Please complete this form in its entirety and return to:

Lindsay Baar
Gaitway High School
PO Box 23129
Chagrin Falls, OH 44023
Fax: 440.708.0029

Application for Admission to Classrooms in the Geauga County Consortium for Emotional Support Services
(Only School Districts can apply)

Identifying Information

Student Name _____ Sex M F Birthdate _____ Grade _____

Parent/Guardian _____ Relationship to Student _____

Address _____ City _____ Ohio Zip Code _____

Student Resides with _____

Student Address if Different than Parent _____

Home Phone _____ Work Phone _____

Cell Phone _____ e-mail address _____

Placing School District _____ School _____

District Representative/Title _____ Phone _____

Please send the following for purpose of determining candidacy

____ Attendance Record

____ Report Card

____ Current ETR

____ Current IEP

____ Discipline History

Academic Information

Ability (IQ) Level _____

OGT Test Results for the following:

Social Studies _____ Science _____ Reading _____ Math _____ Writing _____

Date of last ETR _____ Reevaluation Date _____

Medical Information

Present and Past Medical Diagnoses

_____

Present and Past Medications _____

If Medicaid Eligible- Contact person and number

Community Involvement

Case Manager/Agency _____ Phone _____

Counselor, Social Worker, Psychologist (Name/Agency Providing Service)

_____ Phone _____

Probation Officer (Name/Court) _____ Phone _____

Job & Family Svcs. Caseworker _____ Phone _____

Psychiatrist/Neurologist/Other Medical Doctor (Name/Specialty)

_____ Phone _____

Other Community Professional _____ Phone _____

Behavioral Information

Behavioral Profile _____

Has the student demonstrated any of the following behaviors:

Fire Setting Yes No

Animal Abuse Yes No

Physical Aggression Yes No

If so, please describe the event(s) and the treatment or supportive action taken:

_____

_____

Placement Information

Related Services required (please check)

Occupational Therapy _____

Physical Therapy _____

Speech/Language Pathology _____

Social Work _____

Other (please list) _____

Reason for Out of County Placement Request _____

_____

Other information to assist with determination of placement _____

_____

_____

Home School Contact Person: _____

P.O. Box 23129
Chagrin Falls, OH 44023
Fax: 440.708.0029
wspisak@fieldstonefarmtrc.com

REGISTRATION AND RELEASE

Participant: _____ Date of Birth: _____ Age: _____

Street: _____

City: _____ County: _____ Zip Code: _____

Home Phone: _____ Work/Cell Phone: _____

School or institution presently attending: _____

Primary Email (used for newsletters, billing, etc.): _____

- Participant is a (circle one): minor adult w/a legal guardian independent adult
  (Only parents, legal guardians or independent adults may sign these forms.)
- Please name any caregivers/phone numbers who may transport or be responsible for Participant: _____
  _____
  _____

For demographic data only, please indicate participant's ethnic background. Check any that apply:

Caucasian ☐ Asian ☐ Hispanic/Latino ☐ African American ☐ Native American ☐ Other ☐

Parent or Guardian Name: _____ Occupation: _____

Employer: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Other Parent or Guardian Name: _____ Occupation: _____

Employer: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Parent or Guardian Home Address (if different): _____

Home Phone: _____

In Case of Emergency

In the event of a medical emergency, Fieldstone Farm will provide basic first aid and/or call 911 and will disclose all available health care information to emergency medical personnel

In the event of an emergency, after any parent or guardian names, please list any other names to be contacted:

Emergency Contact Name (in addition to parents or guardians): _____

Phone #1: _____ Phone #2: _____

Please note any medical considerations including allergies (bee stings, asthma, etc.), conditions requiring regular physician's care, and prescribed medications taken regularly: _____
_____
_____
_____

P.O. Box 23129
Chagrin Falls, OH 44023
Fax: 440.708.0029
wspisak@fieldstonefarmtrc.com

CONSENT AND WAIVER

I hereby request that the Participant named above be accepted into the horseback riding and driving program operated by Fieldstone Farm Therapeutic Riding Center (TRC), an Ohio non-profit organization. I acknowledge that Fieldstone Farm TRC has fully explained to me the scope of the equine program, including the potential for injury which can occur from riding, driving or caring for horses. Because of the potential benefits of Fieldstone Farm TRC's program, I hereby waive any claim which I or the Participant may have against Fieldstone Farm TRC, its Trustees, employees or volunteers arising out of any injury which the Participant may sustain while involved in the mounted or unmounted equine program at Fieldstone Farm.

I further understand that in the event of a medical emergency, Fieldstone Farm will provide basic first aid and/or call 911 and will disclose to emergency medical personnel all available health care information about the Participant. I consent to Fieldstone Farm initiating such basic first aid and/or emergency medical treatment and to Fieldstone Farm disclosing the Participant's available health care information.

Date: _____ **Signature:** _____
Circle one: (Independent adult participant or parent or legal guardian)

PHOTO RELEASE

For valuable consideration, the receipt of which from Fieldstone Farm Therapeutic Riding Center is hereby acknowledged, the undersigned hereby grants to Fieldstone Farm permission to take, or have taken, still and moving photographs, videos and films including television pictures of myself or my daughter/son/ward (strike out inapplicable words), _____ _____ and consents and authorizes
(Participant name, please print)
Fieldstone Farm, its advertising agencies, news media, and any other persons involved with Fieldstone Farm and its programs, to use and reproduce the photographs, films, videos and pictures and to circulate and publicize the same by any means deemed appropriate by Fieldstone Farm, including without limitation newspapers, television media, brochures, pamphlets, instructional materials, books and clinical materials.

No inducements or promises have been made to me to secure my signature to this release other than the intention of Fieldstone Farm to use or cause to be used such photographs, films, videos and pictures for the primary purpose of promoting and aiding Fieldstone Farm and its programs.

___ I DO consent ___ I DO NOT consent

Date: _____ Signature: _____
Circle one: (Independent adult participant or parent or legal guardian)

PO Box 23129
Chagrin Falls, OH 44023
440.708.0013
Fax: 440.708.0029
wspisak@fieldstonefarmtrc.com

HEALTH HISTORY

— To be completed by independent adult participant or parent/guardian. Use additional sheets if needed.
Important! This form is due to Fieldstone Farm no later than one week prior to the start of initial session.

Participant Name: _____ Date of Birth: _____
Address: _____ City: _____ Zip: _____ Male / Female

- Participant is a (circle one): **minor** **adult w/a legal guardian** **independent adult**

Name of Parent(s) / Guardian(s): _____
Diagnosis: _____ Date of Onset: _____
Height: _____ Weight: _____
Mobility: Ambulatory-Yes/No Crutches-Yes/No Braces-Yes/No Wheelchair-Yes/No Walker-Yes/No
Special mobility precautions: _____
Medications: _____
Allergies to any medications: _____
Allergies to any food, insect bites, plants, animal dander, other, list here: _____
History of asthma? _____
Does the participant carry an EpiPen? Yes / No Does the participant carry an inhaler? Yes / No

GENERAL QUESTIONS

List any chronic conditions or illnesses: _____

HEALTH AND FUNCTION	Normal	DETAILS
Hearing		
Vision		
Speech		
Heart		
Circulation		
Cognitive Development		
Pulmonary		
Neurological		
Muscular		
Orthopedic (incl. spine & joints)		
Emotional & Psychological		
Behavior		

List precautions, for example, shunts, feeding tubes, etc.: _____

HEALTH QUESTIONS

1. In the past 12 months, has the participant been hospitalized for any serious injury, condition or surgery?
   Yes / No If yes, please explain: _____

2. In the past 12 months, has the participant experienced loss of consciousness, traumatic or otherwise, including seizures of any type?
   Yes / No If yes, please explain: _____

3. In the past 12 months, has the participant experienced a psychotic crisis?
   Yes / No If yes, please explain: _____

4. In the past 12 months, has it been necessary to restrict the participant's activities due to medical reasons?
   Yes / No If yes, please explain: _____

5. Is participant unable to maintain upright sitting posture or head control without assistance?
   Yes / No If no, please explain: _____

Has the participant ever been treated for any of the following? **If yes**, check the box, give date and provide specific details below:

	CONDITIONS	Date
☐	Bleeding or Clotting Disorders	_____
☐	Diabetes	_____
☐	Joint contractures, cerebral palsy or hip dysplasia	_____
☐	Immune Deficiency	_____
☐	Fatigue or limited endurance	_____
☐	Pathologic fractures	_____
☐	Brain injury, including stroke	_____
☐	Conditions of the spine, including, but not limited to: spinal cord injury, curvature, fusion, instability, abnormalities or Spina Bifida	_____
☐	Skin break down or pressure sores	_____

Specific details. Use additional paper if necessary: _____

I hereby affirm that, to the best of my knowledge, the health history information is complete and correct.
Signature of Person completing the Health History: _____
Relationship to Participant: _____ Date: _____

Important! Fieldstone Farm reserves the right to request additional information from, or an evaluation by the participant's licensed medical professional prior to or during the course of equine-assisted programming and/or to restrict or offer alternative activities until such information or evaluation is procured.

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wsp.sak@fieldstonefarmtrc.com

PHYSICIAN'S RELEASE

Important! This form is required for participants who have medical issues deemed precautions to participating in equine-assisted programming.

Participant Name: _____ Date of Birth: _____

A PHYSICIAN's RELEASE is required if:

- ☐ Participant has **Down Syndrome**
- ☐ If any of the HEALTH QUESTIONS on page 2, (#'s 1, 2, 3, 4 or 5) are answered YES
- ☐ If participant has been treated for any of the CONDITIONS listed in the HEALTH QUESTIONS on page 2.

PHYSICIAN'S REPORT

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance and Affect		
Eyes/Ears/Nose/Throat		
Lymph Nodes		
Pulses		
Heart		
Lungs		
Abdomen		
Skin		
Neurologic		
MUSCULOSKELETAL		
Neck		
Back		
Upper Extremities		
Lower Extremities		
FOR PERSONS WITH DOWN SYNDROME		
Neurologic exam reveals symptoms consistent with atlantoaxial instability? YES NO DATE OF EXAM: _____		

PHYSICIAN'S RELEASE

I have examined the above-named participant and, given the participant's diagnosis and health history, this person does not present apparent clinical contraindications for equine sports. I understand that Fieldstone Farm will weigh the medical information provided against the existing precautions and contraindications; therefore, I refer this person to Fieldstone Farm for ongoing evaluation to determine eligibility for participation.

Physician's Signature: _____ Date: _____

Physician's Name (**please** print): _____ Phone: _____

Address/City/Zip: _____

If participant has experienced seizure activity within the past 12 months, the following SEIZURE EVALUATION FORM is required. Participants or their parents or guardians may wish to consult with their physician when completing the following:

SEIZURE EVALUATION FORM

Instructions: Participants/parent/guardians/treating physicians – please complete this form including as much information as possible. Since riding and working around horses is a risk activity, conditions that increase that risk are carefully analyzed. The safety of all participants, volunteers and horses is considered.

Physician Treating Seizures _____ Physician's Phone _____
Type of Seizure (if more than one, please list all types) _____
Date of Last Seizure _____ Frequency of seizures _____
Duration of Each Seizure _____
Typical Causes of Seizure Activity _____
_____

Seizure activity indicators (aura, behaviors or manifestations of oncoming seizure activity) _____
_____

After Affect _____
_____

During a seizure, I / my child/patient:
- ☐ May stare briefly (How long? _____)
- ☐ May walk around
- ☐ May perform aimless activities
- ☐ May suddenly cry / fall / become rigid, followed by muscle jerks / saliva on lips / bluish skin color
- ☐ May experience loss of bladder or bowel control
- ☐ May be confused, have a headache, be fatigued; followed by full return of consciousness
- ☐ Other. Please explain:

Are you / is your child/patient able to know and express when a seizure may occur? What are the signs?_____
_____
_____

Should you / your child experience a seizure while at Fieldstone Farm, beyond employing general first aid, what actions do you suggest we take?

- ☐ Do nothing
- ☐ Dismount from horse
- ☐ Allow _____ minutes to rest and reorient
- ☐ Report observations to parents/guardians immediately
- ☐ Send note home to parent/guardian
- ☐ Other. Please specify:

_____ _____
Participant/Parent/Guardian Date

STUDENT MEDICAL HISTORY

Student Name: _____ District/Residence: _____
Student Address: _____ District/Placement: _____
City & Zip: _____ School Phone: _____
Date of Birth: _____ Family Physician: _____
Student Soc. Sec. #: _____ Physician Phone: _____
Home Phone: _____ Guardian Name: _____
Parents Name: _____ Guardian Address: _____
Father Work #: _____ Guardian Phone #: _____
Mother Work #: _____ Pager or Cell Phone #: _____

In case of an emergency list two people who can be contacted if parents can't be reached:

	Name	Phone	Address
1.			
2.			

If (s)he has a history of any of the following, please check appropriate space:

_____Allergies: explain: _____ Dizziness: explain: _____
_____Heart Problems: explain: _____ Asthma: treatment: _____
_____Seizure Disorder: explain: _____
_____Diabetes: treatment: _____
_____Hearing Problems: explain: _____
_____Speech Problems: explain: _____
_____Vision Problems: explain: _____ _____Glasses: _____Contacts
_____Medications: _____

Name of Drug	*Dosage*	*Times Dispensed*

_____Therapy: types currently receiving:
_____Occupational _____Physical _____Psychotherapy _____Counseling
_____Other: explain: _____
_____Attendant care for personal needs: explain: _____
_____Adaptive devices:
_____Wheel Chair _____Braces _____Cane/Walker
_____Medical Limitations: explain: _____
_____Seizures: explain: _____
_____Generalized _____Tonic clonic _____Absence
_____Other Health Problems: Explain: _____

My child is covered by:

_____
Insurance Plan (required information for student to attend community training)
Policy Number

PURPOSE: To enable parents or guardians to authorize the provision of emergency treatment for a student who becomes ill or injured while under school authority, while parents or guardians cannot be reached.

Student Name: _____ Date _____
Parent /Guardian Signature _____ Print Name _____

The staff at GATEWAY is very interested in providing a safe valuable experience in the community for your son/daughter. If you ha any questions at all, please feel free to call and discuss your concerns.

Signature required on back Please turn over →

MEDICAL CONSENT

PART I OR PART II MUST BE COMPLETED.

PART I: TO GRANT CONSENT

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the administration any treatment deemed necessary by Dr. _____ (preferred physician) or

Dr. _____ (preferred dentist), or in the event the designated preferred practitioner is not available, by another licensed physician or dentist, and the transfer of the student to _____ (preferred hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity of such surgery, are obtained prior to the performance of such surgery.

_____

DATE SIGNATURE OF PARENT/GUARDIAN

DO NOT COMPLETE PART II IF YOU HAVE COMPLETED PART I

PART II: REFUSAL TO CONSENT

I do not give my consent for emergency medical treatment for my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action to:

_____

_____

_____

_____

_____

_____

DATE SIGNATURE OF PARENT/GUARDIAN

Gaitway High School

Learning Outside of the Box

August 5, 2013

Dear Parents/Guardians,

Gaitway High School staff has been certified by the State of Ohio to transport students in the school van. The van will allow the vocational program to travel to different work sites, be used for fieldtrips, and as a positive reinforcement (getting ice cream, lunch, etc.).

To ensure safety of all students and staff, we are using this permission slip to be an umbrella form to use the van to transport students, when needed by certified staff. Please sign the bottom portion of this sheet and return to Gaitway High School. If you have any questions or concerns of this matter, please call Lindsay Baar at (440)708-0013 ext. 152.

Sincerely,

Gaitway High School Staff

Van Permission Slip

____ Yes, I give my child permission to be transported in the Gaitway High School van

____ No, I do not give my child permission to be transported in the Gaitway High School van

Student's name (please print) _____

Guardian's Signature _____ Date _____

Parent Communication Information

Student Name: _____

Parent/Guardian	Home Phone	Cell Phone	Work Phone	Home Email	Work Email

* Sign and return

*Sign and return

Gaitway High School

Actions Which Violate the Gaitway High School Computer Use Agreement

Committing any of the violations below may result in the suspension of computer privileges. Repeated infractions will result in evaluation of continued use.

- Bringing ***any*** food or drink (including water) into any computer area.
- Behaving in an inappropriate manner in, or violating the specific rules of, any computer area.
- Downloading and/or installing ***any*** programs (e.g., *AOL Instant Messenger, MSN Messenger, Yahoo Companion, Yahoo Messenger, Google Earth, Google Toolbar, iTunes, WinRAR, WinZIP*) or ***any*** inappropriate or unauthorized files (e.g., copyrighted music) into your computer account or on a local hard disk drive.
- Engaging in daytrading or online auctions or any other form of personal business or exchange of money.
- Viewing ***any*** inappropriate Web site or file.
- Scanning inappropriate documents (e.g., money, I.D., legal documents, pornography).
- Modifying the hardware and/or software of any computer system or file server in ***any*** way.
- Sending ***any*** inappropriate e-mail (e.g., pornography, criminal activity, hacking information, threats).
- Using and/or tampering with ***any*** other person's computer account, or allowing someone else to use your account.
- Printing multiple copies of any document, printing any document that is not school-related, or printing more than ten (10) pages in one day without specific permission.
- Connecting any non-Gaitway hardware (e.g., your own laptop, personal computer, mp player, phone, camera, external drive, CD-RW, DVD-RW, or non-approved memory storage device) to any computer or to Gaitway's computer network from within Gaitway without specific permission

Violations that are deemed serious (by a system or school administrator) may result in legal action being taken against the offending student. If you are ever unsure about whether a particular Web site, file, or behavior is appropriate, err on the side of caution and do not load or save the site/file. For definitions of "inappropriate" and for more information, read the Gaitway High School Terms and Conditions for Computer and Network Use and talk to a system administrator.

While computer privileges will be suspended immediately upon the discovery of or suspicion of an infraction, the counting of account suspension days begins with the next day after contact is made with the offending student. It is the responsibility of any student who finds his/her account disabled to contact a Mr. Bob Chiancone.

activity that occurs with your account. Attempts to login to the network as a system administrator or gain unauthorized access will result in the cancellation of your computer privileges.

Vandalism
Vandalism will result in the cancellation of your computer privileges. Vandalism is defined as any malicious attempt to alter, harm, or destroy data of another user, computers, accessories, the Internet, or any of the above listed agencies or other networks that are connected to the Internet. This includes, but is not limited to, the uploading, downloading, or creation of computer viruses.

Restitution and Consequences of Contract Violation
Students may be suspended or subject to other disciplinary actions for violation of this contract as provided in the current school Student/Parent Handbook. Students will be required to provide restitution for damages to their assigned laptop or network while the student is in possession of or logged on to the network or using their assigned machine. In the case of no physical damage, but the requirement of staff time to reconfigure a system, students will be charged at the rate of $1 19/hour for a minimum of one hour.

Duration of Agreement
The duration of this agreement begins upon signing and ends when the student leaves Gaitway High School.

* Sign and Return

Gaitway High School

Contract Agreement for Student and Parent

Gaitway High School / Fieldstone Farm TRC

Directions: Please read and fill out the following contract completely and legibly. The signature of a parent or guardian is also required. Please return the contract to your teacher immediately. Any questions should be addressed to Mr. Bob Chiancone at 440.708.0013 ext. 155. Keep the copy of the Terms and Conditions Computer and Network Use for your records.

Student Contract: I have read the Terms and Conditions Computer and Network Use. I understand and will abide by the stated Terms and Conditions. I further understand that violation of the regulations is unethical and may constitute a criminal offense. Should I commit any violation of the regulations, my computer access privileges may be revoked, school disciplinary action may be taken, and/or appropriate legal action may be pursued against me.

Student Name (Please **PRINT**) _____

Student Signature _____ Date _____

Parent or Guardian: (If the applicant is under the age of 18, a parent or guardian must also read and sign this agreement.) As the parent or guardian of this student, I have read the Terms and Conditions. I understand that violation of the regulations is unethical and may constitute a criminal offense. Should my child commit any violation of the regulations, his or her computer access privileges may be revoked, school disciplinary action may be taken, and/or appropriate legal action may be pursued against my child. I further understand that this access is designed for educational purposes and that Fieldstone Farm TRC and Geauga Co. Educational Service Center have taken reasonable precautions to eliminate access to controversial material. However, I also recognize that it is impossible to restrict access to all controversial materials, and I will not hold them responsible for materials acquired by my child through the network. I hereby certify that the information contained on this form is correct.

Parent or Guardian Name (Please **PRINT**) _____

Parent or Guardian Signature _____

Day Phone _____ Evening Phone _____

Date _____

Having your computer privileges suspended means that you are not allowed to use any computer anywhere at Gaitway, even if that computer does not require a local or network login. Doing so constitutes a more serious violation of the Gaitway Computer and Internet Use Agreements.

Gaitway High School administrators reserve the right to suspend the computer privileges of any student who violates any part of the Terms and Conditions for Computer and Network Use. This includes any and all activities that may or may not be specifically listed on this page.

Student Name (Please PRINT)_____

Student Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

* Sign and return

*Sign and return

Gaitway High School

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- Engaging in daytrading or online auctions or any other form of personal business or exchange of money.
- Viewing ***any*** inappropriate Web site or file.
- Scanning inappropriate documents (e.g., money, I.D., legal documents, pornography).
- Modifying the hardware and/or software of any computer system or file server in ***any*** way.
- Sending ***any*** inappropriate e-mail (e.g., pornography, criminal activity, hacking information, threats).
- Using and/or tampering with ***any*** other person's computer account, or allowing someone else to use your account.
- Printing multiple copies of any document, printing any document that is not school-related, or printing more than ten (10) pages in one day without specific permission.
- Connecting any non-Gaitway hardware (e.g., your own laptop, personal computer, mp player, phone, camera, external drive, CD-RW, DVD-RW, or non-approved memory storage device) to any computer or to Gaitway's computer network from within Gaitway without specific permission

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Student Signature _____ Date _____

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Parent or Guardian Signature _____

Day Phone _____ Evening Phone _____

Date _____