The Lorge School
353 W. 17th Street, New York, NY 10011

THE LORGE SCHOOL APPLICATION FOR ADMISSION & INTAKE QUESTIONNAIRE

Date of Intake Appointment: ______________ Intake Personnel: ______________________

STUDENT INFORMATION:

____
Last Name First Name Middle

____
Date of Birth Age NYCID#

____
Home Address Apt #

____
City State Zip

____
Current School Current Grade

School Contact Information: ____

PARENT/GUARDIAN INFORMATION: Parent/Guardian 1 **Foster Parent ___yes ___no**

____
Name (Last, First) Relationship to Student

____
Home Address

____
Home Phone Number Cell Phone Number Email Address

____
Profession Work Phone Number

PARENT/GUARDIAN INFORMATION: Parent/Guardian 2

____
Name (Last, First) Relationship to Student

____
Home Address

____
Home Phone Number Cell Phone Number Email Address

____
Profession Work Phone Number

FOSTER AGENCY:
Name Contact/Phone Number

____

The Lorge School
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PERSONS IN HOUSEHOULD:

Name:	Relation to Student: □Mother □Father □Guardian □Sibling/Age ______ □Other/Who ______
Name:	Relation to Student: □Mother □Father □Guardian □Sibling/Age ______ □Other/Who ______
Name:	Relation to Student: □Mother □Father □Guardian □Sibling/Age ______ □Other/Who ______
Name:	Relation to Student: □Mother □Father □Guardian □Sibling/Age ______ □Other/Who ______

If the child does not live with both parents in one house, please answer the following:
Are Parents:
Separated □ Divorced □
Who is the legal guardian?______________________________
To whom should school notices and school reports be sent?
Mother □ Father □ Other □ ______________________________
What languages does your child speak? ______________________________
What is your child's primary language?______________________________
What is the primary language spoken at home?______________________________

Developmental and Medical History:

Pediatrician______________________________Phone______________
Were there any complications during pregnancy or birth or after?______________
Was your child full term? □Yes □No If No, in what week was he/she born?____ Weight _____
At what age did your child: Sit ___________ Walk ___________ Say first words ___________

Describe your child's general health, including any recent illness, special medical problems, allergies or dietary restrictions:

____
____
____

Does your child experience-sleeping problems? If yes, explain:

____
____

Does your child wear glasses/hearing aids? □Yes □No
Explain:______________________________
Is your child on Medication? □Yes □No
Name of Medication?______________________ Dosage?__________ Purpose?__________
Name of Medication?______________________ Dosage?__________ Purpose?__________
Name of Medication?______________________ Dosage?__________ Purpose?__________

Intervention History:

Has your child received the following intervention services? (Circle all that apply)
Psychiatric/Psychological Services, Academic Support, Audiological/Hearing Service, Occupational Therapy, Physical Therapy, Counseling Services , Speech/Language Therapy, OTHER:____

Please list the names of your child's current and former related service providers including frequency of visits (# visits/week), and services received (OT, PT, Speech, Psychiatrist, Psychotherapist, other)

School History:

Is your child currently enrolled in a school/program? □Yes □No

Please list the names of all schools currently and previously attended:

Name of School **Dates Attended**

What are the areas of concern for your child in their current/ prior school setting? When did these concerns begin and who identified them?

Social and Emotional Development:

How does your child respond to new situations?

What is your child like at home? (Include activity level and relation to siblings)

Does your child have difficulty with transitions from one activity to another? □Yes □No
Explain: ____

Does your child have friends? Does he/she make friends easily?

Briefly describe your child's personality?

Additional Information:

Parent Impressions:
Please tell us about your child's strengths, weaknesses, and study/work habits:

Strengths:
Weaknesses:
Study and work habits:

Please describe your child's special interests and abilities (i.e., sports, computers, music, dancing, art):

What pleases you most about your child?
How much time does your child spend per day watching T.V.?
How much time does your child spend per day using the computer/video games?

I understand the information provided to The Lorge School will be used a long with the screening interview and day visit , if necessary, to make a determination on appropriate acceptance and placement into the program.

Print: Sign: Date:
Parent/Guardian:

Print: Sign: Date:

Phone Number: Email Address:

CBST CASE MANAGER:

The Lorge School

353 W. 17th Street, New York, NY 10011
T: (212) 929-8660 F: (212) 989-8249
admissions@lorgeschool.org

I authorize The Lorge School, located at 353 W. 17th Street, New York, NY 10011, to **request and obtain** my child's records including school records, related service records, and psychiatric records. I give my permission for The Lorge School Intake Personnel below to **discuss** these records with you.

STUDENT NAME:______________________________ DOB:______________________

NYCID:____

I understand that I may withdraw permission for the release of information at any time. I will inform the school in writing if I wish to withdraw my permission.

PARENT OR GUARDIAN CONSENT:

Signature of Parent Guardian: ____

Printed Name of Parent Guardian:____

Date: ____

Please forward all records listed for the above named student at your earliest convenience.

Thank you for your assistance,
The Lorge School Intake Personnel

Printed: ____________________ Signed:_____________________ Date:__________

Email Address: ____

The Lorge School
353 W. 17th Street, New York, NY 10011

RECORDS RELEASE POLICY

To Parent/Guardians:

Pursuant to the regulations governing accessibility/confidentiality of your child's educational/ clinical records, please be advised of the following:

1. Your child's records at The Lorge School are available for your review between the hours of 10:00AM – 2:00PM daily or by special appointment. We request, however, that you give Lorge at least 3 days notice so we may schedule the appropriate person(s) to assist you.
2. Lorge will not disclose information contained in the records without prior written consent of the parent/guardian or the student except as permitted by law.
3. Lorge does maintain a record of request for disclosure made from the education records of all students and this list is available for your examination.
4. All parents/guardians or eligible students have the right to seek correction of our records through request to amend the record and/or a hearing. All parents/guardians and eligible students have the right to place a written rebuttal against any information in the record.
5. Procedures regarding disputed material and/or the destruction of material are available at The Lorge School.
6. There will be no charge to the parent/guardian or eligible student to search, retrieve, or to make copies of the records.

Student:______________________________ DOB:__________ OSIS:__________

PARENT OR GUARDIAN CONSENT:

Signature of Parent Guardian: ______________________________________

Printed Name of Parent Guardian:____________________________________

Date: ____

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admissions@lorgeschool.org

Thank you for your interest in The Lorge School.

The Lorge School uses appropriate accommodations to provide full access to a general education curriculum through a program designed to instill a love for learning. We aim to identify and use students' strengths, and expand their intellectual knowledge and self-awareness.

The Lorge School offers 12-month programming. From September to June we follow the NYC Department of Education calendar and offer a 6-week summer program during July and August for students with 12-month Individualized Education Plans.

Our school staff is a highly skilled multidisciplinary team. We include trained and compassionate special education teachers, social workers, speech and language pathologists, an occupational therapist; and instruction in art, dance, technology, physical education, and vocational skills.

Qualifications

To qualify for placement in our program students must have:

1. An IEP classification of Emotional Disturbance, Learning Disabled or Other Health Impaired.
2. Approval for a Non Public School setting a P-1 Nickerson Letter with and IEP that can be accommodated.

The Admissions Process

We begin with a review of the student's educational and clinical reports. If there is an appropriate opening for the student, we'll schedule an initial intake screening.

During the intake meeting the student and family will tour our school and meet with a clinician for a behavioral screening. At the same time, the parent or caregiver meets with an Intake Coordinator who provides information about our program and gathers a full psychosocial history of the student and an INTAKE QUESTIONNAIRE is completed.

If our program can serve the student's needs, we'll invite you back for a FULL-DAY VISIT. During the VISIT they will meet with the school staff and related service providers. The student will spend time in the classroom. If we are unable to meet students' needs in our program we will try to identify another appropriate placement.

Contact Admissions

If you're unsure whether your student qualifies for our program, please contact our Intake Coordinator at admissions@lorgeschool.org.

The Lorge School
353 W. 17th Street, New York, NY 10011

Students Name:____________________ DOB:______________ OSIS:________________

THE LORGE SCHOOL APPLICATION DOCUMENTATION

- ☐ Application Form
- ☐ Intake Questionnaire/Social History
- ☐ Records Release Form
- ☐ Psychological Testing
- ☐ Related Service Evaluations
- ☐ Copy of Current IEP
- ☐ Most Recent Report Card, School Records/Transcript
- ☐ Any other relevant material that will add to our understanding of the student
- ☐ Attendance Report
- ☐ Full-Day Visit Form

Intake is maintained by two questions in regard to each applicant:

1. Will this student benefit from the program that The Lorge School has to offer?
2. Do we have the appropriate class and related services for this student?

After the admissions intake, The Lorge School Intake Coordinator will follow-up with you within a week to discuss acceptance determination. If a child is accepted for admission, it should be understood that the place can be held only by either a signed P-1 Nickerson Letter or prior approval of funding from the NYC Department of Education (CBST).

If Accepted Please Provide The Lorge School with the Following Documents:

- ☐ General Consent Forms
- ☐ Admission Evaluation Letter of Understanding
- ☐ Timeout Room Letter of Understanding
- ☐ Current Physical/Medical Form
- ☐ Dental Health Certificate
- ☐ HIPPA Form
- ☐ Emergency Release Form
- ☐ Records Release Form
- ☐ Medicaid Consent Release Form
- ☐ Medication Administration Form (MAF)
- ☐ *Secondary*: Outside Lunch Contract
- ☐ *Secondary*: Locker Policy Contract
- ☐ *Secondary*: Employment Certificate Form

I have Received, Please Initial:

1. School Calendar:_________
2. Parent/Student Handbook:_________
3. Contact Information for My Child's Teacher, TA and Providers:_________
4. General School Supply Request:_________

We understand that the admissions process can be difficult for families, and we hope we can be helpful in facilitating the process. It is our aim to make the admissions procedure at The Lorge School as personal and comfortable as possible.

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Health

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name	**Date of Birth**	**Social Security Number**
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form: In accordance with New York State Law and Privacy Rule of the Health Insurance Portability and Accountability of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG ABUSE, MENTAL HEALTH TREATMENT, except psychotherapy notes, and CONFIDENTIAL HIV* RELATED INFORMATION only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of the people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **I AUTHORIZE ALL MY HEALTH CARE PROVIDERS TO RELEASE THIS INFORMATION TO, AND DISCUSS THIS INFORMAITON WITH, THE NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE AND ITS EMPLOYEES, AGENTS AND CONTRACTORS.**

7. Specific information to be released:

☐ Medical Record from (insert date)______________________ to (insert date) ______________________

☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records send to you by other health care providers.

☐ Other: ______________________

Include: (*Indicate by Initialing*)

______**Alcohol/Drug Treatment**
______**Mental Health Information**
______**HIV-Related Information**

8. Reason for release of information: ☐ At request of individual ☐ Other:	9. **THIS AUTHORIZATION WILL EXPIRE ONE (1) YEAR FROM THE DATE THIS AUTHORIZATION IS SIGNED BY THE PATIENT OR REPRESENTATIVE UNLESS OTHERWISE SPECIFIED HERE:**
10. If not the patient, name of person signing form:	11. Authority to sign on behalf of patient:

All items on this form have been complete and my questions about his form have been answered. In addition, I have been provided a copy of the form.

______________________________________ Date: ______________________

Signature of patient or representative authorized by law.

***Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

The Lorge School Emergency Information Verification Form

Please complete the form and sign at the bottom.

School Name: *The Lorge School*	Teacher Name: ______	Class Number (Please circle one) 107, 108, 302, 306, 309, 310, 311, 21, 22, 23

Student's Name: ______	Date of Birth: ______	Sex: (circle one) Male / Female

Permanent Address: ______	Mailing Address if different than residence: ______ Court Orders / Legal Restrictions:

The primary or home number will be used for attendance calls.

Guardian 1: ______ Relationship to Student: ______	Home: ______ Work : ______	E-Mail: ______ Cell: ______
Guardian 2: ______ Relationship to Student: ______	Home: ______ Work : ______	E-Mail: ______ Cell: ______
Emergency 1: ______ Relationship to Student: ______	Home: ______ Work : ______	E-Mail: ______ Cell: ______
Emergency 2: ______ Relationship to Student: ______	Home: ______ Work : ______	E-Mail: ______ Cell: ______
Emergency 3: ______ Relationship to Student: ______	Home: ______ Work : ______	E-Mail: ______ Cell: ______

Health Care Provider Information (for emergency treatment when we are unable to contact you):

Contact Type	Agency Information	Contact Number / Email Address
Primary Care Doctor	Agency: ______ Contact Name: ______ Type of provider ______	
Pyschiatrist	Agency: ______ Contact Name: ______ Type of provider ______	
Psychotherapist	Agency: ______ Contact Name: ______ Type of provider ______	
Foster Care Worker	Agency: ______ Contact Name: ______ Type of provider ______	
Other Outside Support Provider	Agency: ______ Contact Name: ______ Type of provider ______	

Does your child have health insurance coverage Yes or No? ______	Health Information: Medical alerts / Allergies ______ Receives daily medication during school hours (Y/N) ______
If yes, what is the name if the insurance company? ______	Wears glasses and/or contact lenses (Y/N): ______

I, the undersigned, do hereby authorize officials of The Lorge School to contact directly the person(s) named on this card and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency, for the health of said child. In the event that physicians, other persons named on this card , or parents/guardians cannot be contated, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child. I will not hold the school financially responsible for the emergency care and/or transportation of the said child.

______ Signature ______ Printed Name ______ Date

Do Not Write Below This Line. For Office Use Only.

For School Use Only: NYC Student ID : ______	Date Filed: ______
Date Updated in Database ______	Staff Initials: ______

The Lorge School
353 W. 17th Street, New York, NY 10011

GENERAL CONSENT

School Year:________________________

LEAVING THE BUILDING, TRIPS AND PHOTOGRAPHS

Student:___________________________________ DOB:__________ OSIS:_________

Dear Parents/Guardians:

Please check your preference in the appropriate spaces below. If you have any questions or wish to limit your permission to any degree, please make comments below.

CONSENT #1

My child has permission to leave the school building during the lunch hour. I understand that the school is not responsible for my child's safety while out of the building. This privilege will be taken way from the student if the school rules are not respected, a Lunch Contract will be required.

☐ Yes
☐ No

CONSENT #2

My child has permission to take supervised school trips during school hours as part of the school program. I understand that at time, injures may occur during the course of a field trip, and give permission for Lorge school staff to provide appropriate first aid attention if needed. I agree not to hold Lorge staff responsible for accidents that may occur on such trips.

☐ Yes
☐ No

CONSENT # 3

My child may be photographed and/or video taped during school activities for the yearbook, monthly newsletter and other educational purposes.

☐ Yes
☐ No

PARENT OR GUARDIAN CONSENT:

Signature of Parent Guardian: ____

Printed Name of Parent Guardian:______________________________________

Date: ____

The Lorge School

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admissions@lorgeschool.org

Admission Evaluation Letter of Understanding

I understand that my child is subject to an admission evaluation concerning placement in this school. The Lorge School will make a decision about acceptance into the school once this evaluation is complete.

I understand that I am being asked to sign a letter (Form P-2) which will allow my child to be placed in this school of he/she should meet the admission requirements.

I am signing this letter before the admission evaluation is complete in order to speed the processing of any paper work, which may be required for placement and to eliminate the need for me to make an additional trip to the school to sign the letter if my child is accepted. Signing the P-2 form prior to an admission evaluation does not indicate that The Lorge School will accept.

If my child is unable to meet the admission requirements of The Lorge School, the P-2 form will not be processed and my child's records will be returned to me upon request.

I will be notified directly if my child is accepted to The Lorge School.

Student:_______________________________________ DOB:___________ OSIS:__________

PARENT OR GUARDIAN CONSENT:

Signature of Parent Guardian: ____

Printed Name of Parent Guardian:____

Date: ____

Letter of Understanding

I understand that Lorge School provides services for children with learning disabilities and emotional disturbances and other health impairments and as such utilizes the Nonviolent Crisis Intervention Program (NCI) design to address children's emotional outburst. Verbal intervention is a primary tool of the program. In an emergency crisis intervention, as determined by the Dean of Students and after all verbal de-escalation techniques are exhausted, nonviolent physical intervention could be employed.

I understand that trained personnel, in a de-escalation room/time out room, to help my child to regain control over his/her inappropriate behavior could place my child in NCI approved control position, if necessary, as a last resort to prevent injury of my child or others. I understand that The Lorge School will follow my child's behavior intervention plan (BIP) if indicated on his/her IEP.

"Use of a Time Out Rooms" Policy NYSED (May 2011):

What is a Time Out Room?" Time Out" is a technique used to interrupt an unacceptable behavior by removing the student from the situation where the misbehavior is occurring. The State does not regulate the use of time out, but does regulate the use of a separate room where a student may be removed for purposes of "time out."

State regulations define a time out room as an area for a student to safely deescalate, regain control and prepare to meet expectations to return to his or her education program. Time out rooms are to be used in conjunction with a behavioral intervention plan in which a student is removed to a supervised area in order to facilitate self-control or to remove a student from a potentially dangerous situation.

When can a time out room be used? Except for unanticipated situations that pose an immediate concern for the physical safety of a student or others, the use of a time out room can only be used in conjunction with a behavioral intervention plan that is designed to teach and reinforce alternative appropriate behaviors.

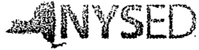
When may a time out room be used? A time out room should be used consistent with a student's IEP and behavioral intervention plan. Removal of a student to a time out room may also be an emergency intervention, provided that the documentation of its use meets the standards in section 200.22(d)(4) of the Regulations of the Commissioner of Education.

If a BIP is not present during intake and The Lorge School determines a need of such, I understand that school will develop it and implement one in conjunction with the CSE to help the student function better within the school. IF BIP is recommended on IEP but school determines that it is not needed, the school will work with the CSE to remove the BIP from the child's IEP.

I understand that school has a right to take my child to the hospital emergency room if necessary and it will be determined on a situational basis. If this is a necessary intervention in a crisis situation, the school will inform me and I will come to the designated hospital to assist my child.

A parent reserves the right to view and observe the De-escalation Rooms and In-House Room at anytime the use of these interventions is listed on their child's IEP/BIP. By signing this document you acknowledge that you read and understood the policy.

______________________________	______________________________
Parent/Guardian Signature	Lorge School Intake Personnel Signature



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Use of Time Out Rooms

The University of the State of New York
New York State Education Department
Office of P-12 Education
Office of Special Education

May 2011

Use of Time Out Rooms - Word (99 KB)

This is one in a series of policy briefs prepared by the New York State Education Department, on topics pertaining to implementation of the Individuals with Disabilities Education Act (IDEA) in New York State.

What is a Time Out Room?

"Time Out" is a technique used to interrupt an unacceptable behavior by removing the student from the situation where the misbehavior is occurring. The State does not regulate the use of time out, but does regulate the use of a separate room where a student may be removed for purposes of "time out."

State regulations define a time out room as an area for a student to safely deescalate, regain control and prepare to meet expectations to return to his or her education program. Time out rooms are to be used in conjunction with a behavioral intervention plan in which a student is removed to a supervised area in order to facilitate self-control or to remove a student from a potentially dangerous situation.

When can a time out room be used?

Except for unanticipated situations that pose an immediate concern for the physical safety of a student or others, the use of a time out room can only be used in conjunction with a behavioral intervention plan that is designed to teach and reinforce alternative appropriate behaviors.

Are there State requirements for the physical space used for time out rooms?

Yes. State regulations require that the physical space used as a time out room meet certain standards.

- The room must provide a means for continuous visual and auditory monitoring of the student and be of adequate width, length and height to allow the student to move about and recline comfortably.
- Wall and floor coverings should be designed to prevent injury to the student, and there must be adequate lighting and ventilation.
- The temperature of the room must be within the normal comfort range and consistent with the rest of the building.

- The room must be clean and free of objects and fixtures that could be potentially dangerous to a student and must meet all local fire and safety codes.
- The time out room must be unlocked and the door must be able to be opened from the inside. The use of locked rooms or spaces for purposes of time out or emergency interventions is prohibited.

Must students be monitored while in time out rooms?

Yes. Staff must be assigned to continuously monitor the student in a time out room. The staff must be able to see and hear the student at all times.

Is the school required to have policy and procedures regarding the use of a time out room?

Yes. Each school which uses a time out room as part of its behavior management approach must ensure that the school's policy and procedures on the use of the time out room are developed and implemented consistent with section 200.22(c) of the Regulations of the Commissioner of Education, including the physical and monitoring requirements, parental rights and the individualized education program (IEP) requirements for students with disabilities.

The school's policy and procedures must minimally include:

- prohibiting placing a student in a locked room or space or in a room where the student cannot be continuously observed and supervised;
- factors which may precipitate the use of the time out room;
- time limitations for the use of the time out room;
- staff training on the policies and procedures related to the use of time out room;
- data collection to monitor the effectiveness of the use of time out rooms; and
- information to be provided to parents.

Parents must also be given a copy of the school's policy on the use of time out rooms.

How is the use of the time out room monitored?

The school must establish and implement procedures to document the use of the time out room, including information to monitor the effectiveness of the use of the time out room to decrease specified behaviors.

When may a time out room be used?

A time out room should be used consistent with a student's IEP and behavioral intervention plan. Removal of a student to a time out room may also be an emergency intervention, provided that the documentation of its use meets the standards in section 200.22(d)(4) of the Regulations of the Commissioner of Education.

Must 'use of a time out room' be indicated in a student's IEP?

As noted above, there may be instances when a student is removed to a time out room on an 'emergency' basis. However, whenever a student's behavioral intervention plan indicates that the student would be removed to a time out room as a planned strategy to address a particular behavior, the student's IEP must specify the use of a time out room, including the maximum amount of time a student will need to be in a time out room as a behavioral consequence as determined on an individual basis in consideration of the student's age and individual needs.

Must a student's parents be informed each time the student is removed to a time out room?

If a student is removed to a time out room on an 'emergency' basis, the school must notify the parent.

If the use of a time out room is indicated in a behavioral intervention plan and in student's IEP, the school district must inform the student's parents prior to the initiation of a behavioral intervention plan that will incorporate the use of a time out room for a student and must give the parents the opportunity to see the physical space that will be used as a time out room.

Legal Reference

8 NYCRR – Section 200.22(c)

NOTE: Please reference the Official Compilation of Codes, Rules and Regulation of the State of New York (8 NYCRR) for regulatory language. An unofficial compilation of these regulations can be found at: http://www.dos.state.ny.us/info/nycrr.htm.

Last Updated: May 23, 2011

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly Press Hard

STUDENT ID NUMBER OSIS ☐☐☐☐☐☐☐☐☐

TO BE COMPLETED BY PARENT OR GUARDIAN

Child's Last Name | First Name | Middle Name | **Sex** ☐ Female ☐ Male | **Date of Birth** *(Month/Day/Year)* __ __ / __ __ / __ __ __ __

Child's Address | **Hispanic/Latino?** ☐ Yes ☐ No | **Race** *(Check ALL that apply)* ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other ____

City/Borough | State | Zip Code | School/Center/Camp Name | District Number __ __ | **Phone Numbers** *Home* ____ *Cell* ____ *Work* ____

Health insurance (including Medicaid)? ☐ Yes ☐ No | ☐ **Parent/Guardian** ☐ **Foster Parent** Last Name | First Name

TO BE COMPLETED BY HEALTH CARE PROVIDER *If "yes" to any item, please explain (attach addendum, if needed)*

Birth history *(age 0-6 yrs)*
☐ Uncomplicated ☐ Premature: ________ weeks gestation
☐ Complicated by ____

Allergies ☐ None ☐ Epi pen prescribed
☐ Drugs *(list)* ____
☐ Foods *(list)* ____
☐ Other *(list)* ____

Does the child/adolescent have a past or present medical history of the following?
☐ Asthma *(check severity and attach MAF/Asthma Action Plan):* ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent
If persistent, check all current medication(s): ☐ Inhaled corticosteroid ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

☐ Attention Deficit Hyperactivity Disorder
☐ Chronic or recurrent otitis media
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes *(attach MAF)*
☐ Orthopedic injury/disability
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ **Other** *(specify)* ____

Explain all checked items above or on addendum

Medications ***(attach MAF if in-school medication needed)***
☐ None ☐ Yes *(list below)*

Dietary Restrictions
☐ None ☐ Yes *(list below)*

PHYSICAL EXAMINATION

Height ________ **cm** (____ %ile)
Weight ________ **kg** (____ %ile)
BMI ________ **kg/m²** (____ %ile)
Head Circumference *(age ≤2 yrs)* ________ **cm** (____ %ile)
Blood Pressure *(age ≥3 yrs)* ______ / ______

General Appearance:

Nl Abnl		*Nl Abnl*		*Nl Abnl*		*Nl Abnl*		*Nl Abnl*	
☐ ☐	HEENT	☐ ☐	Lymph nodes	☐ ☐	Abdomen	☐ ☐	Skin	☐ ☐	Psychosocial Development
☐ ☐	Dental	☐ ☐	Lungs	☐ ☐	Genitourinary	☐ ☐	Neurological	☐ ☐	Language
☐ ☐	Neck	☐ ☐	Cardiovascular	☐ ☐	Extremities	☐ ☐	Back/spine	☐ ☐	Behavioral

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)* ☐ Within normal limits
If delay suspected, specify below
☐ Cognitive *(e.g., play skills)* ____
☐ Communication/Language ____
☐ Social/Emotional ____
☐ Adaptive/Self-Help ____
☐ Motor ____

SCREENING TESTS	*Date Done*	*Results*
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	__/__/__ __/__/__	______ µg/dL ______ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	__/__/__	☐ At risk *(do BLL)* ☐ Not at risk
Hearing ☐ Pure tone audiometry ☐ OAE	__/__/__	☐ Normal ☐ Abnormal
— **Head Start Only** —		
Hemoglobin or Hematocrit *(age 9–12 mo)*	__/__/__	______ g/dL ______ %

	Date Done	*Results*
Tuberculosis *Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school*		
PPD/Mantoux *placed*	__/__/__	Induration ____ mm
PPD/Mantoux *read*	__/__/__	☐ Neg ☐ Pos
Interferon Test	__/__/__	☐ Neg ☐ Pos
Chest x-ray *(if PPD or Interferon positive)*	__/__/__	☐ Nl ☐ Not Indicated ☐ Abnl
Vision *(required for new school entrants and children age 4–7 yrs)*	__/__/__ ☐ with glasses	Acuity *Right* __/__ *Left* __/__ Strabismus ☐ No ☐ Yes

IMMUNIZATIONS – DATES CIR Number of Child ☐☐☐☐☐☐☐☐☐

Vaccine	Dates			
Hep B	__/__/__	__/__/__	__/__/__	__/__/__
Rotavirus		__/__/__	__/__/__	__/__/__
DTP/DTaP/DT		__/__/__	__/__/__	__/__/__
		__/__/__	__/__/__	__/__/__
Hib	__/__/__	__/__/__	__/__/__	__/__/__
PCV	__/__/__	__/__/__	__/__/__	__/__/__
Polio	__/__/__	__/__/__	__/__/__	__/__/__

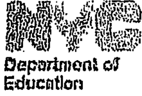
Vaccine	Dates		
Influenza	__/__/__	__/__/__	__/__/__
MMR	__/__/__	__/__/__	__/__/__
Varicella	__/__/__	__/__/__	
Td	__/__/__	__/__/__	__/__/__
Tdap __/__/__	Hep A	__/__/__	__/__/__
Meningococcal	__/__/__	__/__/__	
HPV	__/__/__	__/__/__	__/__/__
Other, *Specify:* ______	__/__/__; ______		__/__/__

RECOMMENDATIONS ☐ Full physical activity ☐ Full diet
☐ Restrictions *(specify)* ____
Follow-up Needed ☐ No ☐ Yes, for ________ Appt. date: __/__/__
Referral(s): ☐ None ☐ Early Intervention ☐ Special Education ☐ Dental ☐ Vision
☐ Other ____

ASSESSMENT ☐ **Well Child** (V20.2) ☐ **Diagnoses/Problems** *(list)* **ICD-9 Code**

Health Care Provider Signature | Date __ __/__ __/__ __ __
Health Care Provider Name and Degree *(print)* | Provider License No. and State
Facility Name | National Provider Identifier (NPI)
Address | City | State | Zip
Telephone (___) ___ – ____ | Fax (___) ___ – ____

DOHMH ONLY **PROVIDER I.D.** ☐☐☐☐☐☐
TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)
Comments
Date Reviewed: __/__/__ I.D. NUMBER ☐☐☐☐☐☐
REVIEWER:



REQUEST FOR CONSENT
FOR MEDICAID REIMBURSEMENT

COMPLETE FORM ON REVERSE SIDE & RETURN.

Dear Parent or Guardian,

I'm writing to ask for your assistance as we work to provide services for your child. Our schools can receive additional funding for some of the services that are provided to students, like your child, who have individualized education plans (IEPs). In order for our schools to receive this funding, we need your consent to (1) access and provide to the state and federal Medicaid programs personally identifiable information from your child's special education records about the special education evaluations, programs and services that are provided to your child and (2) access your child's Medicaid benefits to pay for these services. Please read the information below, complete the attached form and return it to your child's school.

Thank you for your assistance in ensuring that our public schools receive as much funding as possible for the critical supports that are provided to our students.

Sincerely,

Carmen Fariña
Chancellor

Why am I being asked to sign this consent form?

The New York City Department of Education (NYC DOE) uses Medicaid funding to help meet some of the costs of providing special education services to students. With your consent, the NYC DOE can submit claims for evaluations and services that are provided to your child. You are not required to sign up for Medicaid in order for your child to receive the services on his/her IEP.

What information about my child will be provided to state and federal Medicaid programs?

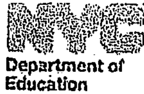
The NYC DOE will provide personally identifiable information about the special education evaluations and services provided to your child. This information may include the IEP, progress notes, attendance records, evaluations and other records and information about evaluations and services provided to your child.

Is there any cost to me or to my family?

There is no cost to you or your family. You will not be required to incur any expenses, premiums, costs or co-payments for the provision of these services. The services that are provided to your child in and outside of school will not be affected in any way. If your family receives Medicaid benefits, your coverage will not be canceled, the lifetime coverage in place will not decrease and services that your family receives will not be affected in any way by the accessing of Medicaid benefits. You will not be required to sign up for or enroll in Medicaid for your child to receive the services on his/her IEP. You will not risk the loss of eligibility for home and community based waivers, if any, that are based on your total health-related expenditures.

Can I change my mind about allowing the NYC DOE to access my child's information and submit claims to the Medicaid program? What if I do not provide my consent?

You may change your mind about this consent at any time. To change your decision, complete a new form and send it to your child's school. The NYC DOE must still provide special education and services to your child at no cost to you even if you do not consent or you withdraw your consent at a later date.



CONSENT TO RELEASE INFORMATION
FOR MEDICAID REIMBURSEMENT

Student's last name	*Student's first name*	*Date of birth*	*NYC Student ID*

Please select one choice below, sign and date the document, and return this form to your child's school.

○ Yes, I understand and agree that the NYC DOE may access my child's special education records, which may include the Individualized Education Program (IEP), progress notes, attendance records, evaluations and other records and information about services and evaluations that may be provided to my child and release this personally identifiable information to State and Federal Medicaid agencies as necessary to claim Medicaid reimbursement. I agree that the NYC DOE may access my child's Medicaid benefits to pay for special education and services provided as per my child's IEP.

SIGNATURE OF PARENT OR GUARDIAN DATE

○ No, I do not give permission for the NYC DOE to access my child's special education records to claim Medicaid reimbursement for special education services provided to my child.

SIGNATURE OF PARENT OR GUARDIAN DATE

ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM

Provider Medication Order Form—Office of School Health —School Year 2017–2018

ATTACH STUDENT PHOTO HERE	Student Last Name First Name Middle	Date of birth __/__/____ MM DD YYYY	Weight (kg) ___._	☐ Male ☐ Female
		OSIS # __ __ __ __ __ __ __ __ __		
	School (include name, number, address and borough)	DOE District __	Grade	Class

The following section to be completed by Student's **HEALTH CARE PRACTITIONER**

Specify Allergy	Specify Allergy	Specify Allergy
☐ Allergy to	☐ Allergy to	☐ Allergy to

History of asthma?	☐ Yes ***(If yes, student has an increased risk for a severe reaction)***				☐ No	**Does this student have the ability to:**		
History of anaphylaxis?	☐ Yes Date __/__/____				☐ No	Self-Manage	☐ Yes	☐ No
If yes, symptoms	☐ Respiratory	☐ Skin	☐ GI	☐ Cardiovascular	☐ Neurologic	Recognize signs of allergic reactions	☐ Yes	☐ No
Treatment	Date __/__/____					Recognize/avoid allergens independently	☐ Yes	☐ No
History of skin testing?	☐ Yes (attach copy of results) Date __/__/____				☐ No	Comments:		

Select In School Medications	**In School Instructions**

1. <u>ONLY SINGLE DOSE AUTO-INJECTORS</u> SELECT BELOW

- ☐ **Epinephrine** Auto-Injector 0.15 mg
- ☐ **Epinephrine** Auto-Injector 0.3 mg
- ☐ Give antihistamine in addition to epinephrine (**must order antihistamine below)**

Select the most appropriate option for this student:

- ☐ Nurse-Dependent Student: nurse or trained school personnel must administer
- ☐ Supervised Student: student self-administers, under adult supervision
- ☐ Independent Student: student is self-carry/self-administer **

_______ Practitioner's initials	I attest student demonstrated ability to self-administer the prescribed medication effectively for school/field trips/school-sponsored events **PARENT MUST INITIAL REVERSE

PRN (check all that apply):

☐ Itching	☐ Shortness of Breath	☐ Vomiting / Diarrhea
☐ Hives	☐ Tightness / Closure	☐ Weak Pulse
☐ Swelling	☐ Hoarseness	☐ Pallor / Cyanosis
☐ Redness	☐ Wheezing	☐ Dizziness / Fainting

Specify signs, symptoms, or situations:

- ➢ Administer Intramuscularly into anterolateral aspect of thigh
- ➢ **Call 911 immediately**

If **no** improvement, repeat in ___ minutes for a maximum of ___ times (not to exceed a total of **3** doses).

2. <u>ORAL MEDICATION</u>: ☐ **Diphenhydramine**

Preparation/Concentration: ____________ Route ______________

Select the most appropriate option for this student:

- ☐ Nurse-Dependent Student: nurse must administer
- ☐ Supervised Student: student self-administers, under adult supervision
- ☐ Independent Student: student is self-carry/self-administer **

_______ Practitioner's initials	I attest student demonstrated ability to self-administer the prescribed medication effectively for school/field trips/school-sponsored events **PARENT MUST INITIAL REVERSE

PRN (check all that apply):

☐ Itchy / Runny Nose	☐ Itchy Mouth	☐ Few Hives
☐ Sneezing	☐ Mildly Itchy Skin	☐ Mild Nausea / Discomfort

Specify signs, symptoms, or situations:

Dose: ________ ☐ **4** hours **or** ☐ **6** hours as needed (specify)

If **no** improvement, indicate instructions:

3. <u>ORAL MEDICATION</u>: ______________________

Preparation/Concentration: ____________ Route ______________

Select the most appropriate option for this student:

- ☐ Nurse-Dependent Student: nurse must administer
- ☐ Supervised Student: student self-administers, under adult supervision
- ☐ Independent Student: student is self-carry/self-administer **

_______ Practitioner's initials	I attest student demonstrated ability to self-administer the prescribed medication effectively for school/field trips/school-sponsored events **PARENT MUST INITIAL REVERSE

PRN ***Specify signs, symptoms, or situations***:

Dose: ________ **Time interval**: ___ (specify min or hours)

<u>Conditions under which medication should not be given</u>:

If **no** improvement, indicate instructions:

HOME Medications (include over-the counter)	**For Office of School Health (OSH) Use Only**
	Revisions per OSH after consultation with prescribing practitioner. ☐ IEP

Health Care Practitioner (Please Print) LAST NAME	FIRST NAME	Signature	
Address		Tel. (___) ___-____	Fax. (___) ___-____
E-mail address		Cell (___) ___-____	
NYS License # **(Required)** ______________		NPI # __________	Date __/__/____

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

FORMS CANNOT BE COMPLETED BY A RESIDENT

TURN TO PAGE 2 ➔

ALLERGIES/ANAPHYLAXIS MEDICATION ADMINISTRATION FORM

Provider Medication Order Form—Office of School Health —School Year 2017–2018

The Following Section to Be Completed by the Student's **Parent/Guardian**

I hereby consent to the storage and administration of medication, as well as the storage and use of necessary equipment to administer the medication, in accordance with the instructions of my child's health care practitioner. I understand that I must provide the school with the medication and equipment necessary to administer medication, including non-Ventolin inhalers. Medication is to be provided in a properly labeled original container from the pharmacy (another such container should be obtained by me for my child's use outside of school); the label on the prescription medication must include the name of the student, name and telephone number of the pharmacy, licensed prescriber's name, date and number of refills, name of medication, dosage, frequency of administration, route of administration and/or other directions; over the counter medications and drug samples must be in the manufacturer's original container, with the student's name affixed to that container. **I understand that all provided medication must be supplied in its original and UNOPENED medication box.** I further understand that I must immediately advise the school nurse) of any change in the prescription or instructions stated above.

I understand that no student will be allowed to carry or self-administer controlled substances.

I understand that this consent is only valid until the end of a New York City Department of Education ("DOE") sponsored summer instruction program session; or such time that I deliver to the school nurse a new prescription or instructions issued by my child's health care practitioner (whichever is earlier). By submitting this MAF, I am requesting that my child be provided specific health services by DOE and the New York City Department of Health and Mental Hygiene (DOHMH) through the Office of School Health (OSH). I understand that these services may include a clinical assessment and a physical examination by an OSH health care practitioner. Full and complete instructions regarding the above-requested health service(s) are included in this MAF. I understand that OSH and their agents, and employees involved in the provision of the above-requested health service(s) are relying on the accuracy of the information provided in this form.

I recognize that this form is not an agreement by OSH and DOE to provide the services requested, but rather my request and consent for such services. If it is determined that these services are necessary, a Student Accommodation Plan may also be necessary and will be completed by the school.

I understand that OSH and DOE and their employees and agents may contact, consult with and obtain any further information they may deem appropriate relating to my child's medical condition, medication and/or treatment, from any health care practitioner and/or pharmacist that has provided medical or health services to my child.

SELF-ADMINISTRATION OF MEDICATION:

Initial this paragraph for use of an epinephrine, asthma inhaler and other approved self-administered medications:

____ INITIAL	I hereby certify that my child has been fully instructed and is capable of self-administration of the prescribed medication. I further consent to my child's carrying, storage and self-administration of the above-prescribed medication in school. I acknowledge that I am responsible for providing my child with such medication in containers labeled as described above, for any and all monitoring of my child's use of such medication, and for any and all consequences of my child's use of such medication in school. I understand that the school nurse will confirm my child's ability to self-carry and self-administer in a responsible manner. In addition, I agree to provide "back up" medication in a clearly labeled container to be kept in the medical room in the event my child does not have sufficient medication to self-administer.
____ INITIAL	I consent to the school nurse or trained school personnel storing and/or administering to my child such medication in the event that my child is temporarily incapable of self-storage and self-administration of such medication.

If you opt to use stocked, you must send your child's ***epinephrine, asthma inhaler and other approved self-administered medications*** *with your child on a* ***school trip day*** *and/or after-school programs in order that he/she has it available. The stock epinephrine is* ***only*** *for use while your child is in the school building.*

Student Last Name First Name MI	Date of birth __ __/__ __/__ __ __ __	School
Print Parent/Guardian's Name	**Parent/Guardian's Signature**	
Parent/Guardian's Address	Date Signed __ __/__ __/__ __ __ __	

Telephone Numbers: Daytime (___)___-____ Home (___)___-____ Cell Phone (___)___-____

Parent/Guardian E-mail Address:

Alternate Emergency Contact's Name:	Contact Telephone Number (___)___-____

DO NOT WRITE BELOW – FOR OSH USE ONLY

Received by: Name Date __ __/__ __/__ __ __ __	**Reviewed by:** Name Date __ __/__ __/__ __ __ __
Self-Administers/Self-Carries: ☐ Yes ☐ No	**Services provided by:** ☐ Nurse ☐ OSH Public Health Advisor ☐ School Based Health Center ☐ DOE School Staff
Signature and Title (RN OR MD/DO/NP):	

*Confidential information should not be sent by e-mail.

ASTHMA MEDICATION ADMINISTRATION FORM

PROVIDER MEDICATION ORDER FORM—Office of School Health—School Year 2017 – 2018

Student Last Name First Name Middle Initial

Date of Birth __ __ / __ __ / __ __ __ __
MM DD YYYY

☐ Male
☐ Female

Attach Student Photo To This Sheet

OSIS # __ __ __ __ __ __ __ __ __

DOE District __ __ Grade ______

School Name, Number, Address, and Borough:

The Following Section Completed By Student's **HEALTH CARE PRACTITIONERS**

Diagnosis
☐ Asthma

Control *(see NAEPP Guidelines)*
☐ Well Controlled
☐ Not Controlled
☐ Unknown

Severity *(see NAEPP Guidelines)*
☐ Intermittent
☐ Mild Persistent
☐ Moderate Persistent
☐ Severe Persistent

Student Asthma Risk Assessment Questionnaire (Y = Yes, N = No, U = Unknown)

History of near-death asthma requiring mechanical ventilation	☐Y	☐N	☐U	
History of life-threatening asthma (loss of consciousness or hypoxic seizure)	☐Y	☐N	☐U	
History of asthma-related PICU admissions (ever)	☐Y	☐N	☐U	
Received oral steroids within past 12 months	☐Y	☐N	☐U	____ times last: __ __/__ __/__ __
History of asthma-related ER visits within past 12 months	☐Y	☐N	☐U	____ times
History of asthma-related hospitalizations within past 12 months	☐Y	☐N	☐U	____ times
History of food allergy or eczema, specify: ______________	☐Y	☐N	☐U	

Quick Relief In-School Medication (Select ONE)

☐ **Albuterol MDI** [*Ventolin® MDI can be provided by school for shared usage (plus individual spacer)*]:
[Parent must sign back]
☐ MDI w/ spacer
☐ DPI

☐ **Other:** Name: ______________ Strength: ______
Dose: _____ Route: ______ Time Interval: ☐ ___ hrs

In-School Instructions

☐ **Standard Order:** Give 2 puffs/1 AMP q 4 hrs. PRN for coughing, wheezing, tight chest, difficulty breathing or shortness of breath ("asthma flare symptoms"). Monitor for 20 mins or until symptom-free. If not symptom-free within 20 mins may repeat ONCE.
If in Respiratory Distress*: Call 911 and give 6 puffs/1AMP; may repeat q 20 minutes until EMS arrives.

☐ **Pre-exercise:** 2 puffs/1 AMP 15-20 mins before exercise.

☐ **URI Symptoms or Recent Asthma Flare (within 5 days):** 2 puffs/1 AMP @ noon for 5 days.

Special Instructions:

Controller Medications for In-School Administration
(Recommended for Persistent Asthma, per NAEPP Guidelines)

☐ **Fluticasone MDI** [*Flovent® 110 mcg MDI can be provide by school for shared usage*]: **[Parent must sign back]**
☐ MDI w/ spacer
☐ DPI

☐ **Other:** Name: ______________ Strength: ______
Dose: _____ Route: ______ Time Interval: ☐ ___ hrs

☐ **Standing Daily Dose:**
___ puffs/1AMP ONCE a day at ___ AM or ___ PM
Special Instructions:

Select the most appropriate option for this student:
☐ Nurse-Dependent Student: nurse must administer medication
☐ Supervised Student: student self-administers under adult supervision
☐ Independent Student: student is self-carry / self-administer (****Parent Initials Back**)

Practitioner Initials: ____ *I attest student demonstrated the ability to self-administer the prescribed medication effectively for school / field trips / school sponsored events.*

Home Medications (include over the counter)
☐ Reliever ______________
☐ Controller ______________
☐ Other ______________

Health Care Practitioner Last Name First Name (Please Print)

Signature

Date __ __/__ __/__ __ __ __

Address

Tel. (_ _ _)_ _ _-_ _ _ _

Fax (_ _ _)_ _ _-_ _ _ _

NPI # _ _ _ _ _ _ _ _ _ _

Email Address

NYS License # **(Required)**

CDC and AAP strongly recommend annual influenza vaccination for all children diagnosed with asthma.

FAX COMPLETED FORMS TO 347-396-8945. INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS. REV 4/17

Turn to PAGE 2 →

FORMS CANNOT BE COMPLETED BY A RESIDENT

ASTHMA MEDICATION ADMINISTRATION FORM

ASTHMA PROVIDER MEDICATION ORDER—Office of School Health—School Year ______-______

The Following Section To Be Completed By Student's **Parent/Guardian**

I hereby consent to the storage and administration of medication, as well as the storage and use of necessary equipment to administer medication, in accordance with the instructions of my child's health care practitioner. I understand that I must provide the school with the medication and equipment necessary to administer medication, including non-Ventolin inhalers. Medication is to be provided in a properly labeled original container from the pharmacy (another such container should be obtained by me for my child's use outside of school); the label on the prescription medication must include the name of the student, name and telephone number of the pharmacy, licensed prescriber's name, date and number of refills, name of medication, dosage, frequency of administration, route of administration and/or other directions; over the counter medications and drug samples must be in the manufacturer's original container, with the student's name affixed to that container. I **understand that all provided medication must be supplied in its original and UNOPENED medication box.** I further understand that I must immediately advise the school nurse of any change in the prescription or instructions stated above.

I understand that no student will be allowed to carry or self-administer controlled substances. I understand that this consent is only valid until the end of a New York City Department of Education ("DOE") sponsored summer instruction program session; or such time that I deliver to the school nurse a new prescription or instructions issued by my child's health care practitioner (whichever is earlier). By submitting this MAF, I am requesting that my child be provided specific health services by DOE and the New York City Department of Health and Mental Hygiene (DOHMH) through the Office of School Health (OSH). I understand that these services may include a clinical assessment and a physical examination by an OSH health care practitioner. Full and complete instructions regarding the above-requested health service(s) are included in this MAF. I understand that OSH and their agents, and employees involved in the provision of the above-requested health service(s) are relying on the accuracy of the information provided in this form. I understand that 30 days before the above-mentioned MAF expiration date, an OSH health care practitioner may examine my child to evaluate his/her asthma symptoms and my child's response to the prescribed medication, and may issue a new MAF. If the OSH health care practitioner determines that no changes to the orders in the MAF are necessary, the OSH health care practitioner may issue a new MAF with the same orders to expire in one year unless my child's health care practitioner provides a new MAF. If an OSH health care practitioner determines based on an examination of my child and pertinent medical history that the orders in the MAF should be changed, the OSH health care practitioner may issue a new MAF with different orders. I, along with my child's health care practitioner of record, will be notified of the issuance of new MAF and of any change in the MAF orders. I further understand that I will have until 30 days before the expiration date of this MAF to submit a new MAF, or to object to this examination in writing, to the school nurse. If I do not submit a new MAF to the school nurse, or notify the school nurse in writing that I object to my child being examined by an OSH health care practitioner, by this deadline, my child may be examined and a new MAF may be issued. I recognize that this form is not an agreement by OSH and DOE to provide the services requested, but rather my request/consent for such services. If it is determined that these services are necessary, a Student Accommodation Plan may also be necessary and will be completed by the school. I understand that OSH and DOE and their employees and agents, may contact, consult with and obtain any further information they may deem appropriate relating to my child's medical condition, medication and/or treatment, from any health care practitioner and/or pharmacist that has provided medical or health services to my child.

****SELF-ADMINISTRATION OF MEDICATION: Initial below for use of an epinephrine, asthma inhaler and other approved self-administered medications:**

☐ Parent Initials — I hereby certify that my child has been fully instructed and is capable of self-administration of the prescribed medication. I further consent to my child's carrying, storage and self-administration of the above-prescribed medication in school. I acknowledge that I am responsible for providing my child with such medication in containers labeled as described above, for any and all monitoring of my child's use of such medication, and for any and all consequences of my child's use of such medication in school. I understand that the school nurse will confirm my child's ability to self-carry and self-administer in a responsible manner. In addition, I agree to provide "back up" medication in a clearly labeled container to be kept in the medical room in the event my child does not have sufficient medication to self-administer.

☐ Parent Initials — I consent to the school nurse storing and/or administering to my child such medication in the event that my child is temporarily incapable of self-storage and self-administration of such medication.

☐ Parent Initials — I hereby certify that I have consulted with my child's health care practitioner and that I consent to the Office of School Health administering stock medication in the event that my child's asthma prescription medication is unavailable.

You must send your child's personal Metered Dose Inhaler (MDI) with your child on a school trip day so that he/she has it available. The stock medication is only for use while your child is in the school building.

Student Last Name	First	MI	Date of Birth __ __/__ __/__ __ __ __	School

Print Parent/Guardian's Name: ______________________ **Parent/Guardian's** Signature: ______________________

Date Signed __ __/__ __/__ __ __ __ Parent/Guardian's Address: Email:

Cell Phone (_ _ _) _ _ _-_ _ _ _ Other Phone (_ _ _) _ _ _-_ _ _ _ **Email:** ______________________

Alternate Emergency Contact Name: ______________________ Emergency Contact Phone: (_ _ _) _ _ _-_ _ _ _

For OFFICE OF SCHOOL HEALTH (OSH) Only

Received By Name: ______________ Date __/__/__ | Reviewed By Name: ______________ Date __/__/__

Self-Administers/Self-Carries: ☐Yes ☐No | Services Provided By ☐Nurse ☐School-Based Health Center ☐OSH Public Health Advisor* ☐OSH Asthma Case Manager*

Supervised Student* ☐Yes ☐No

Signature and Title (RN OR MD/DO/NP): ______________________ ☐ IEP

Revisions per Office of School Health after consultation with prescribing practitioner:

*Respiratory Distress: includes breathlessness at rest, tachypnea, cyanosis, pallor, hunching forward, nasal flaring, accessory respiratory muscle use, abdominal breathing, shallow rapid breathing, mouthing words, wheezing throughout expiration and inspiration or decreased or absent breath sounds, agitation, drowsiness, confusion or exceptionally quiet appearance.

MEDICATION ADMINISTRATION FORM

THIS FORM SHOULD BE USED FOR NON-ALLERGY / NON-ASTHMA MEDICATIONS ONLY

Provider Medication Order Form—Office of School Health—School Year **2017–2018**

ATTACH STUDENT PHOTO HERE	**Student** Last Name / First Name / Middle	**Date of birth** __/__/____ (MM DD YYYY)	☐ Male ☐ Female
		OSIS Number _________	
	School (include name, number, address and borough)	**DOE District** __	**Grade** / **Class**

The following sections to be completed by Student's **HEALTH CARE PRACTITIONER**

1. Diagnosis: ____________ ICD-10 Code ☐ ___.___

Medication: ____________
Generic and/or Brand Name

Preparation/Concentration: ____________

Dose: ____________ Route: ____________

Select the most appropriate option for this student:
- ☐ Nurse-Dependent Student: nurse must administer medication
- ☐ Supervised Student: student self-administers, under adult supervision
- ☐ Independent Student: student is self-carry / self-administer (NOT ALLOWED FOR CONTROLLED SUBSTANCES):**

______ **Practitioner's initials**	I attest student demonstrated ability to self-administer the prescribed medication effectively for school/field trips/school-sponsored events **PARENT MUST INITIAL REVERSE**

In School Instructions
- ☐ Standing daily dose: at __:__ AM / PM and __:__ AM / PM

AND/OR

- ☐ PRN ____________

specify signs, symptoms, or situations

- ☐ Time interval: __ minutes or __ hours as needed.
- ☐ If no improvement, repeat in __ minutes or __hours for a maximum of __ times.

Conditions under which medication should not be given:

2. Diagnosis: ____________ ICD-10 Code ☐ ___.___

Medication: ____________
Generic and/or Brand Name

Preparation/Concentration: ____________

Dose: ____________ Route: ____________

Select the most appropriate option for this student:
- ☐ Nurse-Dependent Student: nurse must administer medication
- ☐ Supervised Student: student self-administers, under adult supervision
- ☐ Independent Student: student is self-carry / self-administer (NOT ALLOWED FOR CONTROLLED SUBSTANCES):**

______ **Practitioner's initials**	I attest student demonstrated ability to self-administer the prescribed medication effectively for school/field trips/school-sponsored events **PARENT MUST INITIAL REVERSE**

In School Instructions
- ☐ Standing daily dose: at __:__ AM / PM and __:__ AM / PM

AND/OR

- ☐ PRN ____________

specify signs, symptoms, or situations

- ☐ Time interval: __ minutes or __ hours as needed.
- ☐ If no improvement, repeat in __ minutes or __hours for a maximum of __ times.

Conditions under which medication should not be given:

3. Diagnosis: ____________ ICD-10 Code ☐ ___.___

Medication: ____________
Generic and/or Brand Name

Preparation/Concentration: ____________

Dose: ____________ Route: ____________

Select the most appropriate option for this student:
- ☐ Nurse-Dependent Student: nurse must administer medication
- ☐ Supervised Student: student self-administers, under adult supervision
- ☐ Independent Student: student is self-carry / self-administer (NOT ALLOWED FOR CONTROLLED SUBSTANCES):**

______ **Practitioner's initials**	I attest student demonstrated ability to self-administer the prescribed medication effectively for school/field trips/school-sponsored events **PARENT MUST INITIAL REVERSE**

In School Instructions
- ☐ Standing daily dose: at __:__ am / pm and __:__ AM / PM

AND/OR

- ☐ PRN ____________

specify signs, symptoms, or situations

- ☐ Time interval: __ minutes or __ hours as needed.
- ☐ If no improvement, repeat in __ minutes or __hours for a maximum of __ times.

Conditions under which medication should not be given:

HOME Medications (include over-the counter)	**For Office of School Health (OSH) Use Only**
	Revisions per OSH after consultation with prescribing health care practitioner. ☐ IEP

Health Care Practitioner (Please Print) LAST NAME	FIRST NAME		Signature
Address	Tel. No. (___)___-____		Fax. No (___)___-____
E-mail address	Cell phone (___)___-____		
NYS License No **(Required)** ___-______	NPI No. __________		Date __/__/____

INCOMPLETE PRACTITIONER INFORMATION WILL DELAY IMPLEMENTATION OF MEDICATION ORDERS

FORMS CANNOT BE COMPLETED BY A RESIDENT

TURN TO PAGE 2 »

MEDICATION ADMINISTRATION FORM

THIS FORM SHOULD BE USED FOR NON-ALLERGY / NON-ASTHMA MEDICATIONS ONLY

Provider Medication Order Form—Office of School Health—School Year 2017–2018

The Following Section To Be Completed By Student's Parent/Guardian

hereby consent to the storage and administration of medication, as well as the storage and use of necessary equipment to administer nedication, in accordance with the instructions of my child's health care practitioner. I understand that I must provide the school with the nedication and equipment necessary to administer medication, including non-Ventolin inhalers. Medication is to be provided in a properly abeled original container from the pharmacy (another such container should be obtained by me for my child's use outside of school); the abel on the prescription medication must include the name of the student, name and telephone number of the pharmacy, licensed rescriber's name, date and number of refills, name of medication, dosage, frequency of administration, route of administration and/or other irections; over the counter medications and drug samples must be in the manufacturer's original container, with the student's name affixed that container. I understand that all provided medication must be supplied in its original and UNOPENED medication box. I further nderstand that I must immediately advise the school nurse of any change in the prescription or instructions stated above.

understand that no student will be allowed to carry or self-administer controlled substances.

understand that this consent is only valid until the end of a New York City Department of Education ("DOE") sponsored summer instruction rogram session; or such time that I deliver to the school nurse a new prescription or instructions issued by my child's health care practitioner vhichever is earlier). By submitting this MAF, I am requesting that my child be provided specific health services by DOE and the New York ity Department of Health and Mental Hygiene (DOHMH) through the Office of School Health (OSH). I understand that these services may clude a clinical assessment and a physical examination by an OSH health care practitioner. Full and complete instructions regarding the bove- requested health service(s) are included in this MAF. I understand that OSH and their agents, and employees involved in the provision the above- requested health service(s) are relying on the accuracy of the information provided in this form. I recognize that this form is ot an agreement by the Department or DOHMH to provide the services requested, but, rather, my request and consent for such services. it is determined that these services are necessary, a Student Accommodation Plan may also be necessary and will be completed by the chool. I understand that the Department, DOHMH and their employees and agents, may contact, consult with and obtain any further formation they may deem appropriate relating to my child's medical condition, medication and/or treatment, from any health care actitioner and/or pharmacist that has provided medical or health services to my child.

SELF-ADMINISTRATION OF MEDICATION:

Initial this paragraph for use of an epinephrine, asthma inhaler and other approved self-administered medications:

______ INITIAL	I hereby certify that my child has been fully instructed and is capable of self-administration of the prescribed medication. I further consent to my child's carrying, storage and self-administration of the above-prescribed medication in school. I acknowledge that I am responsible for providing my child with such medication in containers labeled as described above, for any and all monitoring of my child's use of such medication, and for any and all consequences of my child's use of such medication in school. I understand that the school nurse will confirm my child's ability to self-carry and self-administer in a responsible manner. In addition, I agree to provide "back up" medication in a clearly labeled container to be kept in the medical room in the event my child does not have sufficient medication to self-administer.
______ INITIAL	I consent to the school nurse storing and/or administering to my child such medication in the event that my child is temporarily incapable of self-storage and self-administration of such medication.

SIGN HERE

udent Last Name First Name	Date of birth __/__/____ School
nt Parent/Guardian's Name	Parent/Guardian's Signature
rent/Guardian's Address	Date Signed __/__/____

lephone Numbers: Daytime (___)___-____ Home (___)___-____ Cell Phone (___)___-____

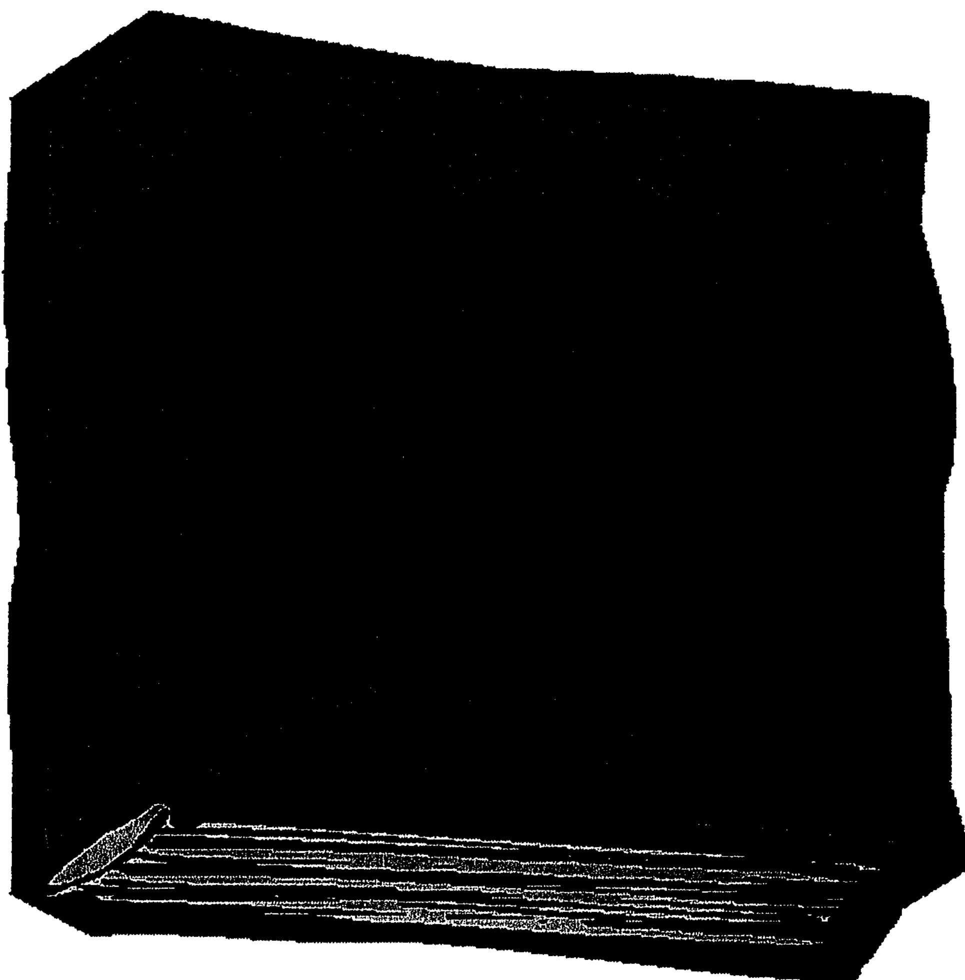
ernate Emergency Contact's Name	Contact Telephone Number (___)___-____

For OFFICE OF SCHOOL HEALTH (OSH) Only

ceived by: Name Date __/__/____	Reviewed by: Name Date __/__/____
ferred to School 504 Coordinator: ☐ Yes ☐ No	Self-Administers/Self-Carries: ☐ Yes ☐ No
rvices provided by: ☐ Nurse ☐ OSH Public Health Advisor ☐ School Based Health Center	
nature and Title (RN OR MD/DO/NP):	Date School Notified & Form Sent to DOE Liaison __/__/____

The Lorge School

353 W. 17th Street, New York, NY 10011
T: (212) 929-8660 F: (212) 989-8249
admissions@lorgeschool.org



NAME:______________________________________

Overview:

The Lorge School has been chartered by New York State for over fifty-years to provide special education services for students with learning and emotional disabilities, and other health impaired.

The Lorge School is located in the Chelsea neighborhood of Manhattan and serves students from every borough of New York City. The school intentionally limits capacity to 96 students in order to maintain its personal and supportive environment.

Mission:

The Lorge School's mission is to create a safe and nurturing community for our students, staff and their families. This is a community that promotes the intellectual, emotional and social growth of the whole child. The Lorge School maintains a structured environment for all students, staff and families. This environment built on nurture, understanding and mutual respect that enables each student to reach their potential as independent, responsible and productive citizens.

CHANGE OF ADDRESS AND/OR TELEPHONE NUMBER

It is IMPERITAIVE that The Lorge School has the most up to date contact information for all our students. Please promptly notify the school if your address and/or telephone number changes. Inform the school secretary or the school administration.

SCHOOL COMMUNITY

Parents, guardians, and family members help to form the school's community. We invite parents to call us with questions, concerns, or simply to share information. We want you to come to school when needed, to attend all meetings and to volunteer services by chaperoning field trips or being a class parent. School staff will be calling you on a regular basis to keep you up to date with your child's progress.

POSSESSION OF CELL PHONES, IPODS, ELECTRONICS

Students are strongly advised NOT to bring cell phones, ipods, game electronics, or other expensive electronics to school. **The Lorge School will not be responsible for these items if they are lost, stoles, or damaged.** If a student does arrive at school with

SUCH AN ITEM, THE STUDENT SHOULD IS REQUIRED TO GIVE IT IN TO A STAFF MEMBER FOR SAFE KEEPING UNTIL THE END OF THE DAY. ELECTRONIC ITEMS THAT ARE CONFISCATED FROM STUDENTS FOR BEING USED IN THE CLASSROOM OR IN INAPPROPRIATE WAYS DURING THE SCHOOL DAYS, WILL ONLY BE RETURNED TO A PARENT OR THEIR DESIGNEE.

EMERGENCY CONTACT

THE SCHOOL MUST HAVE ON FILE FOR EVERY STUDENT THE NAME AND TELEPHONE NUMBER OF AN EMERGENCY CONTACT PERSON. THIS IS NEEDED IN CASE THE STUDENT SHOULD BECOME ILL OR OTHERWISE REQUIRE EMERGENCY ATTENTION.

MEDICATION

IF A STUDENT REQUIRES MEDICATION, THE PARENT/GUARDIAN IS ASKED TO CALL THE SCHOOL AND DISCUSS THE MATTER WITH THE CHILD'S COUNSELOR AND SCHOOL NURSE. PLEASE DO NOT SEND MEDICATION TO SCHOOL WITH A STUDENT WITHOUT FIRST SPEAKING TO LORGE STAFF. IF MEDICATION MUST BE ADMINISTERED AT SCHOOL, PARENTS ARE ASKED TO SPEAK WITH THE SCHOOL NURSE AND SIGN AUTHORIZATION FORMS. PARENTS IN CONJUNCTION WITH PRESCRIBING DOCTORS MUST COMPLETE A 504 FORM TO BE APPROVED PRIOR TO THE LORGE SCHOOL ADMINISTERING MEDICATION.

SCHOOL BUS TRANSPORTATION

IF THERE ARE ANY QUESTIONS OR CONCERNS REGARDING SCHOOL BUSES, PARENT/GUARDIANS SHOULD CONTACT OFFICE OF PUPIL TRANSPORTATION DIRECTLY. THE LORGE SCHOOL HAS NO CONTROL OVER BUSING. THE NUMBER FOR THE OFFICE OF PUPIL TRANSPORTATION IS 718-784-3313 OR THE TRANSPORTATION HOTLINE IS 718-392-8855. IN SOME CIRCUMSTANCES, THE DEAN OF STUDENTS WILL BE ABLE TO ASSIST YOU.

EDUCATIONAL RECORDS

PLEASE BE ADVISED OF THE FOLLOWING IN REGARD TO ACCESS AND CONFIDENTIALITY OF YOUR CHILD'S RECORDS:

1. YOUR CHILD'S RECORDS AT THE LORGE SCHOOL ARE AVAILABLE FOR YOUR REVIEW BETWEEN THE HOURS OF 10:00AM - 2:00PM DAILY OR BY SPECIAL APPOINTMENT. WE REQUEST, HOWEVER, THAT YOU GIVE THE SCHOOL THREE DAYS NOTICE SO WE MAY SCHEDULE THE APPROPRIATE PERSON TO ASSIST YOU.

2. The Lorge School will not disclose information contained in the records without prior written consent of the parent/guardian or eligible student except as permitted by law.

3. The Lorge School maintains a record of request for disclosures made for educational records and a log of access of records of all students. This information is available for your examination.

4. All parents/guardians or eligible students have the right to seek correction of our records through a request to amend the record and/or a hearing. All parents/guardians and/or eligible students also have the right to place a written rebuttal against any information in the record.

5. Procedures regarding disputed records and/or the destruction of records are available at The Lorge School.

6. There will be no charge to the parent/guardian or eligible student to search, retrieve or to make appropriate copies of the records.

Please contact the school if you have questions about your child's educational records.

SUSPENSION PROCEDURES AND DISCIPLNE MEASURES

It is imperative that The Lorge School's responses to student misconduct be addressed by all of the school's departments in accordance to NYSDOE regulations. The vast majority of inappropriate student behavior is remedied according to a specific student's BIP, parent support or loss of privileges in an effective and timely manner.

Rarely it is necessary to separate a student from school for a brief period. The decision to suspend a student can only be made by management. Suspension from school is a severe consequence and it is only considered when a student's behavior presents a clear and present danger of physical injury to the student, other students or

SCHOOL PROPERTY, OR PREVENTS THE ORDERLY OPERATION OF CLASSES OR OTHER SCHOOL ACTIVITIES.

WHEN A STUDENT IS SUSPENDED AND DUE TO MISCONDUCT FOR FIVE DAYS OR LESS, PURSUANT TO EDUCATION LAW 3214(3), THE MANAGEMENT WILL TELEPHONE THE PERSON IN PARENTAL RELATIONSHIP TO THE STUDENT, AND EXPLAIN THE INCIDENT PROPOSING SUSPENSION. DURING THIS CONVERSATION, THE MANAGEMENT WILL INFORM THE PERSON IN PARENTAL RELATIONSHIP TO THE STUDENT OF THEIR RIGHT TO AN INFORMAL CONFERENCE PRIOR TO MAKING THE SUSPENSION EFFECTIVE AND INFORM THE AVAILABILITY OF ALTERNATIVE INSTRUCTION.

IN ACCORDANCE WITH THE NYCDOE, THE LORGE SCHOOL WILL FOLLOW THE, CITYWIDE STANDARDS OF INTERVENTION AND DISCIPLINE MEASURES LOCATED: (HTTP://SCHOOLS.NYC.GOV/NR/RDONLYRES/188AF3E2-F12B-4754-8471-F2EFB344AE2B/0/DISCCODEBOOKLET2013FINAL.PDF)

A WRITTEN NOTICE OF STUDENT SUSPENSION IN THE PARENT'S DOMINANT LANGUAGE WILL BE MAILED NEXT DAY DELIVERY INCLUDING: A DESCRIPTION OF THE CHARGES AGAINST THE STUDENT AND THE INCIDENT FOR WHICH SUSPENSION IS PROPOSED, DATE(S) OF SUSPENSION, THE RIGHT TO REQUEST AN INFORMAL CONFERENCE, AND AVAILABILITY OF ALTERNATIVE INSTRUCTION AT THE LORGE SCHOOL.

SHOULD THE PARENTS REQUEST AND ATTEND AN INFORMAL CONFERENCE, THEY WILL BE PERMITTED TO ASK QUESTIONS OF COMPLAINING WITNESSES UNDER SUCH PROCEDURES AS THE SCHOOL MAY ESTABLISH. A PARENTS' NOTICE AND OPPORTUNITY FOR AN INFORMAL CONFERENCE SHOULD TAKE PLACE BEFORE THE STUDENT IS SUSPENDED UNLESS THE STUDENT'S PRESENCE IN SCHOOL POSES A CONTINUING DANGER TO PERSONS, PROPERTY OR THE STUDENTS IS AN ONGOING THREAT OF DISRUPTION TO THE ACADEMIC PROCESS. IF THE STUDENT'S PRESENCE DOES POSE SUCH A DANGER OR THREAT OF DISRUPTION, THE NOTICE AND OPPORTUNITY FOR AN INFORMAL CONFERENCE WILL TAKE PLACE AS SOON AFTER THE SUSPENSION AS IS REASONABLY PRACTICABLE.

WHEN A STUDENT IS SUSPENDED FROM SCHOOL, PURSUANT TO EDUCATION LAW 3214, THE LORGE SCHOOL WILL PROVIDE ALTERNATIVE MEANS OF INSTRUCTION. THIS INSTRUCTION WILL ENABLE THE STUDENT TO CONTINUE TO PARTICIPATE IN THE CURRICULUM AND TO RECEIVE SERVICES AND MODIFICATIONS, INCLUDING THOSE IN THE IEP THAT WILL HELP THE STUDENT

MEET THE GOALS OF THEIR IEP. ALTERNATIVE INSTRUCTION WILL BE AVAILABLE EACH DAY OF SUSPENSION BETWEEN 3-4 PM FOR ELEMENTARY STUDENTS AND 3-5 PM FOR SECONDARY STUDENTS. A SUSPENDED STUDENT'S TEACHER WILL BE ASKED TO PROVIDE THIS INSTRUCTION FOR HOURLY PAY AS PER THE UFT CONTRACT. IF THE STUDENT'S TEACHER IS UNABLE TO WORK AFTER-SCHOOL, THE INSTRUCTIONAL SUPERVISOR WILL SEEK ANOTHER REASONABLE REPLACEMENT TO PROVIDE INSTRUCTION.

INFORMATION REGARDING STUDENTS SUSPENDED FOR MORE THAN 10 CONSECUTIVE OR CUMULATIVE DAYS AND THE MDR PROCESS ARE BELOW:

MANIFESTATION DETERMINATION REVIEW

DISCIPLINARY CHANGE IN PLACEMENT MEANS A SUSPENSION OR REMOVAL FROM A STUDENT'S CURRENT EDUCATIONAL PLACEMENT THAT IS EITHER:

(1) FOR MORE THAN 10 CONSECUTIVE SCHOOL DAYS; OR

(2) FOR A PERIOD OF 10 CONSECUTIVE DAYS OR LESS IF THE STUDENT IS SUBJECTED TO A SERIES OF SUSPENSIONS OR REMOVALS THAT CONSTITUTE A PATTERN BECAUSE THEY CUMULATE TO MORE THAN 10 SCHOOL DAYS IN A SCHOOL YEAR; BECAUSE THE STUDENT'S BEHAVIOR IS SUBSTANTIALLY SIMILAR TO THE STUDENT'S BEHAVIOR IN PREVIOUS INCIDENTS THAT RESULTED IN THE SERIES OF REMOVALS; AND BECAUSE OF SUCH ADDITIONAL FACTORS AS THE LENGTH OF EACH SUSPENSION OR REMOVAL, THE TOTAL AMOUNT OF TIME THE STUDENT HAS BEEN REMOVED AND THE PROXIMITY OF THE SUSPENSIONS OR REMOVALS TO ONE ANOTHER. THE LORGE SCHOOL DETERMINES ON A CASE-BY-CASE BASIS WHETHER A PATTERN OF REMOVALS CONSTITUTES A CHANGE OF PLACEMENT. THIS DETERMINATION IS SUBJECT TO REVIEW THROUGH DUE PROCESS IN CONSULTATION WITH THE NYCDOE CSE.

GENERAL REQUIREMENTS FOR MANIFESTATION REVIEW: THIS IS A REVIEW OF THE RELATIONSHIP BETWEEN THE STUDENT'S DISABILITY AND THE BEHAVIOR SUBJECT TO DISCIPLINARY ACTION TO DETERMINE IF THE CONDUCT IS A MANIFESTATION OF THE DISABILITY MUST BE MADE IMMEDIATELY, IF POSSIBLE, BUT IN NO CASE LATER THAN 10 SCHOOL DAYS AFTER:

(1) A DECISION IS MADE BY THE LORGE SCHOOL ADMINISTRATION WITH THE NYCDOE CSE TO CHANGE THE PLACEMENT OF A STUDENT TO AN INTERIM ALTERNATIVE EDUCATIONAL SETTING PURSUANT TO SECTION 201.7(E) OF THIS PART; OR

(2) A DECISION IS MADE BY AN IMPARTIAL HEARING OFFICER THROUGH THE NYCDOE TO PLACE A STUDENT IN AN INTERIM ALTERNATIVE EDUCATIONAL SETTING PURSUANT TO SECTION 201.8 OF THIS PART; OR
(3) A DECISION IS MADE BY THE LORGE SCHOOL ADMINISTRATION WITH THE NYCDOE CSE PURSUANT TO SECTION 201.7(A) OR (B) OF THIS PART TO IMPOSE A SUSPENSION THAT CONSTITUTES A DISCIPLINARY CHANGE IN PLACEMENT.

INDIVIDUALS TO CARRY OUT REVIEW: THIS REVIEW DESCRIBED IN SUBDIVISION (A) OF THIS SECTION SHALL BE CONDUCTED BY A MANIFESTATION TEAM IN A MEETING, WHICH SHALL INCLUDE THE LORGE SCHOOL STAFF MEMBERS KNOWLEDGEABLE ABOUT THE STUDENT AND THE INTERPRETATION OF INFORMATION ABOUT CHILD BEHAVIOR, THE PARENT AND RELEVANT MEMBERS OF THE CSE AS DETERMINED BY THE PARENT AND NYCDOE. THE PARENT MUST RECEIVE WRITTEN NOTIFICATION PRIOR TO ANY MANIFESTATION TEAM MEETING TO ENSURE THAT THE PARENT HAS AN OPPORTUNITY TO ATTEND. THE NOTIFICATION SHALL INFORM THE PARENT OF THE PURPOSE OF THE MEETING, THE NAMES OF THE INDIVIDUALS EXPECTED TO ATTEND AND INFORM THE PARENT OF HIS OR HER RIGHT TO HAVE RELEVANT MEMBERS OF THE CSE PARTICIPATE AT THE PARENT'S REQUEST.

CONDUCT OF REVIEW: THE MANIFESTATION TEAM SHALL REVIEW ALL RELEVANT INFORMATION IN THE STUDENT'S FILE INCLUDING THE STUDENT'S IEP, ANY TEACHER OBSERVATIONS, AND ANY RELEVANT INFORMATION PROVIDED BY THE PARENTS TO DETERMINE IF:

(1) THE CONDUCT IN QUESTION WAS CAUSED BY OR HAD A DIRECT AND SUBSTANTIAL RELATIONSHIP TO THE STUDENT'S DISABILITY; OR
(2) THE CONDUCT IN QUESTION WAS THE DIRECT RESULT OF THE SCHOOL DISTRICT'S FAILURE TO IMPLEMENT THE IEP.

DETERMINATION: THE CONDUCT MUST BE DETERMINED TO BE A MANIFESTATION OF THE STUDENT'S DISABILITY OR TO NOT BE A MANIFESTATION OF THE STUDENT'S DISABILITY. IF THE MANIFESTATION TEAM DETERMINES THAT A CONDITION OF THE ABOVE WAS MET, THE SUSPENSION AND CHANGE OF PLACEMENT TAKES PLACE. IF THE MANIFESTATION TEAM DETERMINES THAT THE CONDUCT WAS A MANIFESTATION OF THE STUDENT'S DISABILITY, THE LORGE SCHOOL AND THE CSE SHALL:

(I) CONDUCT A FUNCTIONAL BEHAVIORAL ASSESSMENT AND IMPLEMENT A BEHAVIORAL INTERVENTION PLAN FOR SUCH STUDENT IN ACCORDANCE WITH SECTION 201.3 OF THIS PART; AND

(II) EXCEPT AS PROVIDED IN SECTION 201.7(E) OF THIS PART, RETURN THE STUDENT TO THE PLACEMENT FROM WHICH THE STUDENT WAS REMOVED, UNLESS THE PARENT AND THE LORGE SCHOOL/NYCDOE CSE AGREE TO A CHANGE OF PLACEMENT AS PART OF THE MODIFICATION OF THE BEHAVIORAL INTERVENTION PLAN.

IN ADDITION THE SUSPENSION IS EXPUNGED AND THE STUDENT IS RETURNED TO THEIR PLACEMENT AT THE LORGE SCHOOL WITH MODIFICATIONS NECESSARY ON THEIR IEP.

DEFICIENCIES IN IEP: IF THE MANIFESTATION TEAM DETERMINES THE CONDUCT IN QUESTION WAS THE DIRECT RESULT OF THE SCHOOL DISTRICT'S FAILURE TO IMPLEMENT THE IEP, THE SCHOOL DISTRICT MUST TAKE IMMEDIATE STEPS TO REMEDY THOSE DEFICIENCIES.

TIME-OUT ROOMS

DE-ESCALATION OR "TIME OUT" IS A TECHNIQUE USED TO INTERRUPT AN UNACCEPTABLE BEHAVIOR BY REMOVING THE STUDENT FROM THE SITUATION WHERE THE MISBEHAVIOR IS OCCURRING. THE STATE DOES NOT REGULATE THE USE OF TIME OUT, BUT DOES REGULATE THE USE OF A SEPARATE ROOM WHERE A STUDENT MAY BE REMOVED FOR PURPOSES OF "TIME OUT."

STATE REGULATIONS DEFINE A TIME OUT ROOM AS AN AREA FOR A STUDENT TO SAFELY DEESCALATE, REGAIN CONTROL AND PREPARE TO MEET EXPECTATIONS TO RETURN TO HIS OR HER EDUCATION PROGRAM. TIME OUT ROOMS ARE TO BE USED IN CONJUNCTION WITH A BEHAVIORAL INTERVENTION PLAN IN WHICH A STUDENT IS REMOVED TO A SUPERVISED AREA IN ORDER TO FACILITATE SELF-CONTROL OR TO REMOVE A STUDENT FROM A POTENTIALLY DANGEROUS SITUATION.

WHEN CAN A TIME OUT ROOM BE USED?

EXCEPT FOR UNANTICIPATED SITUATIONS THAT POSE AN IMMEDIATE CONCERN FOR THE PHYSICAL SAFETY OF A STUDENT OR OTHERS, THE USE OF A TIME OUT ROOM CAN ONLY BE USED IN CONJUNCTION WITH A BEHAVIORAL INTERVENTION PLAN THAT IS DESIGNED TO TEACH AND REINFORCE ALTERNATIVE APPROPRIATE BEHAVIORS.

AT THE LORGE SCHOOL, THE 2ND AND 3RD FLOOR DE-ESCALATION ROOMS ARE SAFE SPACES WHERE THE STUDENT CAN MANAGE THEIR FEELINGS; TAKE TIME TO REFLECT ON THEIR BEHAVIOR AND ULTIMATELY WORK ON TENSION REDUCTION THROUGH THERAPEUTIC RAPPORT AND RETURN TO THE

CLASSROOM ENVIRONMENT. THE DE-ESCALATION ROOMS (USED FOR TIME-OUT) AT THE LORGE SCHOOL ARE MONITORED AND MAINTAINED BY THE BEHAVIORAL/CRISIS INTERVENTIONIST, SUPERVISED BY THE DEAN OF STUDENTS.

FIELD TRIPS

STUDENTS TAKING SCHOOL FIELD TRIPS ARE REMINDED THAT ALL STUDENT CONDUCT RULES APPLY. AT NO TIME IS SMOKING PERMITTED ON TRIPS. PARENT OR GUARDIAN MAY BE INVITED TO CHAPERONE AND PARTICIPATE IN THESE EXPERIENCES. PARENT/GUARDIAN MUST PROVIDE THE SCHOOL WITH A SIGNED CONSENT FORM FOR EACH FIELD TRIP.

ATTENDANCE FOR STUDENTS

EACH STUDENT IS TO BE IN SCHOOL EVERY DAY THAT SCHOOL IS IN SESSION. IF A STUDENT IS ABSENT, THE PARENT/GUARDIAN SHOULD CALL THE SCHOOL BEFORE 9:00 A.M. UPON RETURN A NOTE SIGNED BY PARENT/GUARDIAN OR DOCTOR STATING THE REASON FOR ABSENCE SHOULD BE BROUGHT TO THE CLASSROOM TEACHER. IF THE SCHOOL IS NOT PROPERLY NOTIFIED AS TO THE REASON(S) FOR ABSENCE(S), ABSENCE(S) WILL BE CONSIDERED UNEXCUSED. THE SCHOOL IS OBLIGATED TO NOTIFY THE CSE OF ALL UNEXCUSED ABSENCES. THE CSE WILL CONDUCT FOLLOW-UP ACTIVITIES, AS WARRANTED AND UNEXCUSED ABSENCES COULD RESULT IN THE STUDENT LOSING THEIR PLACEMENT AT THE LORGE SCHOOL.

- **EXAMPLES OF EXCUSED ABSENCES: ILLNESS, MEDICAL APPOINTMENTS, AND TRANSPORTATION**
- **EXAMPLES OF UNEXCUSED ABSENCES: BABYSITTING, VISITING FAMILY OR FRIENDS**

SPECIAL DISMISSAL: A STUDENT IS GRANTED EARLY DISMISSAL IN EMERGENCY SITUATIONS OR IF APPOINTMENTS CANNOT BE MADE ON OTHER THAN SCHOOL TIME. A SIGNED, WRITTEN NOTE FROM THE PARENT/GUARDIAN REQUESTING SUCH A DISMISSAL SHOULD BE BROUGHT TO THE CLASSROOM TEACHER **BEFORE** REQUESTING A DIFFERENT DISMISSAL TIME.

IMPORTANT: NO STUDENT CAN BE DISMISSED EARLY WITHOUT A WRITTEN OR TELEPHONE REQUEST FROM A PARENT/GUARDIAN.

DRESS

Lorge has an informal dress code. However, there are rules that must be followed. No reference to drugs, pornography, or obscene language is permitted on shirts, hats, etc. No hats or caps are worn in school. Students are not to wear pants below the waist or hips. Bandanas and/or Doo-Rags are prohibited. Female students may not wear low-cut tops. If students wear inappropriate clothing, they will be provided with something appropriate or the parent/guardian will be requested to take the child home. Students will not be allowed to comb their hair or clip their nails in school for hygienic reasons.

FIRE DRILLS

During fire drills students are to leave the building with the class in a quick, quiet, and orderly manner. In order for the Fire Department to have quick and easy access to the building, all students and staff must stand at a safe distance away from the building and remain with their class. Please wait until the administration gives the signal to return to the building.

GRAFITTI MARKERS

Markers are permitted during Art class or at other activities approved and supervised by staff. Any markers used outside of these activities will be confiscated.

HOMEWORK

Homework is assigned at The Lorge School. Homework reinforces classroom instruction and increases student learning. The amount of homework will vary from day to day. Students are responsible for coming to class prepared with completed homework.

INFECTION CONTROL

Students are not to touch or otherwise come in contact with the blood or body fluids of other students or staff. The Lorge School follows the guidelines of OSHA regarding blood borne pathogens and bodily fluid exposure. In addition, students are responsible for assuring that their own blood and other bodily fluids do not come into contact with other students or adults. The intentional release of body fluids in the school environment will lead to disciplinary action.

SCHOOL HOURS

THE LORGE SCHOOL INSTRUCTIONAL DAY BEGINS AT 8:30 A.M. AND ENDS AT 2:30 P.M. STUDENTS ARE NOT ALLOWED IN THE SCHOOL BUILDING BEFORE 8:00 A.M. OR AFTER 3:00 P.M. UNLESS HE/SHE IS IN A MEETING IN AN ADMINISTRATIVE OFFICE OR IS BEING SUPERVISED BY A STAFF MEMBER. IF THERE ARE ANY SPECIAL CIRCUMSTANCES, PLEASE CONTACT THE DEAN OF STUDENTS.

LATENESS TO SCHOOL

STUDENTS SHOULD ARRIVE AT SCHOOL BETWEEN 8:00 AND 8:30 A.M. STUDENTS SHOULD REPORT TO THEIR CLASSROOMS OR BREAKFAST UPON ARRIVAL. IF STUDENTS ARE NOT HERE BY 8:30 A.M. THEY WILL BE CONSIDERED LATE, AND YOU MUST SIGN IN AT THE SECURITY DESK, UNLESS THE SCHOOL BUS IS LATE.

UNEXCUSED LATENESS FOR STUDENTS ON PUBLIC TRANSPORTATION MAY RESULT IN THE INABILITY TO EARN CERTAIN SCHOOL PRIVILEGES. PARENT/GUARDIAN WILL BE NOTIFIED IF STUDENTS ARE REGULARLY LATE TO SCHOOL. ATTENDANCE AND PROMPTNESS/LATENESS WILL BE RECORDED ON REPORT CARDS AND ATTENDANCE CARDS.

STUDENTS WHO USE PUBLIC TRANSPORTATION ARE EXPECTED TO ARRIVE ON TIME (BY 8:30 AM). LATE ARRIVALS CAUSE UNNECESSARY DISRUPTIONS IN LEARNING FOR OTHER STUDENTS. WHILE THERE MAY BE OCCASIONAL UNAVOIDABLE DELAYS, CAUSED BY TRAFFIC AND MECHANICAL PROBLEMS, ETC, STUDENTS SHOULD PLAN ACCORDINGLY AND LEAVE EARLY ENOUGH TO ARRIVE AT SCHOOL ON TIME.

PUBLIC TRANSPORTATION PASSES

THE BUREAU OF TRANSPORTATION LIMITS THE NUMBER OF METRO CARDS THE SCHOOL MAY ISSUE. IF STUDENTS LOSE THE METRO CARD, IT SHOULD BE REPORTED IMMEDIATELY TO THE DEAN OF STUDENTS WHO WILL HAVE THE LOST CARD CANCELED. A NEW PASS MAY NOT BE IMMEDIATELY AVAILABLE. METRO CARDS ARE ISSUED FOR ELIGIBLE STUDENTS ONLY. ONLY ONE MODE OF TRANSPORTATION IS ALLOWABLE FOR EACH STUDENT EITHER, BUSSING OR PUBLIC TRANSPORTATION.

OUT OF CLASS PASSES

Students should not be in the halls unless they have a pass or are supervised by a staff member. Students are required to be escorted to and from bathrooms, related service sessions and special area classes.

PREPARATION FOR CLASS

In addition to bringing any assigned homework, all students are expected to come to academic classes prepared with notebooks, pens and pencils, books and any other materials requested by the teachers. All students must wear or bring sneakers or rubber sole shoes for physical education class. Students without sneakers will not be allowed to participate in physical education. Students may bring a change of clothes to wear during gym that will be kept locked up when not in use. Students may also bring toothbrushes and deodorant to use at school. At the beginning of each school year, parents will be given a General Supply List.

REPORT CARDS and IEP GOALS

Report cards containing student progress as evaluated by teachers are sent home three times during the year. The IEP Goals for each student will be assessed at this time too. Parents will be invited for Parent-Staff-Conferences in November and March.

STUDENT BEHAVIOR/RESPONSIBILITY

We are all responsible for behaving in the best possible manner. When serious mistakes in judgment are made there are consequences. This may be in the form of specific discipline, additional supervision, or restitution to the school. The Lorge School follows a Positive Behavioral Support Program (PBS). The school-wide rules are to: Be Safe, Be Responsible and Be Respectful.

SCHOOL BOOKS

Textbooks and other books the school loans to the student are valuable and expensive tools. Problems are created if books are lost, forgotten, or damaged. Students are responsible for the books issued, and will be charged for the cost of any book lost or damaged.

STUDENT SAFETY RULES

In accordance with the NYCDOE, The Lorge School will follow the, Citywide Standards of Intervention and Discipline Measures located: (http://schools.nyc.gov/NR/rdonlyres/188AF3E2-F12B-4754-8471-F2EFB344AE2B/0/DiscCodebooklet2013final.pdf)

Students are responsible for knowing and following the below, non-negotiable listed rules. If students break these rules one or more of the steps listed below will be followed. Each behavior infraction is handled on a case-by-case basis and depending upon the details of the situation, administrative action will be taken.

WEAPONS:

No weapons are allowed on school grounds under any circumstance.
If a student brings a real or toy weapon (including water guns) to school: It will be taken away and not given back, Parent/guardian will be notified, Student may be suspended from school and/or The police may be called.

Possession of any of the following weapons will result in an automatic Suspension from School: firearm, firearm silencer or electronic gun, shotgun, rifle or machine gun, switchblade, gravity knife or canesword, billyclub, blackjack, bludgeon, chukka stick or metal knuckles, sandbag, sandclub or slingshot, explosive incendiary bomb or bombshell, dagger, stiletto, dangerous knife, or straight razor, air gun, spring gun or BB gun, acid or other dangerous chemicals, loaded cartridge or ammunition, imitation pistol or water pistol and, any instrument or object used as a weapon.

FIGHTING:

Students may not fight in school.
If a student fights with another student: Both students' parent/guardian may be called. Both students may receive in-house or school suspensions.

ASSAULTING A STAFF MEMBER:

Students may not hit, slap, or kick a staff member either directly or with an object or any kind. If a student assaults a staff member: Parent/guardian will be called, Student will be suspended and/or the police may be called.

DRUGS/ALCOHOL:

STUDENTS MAY NOT POSSES OR USE ALCOHOL OR DRUGS OF ANY KIND IN SCHOOL, BEFORE COMING TO SCHOOL, OR DURING THE LUNCH PERIOD. IF A STAFF MEMBER BECOMES AWARE THAT A STUDENT SHOW SIGNS OF EITHER POSSESSING OR USING DRUGS OR ALCOHOL OF ANY KIND DURING THE SCHOOL-DAY: THE SCHOOL NURSE WILL CONDUCT A SAFETY ASSESSMENT TO DETERMINE IF 911 NEEDS TO BE CALLED. AFTER THE ASSESSMENT, PARENT/GUARDIAN WILL BE CALLED, PARENT/GUARDIAN WILL BE ASKED TO PICK THE STUDENT UP, AND STUDENT MAY BE REMOVED FROM CLASS FOR THE REMAINDER OF THE DAY. THE DRUGS/ALCOHOL WILL BE TAKEN AWAY, THE STUDENT MAY RECEIVE AN IN SCHOOL SUSPENSION AND/OR THE POLICE MAY BE CALLED.

SEXUAL BEHAVIOR:

STUDENTS MAY NOT ENGAGE IN OR SHOW SEXUAL BEHAVIOR TO EACH OTHER WHILE IN SCHOOL OR TO STAFF MEMBERS AT ANYTIME. IF SUCH BEHAVIOR OCCURS: PARENT/GUARDIAN WILL BE INFORMED, STUDENT MAY BE SUSPENDED AND/OR THE POLICE MAY BE CALLED.

STEALING:

STUDENTS ARE NOT PERMITTED TO STEAL. IF STUDENTS ARE CAUGHT STEALING OR WITH STOLEN ITEMS PARENT/GUARDIAN MAY BE NOTIFIED, STUDENT OR HIS/HER FAMILY MAY BE REQUIRED TO REPLACE OR REPAIR ANY ITEM STOLEN OR DAMAGED AND/OR THE POLICE MAY BE CALLED.

UNAUTHORIZED EXIT:

STUDENTS MAY NOT LEAVE THE BUILDING WITHOUT PERMISSION. IF A STUDENT LEAVES THE BUILDING WITHOUT PERMISSION: PARENT/GUARDIAN WILL BE THE IMMEDIATELY NOTIFIED.

DAMAGE TO SCHOOL PROPERTY:

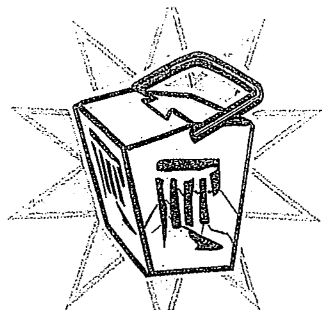
STUDENTS ARE NOT ALLOWED TO DAMAGE SCHOOL PROPERTY UNDER ANY CIRCUMSTANCE. IF STUDENTS WHO INTENTIONALLY BREAK OR DAMAGE SCHOOL PROPERTY OR EQUIPMENT PARENT/GUARDIAN WILL BE BILLED FOR THE REPAIR OR REPLACEMENT OF THE PROPERTY. THIS INCLUDES DISFIGUREMENT OF THE BUILDING (CLASSROOMS, HALLWAYS, OFFICES, ETC.) WITH GRAFFITI.

VISITORS

It is prohibited to bring visitors to school without official permission from school administration. A visitor is any person who is not currently enrolled in Lorge as a student or on our active staff roster.

Any person who has official school business is required to sign-in in the Security Desk and wait to be escorted to his/her destination. If you are requesting permission to visit a student/classroom, you must wait at the front office and obtain permission from the school administration.

Unauthorized visitors will be escorted out of the building.



The Lorge School
353 West 17th Street
New York, NY 10011
212-929-8660

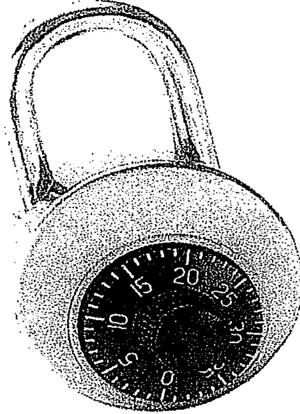
CONTRACT FOR UPPER SCHOOL OUTSIDE SCHOOL

1. Students must have come in to school on time with or with an excused lateness.
2. Students must get a new pass every day before they go outside for lunch
3. Students must return on time (1:05 PM Monday – Friday). Students who do not return on time will not be able to earn lunch privileges the following day.
4. Students must not have a physical incident. If a student has a physical incident after lunch, they will not be able to earn lunch privileges the following day.
5. Students must conduct themselves appropriately outside the building. If a problem occurs outside the building, lunch privileges will be suspended for a specified amount of time.
6. Students may eat the school lunch and then go outside provided there is at least twenty minutes left in the period.
7. On occasion, staff may not allow students to go out for lunch due to weather conditions or safety issues in the street.
8. Teachers, administration, crisis intervention staff reserve the right to cancel lunch any time.
9. **Students must present an Outside Lunch Pass to the Security Guard daily.**

______________________	______________________
Student Signature	Parent Signature
______________________	______________________
Confirmed By	Date

Locker Policy for Upper School Students

Confirmed by:______________ Date: ______________



1. Each student on the 2nd floor will be assigned a locker.
2. The lock provided belongs to The Lorge School and costs $5.00 to be replaced if lost or removed from the building.
3. Each assigned locker is logged with the Dean of Students.
4. Random searches will be conducted at the discretion of the Dean of Students.
5. No Food and /or Drink are to be kept in your locker.
6. The Lorge School is not responsible for lost, damaged, and/or stolen items that are kept in your lockers. There is a zero reimbursement policy.
7. Students are expected to clean their lockers out weekly and to remember their locker combinations.

I ,______________________________, in class, ___________, have read and understand the above Lorge School locker policies and by signing agree to follow such policies and procedures.

AT-17
Rev. 5/10

THE UNIVERSITY OF THE STATE OF NEW YORK
THE STATE EDUCATION DEPARTMENT
ALBANY, NY 12234

APPLICATION FOR EMPLOYMENT CERTIFICATE

See reverse side of this form for information concerning employment of minors.
All signatures must be handwritten in ink, and applicant must appear in person before the certifying official.

THIS APPLICATION DOES NOT AUTHORIZE EMPLOYMENT

PART I – Parental Consent – (To be completed by applicant and parent or guardian)

Parent or guardian must appear at the school or issuing center to sign the application for the first certificate for full-time employment, unless the minor is a graduate of a four-year high school and presents evidence thereof. For all other certificates, the parent or guardian must sign the application, but need not appear in person to do so.

Date.......................

I, ... Age ....
[Applicant]

Home Address ...., apply for a certificate as checked below
[Full Home Address including Zip Code]

- ☐ Nonfactory Employment Certificate – Valid for lawful employment of a minor 14 or 15 years of age enrolled in day school when attendance is not required.
- ☐ Student General Employment Certificate – Valid for lawful employment of a minor 16 or 17 years of age enrolled in day school when attendance is not required.
- ☐ Full-Time Employment Certificate – Valid for lawful employment of a minor 16 or 17 years of age who is not attending day school.

I hereby consent to the required examination and employment certification as indicated above.

....
[Signature of Parent or Guardian]

PART II – Evidence of Age – (To be completed by issuing official only)

.... – Check evidence of age accepted – Document # (if any) ....
[Date of Birth]

Birth Certificate   State Issued Photo   I.D Driver's License   Schooling Record   Other..................
[Specify]

PART III – Certificate of Physical Fitness

Applicant shall present documentation of physical exam from a school or private physician, physician's assistant or nurse practitioner licensed to practice within New York State. Said examination must have been given within 12 months prior to issuance of the employment certificate. Date of physical exam on file with school .... If physical exam is over 12 months, provide student with certificate of physical fitness to be completed by school medical director or private health care provider.

If the physical exam or Certificate of Physical Fitness is limited with regards to allowed work/activity, the issuing official shall issue a Limited Employment Certificate (valid for a period not to exceed 6 months unless the limitation noted by the physician is permanent, then the certificate will remain valid until the minor changes jobs. Enter the limitation on the employment certificate. THE PHYSICIAN'S CERTIFICATION SHOULD BE RETURNED TO THE APPLICANT.

PART IV – Pledge of Employment – (To be completed by prospective employer)

Part IV must be completed only for: (a) a minor with a medical limitation; and (b) for a minor 16 years of age or legally able to withdraw from school, according to Section 3205 of the Education Law, and must show proof of having a job.

The undersigned will employ .... residing at ....
[Applicant]

as .... at ....
[Description of Applicant's Work]   [Job Location]

for .... days per week .... hours per day, beginning .... a.m. .... p.m.

....   Factory   ending........................... a.m. ....p.m.
[Name of Firm]

Nonfactory   ....
[Address of Firm]

....   Starting date ....
[Telephone Number]   [Signature of Employer]

PART V – Schooling Record – (To be completed by school official)

Part V must be completed only for a minor 16 years of age who is leaving school and resides in a district (New York City and Buffalo) which require a minor 16 years of age to attend school, according to Section 3205 of the Education Law.

I certify that the records of ....
[Name of School]   [Address]

Show that .... whose date of birth is ....
[Name of Applicant]

Is in grade...   ....
[Signature of Principal of Designee]

PART VI – Employment Certification – (To be completed by issuing official only)

Certificate Number ....   Date Issued ....

....
[School or Issuing Center]   [Address]   [Signature of Issuing Officer]

GENERAL INFORMATION

An employment Certificate (Student Nonfactory, Student General, or Full Time) may be used for an unlimited number of successive job placements in lawful employment permitted by the particular type of certificate.

A Nonfactory Employment Certificate is valid for 2 years from the date of issuance or until the student turns 16 years old, with the exception of a Limited Employment Certificate. A Limited Employment Certificate is valid for a maximum of 6 months unless the limitation noted by the physician is permanent, then the certificate will remain valid until the minor changes job. It may be accepted only by the employer indicated on the certificate.

A new Certificate of Physical Fitness is required when applying for a different type of employment certificate, if more than 12 months have elapsed since the previous physical for employment.

An employer shall retain the certificate on file for the duration of the minor's employment. Upon termination of employment, or expiration of the employment certificate's period of validity, the certificate shall be returned to the minor. A certificate may be revoked by school district authorities for cause.

A minor employed as a Newspaper Carrier, Street Trades Worker, Farmworker, or Child Model, must obtain the Special Occupational Permit required.

A minor 14 years of age and over may be employed as a caddy, babysitter, or in casual employment consisting of yard work and household chores when not required to attend school. Employment certification for such employment is not mandatory.

An employer of a minor in an occupation which does not require employment certification should request a Certificate of Age.

PROHIBITED EMPLOYMENT

Minors 14 and 15 years may not be employed in, or in connection with a factory (except in delivery and clerical employment in an enclosed office thereof), or in certain hazardous occupations such as: construction work; helper on a motor vehicle; operation of washing, grinding, cutting, slicing, pressing or mixing machinery in any establishment; painting or exterior cleaning in connection with the maintenance of a building or structure; and others listed in Section 133 of the New York State Labor Law.

Minors 16 and 17 years of age may not be employed in certain hazardous occupations such as: construction worker; helper on a motor vehicle, the operation of various kinds of power-driver machinery; and others listed in Section 133 of the New York State Labor Law.

HOURS OF EMPLOYMENT

Minors may not be employed during the hours they are required to attend school.

Minors 14 and 15 years of age may not be employed in any occupation (except farmwork and delivering, or selling and delivering newspapers):

When school is in session:

- — more than 3 hours on any school day, more than 8 hours on a nonschool day, more than 6 days in any week, for a maximum of 18 hours per week, or a maximum of 23 hours per week if enrolled in a supervised work study program approved by the Commissioner.
- — after 7 p.m. or before 7 a.m.

When school is not in session:

- — more than 8 hours on any day, 6 days in any week, for a maximum of 40 hours per week.
- — after 9 p.m. or before 7 a.m.

This certificate is not valid for work associated with newspaper carrier, agriculture or modeling.

Minors 16 and 17 years of age may not be employed: --

When school is in session:

- — more than 4 hours on days preceding school days; more than 8 hours on days not preceding school days (Friday, Saturday, Sunday and holidays), 6 days in any week, for a maximum of 28 hours per week.
- — between 10 p.m. and 12 midnight on days followed by a school day without written consent of parent of guardian and a certificate of satisfactory academic standing from the minor's school (to be validated at the end of each marking period).
- — between 10 p.m. and 12 midnight on days not followed by a school day without written consent of parent or guardian.

When school is not in session:

- — more than 8 hours on any day, 6 days in any week, for a maximum of 48 hours per week.

EDUCATION LAW, SECTION 3233

"Any person who knowingly makes a false statement in or in relation to any application made for an employment certificate or permit as to any matter by this chapter to appear in any affidavit, record, transcript, certificate or permit therein provided for, is guilty of a misdemeanor."

The Lorge School

353 W. 17th Street
New York, NY 10011
T: (212) 929-8660 F: (212) 989-8249

General Supply Request List for Students

1	Pack-highlighters
1	Pack erasers
1	Pack colored pencil (8)
1	Zippered pencil pouch
2	Packs 3x5 index cards
1	Four-function calculator
1	Box of tissues
4	Packs of 200 sheet, loose-leaf paper
6	Two-pocket folders
1	Two-inch binder
5	Composition books (black/white)
3	One-subject spiral notebooks (70-100 pages)
2	Glue sticks
3	Packs of pencils
2	Packs of blue or black pens
1	Pump bottle of hand sanitizer

Other helpful items include…

Paper towels
Clean-up wipes
Tube socks—for dance
Spray cleaner
Ziplock Baggies—all sizes