Advanced Sacred Hope Academy
Mailing Address: 124 E. Miracle Strip Parkway, Suite 503, Mary Esther, Florida 32569
Physical Address: 144 US Highway 98, Suite 101, Mary Esther, Florida 32569
Phone: 850-374-3991 **Fax**: 855-445-0214 **Email**: info@advancedsacredhopeacademy.org

Dear Parents/Guardians,

We are grateful to each one of you for entrusting us with the education and well-being of your children. Our commitment to providing an individualized learning environment is unwavering, and we are dedicated to ensuring that your child receives the best education possible.

We believe in developing a strong bond between parents, teachers, and students. Together, we form a community that values the importance of individualized education and behavior management. We believe in fostering an environment where every child feels loved, supported, and encouraged to reach their full potential.

Throughout the upcoming academic year, we will strive to maintain the highest standards of education, safety, and communication. In partnership with Advanced Behavioral Health Analysis, we aim to provide each student with the tools they need to transition to a mainstream school of your family's choice.

Thank you once again for choosing ASHA as partners in your child's educational journey. We are excited about the possibilities that this academic year holds, and we look forward to witnessing the growth and achievements of your children.

Should you have any questions, suggestions, or concerns, please feel free to reach out. Your feedback is invaluable, and together, we can ensure that this academic year is a positive and enriching experience for every student.

Welcome to Advanced Sacred Hope Academy!

Julie Gracela Webb
Founder

Dani Fordham
Director

MISSION STATEMENT

To transition our students with unique abilities by providing individualized education while cultivating essential life and behavior skills to achieve their fullest potential.

Student Name: _____

Do you want to receive information about starting ABA Therapy for your child? _____

Are you interested in volunteering for ASHA? _____

Submission Date:

_____

WAITLIST?

Y N

Parent Agreement:

____ I have received, read, and agreed to abide by the ASHA Handbook.

____ I have submitted a screen shot or a printed copy of my child's scholarship information that includes award ID number and the type of scholarship.

____ I have submitted all required documentation to ASHA prior to the start of my student's attendance. Students without a completed packet will not start school until packet is completed.

FOR OFFICE USE ONLY

CHECK AS COMPLETED (each item is included in this packet)

Registration Packet	
Medication Permission	
Tuition and Payment Agreement	
Photo and Video Waiver	
Parties and Celebrations Consent	
Preference Assessment	
Safety Care Physical Management Consent	
Video Surveillance Acknowledgement	
Social – Emotional Learning Support Consent	
Tracking Device Agreement	
Medical Form 3040 (School Entry Health Exam)	
Medical Form 680 (Florida Certification of Immunization)	

Entered in Student Registration System	
Registration Paid: (Early Payment Benefit; A 2.99% charge will be added to online payments). No later than March 31, 2024: $150.00 April 1, 2024 – June 30, 2024: $200.00 July 1, 2024, or after: $250.00	
1st Quarter Tuition Paid or Scholarship Information Submitted	

If ABA is requested, provide ABA Intake Form	
If volunteering, provide volunteer packet	

SECTION 1: STUDENT INFORMATION

FIRST NAME	M.I.	LAST NAME	GENDER	AGE

PREFERRED NICKNAME	DATE OF BIRTH	LAST SCHOOL AND GRADE LEVEL COMPLETED

PRIMARY RESIDENCE ADDRESS	CITY	STATE	ZIP CODE

CHILD LIVES WITH:

SECTION 2: PARENT INFORMATION

☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ SINGLE/WIDOWED

PARENT 1 ☐ Enrolling Parent ☐ Custodial Parent

RELATIONSHIP	NAME (FIRST, LAST)

ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	CELL PHONE	WORK PHONE	EMAIL ADDRESS

PARENT 2 ☐ Enrolling Parent ☐ Custodial Parent

RELATIONSHIP	NAME (FIRST, LAST)

ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	CELL PHONE	WORK PHONE	EMAIL ADDRESS

Authorized Persons to pick up your child and Emergency Contacts (other than parents/guardians)
IMPORTANT: Child will be released only to the parent or legal guardian, and persons listed below. Please identify the people who are authorized and/or could be contacted to remove your child from ASHA's facility in case of illness, accident, or emergency if the legal parent or guardian cannot be reached. If possible, please introduce us to the people authorized to pick up your child. For the safety of your child, please notify teachers or staff (verbally or in writing) of who will be picking up your child. Inform all persons to be prepared to show identification to have the child released to them.

Name	Relationship	Phone Number	Pick Up	Emergency
			YES OR NO	

SECTION 3: MEDICAL and BEHAVIORAL HEALTH	
PHYSICIAN NAME:	PHONE NUMBER:
DENTIST NAME:	PHONE NUMBER:

Does your child have any learning disabilities and/or diagnosis? Please list them below.

_____

_____

Is your child toilet trained? _____

Is your child totally verbal? _____

Is your child hearing impaired? _____

Does your child currently receive ABA Therapy? _____

If so, which company is the provider of their therapy services? _____

Has your child ever engaged in any self-injurious behavior? _____

Has your child ever exhibited aggressive behavior at school or with others in their household? _____

Does your child attend any other therapies? _____

If you answered yes to any of the questions above, please provide an explanation (if necessary)

_____

_____

_____

SECTION 4: STUDENT PROFILE

Was the child born prematurely? _____ If yes, how many weeks? _____

Place of birth: _____

Language spoken at home: _____

Please list any other family members permanently residing in the home with the student (pets, too) by name, age, and relationship:

_____

_____

_____

If the child is adopted, list age at adoption: _____ Is the child aware of adoption? _____

Please list any allergies, medical conditions, developmental delays, or any other limitations.

_____

_____

Please describe any special dietary needs that we should be aware of and describe your child's appetite.

_____

_____

What methods of behavior management are used in your home?

_____

_____

Please list any prescribed medications.

Name of Medication	Doctor's Instructions
_____	_____
_____	_____
_____	_____

MEDICATION PERMISSION FORM

If your child requires medication during the school day, the following rules must be observed:

This document must be completed and signed as evidence of your consent.
Complete the medication profile for your child.
Fill out an authorization form for each medication required to be administered.

Please initial.

_____ I acknowledge that there shall be no liability for civil damages as a result of the administration of such medication when the person administering the medication acts as a reasonably prudent person and would act under the same circumstances.

_____ I acknowledge that each medication is required to be in the original pharmacy- labeled container with dosage and instructions included.

_____ I acknowledge that over-the-counter medication must be in the original packaging with the original manufacturer's label attached.

As legal guardian, I hereby give permission to the staff of Advanced Sacred Hope Academy (ASHA) to administer medication to my child (name) _____; and I authorize ASHA to store my child's medication(s). I further agree to inform ASHA of any changes in the administration of the medication, including dosage and reaction, addition, or discontinuation of the medication. I further understand that this consent applies to all medication, whether prescribed by a physician or purchased over the counter without a prescription. I understand that this consent applies to the current school year only.

PARENT/GUARDIAN NAME	SIGNATURE	DATE

AUTHORIZATION FOR MEDICATION

(Fill out this form only if your student will be administered any medication during school hours)

No medication shall be given by staff without the signed permission of parents or legal guardian. Please complete this form as necessary.

Child's Name:

Date	Time	Amount	Staff Initials

Medication:

Amount to be given:

Time(s) to be given:

Directions:

Date	Time	Amount	Staff Initials

Medication:

Amount to be given:

Time(s) to be given:

Directions:

Date	Time	Amount	Staff Initials

Medication:

Amount to be given:

Time(s) to be given:

Directions:

Date	Time	Amount	Staff Initials

Medication:

Amount to be given:

Time(s) to be given:

Directions:

My signature indicates authorization for ASHA staff to administer medication to my child according to the directions provided above.

PARENT/GUARDIAN NAME ______________________ SIGNATURE ______________________ DATE ______________

TUITION PAYMENT AGREEMENT

The Tuition Payment Agreement is a contract between the PARENT and Advanced Sacred Hope Academy (ASHA), and every parent is required to sign and return this form to Advanced Sacred Hope Academy as a condition of being allowed to register for and attend the school. Under this contract, it is the primary responsibility of the PARENT to pay the entirety of the tuition and other fees due to ASHA. By signing below, the RESPONSIBLE BILLING PARTY agrees to be a guarantor of all tuition and other fees due to ASHA. Nevertheless, the PARENT is the only person to whom ASHA owes contractual obligations and the PARENT always remains primarily responsible to ensure payment to ASHA of all amounts due on the STUDENT'S Account.

Satisfactory arrangements for the payment of the total charges for each semester's tuition and other fees MUST be made prior to the first day of classes. Satisfactory arrangements are (1) timely payment pursuant to the Full Payment Plan; or (2) selection of the Payment Plan AND payment of all monthly installments which are billed on the STUDENT'S statements prior to the first day of classes. The Payment Plan is a privilege, which may be revoked for cause. Under either payment plan, all payments/installments are due and payable in full upon receipt of each statement and become delinquent after the 6th day of the month they are due. Delinquent accounts are subject to a late charge of one percent (1%) of the past due amount each month the account is delinquent. In addition, all past due charges from the previous school year MUST be paid prior to registering for and attending in the next school year.

Additional fees, to include, but are not limited to behavioral and mental health services, will be determined individually by the School Director and the School BCBA.

If your student(s) receive a scholarship from the Florida Department of Education, it is your responsibility to submit a copy of the scholarship information, to include the award type and student ID to ASHA prior to the start of the student's attendance.

2024-2025 TUITION AND FEES	
Annual Tuition	$10,500.00
Additional Services	**Annual Fee**
Behavior Management Moderate	$10,500.00 + $10,841.00
Behavior Management Severe	$10,500.00 + $21,125.00

*ASHA Tuition is individualized to tailor each student's needs.

Scholarship Accepted
Florida Tax Credit
Florida Empowerment Scholarship for Students with Unique Abilities and Educational Options
AAA Scholarship
**If a student is receiving a scholarship from any of the programs above, parents will not be required to fulfill any fees not recoverable from the scholarship.*

By signing this Tuition Payment Agreement, the PARENT (and, if applicable, the RESPONSIBLE BILLING PARTY) agrees to pay all reasonable collection costs, including reasonable attorney fees and collection agency fees, incurred to collect any delinquent accounts.

PARENT/GUARDIAN NAME _____ SIGNATURE _____ DATE _____

PHOTO AND VIDEO WAIVER FORM

WEBSITES AND SOCIAL MEDIA USE

_____ I give my consent for my child to have photos taken by Advanced Sacred Hope Academy for websites and social media use.

_____ I do not give my consent for my child to have photos taken by Advanced Sacred Hope Academy for websites and social media use.

CLASSROOM USE ONLY

_____ I give my consent for my child to have photos taken by Advanced Sacred Hope Academy for classroom use only.

_____ I do not give my consent for my child to have photos taken by Advanced Sacred Hope Academy for classroom use only.

PARENT/GUARDIAN NAME	SIGNATURE	DATE

PARTIES AND CELEBRATIONS

_____ I give my child permission to participate in all parties and celebrations.

_____ I DO NOT give my child permission to participate in all parties and celebrations.

_____ If necessary, I will provide alternative snacks due to my child's food allergies.

PARENT/GUARDIAN NAME	SIGNATURE	DATE

STUDENT PREFERENCE ASSESSMENT

Select the type of reinforcers and interests of your child.

Sensory Reinforcers	Social Reinforcer	Activity Reinforcer	Interests
Swinging	Hugs	Drawing	Animals
Blowing Bubbles	Adult Attention	Paint	Alphabet
Being Held	High Five	Books	Cars
Squeezes	Verbal Praise	Computer	Dolls
Jumping	Thumbs Up	iPad	Dinosaurs
Roll up in a blanket	Applause	Puzzles	Numbers
Spinning	Eye Contact	Water Play	Shapes
Back Rub	Handshake	Sand Play	Tools
Olfactory (smell)	1 on 1 time	Musical Toys	Trains
Pressure	Sit with adult	Going for a walk	Trucks
Other _____	Tickles	Dress up	Weather
_____	Other _____	Other _____	Other _____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

STUDENT PREFERENCE ASSESSMENT

Favorite Activities

Favorite Music

Favorite Toys

Items Student Does **NOT** Like OR do not have permission to have access to

Drinks	
Food	
TV Shows	Allowed to watch: __TV-Y __TV-Y7 __TVY7-FV __TV-G __TV-PG Shows/Genres NOT allowed to watch _____
Movies	Allowed to watch: __G __PG __PG-13 Movies/Genres NOT allowed to watch _____
Other	

SAFETY-CARE PHYSICAL MANAGEMENT CONSENT FORM

The Health and Safety of all students and staff at Advanced Behavioral Health Analysis (ABHA) and Advanced Sacred Hope Academy (ASHA) is a high priority. ABHA and ASHA staff are trained in Applied Behavior Analysis and Safety Care by Quality Behavioral Solutions, a crisis de-escalation and physical management curriculum. Physical management may be implemented in response to dangerous behaviors when preventative de-escalation techniques fail. If a student is engaging in continuous physical aggression and/or self-injury, physical management procedures utilized may include the following:

- Partial manual guidance (placing a hand on the student's shoulder to lead them to a different area)
- Full manual guidance (picking the student up and transporting them to a different area)
- Blocking of limbs, head, or hands
- Physical immobilization of limbs

Physical intervention is always used as a last resort and is only used in cases of imminent risk of harm to the individual or others. Physical intervention is always implemented using a least-to-most intrusive model. Staff will begin with the least restrictive but most effective level of physical intervention and progress to a more restrictive intervention if necessary to keep everyone involved safe. Risks of physical intervention may include an increase in agitation and/or problematic behaviors, redness and/or bruising of the skin, minor skin abrasions, and increase in blood pressure. Less common and extremely rare risks include broken bones, sprains, and other serious injuries.

If a student has medical concerns that may be worsened using physical management, our staff must be informed. Please indicate below:

_____The student DOES NOT have any known medical complications that may be worsened using physical management.

_____ The student DOES have a known medical complication that may be worsened using physical management.

Please list medical concerns:

_____

_____

Please read the following and acknowledge each statement by signing your initials:

_____ I understand the potential risks associated with the use of physical intervention and I have informed ABHA and ASHA staff of all known medical complications the student has.

_____ I understand that ABHA and/or ASHA are not responsible for injury that may result in the implementation of physical interventions. I further understand any physical management procedures used will only be implemented if their potentially harmful effects outweigh those of the problematic behavior.

_____ I understand that my refusal to consent may result in a need for an alternative setting/treatment.

_____ I have had the opportunity to ask any questions and have had them answered in full.

I, _____ (Legal Guardian) consent to and authorize ABHA and ASHA staff to implement physical management procedures when necessary to keep _____ (Student) and others safe.

I, _____ (Legal Guardian) elect **NOT** to have any form of safety-care physical management used on my child. I understand if my child exhibits aggression toward themselves or another child/teacher/therapist, they will be escorted to the safety room, and I will be called and expected to pick my child up immediately.

This consent is valid for one year following the date of signature below or until changed by parent or legal guardian.

PRINT PARENT/GUARDIAN NAME	SIGNATURE	DATE

VIDEO SURVEILLANCE

PURPOSE

The installed cameras are used for real time view of ABHA/ASHA area of responsibility. Video cameras are used for live supervision, therapist training, and to ensure the safety of clients and therapists as well as to protect the integrity of ABHA/ASHA and its employees.

CONFIDENTIAL RECORDINGS

Temporary live recordings remain confidential and release of videos to outside authority requires permission from all subjects recorded and involvement of our legal team.

The Health Insurance Portability and Accountability Act (HIPAA) protects the privacy and security of our clients. ABHA and ASHA are required to obtain permission and a signed release from parents of children shown as well as therapists, other employees, and volunteers in video footage.

It is our policy to protect the privacy of our learners, their families, as well as ABHA and ASHA employees and volunteers.

Parents or Guardians wishing to review footage of any part of video recording may request access through our legal team, Fleet, Smith & Freeman at 850-651-4006.

ABHA and ASHA live recording do not subscribe to lifetime storage of recording.

ACKNOWLEDGEMENT

PARENT/GUARDIAN NAME	SIGNATURE	DATE

SOCIAL – EMOTIONAL LEARNING SUPPORT

INTAKE FORM

The Counseling Process/Confidentiality

ASHA obtains the services of a mental health coach (MHC), under the supervision of Julie Gracela Webb, LMHC-QS to provide counseling options for our students. This therapy will be conducted throughout your child's school day and be held in a private room via telehealth.

The counseling process is designed to enhance your child's overall well-being through a professional therapeutic relationship. In these sessions, your child will be encouraged to openly express themselves as part of their learning journey. Using strategies from approaches like Acceptance and Commitment Therapy, ASHA MHC will work with your child to achieve our jointly defined goals.

Confidentiality is a cornerstone of our process, abiding by ethical standards and Florida law. Situations requiring disclosure, such as abuse suspicions or safety concerns, will be handled according to legal mandates. Your child's privacy is of utmost importance during these sessions. Privacy is paramount in building and preserving the trust built throughout the process. ASHA MHC's practice involves sharing general treatment information with you. ASHA MHC will address issues impacting your child both within and outside the home. Your child's disclosures will remain confidential unless consent is granted. At treatment's end, ASHA MHC will provide an overview of topics covered, progress achieved, and potential areas needing future attention. Remember, you and your child have the right to terminate sessions at any time. This collaborative approach ensures a personalized and empowering therapeutic experience.

Would you like for your child to receive this service?	**YES**	**NO**

If yes, please fill out the following Demographic Information. (This form is to be submitted to Julie Webb for data collection)

CHILD'S NAME		DATE OF BIRTH
EXISTING DIAGNOSIS (IF APPLICABLE)		
GUARDIAN NAME	RELATIONSHIP	PHONE NUMBER
GUARDIAN NAME	RELATIONSHIP	PHONE NUMBER
EMERGENCY CONTACT (OTHER THAN PARENT/GUARDIAN)	RELATIONSHIP	PHONE NUMBER

Child's Treatment/Medical History

Is your child currently under the care of a psychiatrist?	**YES**	**NO**	If yes, specify name and frequency of care

Is your child currently taking any psychotropic medication?	**YES**	**NO**	If yes, please specify name, dosage, and frequency

Is your child diagnosed with any medical conditions?	**YES**	**NO**	If yes, please specify.

What are your top three concerns?

_____

_____

_____

TRACKING DEVICE POLICY

We understand having a child with special needs can cause a caregiver to face anxiety while their child is away from their care.

Here at ASHA, we pride ourselves in our transparency with our parents, so they can rest assured while their student is away from their care receiving services, they are continually being monitored via video/audio systems. Our school, as well as our clinic, has continual video/audio monitoring in all our outdoor spaces, therapy spaces, as well as our office spaces.

We encourage active parent participation and accept parent volunteer(s). We do require volunteers to be vetted with a fingerprint/background check for the safety of all our students.

We do allow your child to wear a GPS tracking device for safety, however, if the device includes any form of a listening mechanism, one or two-way, this will violate the confidentiality of our other students/therapy clients and therefore, be a breach of HIPPA laws and regulations, and therefore, is not allowed.

If you should have any concerns or questions regarding this policy, please feel free to reach out to Director of ASHA (Dani Fordham).

Thank you for your corporation and understanding that each of our students deserves to receive services that maintain their confidentiality.

With gratitude,
ASHA Staff

AGREEMENT

I have read and understand that audio or video monitoring devices are not allowed at ASHA, and I will not allow my child to wear or use any such device, nor will I attach any such device to my child or their belongings. I understand that if I violate this policy, I would be breaching the other students' rights to privacy and dignity to receive therapy services.

PARENT/GUARDIAN NAME	SIGNATURE	DATE

ASHA SUPPLY LIST

Item	Count	
Clorox Wipes (3-pack)	1 pack	
Baby Wipes	3 packs	
Kleenex Tissues	4 boxes	
Hand Sanitizer (12 oz or more)	1 bottle	
Pencil Box	1 box	
Crayola Markers (8-pack)	2 boxes	
Crayola Crayons (24-pack)	1 box	
Liquid Elmer's Glue (Small)	1 bottle	
Glue Sticks	5-count	
Pencil #2 Ticonderoga (24 count)	1 box	
Wide-ruled Notebook Paper	2 packs	
Scissors (Age Appropriate)	1 count	
Plastic Double Pocket Folders with prongs	3 counts	
Plastic Double Pocket Folders without prongs	3 counts	
Card Stock (White)	1 pack	
Card Stock (Colors)	1 pack	
Copy Paper	2 packs	
Personal Headphones	1 pair	

DONATIONS ARE GREATLY APPRECIATED!
Toys and Snacks for School Store
Additional Hand Sanitizer
Clorox/Lysol Wipes
Dry Erase Markers (Assorted color, 8-pack)
Dry Erase Marker (Black)
Sharpie (Fine Point, Black)
Sharpie (Assorted color)