Admissions Information Collection Packet

Admissions Policy

At INSPiRE for Autism, Inc. we seek to serve individuals who have a primary diagnosis of autism spectrum disorders (ASD), which significantly impairs their participation in the regular public school system. We offer educational and vocational training which seeks to maximize the potential for adolescents and young adults with autism to lead satisfying, self-sustaining lives in connection with their communities.

Admissions Process – Overview

- Once the student's IEP team has met and all parties involved have agreed the student should be placed at INSPiRE, the parent/s or guardian/s must complete this information packet in it's entirety and return it to INSPiRE prior to the student starting at the school.
- The sending district will enter into a Student Services Agreement with INSPiRE.
- INSPiRE will ensure adequate staffing.
- INSPiRE will determine classroom placement and assignment of Paraeducator/s.
- Once these steps are completed, the student's start date will be determined.

I.N.S.P.i.R.E. for Autism, Inc.

An Integrated School Program for Independence, Relationships and Entrepreneurship

A complete application includes:

____ Application for Admission

____ Parent Questionnaire

____ Copy of current IEP or other plan including most recent assessments

____ Copy of most recent progress reports and evaluations

____ Request for Records

The I.N.S.P.i.R.E. School is a Vermont Independent Therapeutic School with approval to serve students with Autism Spectrum Disorder, Developmental Delay, Intellectual Disability, and Speech or Language Impairment.

Notice of Nondiscrimination: The I.N.S.P.i.R.E. School shall provide equal educational opportunity and treatment for all students in all aspects of academic and activities programming without regard to race, creed, color, national origin, gender, marital status, sexual orientation including gender identity, and physical, mental, or social disabilities. The I.N.S.P.i.R.E. School shall be free from sexual, physical, and verbal harassment.

Admissions Process

INSPIRE for Autism, Inc. is licensed to serve up to 25 students for the 2024-2025 academic year. We will consider and approve applications as they are completed and will produce a waiting list for future enrollment. However, as seats may fill quickly, we encourage prospective students to submit the application as early as possible.

Applicant Information:

____

First Name Middle Last Nickname

Gender Identity: ________________ Enrollment Date: ________________

Date of Birth: ________________

Parent or Guardian 1:		Parent or Guardian 2:	
Name:		Name:	
Address:		Address:	
Phone #:		Phone #:	
E-Mail:		E-Mail:	
Occupation:		Occupation:	
Work Address:		Work Address:	
Work Phone #:		Work Phone #:	
Guardian (y/n):		Guardian (y/n):	

Parental Status

Married: _______ Divorced: _______ Single Parent: _______ Other: _______

Name of Custodial Parent (if necessary):

____

(A copy of the custody agreement must accompany the enrollment materials.)

Person to whom communications should be sent:

Parent/Guardian 1 _______ Parent/Guardian 2 _______ Both _______

Emergency Contact Person (in case parent or guardian cannot be reached):

Name: ____

Address: ____

Telephone: ____

Relation to applicant: ____

Present/Sending School Information:

Present school: ____

Address: ____

Telephone: ____

Case Manager: ____

Principal: ____

Grades or years attended: ____

Description of Current Placement:

____

____

____

____

____

____

Tell us about your child's strengths:

Tell us about their challenges:

Tell us about their interests:

Please provide a brief history of their education and (other treatments sought, successful programs, what has worked well and poorly):

____

____

____

____

____

____

____

This student is currently receiving (please check all that apply):

_____ Individualized Educational Plan

_____ OT

_____ PT

_____ ABA

_____ Speech

_____ Other Services (such as nurse, feeding specialist, etc. please describe)

____

____

____

____

____

____

In order to process this applicant's Admission Application, the undersigned agrees that all information received by the Admission Office, from any source, shall be completely confidential and will not be divulged to anyone, including the candidate and his/her family, unless such disclosure is deemed by the administration to be necessary and appropriate.

Date: ______________________________ ____

Parent or Guardian Signature

Student Health Information Form

Last name First name Middle name

Date of Birth Age School year

Parent/Guardian Information:

Mother's Name: ____________________ Home Phone: ____________________
Home Mailing Address: ____________________ Work Phone: ____________________
____________________ Cell Phone: ____________________
Physical Address (if different): ____________________ E-mail: ____________________
____

Father's Name: ____________________ Home Phone: ____________________
Home Mailing Address: ____________________ Work Phone: ____________________
____________________ Cell Phone: ____________________
Physical Address (if different): ____________________ E-mail: ____________________
____

Marital Status of Parents: [ ] Married [ ] Divorce
Student lives with: [ ] Mother [ ] Father [ ] Both Parents [ ] Other (please explain): ____________________
____

Health Care Provider Name Phone Number Date of last exam

Dentist Name Phone Number Date of last exam

Eye Doctor Name Phone Number Date of last exam

Does your child have health insurance? [ ]Yes [ ] No

If yes, Please attach a photo copy of both sides of the Health Insurance card

Medical Insurance Information

Name of Insurance____

Subscriber Name____

Subscriber Policy Number______________________ Group Number__________________

Name of Secondary Insurance____

Subscriber Name____

Subscriber Policy Number______________________ Group Number__________________

Permission to administer Over-the-Counter (OTC) medications.

I give permission for the medication listed below to be given to my child at school by the school admin or his/her designee.

Consumable:			**For topical application:**		
Acetaminophen (Tylenol)	Yes	No	Antibiotic Ointment	Yes	No
Ibuprofen (Advil)	Yes	No	Anti Itch Cream	Yes	No
Benadryl (for allergic reaction)	Yes	No	Sun Block	Yes	No
Cough Drops	Yes	No	Insect Repellant	Yes	No

Parent/Guardian Signature_________________________________ Date_______________

For office use. Date received_______________

Admin Signature_______________________

Is your child fully vaccinated? [ ]Yes [ ]No

The school will need a current copy of their immunizations on file. Thank you.

Does the student have any medical conditions/health issues that we should be aware of?
[ ]Yes [ ] No
If yes, please explain how this medical condition/Health issues should be managed at school:

____

____

Does the student have any food or medication allergies? **[ ]Yes [ ] No**
If yes, please explain what the allergy is and how is it managed at home:__________________

____

____

Will the student need to have medication administered at school? **[ ] Yes [ ] No**
If yes, please send medication in original prescription container with prescription medical order signed by the prescribing physician. Medications cannot be administered at school without signed orders from the prescribing physician.

Permission to administer Prescription Medication.

I give permission for any medication prescribed by my child's doctor to be given to my child at school by the school admin or his/her designee as prescribed.

Parent/Guardian Signature_________________________________ Date_____________

For office use. Date received_____________

Admin Signature______________________

Permission for Emergency Medical treatment & Financial Responsibility

Student Name________________________ DOB______________

I give permission to ***I.N.S.P.i.R.E. School for Autism***, through its authorized representatives:

1. To give or seek temporary medical and/or dental treatment for my child until I am notified.
2. To receive protected health information access for medical, pharmacy, dental, vision, and other related plans.
3. I give permission for my child to be transported off-campus for visits to other medical services as necessary.

I also understand I am responsible and financially liable for the medical and/or dental care of my child who is a student at ***I.N.S.P.i.R.E. School for Autism***. If applicable, I authorize ***I.N.S.P.i.R.E. School for Autism*** to release any medical information necessary to process Medicaid and/or other insurance claims on behalf of my child.

Parent/Guardian signature____

Parent/Guardian name printed____

Date______________

For office use. Date received_____________

Admin Signature______________________

Emergency Contact Information, Other than with whom the student lives.

Contact #1______________________________ Home Phone______________________

Work Phone______________________

Contact #2______________________________ Home Phone______________________

Work Phone______________________

Release of Information

I give permission for school administrators at the ***I.N.S.P.i.R.E. School for Autism*** to send and receive confidential medical information to my child's health care provider(s).

Physician's Name______________________________ Phone Number____________________

Fax Number______________________

Dentist's Name________________________________ Phone Number____________________

Fax Number______________________

Specialist's Name______________________________ Phone Number____________________

Fax Number______________________

Parent/Guardian Signature____

Parent/Guardian Name Print____

Date______________

For office use. Date received_______________

Admin Signature________________________

Recommended PRN Medications During School Hours

Student Name: ______________________ Date: ____________________

Problem	Recommended Medication/Treatment	Dose	Directions/Comments
Headache			
Earache			
Fever			
Menstrual Cramps			
Constipation			
Diarrhea			
Cough			
Sore Throat			
Abrasion			
Rash			
Other			
Other			
Other			

Physician's Signature: ______________________________ Date: ______________

Physician's Printed Name: ____________________________________

INSPiRE for Autism Emergency Room/EMS Information Sheet

Student's Name: ______________________________
Last First Middle

Date of Birth: ______________
MM/DD/YY

Address: ______________________________
City/State/Zip: ______________________________
Home Phone #: ______________ Cell #: ______________

Person(s) student lives with: [ ] Parent 1 [ ] Parent 2 [ ] Both [ ]Guardian

Parent/Guardian 1: ______________________________
Employer: ______________ Phone #: ______________ Cell #: ______________
Parent/Guardian 2: ______________________________
Employer: ______________ Phone #: ______________ Cell #: ______________

Please list two emergency contacts who have permission to assume temporary care of your child if you cannot be reached:

Contact 1: ______________________________
Relation: ______________ Phone #: ______________ Cell #: ______________
Contact 2: ______________________________
Relation: ______________ Phone #: ______________ Cell #: ______________

Medical Information

For Emergency purposes, I wish to share the following information with The Inspire School for Autism:

Health Conditions ______________________________
Allergies ______________________________
Medications ______________________________
Insurance Name ______________ Subscriber ______________
Subscriber # ______________ Group # ______________
Primary Name ______________ Phone# ______________
Dentist Name ______________ Phone# ______________

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician and follow his/her instructions. If it is impossible to contact this physician, the school may make whatever arrangements deemed necessary to ensure the health and safety of the student. In the event of a life-threatening injury or medical emergency, I understand the school will call EMS for transport to the E.R., then notify myself or the contacts on this form after EMS has been called.

Signature of Parent/Guardian ______________________________ Date______________

School Contact Information Phone: (802) 275-7301 Fax: (802) 251-0474

Photography Release Form

PLEASE CHECK ONE:

☐ I, ____ hereby grant permission to The I.N.S.P.i.R.E. School for Autism, Inc. to publicly post, reproduce, or publish photos and/or video clips of my child ______________________________________ for the purpose of press releases and school promotional or fundraising activities which can include but is not limited to, books, cards, calendars, invitations and school-owned/controlled websites or social media accounts without any compensation or recognition given to me.

☐ I do not grant permission to The I.N.S.P.i.R.E. School for Autism to publish photographs or videos of my child __________________________________.

____
Parent or legal guardian (print)

____
Parent or legal guardian (sign)

_____/_____/_____
Date

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