnick Schools and enCircle. I further understand that any violation of the regulations above against School policy, may be unethical or constitute a criminal offense. Should I commit any violation, my access privileges may be revoked, school disciplinary action may be taken, and/or appropriate legal action may be initiated.

---

User Name (Please Print)

---

User Signature

---

Date

**Parent Agreement** (to be signed by parents of all student users under the age of eighteen)

As parent or guardian of [please print name of student]\_\_\_\_\_, I have read the Acceptable Use Policy. I understand that this access is designed for educational purposes. Minnick Schools and enCircle have taken reasonable steps to control access to the Internet, but cannot guarantee that all controversial information will be inaccessible to student users. I agree that I will not hold enCircle responsible for materials acquired on the network.

Further, I accept full responsibility for supervision if and when my child's use is not in a school setting. I hereby give permission for my child to use network resources, including the Internet that are available through enCircle.

---

Parent Name (Please Print)

---

Parent Signature

---

Date





## CONSENT FOR BEHAVIOR ANALYTIC SERVICES

Dear Parent/Guardian,

Minnick Schools incorporates behavior analytic services into its programming to support the implementation of students' IEPs and help students meet academic and behavior goals. These services are based on the principles and procedures of behavior analysis and may include, but are not limited to, the following:

- Classroom and student observations
- Development of data collection systems
- Ongoing data collection and analysis
- Academic and behavioral program support
- Preference assessments
- Implementation of evidence-based interventions to decrease challenging/disruptive behaviors, increase appropriate behaviors, and teach new skills
- Criterion-referenced skill assessments (e.g., The Assessment of Functional Living Skills)
- Functional behavior assessments (requires separate consent)
- Development, implementation, and monitoring of behavior intervention and safety plans
- Consultation with classroom staff
- Staff training

Challenging and disruptive behaviors may increase temporarily when changes to behavior intervention strategies are made. Over time, challenging and disruptive behaviors typically decrease, and appropriate replacement behaviors and skills increase.

If you have any questions regarding behavior analytic services provided by Minnick Schools, you may contact your student's principal at any time. You may withdraw your consent at any time by contacting your student's principal and providing written notice. If you withdraw consent, alternative options regarding services will be discussed.

I, \_\_\_\_\_, understand whom to contact with questions regarding behavior analytic services provided by Minnick Schools and have been given the opportunity to ask questions and receive answers. Further, I give permission for Minnick Schools to provide behavior analytic services as described above.

\_\_\_\_\_  
Student Name (Please Print)

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date