THE SONIA SHANKMAN ORTHOGENIC SCHOOL
AT THE UNIVERSITY OF CHICAGO
6245 S. Ingleside Ave.
Chicago, Illinois 60637

Telephone (773) 420-2900
Facsimile (773) 420-2805

Student's Name: _____

ORTHOGENIC SCHOOL ADMISSION CHECKLIST - RESIDENTIAL

Please return the following items prior to admission:

- ☐ (1.a.) Student Emergency Contact Information *(Revised)*
- ☐ (1.b.) Court Documentation *(Child Custody, Visitation, &/or Guardianship, if applicable)*
- ☐ (1.c.) Copy of Insurance Card/s *(Please copy front & back)*
- ☐ (1.d.) Medical Evaluation for Placement
- ☐ (1.e.) Immunizations & (1.f.) Physical (*Child Health Examination Form)*
- ☐ (1.g.) Dental Exam or Dental Waiver *(Dental Examination Record/Waiver Forms)*
- ☐ (1.h.) Copy of Birth Certificate
- ☐ (1.i.) Copy of Social Security Card
- ☐ (1.j.) Parent Information Form *(Optional)*
- ☐ (1.k.) Contract *(Contract will be provided, reviewed & signed on the day of admission)*
- ☐ (1.l.) ICG Funding Confirmation *(If applicable, please provide ICG award letter)*
- ☐ (2.a.) Consent for Residential Treatment & Participation in School Activities *(Revised)*
- ☐ (2.b.) Consent for Psychodiagnostic Assessment & Release of Info
- ☐ (2.c.) Consent to Administer Over-the-Counter (OTC) Pharmaceuticals
- ☐ (2.d.) Electronic Device & Internet Policy & Consent
- ☐ (2.e.) Consent for Parents' Association Directory
- ☐ (2.f.) Consent Regarding Infectious Disease
- ☐ (3.a.) Acknowledgement of Receipt: Health & Ed Info & Consent Practices *(Revised)*
- ☐ (3.b.) Acknowledgement of Receipt: Behavior Mgmt Plan & Treatment Plan
- ☐ (3.c.) Acknowledgement of Receipt: Student Manual & Family Handbook
- ☐ (3.d.) Acknowledgement of Receipt: Client Rights
- ☐ (3.e.) Acknowledgement of Receipt: Client Grievance Policy
- ☐ (3.f.) Acknowledgement of Receipt: Subpoena Policy
- ☐ (3.g.) Acknowledgement of Truthful & Full Disclosure
- ☐ (3.h.) Psychiatric Billing & Financial Aid *(If applicable)*
- ☐ (4.a.) Child Behavioral Checklist & Medical History Form
- ☐ (4.b.) Medical History provided by Parent/Guardian

Please note that the numbering system is for our internal use.

Updated:: March 2015

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STUDENT EMERGENCY CONTACT INFORMATION

In an emergency, it may be necessary to contact you immediately. For that reason, please notify the Orthogenic School of any changes to your current home, business, &/or cell numbers. If an emergency should arise & we cannot reach you, please list the name of a family member or friend that can be contacted. In addition, please provide an alternate emergency contact in the event you cannot be reached.

Student's Legal Name: _____ **Nick Name:** _____

Student's Residence

Residing with Parent(s)/Guardian Name: _____

Mother's /Guardian's Info

Mother/Guardian Name: _____

Home Address / City / Zip: _____

Hm Phone: _____ Cell: _____ Wk:_____

Email: _____

Father's Information

Father's Name: _____

Home Address / City / Zip: _____

Hm Phone: _____ Cell: _____ Wk:_____

Email: _____

Emergency Contact

Emergency Contact: _____ Relationship:_____

Home Address / City / Zip: _____

Hm Phone: _____ Cell: _____ Wk:_____

Alternate Emergency Contact

Name & Relationship: _____

Home Address / City / Zip: _____

Hm Phone: _____ Cell: _____ Wk:_____

I.C.

SONIA SHANKMAN ORTHOGENIC SCHOOL AT THE UNIVERSITY OF CHICAGO

Insurance Information

Insurance Company: _____

Name of Insured: _____

Certification Number: _____

Insurance Company Number Two: _____

Name of Insured: _____

Certificate Number: _____

Please attach a copy of your child's insurance card – please copy front & back. Thank you.

I. d.

The Sonia Shankman Orhogenic School
MEDICAL EVALUATION FOR RESIDENTIAL PLACEMENT

Student's Name:_____ _____ **D.O.B.:** _____

Date of Admission: _____ **Date of Medical Screen**_____

Dormitory: _____

The findings reported in this evaluation are based on the medical screen listed above. Should the student's medical condition change, a medical exam will be necessary to evaluate the continued appropriateness for placement.

This student has been examined and as of the date of this examination has been found to have:

☐ No communicable disease that would pose a threat to the health of others at the O School.

☐ The following communicable disease(s) which may pose a threat to the health of others at the O School.

_____

_____

The Orthogenic School uses a variety of verbal behavioral treatment techniques in accordance with TCI practices (Therapeutic Crisis Intervention).

Upon my examination of the student and review of medical records, I have determined that as of the date of this examination, the following barriers may exist to the student responding to the verbal treatment techniques used in Orthogenic School facilities:

☐ Significant hearing impairment:

_____

_____

☐ Significant visual impairment:

_____

_____

☐ Other(please describe):

_____

_____

I.d.

In addition, Orthogenic School staff use the manual restraint techniques taught in the Therapeutic Crisis Intervention (TCI) curriculum when necessary to prevent the client from inflicting physical harm to him/herself or to others.

Upon examination of the student and review of medical records, I have determined that as of the date of this examination:

☐ There are currently no contraIndications to the use of manual restraint techniques as described in the Therapeutic Crisis Intervention curriculum.

☐ There are medical contraindications to the use of manual restraints based on the existence of the following medical conditions:

_____

_____

_____

Based on the above conditions, the use of manual restraint is not recommended for this student.

_____ _____

M.D. Signature Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Program Manager Signature Date

STATE OF ILLINOIS
DEPARTMENT OF HUMAN SERVICES
CERTIFICATE OF CHILD HEALTH EXAMINATION

Please Print

Student's Name Last First Middle	**Birth Date** Month/Day/ Year	**Sex**	**School**	**Grade Level /ID#**
Address Street City ZIP code	Parent/ Guardian		Telephone # Home Work	

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

VACCINE/DOSE	1 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	6 MO DA YR
Diphtheria, Tetanus and Pertussis (DTP or DTaP)						
Diphtheria and Tetanus (Pediatric DT or Td)						
Inactivated Polio (IPV)						
Oral Polio (OPV)						
Haemophilus influenzae type b (Hib)						
Hepatitis B (HB)						
Varicella (Chickenpox)				Comments		
Combined Measles, Mumps and Rubella (MMR)						
Measles (Rubeola)						
Rubella (3-day measles)						
Mumps						
Pneumococcal (not required for school entry)	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23
Check specific type (PCV7, PPV23)						
Other (Specify hepatitis A, meningococcal, etc.)						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.

Signature **Title** **Date**

Signature
(If adding dates to the above immunization history section, put your initials by date(s) and sign here.) **Title** **Date**

Signature
(If adding dates to the above immunization history section, put your initials by date(s) and sign here.) **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

***MEASLES (Rubeola)** **MO DA YR** **MUMPS** **MO DA YR** **VARICELLA** **MO DA YR** **Physician's Signature**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease **Signature** **Title** **Date**

3. Laboratory confirmation (check one) ☐ **Measles** ☐ **Mumps** ☐ **Rubella** ☐ **Hepatitis B** ☐ **Varicella**
Lab Results **Date MO DA YR** **(Attach copy of lab report, if available.)**

VISION AND HEARING SCREENING DATA

Pre-school – annually beginning at age 3; School age – during school year at required grade levels

Date																						
Age/Grade																						
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L
Vision																						
Hearing																						

Code:
P = Pass
F = Fail
U = Unable to test
R = Referred
G/C = Glasses/ Contacts

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(Complete Both Sides)

Student's Name (Last First Middle)	Birth Date (Month/Day/ Year)	Sex	School	Grade Level/ I.D.#

HEALTH HISTORY **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

ALLERGIES (Food, drug, insect, other)

MEDICATION (List all prescribed or taken on a regular basis.)

Diagnosis of asthma? Child wakes during the night coughing	Yes Yes	No No	Indicate Severity	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Birth defects?	Yes	No		Hospitalizations? When? What for?	Yes	No	
Developmental delay?	Yes	No					
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		Surgery? (List all.) When? What for?	Yes	No	
Diabetes?	Yes	No		Serious injury or illness?	Yes	No	
Head injury/Concussion/Passed out?	Yes	No		TB skin test positive (past/present)?	Yes*	No	*If yes, refer to local health department.
Seizures? What are they like?	Yes	No		TB disease (past or present)?	Yes*	No	
Heart problem/Shortness of breath?	Yes	No		Tobacco use (type, frequency)?	Yes	No	
Heart murmur/High blood pressure?	Yes	No		Alcohol/Drug use?	Yes	No	
Dizziness or chest pain with exercise?	Yes	No		Family history of sudden death before age 50? (Cause?)	Yes	No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Dental ☐Braces ☐Bridge ☐Plate Other Other concerns?			
Ear/Hearing problems?	Yes	No		Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature** **Date**			
Bone/Joint problem/injury/scoliosis?	Yes	No					

Entire section below to be completed by MD/DO/APN/PA (*INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES)

PHYSICAL EXAMINATION REQUIREMENTS **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING **BMI>85% age/sex** Yes ☐ No ☐ And any two of the following: **Family History** Yes ☐ No ☐ **Ethnic Minority** Yes ☐ No ☐
Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes ☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE* Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.
Blood Test Indicated? Yes ☐ No ☐ **Blood Test Date** **Blood Test Result** (Blood test required in Chicago and other high risk zip codes.)

TB SKIN TEST Recommended only for children in high-risk groups including children who are immunosuppressed due to HIV infection or other conditions, recent immigrants from high prevalence countries, or those exposed to adults in high-risk categories. See CDC guidelines. **Date Read** / / **Result** **mm**

LAB TESTS *INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES	Date	Results		Date	Results
Hemoglobin * or Hematocrit *			Sickle Cell * (as indicated)		
Urinalysis			Other		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin			Endocrine		
Ears			Gastrointestinal		
Eyes Normal Yes☐ No☐ Objective screening Yes☐ No☐ Result_____ Amblyopia Yes☐ No☐ Referred to Opthalmologist/Optometrist Yes☐ No☐			Genito-Urinary		LMP
			Neurological		
Nose			Musculoskeletal		
Throat			Spinal examination		
Mouth/Dental			Nutritional status		
Cardiovascular/HTN			Mental Health		
Respiratory					

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ☐ **No** ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in **(If No or Modified,please attach explanation.)**
PHYSICAL EDUCATION **Yes** ☐ **No** ☐ **Modified** ☐ **INTERSCHOLASTIC SPORTS** (for one year) **Yes** ☐ **No** ☐ **Limited** ☐

Physician/Advanced Practice Nurse/Physician Assistant performing examination

Print Name **Signature** **Date**

Address **Phone**

(Complete both sides)

Illinois Department of Public Health
PROOF OF SCHOOL DENTAL EXAMINATION FORM

To be completed by the parent (please print):

Student's Name: Last	First	Middle	Birth Date: (Month/Day/Year) / /
Address: Street	City	ZIP Code	Telephone:
Name of School:	Grade Level:		Gender: ☐ Male ☐ Female
Parent or Guardian:	Address (of parent/guardian):		

To be completed by dentist:

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present**

☐ Yes ☐ No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

☐ Yes ☐ No **Untreated Caries —** At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

☐ Yes ☐ No **Soft Tissue Pathology**

☐ Yes ☐ No **Malocclusion**

Treatment Needs (check all that apply)

☐ **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

☐ **Restorative Care** — amalgams, composites, crowns, etc.

☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis

☐ **Other** — periodontal, orthodontic

Please note _____

Signature of Dentist _____ Date _____

Address _____ Telephone _____
Street City ZIP Code

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.idph.state.il.us

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P.O.#346085 5M 10/05

Illinois Department of Public Health
DENTAL EXAMINATION WAIVER FORM

Please print:

Student's Name: Last First Middle			Birth Date: (Month/Day/Year) / /
Address: Street City ZIP Code			Telephone:
Name of School:		Grade Level:	Gender: ☐ Male ☐ Female
Parent or Guardian:		Address (of parent/guardian):	

I am unable to obtain the required dental examination because:

☐ My child is enrolled in the free and reduced lunch program and is not covered by private or public dental insurance (Medicaid/KidCare).

☐ My child is enrolled in the free and reduced lunch program and is ineligible for public insurance (Medicaid/KidCare).

☐ My child is enrolled in Medicaid/KidCare, but we are unable to find a dentist or dental clinic in our community that is able to see my child and will accept Medicaid/KidCare.

☐ My child does not have any type of dental insurance, and there are no low-cost dental clinics in our community that will see my child.

Signature _____ Date _____

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.idph.state.il.us

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P.O.#346086 5M 10/05

1j.

The Sonia Shankman Orthogenic School
Parents Information Sheet (Optional)

Student's Legal Name: Nick Name:

Student's Residence
Residing with Parent(s)/Guardian Name:

Mother's/Guardian's Info
Mother/Guardian Name:
Home Address: City, ZIP
Telephone – Home Cell:

Occupation (Include Title)

Name of Employer

Employer's Street Address City State ZIP

Office Telephone

Office E-Mail

Number of years at this company?

Father's Information
Father's Name
Home Address: City ZIP
Telephone – Home Cell:

Occupation (Include Title)

Name of Employer

Employer's Street Address City State ZIP

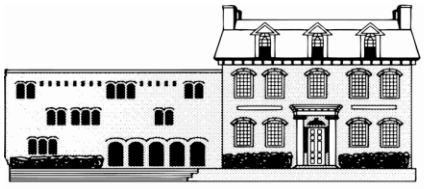
Office Telephone

Office E-Mail

Number of years at this company?

Other Significant Family Member
Name & Relationship:
Home Address:
Telephone – Home Cell:

Emergency Contact
Emergency Contact: Relationship:
Home Address: City ZIP
Home: Cell:



THE SONIA SHANKMAN ORTHOGENIC SCHOOL
at The University of Chicago Operated by The Leslie Shankman School Corporation

CONSENT FOR TREATMENT SERVICES AND PARTICIPATION IN SCHOOL ACTIVITIES (RESIDENTIAL) 2014-2015

I (We) the parent(s)/guardian(s) of_____, hereby give consent for my son/daughter/ward to receive residential treatment, mental health treatment, and educational services provided by clinicians, other professionals, and supervised paraprofessionals at the Sonia Shankman Orthogenic School.

I (student) _____hereby admit myself into the Sonia Shankman Orthogenic School and consent to receive residential treatment, mental health treatment, and educational services provided by clinicians, other professionals, and supervised paraprofessionals at the Sonia Shankman Orthogenic School.

Consent for Psychiatric Treatment

I (We) am voluntarily requesting diagnoses and treatment for (student) _____ to be evaluated and treated either at the Sonia Shankman Orthogenic School or Rush University Medical Center and to receive psychiatric treatment and or tests that the treating psychiatrist deems necessary.

I (We) agree to transfer primary psychiatric care for (student) _____to the Orthogenic School Psychiatrist, Dr. Louis Kraus, M.D., Associate Professor and Chief of Child and Adolescent Psychiatry at Rush University Medical Center, or his designee. I understand that Child Psychiatry Fellows of Rush University Medical School will also perform evaluations and assist in providing care under Dr. Kraus' supervision.

☐ **I (WE) ELECT TO WORK WITH AN EXTERNAL PSYCHIATRIST (SEE BELOW)**

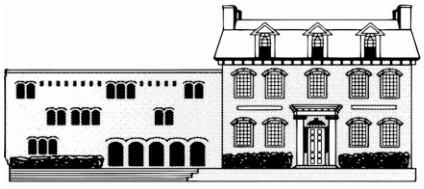
******IF YOU ELECT TO WORK WITH AN EXTERNAL PSYCHIATRIST, PLEASE COMPLETE THE ATTACHED "ACKNOWLEDGEMENT OF DECLINING PSYCHIATRIC SERVICES" FORM → ATTACHED TO THIS PACKET.***

Consent for Medical Treatment

I (We) hereby consent for (student) _____to be seen by the Orthogenic School Medical Director, Dr. Peter Smith, M.D., Assistant Professor of Pediatrics at the University of Chicago Hospitals and/or Clinics/La Rabida Hospital, and to receive necessary medical treatment and/or tests Dr. Smith, or other assigned treating physicians, deem necessary. We understand that in emergencies parents/guardians may not be informed of the treatment until after the care has been rendered and the student's condition is more stable.

I (We) hereby consent for (student) _____ to receive routine health and wellness monitoring and first aid provision by the Orthogenic School Nursing Department, in consultation with the Orthogenic School Medical Director (or his designee), and program staff.

I (We) hereby consent for (student) _____ to be administered prescribed medication, and specific over-the-counter medication as agreed to at admission, while he/she is in the care of the Orthogenic School.



Consent for Psychiatric and Medical Emergency Interventions

I (We) hereby consent for (student) _____to be provided with appropriate interventions by the clinical and medical staff of the Orthogenic School in the event of psychiatric or medical emergencies. Such interventions include, but are not limited to, the authorization of transportation by ambulance and communication with ambulance and hospital staff regarding the student's condition. We understand that in emergencies parents/guardians may not be informed of the treatment until after the care has been rendered and the student's condition is more stable.

Exchange of Information and Limitation on Confidentiality

I (We) understand and hereby acknowledge that participation of (student) _____ in the services provided by the Orthogenic School will have limits with regard to confidentiality. The staff of the Orthogenic School may periodically consult with outside consultants. The staff will also periodically release reports of the student's progress and treatment to applicable funding, accrediting, and licensing agencies. The Orthogenic School will ensure that these entities are fully aware of the provisions of HIPAA (Health Insurance Portability and Accountability Act), and of their requirement to maintain confidentiality.

I (We) understand that in order to best meet the emotional, physical, and educational needs of the student, it will be necessary for pertinent information (including psychological information) to be exchanged with program staff who work with the student. This information will be used for the coordination of services.

I (We) understand and hereby acknowledge that staff of the Orthogenic School conduct internal program assessments (including the administration of surveys to evaluate programs) as part of the Continuous Quality Improvement Process, and that this process is part of the provision of services while the student is enrolled at the Orthogenic School. I understand and acknowledge that the Orthogenic School will periodically collect, evaluate, and distribute *de-identified* data in the form of outcome/evaluation reports to the Board of Directors and other stakeholders (including in PR materials and newsletters), regulating bodies, and compliance/accrediting agencies – in accordance with the policies and practices described in the NOTICE OF HEALTH AND EDUCATIONAL INFORMATION AND CONSENT PRACTICES provided to me at student admission.

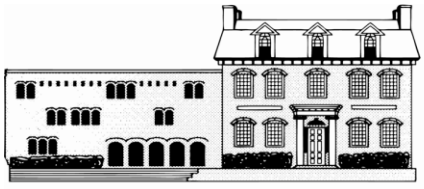
I (We) understand that the Orthogenic School staff are Mandated Reporters of child abuse and neglect and, in accordance with this law, they are compelled to complete a DCFS hotline call when they become aware of any suspected concerns in these areas. Similarly, I understand that if the school becomes aware that there is a threat of imminent harm to self or other, that may result in severe bodily injury or death, the school may communicate with appropriate authorities to ensure the safety of all involved.

Policies on Visitation and Written/Telephone Communication

I (We) understand and hereby acknowledge that I have been informed of the limitations set by the Orthogenic School on visitation and written/telephone communication. I acknowledge having read and received all policies relevant to these issues at admission.

Behavior Management Plan **<u>SEE ATTACHED UPDATED "BEHAVIOR MANAGEMENT PLAN"</u>

I (We) have been provided with a written copy of the Sonia Shankman Orthogenic School's Behavior Management Plan prior to admission, and with an updated version attached to this mailing. I agree to the Behavior Management Plan and acknowledge that it is part of the treatment provided at the Orthogenic School.



THE SONIA SHANKMAN ORTHOGENIC SCHOOL
at The University of Chicago Operated by The Leslie Shankman School Corporation

Limitations on the Use of Electronic Devices, Electronic Communication, and Access to the Internet
****SEE AND SIGN ATTACHED UPDATED "ELECTRONIC DEVICE/INTERNET ACCESS POLICY"**

I (We) understand and hereby acknowledge that I have been informed of the limitations set by the Orthogenic School regarding use of electronic devices and internet access *(see attached updated policy)*. This includes limitations around the use of the school's computer resources, and the unauthorized use of computers/laptops, cell phones, tablets, and other similar electronic devices owned by the student, school, or another student. I agree to those limitations and acknowledge that they are part of the treatment provided at the Orthogenic School.

I (We) hereby acknowledge that only students participating in the Transitional Living Center (TLC) Program – or those with explicit permission from a Dorm Manager or Case Manager – are permitted to have cell phones (or similar devices, used for electronic communication). I agree to those limitations and acknowledge that they are part of the treatment provided at the Orthogenic School.

I (We) understand and hereby acknowledge that I have been informed that the school retains the right to access and review any electronic communications or activities that may be contained in a student's computer/laptop, cell phone, tablet, or other similar electronic device, if a reasonable concern or clinical issue presents itself.

By my signature I acknowledge having read and received all policies relevant to the unauthorized use of computers/laptops, cell phones, tablets, and other similar electronic devices, and access to the internet. *SEE AND SIGN ATTACHED UPDATED POLICY.*

Participation in Field Trips, Dormitory Group Outings, and Supervised Off-Campus Activities

I (We) give consent for (student) _____, to participate in field trips, dormitory group outings, and other off-campus activities supervised by staff of the Orthogenic School. I understand that this consent does not guarantee a student's automatic participation in off-campus activities, because participation may be dependent on availability of staff and transportation, and that staff will exercise their professional judgment to determine if participation is safe and appropriate for a student.

➔ PARENT/GUARDIAN NAME: _____

SIGNATURE:_____ DATE:_____

➔ STUDENT NAME: _____

SIGNATURE:_____ DATE:_____
(If the student is a minor, the custodial parent/guardian must sign this consent form. If the student is at least 12 years of age, the student must sign in addition to the parent/guardian).

➔ WITNESS NAME: _____

SIGNATURE:_____ DATE:_____

This consent shall expire one (1) calendar year from the date signed.

CONSENT FOR PSYCHODIAGNOSTIC ASSESSMENT AND RELEASE OF INFORMATION

The Sonia Shankman Orthogenic School provides psychodiagnostic assessments of students without charge to parents/guardians. These assessments are administered by diagnostic practicum students participating in a seminar on psychodiagnostic assessments. Lauren Berebitsky, Psy D and Pete Myers, Psy D interpret the results of the assessments.

The assessment also includes a clinical interview. The initial clinical interview may be audiotaped for use by the practicum student during a presentation in the seminar on diagnostic assessment. All identifying information, including protected health information as defined by Health Insurance Portability and Accountability Act of 1996 (HIPAA), will be deleted from the tape before use in the seminar. The focus of the presentation is on the practicum student's interviewing skills, not on the Orthogenic School student.

I(We) the parent(s)/guardian of_____, hereby give my/our consent for my son/daughter/ward to participate in a psychodiagnostic assessment under the supervision of Lauren Berebitsky, Psy D and Pete Myers, Psy D.

I(We) agree that an audiotape can be made of the initial clinical interview and that the practicum student may present the tape during doctoral seminar on psychodiagnostic assessment.

I(We) understand that I(we) may review the diagnostic information and the information recorded on the audiotape upon request.

I(We) understand that refusal to consent will not interfere with my child/ward's rights to receive treatment and the I(we) may revoke consent at any time.

SIGNED:_____ DATE:_____
Parent or Guardian

_____ DATE:_____
Student

WITNESS:_____ DATE:_____

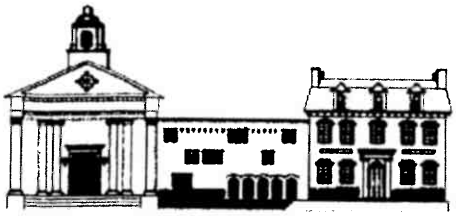
(If the student is a minor, the custodial parent/guardian must sign this consent form. If the student is at least 12 years of age, the student must sign in addition to the parent/guardian).

This consent shall expire one (1) calendar year from the date signed.

Under the provisions of the Illinois Mental Health & Developmental Disabilities Confidentiality Act this information and the psychodiagnostic information obtained by the assessment may not be redisclosed to any agency or person unless the person who consented to this disclosure specifically consents to the redisclosure.

Under the provisions of the Federal Drug and Alcohol Confidentiality Law records including information regarding drug and alcohol treatment or any such information may be further disclosed without authorization for such redisclosure.

2.c.



The Sonia Shankman Orthogenic School
at the University of Chicago

1365 East 60th Street, Chicago IL 60637 - www.oschool.org - (p) 773-702-1203 (f) 773-702-1304

OVER-THE-COUNTER MEDICATION CONSENT FORM

Occasionally your child may unexpectedly need non-prescription over-the-counter medication. For these occasions, the Orthogenic school must have written parental/guardian permission. Examples include headache, minor muscle aches, menstrual cramps, dental pain, etc. If, at any time, you wish to change your mind about this consent, you may do so in writing to the school.

Over –the-counter medications and vitamins need to be in the original package and labeled with the student's name. The school retains the discretion to reject requests for dispensing of medications that may be contra- indicated. The medications will not be dispensed in any manner inconsistent with the instructions on the brand label unless the school receives a written order from a physician/practitioner authorizing such administration. **Vitamins** will be given as provided by the parent(s)/guardian with school MD approval.

I understand that the Orthogenic School and its authorized staff will not be held liable for any adverse events that may arise from the administration of these medications.

While the school maintains a limited supply of commonly used over-the-counter medications, parents/guardians are expected to provide what the child requires on a regular basis.

If your child has anaphylactic reactions, please have your child's doctor provide the school with a written anaphylaxis management plan. In the absence of a plan from your own physician, you may rely on the school's physician to manage any reaction that may occur.

If there are additional over-the-counter medications not listed here that you wish your child to take, please fill out the final page, sign it and return it to the school.

If there are any questions, please contact the nursing office at 773-834-2007.

Student's Name _____

Medication Allergies_____

Please check any medication(s) you wish to be made available to your child under nursing discretion:

For headache/fever/muscle aches/menstrual cramps:

- ☐ Acetaminophen **(Generic Tylenol)** 1 or 2 325/500 mg tabs every 4-6 hours
- ☐ Ibuprofen **(Generic Motrin)** 1 or 2 200 mg tabs every 4-6 hours
- ☐ Ms. Aid **(Generic Pamprin)** 1 or 2 tabs every 4-6 hours

For mild cold symptoms:

- ☐ Cough drop (**Generic Halls)1** or 2 for mild cough or throat discomfort.
- ☐ Throat lozenge **(Cepacol)** 1 or 2 for mild sore throat.

For mild stomach discomfort:

- ☐ Antacid 2 tabs **(Generic Tums, Pepto-Bismol)**

For mild allergic reactions:

- ☐ Diphenhydramine **(Generic Benadryl)** 1 or 2 (25mg tabs) every 4-6 hours
- ☐ Loratadine **(Generic Claritin, non-drowsy)** 10 mg tab (1 tab in 24 hours)

For diarrhea:

☐ Loperamide **(Generic Imodium)** (no more than 2 caps in a 24 hour period for no more than two consecutive days) **Requires school physician order.**

For mild skin irritation:

- ☐ Hydrocortisone Cream 1% for skin irritations and rashes due to dermatitis, poison ivy/oak, soaps and detergents.
- ☐ Antibiotic Ointment **(Generic Neosporin)** for minor cuts and abrasions
- ☐ Sting and insect bite swab for insect sting relief
- ☐ Burn Spray/Aloe for mild burns and sunburn

****

I give permission for my child_____ to receive any medications indicated above as deemed necessary by the school nurse. I understand that generic equivalent medications may be used in place of brand-name items.

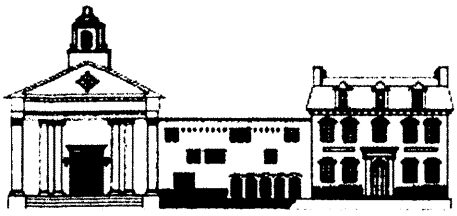
☐ **I DO NOT WANT ANY OVER-THE-COUNTER MEDICATIONS GIVEN TO MY CHILD.**

Signature of:
Parent(s)/Guardian_____**Date**_____

_____**Date**_____

Physician Signature_____**Date**_____

2.c.



The Sonia Shankman Orthogenic School
at the University of Chicago

1365 East 60th Street, Chicago IL 60637 - www.oschool.org - (p) 773-702-1203 (f) 773-702-1304

STUDENT OVER-THE-COUNTER MEDICATION CONSENT FORM

Please administer to my child_____, the over-the-counter medication(s) as listed below.

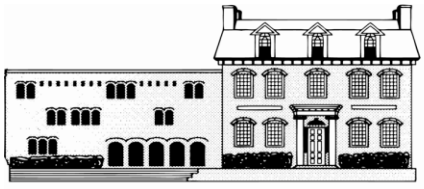
REMINDER: - All medications must be kept in the original container with labeled instructions clearly visible.

MEDICATION	REASON FOR MEDICATION
1.)	
2.)	
3.)	
4.)	
5.)	

Parent(s)/Guardian signature_____DATE_____

_____DATE_____

Physician signature_____DATE_____



THE SONIA SHANKMAN ORTHOGENIC SCHOOL
at The University of Chicago Operated by The Leslie Shankman School Corporation

ORTHOGENIC SCHOOL ELECTRONIC DEVICE and INTERNET ACCESS POLICY
UPDATED OCTOBER 2014

It is the goal of the Sonia Shankman Orthogenic School to provide its students with computer and internet access, in order to enhance their learning and, at times, for recreational purposes. Because there are some potential dangers associated with these technologies, their use must be monitored for everyone's safety. Additionally, given the cost of the equipment, monitoring is required to protect devices in order to ensure their availability and functioning at all times. As technologies evolve, so will policies regarding their use.

Internet Access:

- Internet use within the classroom shall be limited to staff approved academic purposes.
- Internet use shall be limited to sites and purposes that are appropriate and approved by staff.
- Students may only access the internet with authorization from staff. The use of any other person's password, or unauthorized use of a wireless connection (inside or outside the building), is strictly prohibited. This includes the use of non-computer personal electronic devices.

Software:

- Students may not bring in, download, or copy any shareware, licensed software, or freeware from home or elsewhere. Software shall only be downloaded to Orthogenic School-owned computers by staff.
- Students may not take any software from the Orthogenic School to use at home or elsewhere.
- Students may only use software provided by the Orthogenic School for Orthogenic School computers.

Shared Resources:

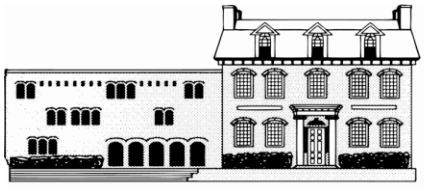
- Students may not attempt to evade, disable, or "crack" passwords or security measures put in place to protect others' property or facilities, or computer settings.
- Designated staff has the final say regarding use of any element connected to the computer, network, and connected peripherals.
- Students may not attempt to bypass limits set on computers, including any resource allocation parameters (ex. printing limits).

Hardware:

- Students shall refrain from harming or damaging the computers and accessories (including software and peripherals) that belong to the Orthogenic School. When appropriate and necessary, students and/or families will be held financially responsible for any damage to Orthogenic School property.
- Students shall refrain from attempting to fix or alter the hardware in any way. Computer maintenance shall be provided exclusively by the Orthogenic School Information Technology Support team.

Intellectual/Property Rights/Commercial Information:

- Students may not quote in any letters, papers, or emails, any source without attribution and permission.
- Orthogenic School computers shall not be used to create/alter legal or official documents.
- Students may not use the Orthogenic School computer network for commercial activity.



Email Access:

Students who are eligible for email should note that:

- Students may only email from designated computers at designated times, and with explicit permission from Orthogenic School staff.
- Students should only access email accounts approved by their parents, guardians, and the Orthogenic School.
- Classroom computers are not to be used for student email. Students should not be accessing email accounts during the school day.
- Email, as well as other mail service at the Orthogenic School, is subject to monitoring if clinically appropriate and/or necessary.
- Email should not be sent to other students without staff knowledge and approval, just as students should not pass notes.

Digital Millennium Copyright Act (DMCA):

Downloading and distributing copyrighted files is a violation of the *Digital Millennium Copyright Act (DMCA)*, which makes it a violation of Federal Law, for which the Orthogenic School will not bear any legal responsibility. The Orthogenic School cannot protect individuals who distribute copyrighted material without the appropriate license. The student and/or student's family will be responsible for financial and/or legal action taken in response to any violated copyright laws.

Personal Electronic Devices (Laptops, Computers, Cell Phones, Tablets, and Other Similar Devices):

1. Electronic devices (as described above) may only be used with staff permission, and in accordance with all regulations stated within "Electronic Device and Internet Access Policy."

2. Staff retains the right to access and review any electronic communications or activities that may be contained in an electronic device, if a reasonable concern or clinical issue presents itself.

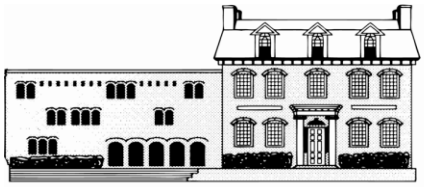
3. Only students participating in the Transitional Living Center (TLC) Program – or those with explicit permission from a Dorm Manager or Case Manager – are permitted to have cell phones (or similar devices, used for electronic communication).

4. Electronic devices may not be connected to the Orthogenic School's wireless network system, because doing so compromises the security and performance of the overall networked system.

5. Electronic devices are not to be shared or passed around. Each device should ONLY be in the possession of the student who owns it. This applies when in the classroom and in the dormitory.

6. Electronic devices may be used in the classrooms exclusively for educational purposes, as approved and directed by staff. Electronic devices are not to be used during the school day for video-games, listening to music, or other non-educational purposes.

7. Headphones should not be brought to school, and should not be used during the school day.



8. When using a laptop or tablet (or other similar device) in the classroom or in the dormitory, the screen must be visible to staff at all times.

9. Recreational use of electronic devices in the dormitory is subject to staff approval. Excessive use of electronic devices for recreational purposes that results in a student becoming isolated and not engaging with others (thus not participating in the program) shall be curtailed.

10. Laptop hard drives, CDs, DVDs, flash drives, and all other memory products may be viewed at any time by staff, in order to ensure that contraband materials, and/or particularly graphic or disturbing images, are not present in the Orthogenic School.

11. The safety and protection of electronic devices is the responsibility of the student who owns it. The Orthogenic School is not liable for replacing or fixing lost or damaged electronic devices. A secure cabinet is available for the storage of electronic devices, and other valuable items, when not in use.

By signing this contract (which is required at admission – and when updates are made), I acknowledge that I will be participating in a global electronic community, and that there are certain responsibilities that I accept as a member of this community.

I understand that the access given to students is a privilege, and not a right, and therefore, I consent to these policies and guidelines. I understand that violation of this policy may result in:

- Suspension/revocation of electronic device privileges
- Compensatory damage/replacement fees
- Legal action

Additionally, as a member of this community, I am aware that it is also my responsibility to notify school staff in the event that I believe another student may be violating these provisions, or compromising the system.

Any further violation of this contract by the undersigned student will result in electronic devices being permanently sent home – due to prior violations of previously signed computer contacts. Families will be requested to keep electronic devices at home.

<u>No student shall be allowed access to electronic devices without a signed copy of this contract on file.</u>

➔ PARENT/GUARDIAN NAME: _____

SIGNATURE:_____ DATE:_____

➔ STUDENT NAME: _____

SIGNATURE:_____ DATE:_____

THE SONIA SHANKMAN ORTHOGENIC SCHOOL
AT THE UNIVERSITY OF CHICAGO
6245 S. Ingleside Ave.
Chicago, Illinois 60637

Telephone (773) 420-2900
Facsimile (773) 420-2805

Consent for Parents' Association Directory

Dear Parents and Guardians:

Federal and State confidentiality law allow distribution of "directory information" among parents at the same school. However, out of respect for your confidentiality concerns, we seek your consent to include your contact information in a directory that we would like to distribute to all parents of children at the school. Please check the appropriate box below and we will defer to your wishes. We do think that it would be productive for parents to communicate with each other and urge you to consent accordingly.

Contact Information

Name: _____

Address: _____

_____

Home Phone: _____

Cell/Work Phone: _____

E-Mail: _____

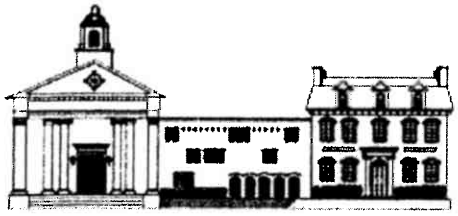
Please Indicate Your Preference

- ☐ Include all contact information in directory
- ☐ Include name, phone and e-mail in directory
- ☐ Include name and e-mail in directory
- ☐ Do not include any information in directory

Signature: _____

Date: _____

2.f.



The Sonia Shankman Orthogenic School
at the University of Chicago

1365 East 60th Street, Chicago IL 60637 - www.oschool.org - (p) 773-702-1203 (f) 773-702-1304

Contagious Infection Agreement:

I understand and agree that, if my child develops a contagious illness or infection and that if the consulting physician of the Orthogenic School recommends that my child return home in order to prevent further contagion of other students and staff members, I will make every effort to take my child home until they are no longer contagious.

Parent Signature_____

Parent Signature_____

Date_____

Orthogenic School Staff_____

Notice of Health and Educational Information and Consent Practices

This notice describes the Sonia Shankman Orthogenic School's practices regarding protected health information and educational information. It also describes the Orthogenic School's practices regarding consents for treatment and participation in School activities. These policies apply to the activities of all School employees, staff, interns, and other professionals including our business associates and consultants.

"Protected health information" is information about the Student, including demographic information that may identify the Student that relates to present, or future, physical and mental health related health care services. The Orthogenic School is committed to treating and using students' educational and protected health information responsibly. We restrict access to nonpublic personal information about students and their family members to those requiring information in providing treatment and educational services. We maintain physical, electronic, and procedural safeguards that comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal and state laws governing both health and educational information.

Information Release Forms

We ask families of applicants to complete two releases that allow us to receive and to exchange information with a student's current or previous school(s), evaluators and health care providers. In accordance with state and federal laws, applicants over 12 years old are also asked to sign the releases.

When the Student enrolls at the School, additional releases will be required to allow the School's staff to exchange information with the Student's home school district and/or other local and state agencies (e.g., the Illinois Department of Human Services Individual Care Grant Program) responsible for the Student. Parents/guardians and Students will be asked to sign forms documenting their consent to treatment and involvement in specific School activities. We will ask Students and Parents to update these forms at least once each year in conjunction with enrollment procedures for the following School year or near the anniversary date of the Student's enrollment.

Policy and Practices Regarding Protected Health Information

The Sonia Shankman Orthogenic School may use or disclose protected health information for the following reasons:

- **Student's Care and Treatment and Means of Communication Among the Professionals Who Contribute to the Student's Care and Education**

We may use protected health information about Students to provide mental health treatment and services. Additionally, we use that information to develop an effective Treatment Plan, to discuss treatment options, for purposes of assessment and to enhance all services rendered. We may disclose this information to the persons involved in treating a Student, which may include consultants, clinicians, dormitory personnel, interns, supervisors, administrators, nurses, and any other Orthogenic School personnel who are involved in providing services to a Student.

- **To Obtain Payments and Reimbursements**

We may use and disclose protected health information and educational information so that the treatment and educational services a Student receives may be billed and collected from the responsible family member, public agency, insurance company or other third party.

- **Quality Assurance and Evaluation**

We may use and disclose protected health information to review treatment and services and to evaluate the performance of staff in treating a Student. We may also combine protected health information about many Students to determine what additional services the School should offer, what services are not needed, and whether certain new services are effective. Information used in this way is "de-identified" to protect privacy. We may also disclose this information to clinicians, interns, and other personnel for review and learning purposes.

- **Authorizations**

You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your medical information for any reason except those described in this notice.

- **Disclosures to Parents/Guardians and Other Personal Representative**

We may disclose protected health information to a student's parent/guardian or personal representative (individual authorized by law) except in cases when in our professional judgment such disclosure would endanger the Student. If a Student is present, then prior to use or disclosure of the information, we will obtain the Student's agreement to disclose the information. In the alternative, we will provide the Student an opportunity to object to the disclosure, or reasonably infer from the circumstances, based on the exercise of professional judgment, that the Student does not object to the disclosure. In the event of the Student's incapacity or in emergency circumstances, we will disclose a Student's personal health information that is directly relevant to the person's involvement in the Student's care.

- **Other Applicable Laws**

We will not use or disclose personal health information if it is prohibited or materially limited by other applicable law including, but not limited to, the Illinois Medical Practice Act; Illinois Mental Health and Developmental Disabilities Code; Act; Illinois Mental Health and Developmental Disabilities Confidentiality Act; Illinois AIDS Confidentiality Act; Genetic Information Privacy; the Federal Drug Abuse, Prevention, Treatment, and Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment; Rehabilitation Act of 1973, Illinois School Student Records Act; the Individual with Disabilities Education Improvement Act of 2004; and, the Family Educational Rights and Privacy Act.

- **Research**

Under certain circumstances (e.g., only with express authorization of the student and/or parent/guardian), we may use and disclose protected health information, only in formats that preserve anonymity, for research purposes. All research projects are subject to a special approval process. This process evaluates a proposed research project and its use of information, balancing the research needs with Students' need for privacy of their protected health information. Before we use or disclose protected health information for research, the project will have been approved through the Institutional Review Board.

- **As Required By Law**

We will disclose protected health information about you when required to do so by federal, state, or local law.

- **To Avert a Serious Threat to Health or Safety**

We may use and disclose personal health information about the Student when necessary to prevent a serious threat to the Student or another person. Any disclosure would only be made to prevent a serious threat to the Student or another person.

- **Public Health Risks**

We may disclose protected health information about Students for public health activities and to fulfill certain legal requirements to report information. These activities generally include the prevention or control of disease, injury or disability, the reporting of child abuse and neglect, or to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

- **Oversight and Accreditation Activities**

We may disclose protected health information to an oversight organization for activities required to maintain or receive agency licensure, certification or accreditation. These activities include, but are not limited to audits, site visits, and inspections. These activities are necessary to monitor agency performance and compliance with civil rights laws and child welfare requirements.

- **Lawsuits and Disputes**

If a Student or the Student's family are involved in a lawsuit or a dispute, we may disclose protected health information about a Student in response to a court or administrative order. We may also disclose protected information about a Student in response to an order by a court, but only if good faith efforts have been made to notify you of the request.

- **Law Enforcement**

We may release protected health information if required to do so by law in response to a court order, a law that requires disclosure (e.g., in a case where child abuse is indicated), in response to an administrative request (if a parent/guardian makes a complaint against a state agency).

- **Medical Examiners and Funeral Directors**

We may release protected health information to a medical examiner or funeral director. This may be necessary to allow a medical examiner or funeral director to identify a deceased person or determine the cause of death, as necessary, to expedite necessary arrangements.

- **National Security Activities**

We may release protected health information about a Student or a former Student to authorized federal officials for national security activities as required by law.

- **Fundraising**

We may use protected health information to contact parents/guardians and former Students for our fund-raising purposes. We will limit our use and disclosure to your demographic information (e.g., age, address, etc.) and the dates of receipt of services at the school. We may disclose this information to a business associate to assist us in our fund-raising activities.

RIGHTS OF STUDENTS AND FAMILIES

Although the actual physical and/or computerized record contains a Student's protected health information, and remains the School's property, Students and parents/guardians have the rights to:

- Request a restriction on certain uses and disclosures of your information
- Obtain a paper copy of this notice of information practices upon request
- Inspect and copy your health record
- Amend your health record
- Obtain an accounting of disclosures of your health information
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

OUR RESPONSIBILITIES

The Sonia Shankman Orthogenic School shall:

- Maintain the privacy of protected health information
- Provide students and parents/guardians copies of notices as to our legal duties and privacy practices with respect to information we collect and maintain
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

As previously noted, we reserve the right not to disclose protected health care information to a Student's personal representative (i.e., parent/guardian or other person authorized by law) when in our professional judgment such disclosure would endanger the Student.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised noticed to the address you have supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice.

Other uses and disclosures of protected health information not covered by this notice or the laws that apply to the Sonia Shankman Orthogenic School will be made only with your written permission. If you provide the Orthogenic School with permission to use or disclose protected health information, you may revoke that permission, in writing, at any time. If you revoke your permission, the Orthogenic School will no longer use or disclose protected health information for the reasons covered by your written authorization. You understand that the Orthogenic School is unable to take back any disclosures that have already been made with your permission, that the Orthogenic School is required to retain records of the treatment that has been provided, and that failure to consent to the release and exchange of information could result in an incomplete understanding of the Student's needs and result in inadequate treatment.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions and would like additional information, you may contact the Sonia Shankman Orthogenic School's Privacy Officer, Ms. Badesch, at 773-702-1203.

If you believe your privacy rights have been violated, you can file a complaint with the Privacy Officer or with the Office of Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint. The address for the Office for Civil Rights is listed below:

Office for Civil Rights

U.S. Department of Health and Human Services

Region V

233 North Michigan Avenue, Suite 240

Chicago, Illinois 60601

(312) 886-2359

(312) 866-1807 (FAX)

(312) 353-5693 (TDD)

3.a.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH AND EDUCATIONAL INFORMATION AND CONSENT PRACTICES

I(we) acknowledge receipt of the NOTICE OF HEALTH AND EDUCATIONAL INFORMATION AND CONSENT PRACTICES OF THE SONIA SHANKMAN ORTHOGENIC SCHOOL. Its contents were explained to me and I(we) fully understand them.

SIGNED:_____
Parent or Guardian

SIGNED: _____
Student (Where Student is over 12)

Date Signed:_____

WITNESS:_____

Method of Distribution: ☐mail ☐fax ☐in person

N.B. For students 18 years-of-age and older, signature of the parent or guardian indicates that the individual has been designated the "personal representative" of the student and is entitled to full disclosure of healthcare information as provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

☐Yes, I request restrictions to the Orthogenic School's routine use and/or disclosure of PHI as described in their Notice (as outlined below)
I, _____, request the following restrictions:
_____
_____
_____
Please attaché page 2 (Orthogenic School's Response to Restriction Request)

☐No, I am not requesting any restrictions to the Orthogenic School's routine use and/or disclosure of PHI as described in their notice at this time.

ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION:

- **BEHAVIOR MANAGEMENT PLAN**
- **INDIVIDUAL TREATMENT PLANNING PROCESS**

I (we) acknowledge receipt of the BEHAVIOR MANAGEMENT PLAN OF THE SONIA SHANKMAN ORTHOGENIC SCHOOL. Its contents were explained to me and I (we) fully understand and agree to them.

SIGNED:_____
Parent or Guardian

SIGNED: _____
Student

Date Signed:_____

WITNESS:_____

Method of Distribution: ☐mail ☐fax ☐in person

I (we) acknowledge receipt of the INDIVIDUAL TREATMENT PLANING POLICIES AND PROCEDURES OF THE SONIA SHANKMAN ORTHOGENIC SCHOOL. Its contents, including the development, review and modification policies and procedures, were explained to me and I (we) fully understand and agree to them.

SIGNED:_____
Parent or Guardian

SIGNED: _____
Student

Date Signed:_____

WITNESS:_____

Method of Distribution: ☐mail ☐fax ☐in person

3.c.

ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION:

- **STUDENT MANUAL**
- **FAMILY HANDBOOK**

I (we) acknowledge receipt of the STUDENT MANUAL OF THE SONIA SHANKMAN ORTHOGENIC SCHOOL. Its contents were explained to me and I (we) fully understand and agree to them.

SIGNED: _____
Student

Date Signed: _____

WITNESS: _____

Method of Distribution: ☐mail ☐fax ☐in person

I (we) acknowledge receipt of the FAMILY HANDBOOK OF THE SONIA SHANKMAN ORTHOGENIC SCHOOL. Its contents were explained to me and I (we) fully understand and agree to them.

SIGNED: _____
Parent or Guardian

SIGNED: _____
Student

Date Signed: _____

WITNESS: _____

Method of Distribution: ☐mail ☐fax ☐in person

3.d.

The Sonia Shankman Orthogenic School

The University of Chicago

1365 E. 60th Street
Chicago, Illinois 60637

Client Rights

The Orthogenic School pledges to protect the rights that are guaranteed to our clients in accordance with Chapter II of the Illinois Mental Health and Developmental Disabilities Code (IMHDD) [405 ILCS 5]. Clients' rights will be explained to them in a language or a method of communication understood by the client. All personnel of the Orthogenic School shall recognize and honor the following rights of children.

1. Every client has the right to service without discrimination as to race, color, religion, sexual, preference, or ethnic or national origin.
2. Every client has the right to be offered the service setting which is least restrictive to the client's physical and social liberties to achieve substantial therapeutic benefit.
3. Every client has the right not to be subject to physical restraint unless the client's behavior could result in hard to him/herself or others.
4. Every client has the right to be free from fear, injury, neglect, abuse, and sexual exploitation.
5. Every child has the right to prompt medical care for the prevention, diagnosis, and treatment of medical, dental, and mental health problems.
6. Every client and his/her family have the right to be actively involved in the treatment planning process, the development of an individual treatment and discharge plan including the right to voice grievances and to make recommendations/suggestions with regard to these plans and services provided.
7. Every child has the right to culturally competent care, i.e. care which recognizes and accepts variations in cultural practices and values.
8. Every child has the right to refuse services not essential to a court and/or guardian approved plan of treatment.
9. Every client has the right to learn the program rules, regulations, and discipline methods that apply to their behavior, why they are used, and how they affect clients.
10. Every client has the right to communicate freely with individuals in accordance with program guidelines.
11. Every client has the right to a safe and clean environment.
12. Every client has the right to have nutritious and balanced meals.
13. Every client has the right to maintain personal property and to have a place for safe storage of property.
14. If any rights, according to Chapter II of the Confidentiality Act of the IMHDD Code are to be restricted, this will be justified and documented in the case file, and the client, guardian, and any other agency designated will be notified.
15. Every client has the right to express opinions and grievances and appeal adverse decisions up to the highest level in the agency and has the right to be heard in issues concerning his/her care, treatment, and plans for the future.
16. Every client has the right to confidentiality in accordance with the Confidentiality Act of the IMHDD Code and in the Health Insurance Portability and Accountability Act (HIPAA) of 1996.
17. Every client has the right to receive an education appropriate to his/her individual abilities and educational needs.
18. Every client has the right to enjoy freedom of thought, conscience and religion, including access to his/her preferred religious services.
19. Every client has the right to be provided with opportunities to establish close personal relationships with other children and with caring adults.
20. Every client has the right to be free from exploitation in employment and employment related training.
21. Every client has the right to contact the Guardianship and Advocacy Commission, Equip for Equality, Inc., and DCFS as appropriate. The client will be offered staff assistance in contacting these organizations, giving the client the necessary contact information.
22. Services will not be denied, reduced, suspended, or terminated for clients exercising their rights

Student's Copy 3.d.

Orthogenic School Client Rights

1. Every student has the right to service without discrimination as to race, color, religion, sexual preference, or ethnic or national origin.
2. Every student has the right to be offered the service setting that is least restrictive to the student's physical and social liberties to achieve substantial therapeutic benefit.
3. Every student has the right not to be subject to physical restraint unless the student's behavior could result in harm to him/herself or others.
4. Every student has the right to be free from fear, injury, neglect, abuse, and sexual exploitation.
5. Every child has the right to prompt medical care for the prevention, diagnosis, and treatment of medical, dental, and mental health problems.
6. Every student and his/her family have the right to be actively involved in the treatment planning process, the development of an individual treatment and discharge plan including the right to voice grievances and to make recommendations/suggestions with regard to these plans and services provided.
7. Every child has the right to culturally competent care, i.e. care which recognizes and accepts variations in cultural practices and values.
8. Every child has the right to refuse services not essential to a court and/or parent/guardian approved plan of treatment.
9. Every student has the right to learn the program rules, regulations, and discipline methods that apply to their behavior, why they are used, and how they affect students.
10. Every student has the right to communicate freely with individuals in accordance with program guidelines.
11. Every student has the right to a safe and clean environment.
12. Every student has the right to have nutritious and balanced meals.
13. Every student has the right to maintain personal property and to have a place for safe storage of property.
14. If any rights, according to Chapter II of the Confidentiality Act of the IMHDD Code are to be restricted, this will be justified and documented in the case file, and the student, guardian, and any other agency designated will be notified.
15. Every student has the right to express opinions and grievances and appeal adverse decisions up to the highest level in the agency and has the right to be heard in issues concerning his/her care, treatment, and plans for the future.
16. Every student has the right to confidentiality in accordance with the Confidentiality Act of the IMHDD Code and in the Health Insurance Portability and Accountability Act (HIPAA) of 1996.
17. Every student has the right to receive an education appropriate to his/her individual abilities and educational needs.
18. Every student has the right to enjoy freedom of thought, conscience and religion, including access to his/her preferred religious services.
19. Every student has the right to be provided with opportunities to establish close personal relationships with other children and with caring adults.
20. Every student has the right to be free from exploitation in employment and employment related training.
21. Every student has the right to contact the Guardianship and Advocacy Commission (866.274.8023), Equip for Equality, Inc., (800.537.2632) and DCFS (312.814.6800) as appropriate. The student will be offered staff assistance in contacting these organizations.
22. Services will not be denied, reduced, suspended, or terminated for students exercising their rights.

3.d.

ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION:

- **CLIENT RIGHTS**

I (we) acknowledge receipt of the CLIENT RIGHTS OF THE SONIA SHANKMAN ORTHOGENIC SCHOOL. Its contents were explained to me and I (we) fully understand and agree to them.

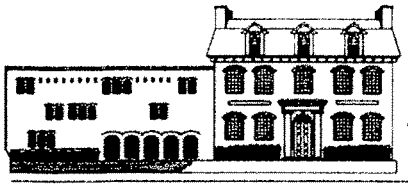
SIGNED:_____
Parent or Guardian

SIGNED: _____
Student

Date Signed:_____

WITNESS:_____

Method of Distribution: ☐mail ☐fax ☐in person



THE SONIA SHANKMAN ORTHOGENIC SCHOOL
at The University of Chicago Operated by The Leslie Shankman School Corporation

Policy and Procedure Regarding Client Grievances

Purpose and Scope:

The cornerstone of the Sonia Shankman Orthogenic School's client grievance policy is its "Open Door" policy. The purpose of the Orthogenic School's Open Door Policy is to implement the philosophy that all students, parents, guardians, and responsible family members should have free and immediate access to supervisory personnel to raise any type of treatment and program concerns.

Student, parents, and/or guardians are encouraged to raise treatment and program concerns with the staff member assigned and directly responsible for the student's care as soon as possible after the events that cause the concerns. Alternatively, if the student, parents, and/or guardians believe that the immediate staff member or supervisor is not the appropriate person with whom to raise such matter, the student, parents, and/or guardians are encouraged to bring his or her concerns to the attention of any other supervisor, member of management team or the Co-Directors. Therefore, it is only after all avenues of resolve have been pursued within the Orthogenic School that an employee would contact a member of the Board of Directors, or any outside agency.

Student, parents, and/or guardians are further encouraged to pursue discussion of their concerns with the management official they have approached until the matters they have raised are fully resolved. The Orthogenic School cannot guarantee that in each instance the student, parents, and/or guardians will be satisfied with the result, but in each case an attempt will be made to explain the resolution of the matter to them, even when it is not the result that they sought.

The Orthogenic School believes that such concerns are best addressed through informal and open communication. No student, parents, and/or guardians will be disciplined or otherwise penalized or retaliated against for raising a good-faith concern. The Orthogenic School will attempt to keep confidential all such expressions of concern, their investigation, and the terms of their resolution. At the same time, however, some dissemination of information to others may be appropriate during the process of investigating and resolving the concerns.

Written Grievances:

Student, parents, and/or guardians who conclude that their treatment and/or program concerns should be brought to the attention of the Orthogenic School are also encouraged to submit a written grievance or complaint whenever such a problem cannot be resolved with the immediate staff member or their supervisor after an attempt to work things out through the Open Door Policy. Student, parents, and/or guardians who submit a written grievance or complaint under this procedure will not be subject to any reprisals. However, student, parents, and/or guardians submitting a written grievance or complaint should do so in such a manner that will not disrupt or interfere with the work of any other employees or disrupt the treatment and care of other students. Any student, parents, and/or guardians having a grievance or complaint that cannot be resolved initially should forward the grievance or a written complaint to the Co-Directors. The Co-Directors will review the grievances within 48 hours. Thereafter, the matter will be resolved promptly, or alternatively, the Orthogenic School will conduct a formal investigation pursuant to the Internal Complaint Review Procedure, which is described below.

Internal Complaint Review Procedure:

The purpose of the Internal Complaint Review Procedure is to afford all of the Orthogenic School's student, parents, and/or guardians the opportunity to seek internal resolution of their complaints. The International Complaint Review Procedure is intended to supplement the Open Door Policy. The Orthogenic School will attempt to treat all internal complaints and their investigation in a confidential manner, while at the same time recognizing, however, that some dissemination of information to others may be appropriate in the course of investigation and resolving internal complaints. The Orthogenic School will not retaliate or seek reprisals from anyone who brings a complaint in good faith, regardless of whether or not the complaint is found to have merit.

Procedure:

1. Filing of Complaint

Student, parents, and/or guardians should prepare a written complaint and direct it to the attention of the Co-Directors as soon as possible after the events that give rise to their concerns. The written complaint should set forth in detail the reasons for the complaint and the resolution sought by the client. It should be signed and dated by the client and then sent to the Co-Directors in a confidential envelope (often times via the Director of Compliance). Client Grievance forms will be freely available to all clients – initially through the Student Manual.

2. Investigation

The Co-Directors, upon receipt of a written complaint, will send the student, and parents or guardians an acknowledgement that the complaint was received and that it is under review. The Co-Directors will direct the investigation of the complaint. Where necessary, the investigation will include a face-to-face meeting with the student, parents, and/or guardians and with others who are named in the complaint or who may have knowledge of the facts pertinent to the complaint.

3. Resolution

On completion of the investigation, the Co-Directors will take action to resolve the complaint. In addition, the Co-Directors will meet with the student and parents or guardians to discuss the resolution of the complaint.

Sonia Shankman Orthogenic School Student or Parent Grievance Form

If after having attempted to resolve matters through the school's Open Door Policy, the student, parent, and/or guardian continues to feel further resolution is needed, the person(s) involved should complete the following form as soon after the event as possible. The completed formed should be given to the Co-Directors. The person completing the form will be given written acknowledgement of receipt of the form within 48 hours.

Type of Complaint (check one)

_____ Alleged discrimination on the basis of race, sex, religion, national origin, mental or physical handicap

_____ Alleged unfair treatment by staff member

_____ Alleged poor service by staff member

_____ Alleged abusive or neglectful treatment by staff member

_____ Other _____

Please describe the nature of your complaint (Attach sheet if necessary)

_____
_____
_____
_____
_____
_____

Please describe the resolution that you are seeking (Attach sheet if necessary)

_____
_____
_____

_____

Signature and Date

Your complaint will be reviewed and resolved by the Co-Directors of the Sonia Shankman Orthogenic School within two weeks. You will be notified of our findings in writing.

Sonia Shankman Orthogenic School Student, Parent and/or Guardian Grievance Resolution Form

Staff Members Evaluation of Problem: (Please include a description of your efforts to discuss the complaint with the client)

Supervisor's Comments:

Academic Coordinator/Associate Director's Comments:

Co-Directors' Comments:

Findings:

Staff Members Signature and Date

Academic Coordinator/Associate Director's Signature and Date

Supervisors Signature and Date

Co-Director's Signature and Date

3.e.

ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION:

- **CLIENT GRIEVANCE POLICY**

I (we) acknowledge receipt of the CLIENT GRIEVANCE POLICY OF THE SONIA SHANKMAN ORTHOGENIC SCHOOL. Its contents were explained to me and I (we) fully understand and agree to them.

SIGNED:_____
Parent or Guardian

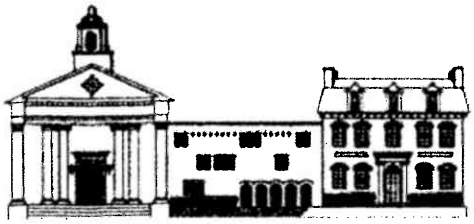
SIGNED: _____
Student

Date Signed:_____

WITNESS:_____

Method of Distribution: ☐mail ☐fax ☐in person

3. f.



THE SONIA SHANKMAN ORTHOGENIC SCHOOL
AT THE UNIVERSITY OF CHICAGO
1365 East Sixtieth Street
Chicago, Illinois 60637

Telephone (773) 702-1203
Facsimile (773) 702-1304

Subpoena Policy

The Orthogenic School Board of Directors has therefore decided to implement the following procedures whenever a subpoena is received in any civil matter not involving a dispute with the school itself. The purpose of this policy is to ensure a stable and safe environment for our children while at the same time attempting to reasonably accommodate individuals who for one reason or another feel a need to request or compel testimony of staff or copies of confidential records.

I. SUBPOENAS FOR RECORDS ONLY

Whenever a subpoena for records only is received, we will first determine if mental health records are included in our files. If they are, as to those records only, Illinois law requires that any properly served subpoena must be accompanied by a court order. The court order must give permission to the subpoenaing party to serve the subpoena and it must also grant access to "personally identifiable" mental health records. Service of a subpoena for mental health records, without an accompanying court order as above described, is a defectively served subpoena and will not be accepted. In addition, under Illinois decisional case law, an attorney who defectively serves a subpoena for mental health records is subject to a disciplinary complaint and possible malpractice action.

If there is a compelling reason, in the sole discretion of the administration, a subpoena for records may be met by a "motion to quash." This means that we will challenge the subpoena. We will challenge a subpoena if we think there is information in the file that might cause harm to the child or children in question, or if the subpoena is served for any improper purpose. In such an event, we will retain legal counsel, challenge the subpoena, and bill the subpoenaing party accordingly, pursuant to III below.

II. SUBPOENA OF A WITNESS FOR TESTIMONY OR DEPOSITION

1. SUBPOENA OF THE PRINCIPAL OR EXECUTIVE DIRECTOR

If we receive a subpoena for the in-court testimony of the Principal or Executive Director about our program, we will usually accommodate the request but will try to restrict testimony to a description of our programs. We will generally resist multiple depositions, court dates, and the like and will retain legal counsel for this purpose should testimony become too disruptive for the functioning of the Sonia Shankman Orthogenic School.

In addition, we will resist any subpoena if we think that it was served for an improper purpose, such as to harass or intimidate.

2. SUBPOENA OF ANYONE OTHER THAN THE EXECUTIVE DIRECTOR OR PRINCIPAL

We will resist all subpoenas for in-court testimony served upon anyone other than our Principal or Executive Director. The purpose of this policy is to ensure a stable and continuous service environment for the children we serve. To permit lawyers or parents in a domestic relations or other dispute to act out their own conflicts by disrupting staff through subpoenas that take our staff away from serving children will not be tolerated. We expect families who insist on doing this to pay for any and all costs, including our attorney fees, if they cause a subpoena to be served that in our sole discretion requires the involvement of our attorney.

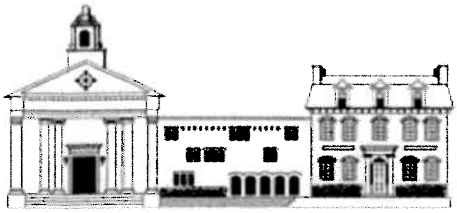
III. PAYMENT FOR SERVICES

We extend the availability of our Executive Director for testimony as a courtesy to our families. However, at times in legal cases the records registrar is required to "authenticate" a record. With respect to any testimony for the narrow purpose of records authentication, we will allow our records custodian to testify for a flat fee of $500.00. The time of the Executive Director to be qualified in the case as an "expert," in other words, to offer opinions rather than just testimony as to things observed or heard, or testimony about our services, the hourly rate is $500.00. Hourly charges apply to preparation, travel, waiting, and actual testimony time. We reserve the right to request advance payment for these charges.

We, the parents of _____, a child served by the Sonia Shankman Orthogenic School, have read the above policy on subpoenas. We certify that should we enter into a civil dispute as with any party other than the school or faculty itself, we will not subpoena anyone for testimony for any purpose in such proceedings; and, we agree as part of our contract with this facility to pay for any and all attorney fees that might be incurred as a result of a subpoena served by us upon this facility which would in the sole discretion of management require retention of legal counsel. We also understand, and agree in advance, that our family may be dismissed from the facility if responding to subpoenas and other legal procedures would, in the sole discretion of the administration, be too burdensome and/or disruptive. We intend that this document shall be incorporated into our current contract with this facility.

X_____ X_____
Parent Parent

Accepted: X_____ Title: _____



The Sonia Shankman Orthogenic School
at the University of Chicago

1365 East 60th Street, Chicago IL 60637 - www.oschool.org - (p) 773-702-1203 (f) 773-702-1304

Acknowledgement of Responsibility to
Provide Full and Accurate Disclosure of Admission Intake Information

In signing below, I (we) _____, the parent/guardian of Orthogenic School student _____, acknowledge that I (we) am (are) aware of my (our) responsibility to provide the Sonia Shankman Orthogenic School at the University of Chicago with all known requested information and/or known relevant information about my (our) child and family, in order for the school's multidisciplinary team to make a complete and thorough assessment of and intervention plan for my (our) child's needs while in the Orthogenic School's care.

This information may include, but is not limited to, past and current medical, psychiatric, psychological, counseling, academic, and legal matters – whether it be an assessment, intervention, or involvement with an individual or agency.

I (We) am (are) aware that this information is vital to the quality of programming the school can offer my (our) child and family, as well as the overall quality of the school's programming in general.

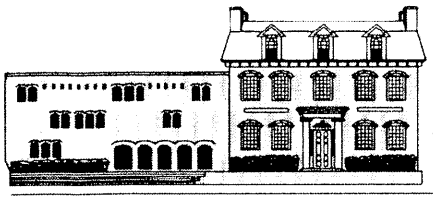
I (We) acknowledge that the school has stated its commitment to uphold all applicable privacy and confidentiality laws and regulations regarding this information.

I (We) also acknowledge my (our) understanding that the school retains the right to immediately re-evaluate the appropriateness of my (our) child's placement within its programs if and when the school becomes aware of requested or relevant information that I (we) had previously not disclosed, whether intentionally or unintentionally. Such a re-evaluation can and may lead to such changes as discharge from the program.

Parent/Guardian Signature: _____ Witness Signature:_____

Date: _____ Date:_____

3.h.



THE SONIA SHANKMAN ORTHOGENIC SCHOOL
at The University of Chicago Operated by The Leslie Shankman School Corporation

December 22, 2010

Re: Psychiatric Billing Policy

Dear Parents of Orthogenic School Students:

We want to review our billing policy and fees for Psychiatric Medication Management Services. As part of our review and analysis, we consulted with legal counsel to ensure that our policy would stand up to government requirements. It was our goal to develop a policy that was fair and legal and would ease the financial burden on families for which paying would represent a serious financial hardship. We also want to make you aware that *psychiatric services are not* included in either our Tuition or Room & Board Rate contracts with the states and school districts and in order for our organization to provide appropriate care to your children, we need to cover as much of the cost of these services as possible.

Our new policy and procedures are as follows:

1) We will bill and collect from our parents directly for these services. These invoices will now be sent every month. We will attach to this invoice a bill that has all the information needed for reimbursement from your insurance company. We will not be billing third-party insurers for our services and we do not negotiate reduced rates with any insurers.

2) For the time being, we will be capping the bill at 1 visit per month (This will be either $150 or $250 depending on the nature of the visit). As you can see below this may be less than the actual fee for a visit or represent a substantial discount if your child should be seen more than once a month. Your bill will detail the visits and show a discount at the bottom with your total to pay which will be 1 visit per month. *We have done this to ease the financial burdens on our families, however, we retain the right to change this policy if the financial health of our organization requires it.*

3) Parents will be responsible for getting any authorizations they may need for Mental Health Services according to their particular plan.

4) It is likely that we will not be a provider in any managed care contracts. However, parents in the past have been able to obtain "in network" status for these services when they appeal to their insurance company and explain that while their child is at this school, they do not have the choice of using any "network" psychiatrist. We encourage you to appeal to your insurer.

1365 E. 60th Street Chicago, IL 60637 **Phone:** 773-702-1203 **Fax:** 773-702-1304 http://www.oschool.org

3.h.

5) For those parents who do not have insurance coverage and/or for whom payment represents a financial hardship, we have implemented a scholarship and reduced fee schedule enclosed with this mailing. For those of you who cannot negotiate an "in network" rate and for whom the co-payment represents a substantial hardship, you may apply for financial assistance. Please contact the finance office at 773-834-8686 to request a financial aid application. .

We developed what we believe are fair and competitive fees based on our market place. Our fee schedule is as follows:

CPT CODE	**FEE**
90862 Medication Mgmt (15–30 minutes)	$175
90805 Individual Therapy & Med Mgmt (20-30 minutes)	$175
90807 Individual Therapy & Med Mgmt (45-60 minutes)	$250

Thanks for your help with these changes. Please call our CFO, Abby Simon at 773-834-5077 with any questions.

Thank-you.

Sincerely,

Pete Myers, Co-Director
Sonia Shankman Orthogenic School

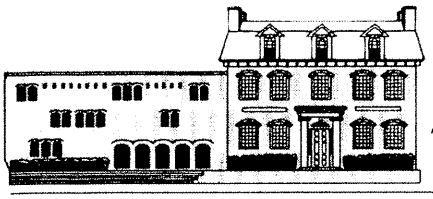
Diana Kon, Co-Director
Sonia Shankman Orthogenic School

Sonia Shankman Orthogenic School
Financial Aid Fee Schedule
July 2010

Annual Gross Income	# of Members in Household			
	3	4	5	6+
$0 - $33,000	10%	10%	10%	10%
$33,001 - $37,000	20%	15%	10%	10%
$37,001 - $41,000	25%	20%	15%	10%
$41,001 - $45000	30%	25%	20%	15%
$45,001 - $49,000	35%	30%	25%	20%
$49,001 - $53,000	40%	35%	30%	25%
$53,001 - $57,000	45%	40%	35%	30%
$57,001 - $61,000	50%	45%	40%	35%
$61,001 - $65,000	55%	50%	45%	40%
$65,001 - $69000	60%	55%	50%	45%
$69,001 - $73,000	65%	60%	55%	50%
$73,001 - $77,000	70%	65%	60%	55%
$77,001 - $81,000	75%	70%	65%	60%
$81,001 - $85000	80%	75%	70%	65%
$85,001 - $89000	85%	80%	75%	70%
$98,001 - $93,000	90%	85%	80%	75%
$93,001 - $97,000	95%	90%	85%	80%
$97,001 - $101,000	100%	95%	90%	85%
$101,001 - $105,000	100%	100%	95%	90%
$105,001- $109,000	100%	100%	100%	95%
$109,001 +	100%	100%	100%	100%

Note: Exceptions will be made for exceptional situations

3. h.



THE SONIA SHANKMAN ORTHOGENIC SCHOOL
at The University of Chicago Operated by The Leslie Shankman School Corporation

Financial Aid Application

Name:_____

Address:_____

_____

_____

Child's Name:_____

Annual Gross Income:$_____

Estimated Annual Expenses $_____

Number of Family Members in the Household _____

Specific financial circumstances you would like to bring to our attention:

_____

_____

_____

_____

_____

_____

_____

Signed tax return included _____ (required for processing)

I/We attest that the information provided here is truthful and accurate

Signature_____Date:_____

4.a.

CHILD BEHAVIOR CHECKLIST FOR AGES 4–18

For office use only
ID #

Please Print

CHILD'S FULL NAME: FIRST MIDDLE LAST

SEX ☐ Boy ☐ Girl

AGE

ETHNIC GROUP OR RACE

TODAY'S DATE Mo. _____ Date _____ Yr. _____

CHILD'S BIRTHDATE Mo. _____ Date _____ Yr. _____

GRADE IN SCHOOL _____

NOT ATTENDING SCHOOL ☐

Please fill out this form to reflect *your* view of the child's behavior even if other people might not agree. Feel free to print additional comments beside each item and in the spaces provided on page 2.

PARENTS' USUAL TYPE OF WORK, even if not working now. *(Please be specific—for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.)*

FATHER'S TYPE OF WORK: _____

MOTHER'S TYPE OF WORK: _____

THIS FORM FILLED OUT BY:

☐ Mother (full name) _____

☐ Father (full name) _____

☐ Other—full name & relationship to child: _____

I. Please list the sports your child most likes to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

☐ None

Compared to others of the same age, about how much time does he/she spend in each?

	Don't Know	Less Than Average	Average	More Than Average
a. _____	☐	☐	☐	☐
b. _____	☐	☐	☐	☐
c. _____	☐	☐	☐	☐

Compared to others of the same age, how well does he/she do each one?

	Don't Know	Below Average	Average	Above Average
a. _____	☐	☐	☐	☐
b. _____	☐	☐	☐	☐
c. _____	☐	☐	☐	☐

II. Please list your child's favorite hobbies, activities, and games, other than sports. For example: stamps, dolls, books, piano, crafts, cars, singing, etc. (Do ***not*** include listening to radio or TV.)

☐ None

Compared to others of the same age, about how much time does he/she spend in each?

	Don't Know	Less Than Average	Average	More Than Average
a. _____	☐	☐	☐	☐
b. _____	☐	☐	☐	☐
c. _____	☐	☐	☐	☐

Compared to others of the same age, how well does he/she do each one?

	Don't Know	Below Average	Average	Above Average
a. _____	☐	☐	☐	☐
b. _____	☐	☐	☐	☐
c. _____	☐	☐	☐	☐

III. Please list any organizations, clubs, teams, or groups your child belongs to.

☐ None

Compared to others of the same age, how active is he/she in each?

	Don't Know	Less Active	Average	More Active
a. _____	☐	☐	☐	☐
b. _____	☐	☐	☐	☐
c. _____	☐	☐	☐	☐

IV. Please list any jobs or chores your child has. For example: paper route, babysitting, making bed, working in store, etc. (Include ***both*** paid and unpaid jobs and chores.)

☐ None

Compared to others of the same age, how well does he/she carry them out?

	Don't Know	Below Average	Average	Above Average
a. _____	☐	☐	☐	☐
b. _____	☐	☐	☐	☐
c. _____	☐	☐	☐	☐

4-95 Edition

V. 1. About how many close friends does your child have? (Do *not* include brothers & sisters) ☐ None ☐ 1 ☐ 2 or 3 ☐ 4 or more

2. About how many times a week does your child do things with any friends outside of regular school hours? (Do *not* include brothers & sisters) ☐ Less than 1 ☐ 1 or 2 ☐ 3 or more

VI. Compared to others of his/her age, how well does your child:

	Worse	About Average	Better	
a. Get along with his/her brothers & sisters?	☐	☐	☐	☐ Has no brothers or sisters
b. Get along with other kids?	☐	☐	☐	
c. Behave with his/her parents?	☐	☐	☐	
d. Play and work alone?	☐	☐	☐	

VII. 1. For ages 6 and older—performance in academic subjects. ☐ **Does not attend school because** _____

Check a box for each subject that child takes	Failing	Below Average	Average	Above Average
a. Reading, English, or Language Arts	☐	☐	☐	☐
b. History or Social Studies	☐	☐	☐	☐
c. Arithmetic or Math	☐	☐	☐	☐
d. Science	☐	☐	☐	☐
Other academic subjects – for example: computer courses, foreign language, business. Do ***not*** include gym, shop, driver's ed., etc. e. _____	☐	☐	☐	☐
f. _____	☐	☐	☐	☐
g. _____	☐	☐	☐	☐

2. Does your child receive special remedial services or attend a special class or special school? ☐ **No** ☐ **Yes—kind of services, class, or school:**

3. Has your child repeated any grades? ☐ **No** ☐ **Yes—grades and reasons:**

4. Has your child had any academic or other problems in school? ☐ **No** ☐ **Yes—please describe:**

When did these problems start?

Have these problems ended? ☐ **No** ☐ **Yes – when?**

Does your child have any illness or disability (either physical or mental)? ☐ **No** ☐ **Yes—please describe:**

What concerns you most about your child?

Please describe the best things about your child:

Below is a list of items that describe children and youth. For each item that describes your child ***now or within the past 6 months***, please circle the ***2*** if the item is ***very true or often true*** of your child. Circle the ***1*** if the item is ***somewhat or sometimes true*** of your child. If the item is ***not true*** of your child, circle the ***0***. Please answer all items as well as you can, even if some do not seem to apply to your child.

Please Print

0 = Not True (as far as you know) 1 = Somewhat or Sometimes True 2 = Very True or Often True

0 1 2 1. Acts too young for his/her age
0 1 2 2. Allergy (describe): _____
_____
0 1 2 3. Argues a lot
0 1 2 4. Asthma
0 1 2 5. Behaves like opposite sex
0 1 2 6. Bowel movements outside toilet
0 1 2 7. Bragging, boasting
0 1 2 8. Can't concentrate, can't pay attention for long
0 1 2 9. Can't get his/her mind off certain thoughts; obsessions (describe): _____
_____
0 1 2 10. Can't sit still, restless, or hyperactive
0 1 2 11. Clings to adults or too dependent
0 1 2 12. Complains of loneliness
0 1 2 13. Confused or seems to be in a fog
0 1 2 14. Cries a lot
0 1 2 15. Cruel to animals
0 1 2 16. Cruelty, bullying, or meanness to others
0 1 2 17. Day-dreams or gets lost in his/her thoughts
0 1 2 18. Deliberately harms self or attempts suicide
0 1 2 19. Demands a lot of attention
0 1 2 20. Destroys his/her own things
0 1 2 21. Destroys things belonging to his/her family or others
0 1 2 22. Disobedient at home
0 1 2 23. Disobedient at school
0 1 2 24. Doesn't eat well
0 1 2 25. Doesn't get along with other kids
0 1 2 26. Doesn't seem to feel guilty after misbehaving
0 1 2 27. Easily jealous
0 1 2 28. Eats or drinks things that are not food — ***don't*** include sweets (describe): _____
_____
0 1 2 29. Fears certain animals, situations, or places, other than school (describe): _____
_____
0 1 2 30. Fears going to school
0 1 2 31. Fears he/she might think or do something bad
0 1 2 32. Feels he/she has to be perfect
0 1 2 33. Feels or complains that no one loves him/her
0 1 2 34. Feels others are out to get him/her
0 1 2 35. Feels worthless or inferior
0 1 2 36. Gets hurt a lot, accident-prone
0 1 2 37. Gets in many fights
0 1 2 38. Gets teased a lot
0 1 2 39. Hangs around with others who get in trouble
0 1 2 40. Hears sounds or voices that aren't there (describe): _____
_____
0 1 2 41. Impulsive or acts without thinking
0 1 2 42. Would rather be alone than with others
0 1 2 43. Lying or cheating
0 1 2 44. Bites fingernails
0 1 2 45. Nervous, highstrung, or tense
0 1 2 46. Nervous movements or twitching (describe):
_____
_____
0 1 2 47. Nightmares
0 1 2 48. Not liked by other kids
0 1 2 49. Constipated, doesn't move bowels
0 1 2 50. Too fearful or anxious
0 1 2 51. Feels dizzy
0 1 2 52. Feels too guilty
0 1 2 53. Overeating
0 1 2 54. Overtired
0 1 2 55. Overweight
56. Physical problems ***without known medical cause:***
0 1 2 a. Aches or pains (***not*** stomach or headaches)
0 1 2 b. Headaches
0 1 2 c. Nausea, feels sick
0 1 2 d. Problems with eyes (***not*** if corrected by glasses) (describe): _____
0 1 2 e. Rashes or other skin problems
0 1 2 f. Stomachaches or cramps
0 1 2 g. Vomiting, throwing up
0 1 2 h. Other (describe): _____
_____

Please see other side

Please Print

0 = Not True (as far as you know) 1 = Somewhat or Sometimes True 2 = Very True or Often True

0 1 2 57. Physically attacks people
0 1 2 58. Picks nose, skin, or other parts of body (describe): _____
_____
0 1 2 59. Plays with own sex parts in public
0 1 2 60. Plays with own sex parts too much
0 1 2 61. Poor school work
0 1 2 62. Poorly coordinated or clumsy
0 1 2 63. Prefers being with older kids
0 1 2 64. Prefers being with younger kids
0 1 2 65. Refuses to talk
0 1 2 66. Repeats certain acts over and over; compulsions (describe): _____
_____
0 1 2 67. Runs away from home
0 1 2 68. Screams a lot
0 1 2 69. Secretive, keeps things to self
0 1 2 70. Sees things that aren't there (describe):
_____
_____
0 1 2 71. Self-conscious or easily embarrassed
0 1 2 72. Sets fires
0 1 2 73. Sexual problems (describe): _____
_____
_____
0 1 2 74. Showing off or clowning
0 1 2 75. Shy or timid
0 1 2 76. Sleeps less than most kids
0 1 2 77. Sleeps more than most kids during day and/or night (describe): _____
_____
0 1 2 78. Smears or plays with bowel movements
0 1 2 79. Speech problem (describe): _____
_____
0 1 2 80. Stares blankly
0 1 2 81. Steals at home
0 1 2 82. Steals outside the home
0 1 2 83. Stores up things he/she doesn't need (describe): _____
_____
0 1 2 84. Strange behavior (describe): _____
_____
0 1 2 85. Strange ideas (describe): _____
_____
0 1 2 86. Stubborn, sullen, or irritable
0 1 2 87. Sudden changes in mood or feelings
0 1 2 88. Sulks a lot
0 1 2 89. Suspicious
0 1 2 90. Swearing or obscene language
0 1 2 91. Talks about killing self
0 1 2 92. Talks or walks in sleep (describe): _____
_____
0 1 2 93. Talks too much
0 1 2 94. Teases a lot
0 1 2 95. Temper tantrums or hot temper
0 1 2 96. Thinks about sex too much
0 1 2 97. Threatens people
0 1 2 98. Thumb-sucking
0 1 2 99. Too concerned with neatness or cleanliness
0 1 2 100. Trouble sleeping (describe): _____
_____
0 1 2 101. Truancy, skips school
0 1 2 102. Underactive, slow moving, or lacks energy
0 1 2 103. Unhappy, sad, or depressed
0 1 2 104. Unusually loud
0 1 2 105. Uses alcohol or drugs for nonmedical purposes (describe): _____
_____
0 1 2 106. Vandalism
0 1 2 107. Wets self during the day
0 1 2 108. Wets the bed
0 1 2 109. Whining
0 1 2 110. Wishes to be of opposite sex
0 1 2 111. Withdrawn, doesn't get involved with others
0 1 2 112. Worries
113. Please write in any problems your child has that were not listed above:
0 1 2 _____
0 1 2 _____
0 1 2 _____

PLEASE BE SURE YOU HAVE ANSWERED ALL ITEMS.

UNDERLINE ANY YOU ARE CONCERNED ABOUT.

SONIA SHANKMAN ORTHOGENIC SCHOOL AT THE UNIVERSITY OF CHICAGO

Medical History

Child's Name _____ D.O.B. _____ Age_____.

Immunization: (complete immunization information required, fill out dates below or attach copy of records, these can be obtained from doctor or school).

DPT: _____ _____ _____ _____ _____
OPV: _____ _____ _____ _____ _____
DT: _____ _____ _____
Measles: _____ _____
German Measles (Rubella): _____ _____
Mumps: _____
BCG: _____ _____ _____ (Not Required)
Tuberculosis Test: (Most Recent) _____

Other Immunizations:
Hearing: Last Examination: _____ Problems:

Speech Problems:

Vision: Last Examination: _____ Problems:

Birth History:
Pregnancy Complications:

Delivery Complications:

Birth Weight: Prematurity:
Postmaturity:
Problems in first week of life:

Problems in first two months of life:

Medical History:

Hospitalizations:

Surgery:

Injuries:

Allergies:

Other problems with medication:

Illnesses:
Ear Infections:
Pneumonia:
Chicken Pox: Age:

Abdominal Pain:

Sleeping Difficulties:

Diet or growth problems:

Tics (unusual movements):

Seizures:

Other symptoms or medical problems:

Medication currently or frequently taken:

Specialized testing results (e.g. EEG, CAT scan):

Family Medical History (Name, age, medical problems)
Father:

Mother:

Siblings:

Any family history of the following (circle):
Diabetes, High blood pressure, Heart attacks (age _____), Seizures, Other neurological problems (_____), Difficulties in reading or learning, Asthma, Alcoholism, Deafness, Mental illness, Other: