

STUDENT APPLICATION FOR ADMISSION



RISE RESOURCE CENTER

Reaching Independence through Support and Education



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STUDENT INFORMATION

Applying for grade: _____ Date of Birth: _____ Gender: _____

Student's Legal Name: _____

Residential Address: _____

City: _____ State: _____ Zip: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Guardian Name: _____ Phone: (____) _____

Email: _____

Name of present school: _____ Current Grade: _____

Address of present school: _____

City: _____ State: _____ Zip: _____

Phone number of present school: (____) _____ Does your child have an IEP?

Yes / No

All application pages must be complete upon submission	Release of records
Current Immunization Records	\$200 non-refundable registration fee
Birth Certificate	Internal use only:
Two most current Report cards and standardized tests	Staff Signature:
Signed tuition agreement	Date:



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FAMILY INFORMATION

Father

Mother

Name	Name
Address	Address
City, State, Zip	City, State, Zip
Home phone	Home phone
Work phone	Work phone
Cell phone	Cell phone
Email	Email
Occupation	Occupation
Employer	Employer

Please circle all that apply:

Parents married/live
together

Father deceased

Mother remarried

Parents
separated/divorced

Mother deceased

Father remarried

Single parent household

Joint Custody

Living with other relative
(name/relationship:)

Who has legal custody of the student: _____

With whom does the student reside? _____

Who has financial responsibility for the student's tuition? _____

Who is authorized to pick the student up from the RISE campus? _____

Who is NOT authorized to pick the student up from RISE campus? _____



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EMERGENCY CONTACT FORM

In case of an emergency, please notify:

1) Contact one

- Name: _____
- Relationship: _____
- Address: _____
- Phone: _____

2) Contact two

- Name: _____
- Relationship: _____
- Address: _____
- Phone: _____

3) Contact three

- Name: _____
- Relationship: _____
- Address: _____
- Phone: _____



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MEDICATION WAIVER

Dear parent/guardian,

Written permission from the parent/guardian, with instructions from the physician must be provided if medication is to be administered in order for your child to receive them during the school day.

Please list any medications that your student currently takes including any recent medication changes (additional medications or increase/decrease in dosage)

I hereby authorize the special educator and designated staff to administer and supervise self-administration of the following medications: (write N/A if no meds to be administered.)

Name of MEDICATION (1): _____

Dose: _____ Time of day: _____

Reason: _____ Side effects: _____

Name of MEDICATION (2): _____

Dose: _____ Time of day: _____

Reason: _____ Side effects: _____

Name of MEDICATION (3): _____

Dose: _____ Time of day: _____

Reason: _____ Side effects: _____

Name of MEDICATION (4): _____

Dose: _____ Time of day: _____

Reason: _____ Side effects: _____

Medications must be in original container and labeled with:

Student name, name of medication, dose, time to be given, name of physician

I release school personnel from any liability from my child taking these medications.

Parent/guardian signature: _____ Date: _____

Name of physician: _____ Dr. phone number: _____



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PARENT/GUARDIAN INPUT

Member's in your student's immediate family or household:

Things your student likes to do:

How does your child communicate to you? Voice/Body Language/Parental Intuition...

What is your student's level of independence with personal/self care (bathroom, hygiene, eating)?

What are 3 goals you have for your student this year?

- 1.
- 2.
- 3.

Additional comments:



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GENERAL LIABILITY WAIVER

I (your name), _____, Email address: _____

representing myself and my family including my children (name), _____

HEREBY WAIVE AND RELEASE, indemnify, hold harmless and forever discharge RISE Resource Center, Inc., its agents, volunteers, employees, officers, directors, affiliates, successors and assigns, of and from any and all claims, demands, debts, contracts, expenses, causes of action, lawsuits, damages and liabilities, of every kind of nature, whether known or unknown, in law or equity, that I ever had or may have, arising from or in any way related to my participation in any of the events, classes, fundraisers, special events, special projects, projects or activities conducted by, on the premises of, or for the benefit of, RISE Resource Center, Inc.

By this Waiver, I assume any risk, and take full responsibility and waive any claims of personal injury, death or damage to personal property associated with RISE Resource Center, Inc., and any of their volunteers, board of directors, employees or officers.

I have read, understand and fully agree to the terms of this WAIVER AND RELEASE. I understand and confirm that by signing this WAIVER AND RELEASE I have given up considerable future legal rights. I have signed this agreement freely, voluntarily, under no duress or threat of duress, without inducement, promise or guarantee being communicated to me. My signature is proof of my intention to execute a complete and conditional WAIVER AND RELEASE of all liability to the full extent of the law. I am 18 years of age or older and mentally competent to enter into this waiver.

Student name:

Guardian signature:

Date:



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PHOTO RELEASE

Photo Release I grant RISE Resource Center, or its volunteers/employees, the right to take photographs of me and my family. I authorize RISE Resource Center the right to copyright, use and publish the photographs, in print or electronically, with or without my name, for any lawful purpose, including for example such purposes as publicity, advertising and Web content. I have read and understood the above.

Student name:

Guardian signature:

Date:



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STUDENT PHYSICAL HEALTH INFORMATION FORM

Student Name: _____

Please provide immunization documentation.

Please describe student's overall health: _____

Please list any previous surgeries: _____

Does student have problems with: (describe)

- Head: (migraines, injury, ear infection, vision, hearing, etc.) _____
- Body: _____
- Arms: _____
- Legs: _____
- Internal organs: (stomach/vomiting, thyroid, kidneys, bowel/bladder, skin, etc.) _____

Are there any chronic illnesses (**please circle**):

Heart conditions	Diabetes	Other (please
high/low blood pressure	food or insect allergies	specify) _____
epilepsy/seizures	Recent surgeries or implants	
asthma/respiratory	Pyrrole Disorder	

Please list any other medical concerns you may have about your child (pica, food aversions, digestive, eating disorders, etc):

Please List any allergies the student has, include reactions, treatment and prevention:



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Have parents provided assistive devices or tools: walker/cane/crutches/wheelchair, brace/splint, glasses, hearing aid, communication device, earphones, epi pen, Other?

STUDENT SOCIAL EMOTIONAL/MENTAL HEALTH

SYMPTOM/PROBLEM CHECKLIST

Please check any that your student experiences

- | | | |
|---|--|--|
| <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Difficulties sitting still | <input type="checkbox"/> Resistant to change |
| <input type="checkbox"/> Lack of interest in activities | <input type="checkbox"/> Not interested in peers | <input type="checkbox"/> Refusal to go to school |
| <input type="checkbox"/> Fatigue low energy | <input type="checkbox"/> History of being bullied | <input type="checkbox"/> Perfectionism |
| <input type="checkbox"/> Concentration problems | <input type="checkbox"/> Talks excessively or interrupts | <input type="checkbox"/> Lying |
| <input type="checkbox"/> Appetite/weight changes | <input type="checkbox"/> Impulsive | <input type="checkbox"/> Trouble with the law |
| <input type="checkbox"/> Morbid thoughts | <input type="checkbox"/> Difficulty following rules | <input type="checkbox"/> Running away |
| <input type="checkbox"/> Suicidal thoughts or threats | <input type="checkbox"/> Excessive worry of fearfulness | <input type="checkbox"/> Hurting others sexually |
| <input type="checkbox"/> Suicidal threats or attempts | <input type="checkbox"/> Anxiety or panic attacks | <input type="checkbox"/> Fire setting |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Social fears or shyness | <input type="checkbox"/> Drug or alcohol use |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Separation problems | <input type="checkbox"/> Excessive swearing |
| <input type="checkbox"/> Cries easily | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Blames others for mistakes |
| <input type="checkbox"/> Short attention span | <input type="checkbox"/> Odd beliefs or fantasizing | <input type="checkbox"/> Stealing |
| <input type="checkbox"/> Aggressive behaviors | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Intentionally hurting others/fighting |
| | <input type="checkbox"/> Frequent tantrums | <input type="checkbox"/> Angry and resentful |

Please elaborate on any checked boxes:



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List any history of mental illness or addiction in immediate or extended family (Ex: Depression, anxiety, bi-polar disorder, suicide attempts, alcoholism, drugs, ADHD, schizophrenia, etc.):

Has child witnessed domestic violence? __Y, __N, Specify:

LIFE STRESSORS/TRAUMA HISTORY

1. Has your child been verbally abused? __Y, __N, __Suspected. Specify:

2. Has your child been physically abused? __Y, __N, __Suspected. Specify:

3. Has your child been sexually abused? __Y, __N, __Suspected. Specify:

4. Other stressors or traumas?



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RISE Seizure Action Plan

Does your student have a history of seizures? Yes No

If yes, please complete the below seizure response agreement and the attached questionnaire provided by the CDC and Epilepsy Foundation.

RISE Resource Center reserves the right to call Emergency Medical Services (EMS) once a seizure has lasted 5 minutes. If a parent requests that RISE Administrative staff call EMS prior to the 5 minute mark please indicate below.

I, _____, the parent/guardian of _____ request that RISE Resource Center call Emergency Medical Services once my child's seizure has lasted _____. I understand that if not otherwise specified, RISE Resource Center's administrative staff will proceed to call Emergency Medical Services (911) if my student has a seizure lasting 5 minutes.

In addition to Emergency Medical Services, I ask that the following person(s) is contacted:

Parent Guardian Signature: _____

Date: _____



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OFF CAMPUS PERMISSION SLIP

I _____, the Parent/Legal Guardian of
_____ (the "Student") request that the School allow the student to participate in participating in activities at designated locations within the community. I understand that participating in these activities may include walking to/from location, or, receiving transportation from a designated RISE staff member. I give permission for the Student to participate in these activities, which may include, but are not limited to:

- | | |
|-----------------------------------|-------------------------------------|
| - Jail Trail, Old Town Cottonwood | - Garrison Park, Cottonwood |
| - Riverfront Park, Cottonwood | - Dead Horse State Park, Cottonwood |
| - Cottonwood Public Library | - Tuzigoot, Cottonwood |

Activities may include but are not limited to: Playing on the playground, hiking, swimming, going to the library, etc. . As Parent/Legal Guardian, I remain fully responsible for any legal responsibility resulting from any personal actions taken by the Student. I understand that the Student will be under the supervision of the designated school personnel and chaperones and that all school rules will be in effect.

In consideration for the Students participation, on behalf of myself and the Student, I hereby release, absolve, indemnify and agree to hold harmless the School and any of their employees of said trip from any and all liability for any and all injuries that may arise out of participation in this activity. I hereby assume all risks and hazards incidental to participation in this activity.

I represent and certify that I, as parent/guardian of the Student, have read the entirety of this document and fully understand the contents, consequences and implications of signing this document and that I agree to be bound by this document.

Signature of Parent/Guardian

Please Print Name

Date



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Please indicate which skills you would like your child to work on at school

LIFE SKILL	YES	NO	IMPORTANCE (1-16)
Toothbrushing			
Hair Care			
Nail Filing			
Nail Clipping			
Face Shaving			
Leg/arm Shaving			
Face Washing			
Handwashing			
Deodorant			
Lotion			
Toilet Training <small>(including wiping)</small>			
Showing <small>(hair washing, body washing/rinse/dry)</small>			
Laundry <small>(wash, dry, fold)</small>			
Lip Balm Application			
Dressing			
Shoe Tying			
Nail painting/removal			
Use of tissue for Nose hygiene			

Signature: _____ Date: _____



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REQUIRED SCHOOL SUPPLIES

- Backpack
- 1" binder/s (white)
- Dividers
- Page protectors
- 8x13 whiteboard
- Thin dry erase markers
- 5 single subject Notebooks
- Crayons or colored pencils
- Reusable water bottle with student's name on it
- Highlighters
- Pencils, Erasers
- Scissors (adaptive scissors)
- Glue sticks
- Pens
- Sets of clothes/toiletries for backpack and to keep at school

SUGGESTED DONATIONS

- Markers
- Sharpies
- Tape
- Paperclips
- Copy paper
- Velcro
- Lamination pouches
- Chromebooks
- Body sock
- Ankle weights
- Small dumbbell weights
- Resistance bands
- Yoga Balls
- Compression socks
- Compression shirt
- Weighted vest
- Weighted blanket
- Board games
- Ziploc Bags
- Slime/sensory putty



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RISE Before and After Care

Student's Legal Name: _____

Residential Address: _____

City: _____ State: _____ Zip: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Guardian Name: _____ Phone: (____) _____

Email: _____

Name of present school: _____ Current Grade: _____

Address of present school: _____

City: _____ State: _____ Zip: _____

My student will attend RISE

___ Before School

___ After School

___ Both

My student will arrive at: _____ am/pm

My student will be picked up at: _____ am/pm



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The following are authorized to pick up/drop off my student:

- Name: _____

- Relationship: _____

- Address: _____

- Phone: _____

- Name: _____

- Relationship: _____

- Address: _____

- Phone: _____

- Name: _____

- Relationship: _____

- Address: _____

- Phone: _____