MINNICK SCHOOLS

enCircle

Main Office: 2965 Colonnade Dr. SW, Ste 310 Roanoke, VA 24018 • Phone (540) 774 – 7100 • Fax (540) 774 – 1084

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

Grundy: 3019 Slate Creek Road, Grundy, VA 24614 • Phone (276) 230 - 0616

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

Lynchburg: 601 12th St., Lynchburg, VA 24504 • (434) 333 – 0208

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

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

Wise Adapted Program: 6408 Glamorgan Chapel Road, Wise VA 24293 • Phone (276) 321 – 7069

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

Thank you for your interest in Minnick Schools. To complete the application process, please provide the following information and note that we cannot enroll a student until all applicable components have been submitted:

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

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

Ashley Wittl-Osborne
Director of Educational Services
awittl@enCircleAll.org

MINNICK SCHOOLS

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PUBLIC SCHOOL REFERAL TO MINNICK SCHOOLS

Minnick School Location: _____

Date of Referral: _____

Student's Full Name: _____ Race/Ethnicity: _____

Birth Date: _____ Birthplace: _____

Referring School System: _____

Director of Special Education: _____

Address: _____

_____

Telephone Number: _____

Parent/Legal Guardian: _____ Occupation/Employer: _____

Address: _____

_____

Home Phone Number: _____ Work Phone Number: _____

Cell Phone Number: _____ Email Address: _____

Parent/Legal Guardian: _____ Occupation/Employer: _____

Address: _____

_____

Home Phone Number: _____ Work Phone Number: _____

Cell Phone Number: _____ Email Address: _____

MINNICK SCHOOLS
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PUBLIC SCHOOL REFERAL TO MINNICK SCHOOLS

School Student Currently Attending: _____

Assigned Public School (if different from above): _____

State Testing Identifier: _____

Primary Disability: _____

Current Grade Level (as of referral date): _____

Reason for Referral: _____

_____

_____

School Contact Person(s)

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

Name: _____ Title: _____

Address: _____

_____

Phone Number: _____ Email Address: _____

Name: _____ Title: _____

Address: _____

_____

Phone Number: _____ Email Address: _____

Name: _____ Title: _____

Address: _____

_____

Phone Number: _____ Email Address: _____

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CONFIDENTIAL – FOR PROFESSIONAL USE ONLY

ACADEMIC YEAR 2024 – 2025

STUDENT DATA FOR INITIAL AND ANNUAL ENROLLMENT

Date: _____ Grade Level for the 24-25 School Year: _____

Student Name: _____
first *middle* *last*

Date of Birth: _____ Place of Birth: _____

Sex assigned at birth: ☐ Male ☐ Female Race/Ethnicity: _____

Gender Identity *(if different than sex assigned at birth):* _____

Address: _____

Parent/Guardian Name: _____

Address: _____

Primary Phone Number: _____ ☐ cell ☐ home ☐ work

Secondary Phone Number: _____ ☐ cell ☐ home ☐ work

Email address: _____

Employer: _____

Parent/Guardian Name: _____

Address: _____

Primary Phone Number: _____ ☐ cell ☐ home ☐ work

Secondary Phone Number: _____ ☐ cell ☐ home ☐ work

Email address: _____

Employer: _____

Child is in custody of: ☐ **Mother** ☐ **Father** ☐ **Both** ☐ **Other** _____

Emergency Contacts *(must be able to pick student up from school):*

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

MINNICK SCHOOLS
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ACADEMIC YEAR 2024 – 2025 ***CONSENT FOR IMPLEMENTATION OF SAFETY-CARE***

Student Name: _____

Parent/Guardian Name: _____

The staff of the Minnick Schools are trained in Safety-Care, a competency-based crisis prevention training program for professional staff working with individuals who have the potential for aggressive behavior. It was developed and is provided by Quality Behavior Solutions, Inc. Across sites, there are Minnick Schools employees who have been trained by a Safety-Care Master Trainer and are then authorized to serve as Safety-Care trainers within our schools.

Safety-Care provides the skills and competencies necessary to effectively prevent, minimize, and manage behavioral challenges with dignity, safety, and the possibility of change. Safety-Care delivers the tools and strategies needed to be safe when working with behaviorally challenging individuals using up-to-date and effective technologies from Applied Behavior Analysis (ABA) and Positive Behavior Interventions & Supports (PBIS). Safety-Care promotes a reinforcement-based approach to developing new skills, maintaining safety, and reducing or eliminating restrictive interventions such as restraint.

Minnick Schools staff are prepared to initiate physical interventions, including restraints, as trained through Safety-Care when a student is at risk of hurting themselves and/or others and has not responded to less restrictive strategies to redirect the behavior. Staff will manage aggression and other dangerous behaviors using a comprehensive set of physical procedures that are safe, effective, and brief. None of the procedures intentionally cause pain, apply pressure to torso or joints, or put the person into an uncomfortable or awkward position.

Every effort will be made to notify parent/guardian and placing school division on the same day a restraint or seclusion was implemented. Every use of restraint or seclusion is documented through an incident report and becomes part of the student's record. A copy of the incident report is provided to parent/guardian and the placing school division.

I consent for my child to participate in the behavior management system as described here and in the Parent/Student Handbook – including the use of Safety-Care and time-out.

Parent/Guardian Signature: _____**Date**: _____

**This consent will remain in effect through June 30, 2025, unless notified in writing by parent/guardian.*

MINNICK SCHOOLS
enCircle

ACADEMIC YEAR 2024 – 2025

HEALTH INFORMATION FORM

Student Name: _____ Date of Birth: _____

Physician's Name: _____ Physician's Phone #: _____

Preferred Hospital: _____

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

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

_____

_____

_____

HEALTH CONCERNS *(Please explain any conditions indicated above)*

_____

_____

_____

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

_____

_____

_____

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

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

☐ Yes (please list below) ☐ No

Name of Drug	Dosage	How Often	School or Home

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

Parent/Guardian Signature: _____**Date**: _____

MINNICK SCHOOLS

enCircle

ACADEMIC YEAR 2024 – 2025

HEALTH INFORMATION ACKNOWLEDGEMENT FORM

STUDENT NAME: _____ **DATE OF BIRTH:** _____

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

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

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

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

A) a temperature greater than 100°
B) vomiting
C) diarrhea
D) rash with fever
E) appears severly ill

☐ Please call the school if your child will be absent due to illness or injury.

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

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

Parent/Guardian Signature: _____**Date**: _____

MINNICK SCHOOLS
enCircle

ACADEMIC YEAR 2024 – 2025 ***AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT***

Student Name: _____ **Date of Birth:** _____

Parent/Guardian Name: _____

I hereby give any paid staff and/or designated volunteer of Minnick Schools bearing this notification, full permission to seek the services and carry out the recommendations of medical, dental, and/or psychological/psychiatric professionals to provide on-going medical, dental, psychiatric needs pertaining to my child. It is understood that in the case of a crisis or emergency when immediate care is necessary, the parent/guardian of the above-named student will be notified immediately. However, in the event all efforts to contact the parent/guardian have proven unsuccessful, I further authorize enCircle – Minnick Schools to seek immediate medical, dental, or mental health care. I understand this care will not include any surgical procedure or any experimental procedure without written informed consent.

**This authorization will remain in effect through June 30, 2025, unless notified in writing by parent/guardian.*

Parent/Guardian Signature: _____**Date**: _____

MINNICK SCHOOLS

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ACADEMIC YEAR 2024 – 2025 ***CONSENT FOR ADMINISTRATION OF ACETAMINOPHEN***

Student Name: _____ **Date of Birth:** _____

Parent/Guardian Name: _____

☐ **I give permission**

☐ **I do not give permission**

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

**This consent will remain in effect through June 30, 2025, unless notified in writing by parent/guardian.*

Parent/Guardian Signature: _____**Date**: _____

MINNICK SCHOOLS

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ACADEMIC YEAR 2024 – 2025

PARENT/PHYSICIAN CONSENT FORM FOR THE ADMINISTRATION OF MEDICATION

POLICY STATEMENT: No student is permitted to have in their possession either prescription or non-prescription medication. Non-prescription medication will not be administered without written permission from a physician. When a youth must take medication, whenever possible, it should be administered before or after school hours. However, when it is necessary for a student to take prescription or non-prescription medication during school hours, specially trained staff will administer medication(s) if a completed administration of medication form is on file at the school. If a youth is taking more than one medication, additional forms must be completed for each medication. This consent remains in effect through June 30, 2025, unless discontinued prior to that date. To discontinue administration of any medication, please provide written notification to the school.

Student Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

Medication Name: _____

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

Time to be given: _____ Amount to be given: _____

Date to be given: (beginning) _____ (ending) _____

Reason for giving medication: _____

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

Additional comments or instructions:

_____

_____

Signature of Parent/Guardian: _____ **Date:** _____

Physician's Signature: _____ **Date:** _____

Physician's Name: _____

Address: _____

Telephone Number: _____

MINNICK SCHOOLS
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ACADEMIC YEAR 2024 – 2025 ***STUDENT SUPPORT SERVICES***

Student's Name: _____ Date of Birth: _____

Parent/Guardian Name: _____ Relationship: _____

Phone Number: _____

Presenting Behaviors (please check all that apply):

☐ **Threatened to run away** ☐ **Past runaway - # of times _____**

☐ **Skipping school** ☐ **Threatened suicide** ☐ **Attempted suicide**

☐ **Currently suicidal** ☐ **Family conflicts** ☐ **Substance abuse**

☐ **Anger problems** ☐ **Depressed mood** ☐ **Grief or loss**

☐ **Lying** ☐ **Negative attitude** ☐ **Anxiety**

☐ **Sexual Abuse** ☐ **Physical abuse** ☐ **Family Substance Abuse**

☐ **Exposed to traumatic event - Specify: _____**

ADDITIONAL INFORMATION/CONCERNS:

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

**This consent will remain in effect through June 30, 2025, unless notified in writing by parent/guardian.*

Parent/Guardian Signature: _____**Date**: _____

MINNICK SCHOOLS

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ACADEMIC YEAR 2024 – 2025 ***PERMISSION TO TRANSPORT***

Student Name: _____ Date of Birth: _____

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

**This consent will remain in effect through June 30, 2025, unless notified in writing by parent/guardian.*

Parent/Guardian Signature: _____**Date**: _____

MINNICK SCHOOLS

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ACADEMIC YEAR 2024 – 2025

STATEMENT OF STUDENT RIGHTS

Student Name: _____ **Date of Birth:** _____

Parent/Guardian Name: _____

My signature below verifies:

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

_____

Signature of Student **Date**

_____

Signature of Parent/Guardian **Date**

MINNICK SCHOOLS
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Consent for the Release/Exchange of Information

In addition to the support available in school, many students and families receive services from outside agencies. Each agency needs specific information to provide services and benefits. By signing this form, I am allowing enCircle – Minnick Schools and outside agencies to exchange information so it will be easier for them to work together effectively to provide or coordinate services and/or benefits.

****A separate form must be completed for each entity you wish for enCircle – Minnick Schools to release/exchange information. Additional forms available upon request. ****

Student Name: _____ **Date of Birth:** _____

Parent/Guardian Name: _____ **Relationship to Student:** _____

I give permission for enCircle – Minnick Schools to release/exchange information with:

Name of Person, Agency, Company, etc.: _____

Address: _____

Phone Number: _____ Fax Number: _____

Email Address: _____

Please check the information to be released/exchanged:

- ☐ medical records
- ☐ psychological records
- ☐ educational records
- ☐ discharge records
- ☐ other (please specify): _____
- ☐ medical diagnosis
- ☐ mental health diagnosis
- ☐ assessment information

This consent is effective through June 30, 2025. The parent/guardian may revoke consent at any time by submitting a written request to school personnel.

Date: _____ **Parent/Guardian Signature:** _____

The guardian represents and warrants to enCircle – Minnick Schools that they have full power and authority to sign this document and give consent to the use of the designated information and supporting paperwork of the designation is in the file of the student served.

MINNICK SCHOOLS
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CONSENT FOR BEHAVIOR ANALYTIC SERVICES

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

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

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

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

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

_____ _____

Student Name (Please Print) **Parent/Guardian Name** (Please Print)

_____ _____

Parent/Guardian Signature **Date**

MINNICK SCHOOLS
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ACADEMIC YEAR 2024 – 2025

Technology Access Survey

Student Name: _____

What type of technology do you have available for your child to use for schoolwork at home? (Check all that apply)

□ Desktop PC
□ Laptop PC
□ iPad
□ Android Tablet
□ Kindle or Nook
□ Chromebook
□ Smart Phone
□ None
□ Other (please specify)

Would you allow your child to use a device that the school issued for schoolwork at home?

□ Yes □ No

How many devices are being used in the household?

□ 1 □ 2 □ 3 □ 4 □ 5+

What type of Internet do you have at home?

□ Broadband (via cable vendor hotspot)
□ DSL (through phone company)
□ Dial-Up (must connect via phone dial)
□ Satellite (via a satellite dish)
□ Cellular service
□ I do not know
□ We do not have internet access
□ We do not want internet access

What is the connection speed of the internet at your home?

□ No Internet
□ Slow (0–5 Mbps): Stream music, email, and basic web browsing.
□ Moderate (5–40 Mbps): Skype and Facetime calls, play online video games (single player), stream video from Netflix on a single device.
□ Fast (40 – 100 Mbps): Stream video from Netflix or YouTube on multiple devices, download large files.
□ Lightning speeds (100-500Mbps): Download large files quickly, enjoy 4K Netflix on multiple devices

If you do not have Internet access at home, do you have an alternate method for accessing the internet?

□ No, we cannot access the internet
□ Yes. Access at a local restaurant or business
□ Yes. Access at the local library
□ Yes. Access at a friend's or family member's house.