MOUNT PROSPECT
ACADEMY
Client-Centered Continuum of Care

A program of:

Becket
Family of Services

INTAKE PACKET

Student's Name in Full: **D.O.B.:**

Programs:

MPA at Campton (Males)
- ☐ Shelter Care
- ☐ Enhanced Residential Treatment (ERT)

MPA at Pike (Males)
- ☐ Hall Farm: Long-term Care/Developmental Disabilities
- ☐ Blake House/Mitchell House: Residential Sub Acute Care

MPA at Plymouth (Males)
- ☐ Comprehensive Assessment and Short-term Treatment (CAST)
- ☐ Summit Program: Long-term Residential Care

MPA at Rumney House (Males)
- ☐ Residential Treatment

MPA at Warren (Males)
- ☐ Adventure-Based Residential Treatment

MPA at Hampton (Females)
- ☐ Shelter Care
- ☐ Enhanced Residential Treatment (ERT)
- ☐ Comprehensive Assessment and Short-term Treatment (CAST)

Referral Type: ☐CHINS ☐Delinquent ☐DCYF/DCF ☐School Referral

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Service Start Date:

The following documents are required for student admission:

Youth/Child Information Sheet ☐ (NH DCF/DJJS)
Immunization Record ☐
Insurance Card ☐
Current IEP (if applicable) ☐

***Packet will not be considered valid without required witness signatures.**

Submit completed info to:

MPA at Hampton	Fax: 603-782-2832 Scan: heather.foley@becket.org
All other Programs	Fax: 603-536-3074 Scan: camille.laboe@becket.org and gail.fitzgibbon-bizel@becket.org

Parent or Legal Guardian	
Name:	
Relationship:	Date of birth:
Home address:	
Home phone:	Cell phone:
Employer:	Work phone:
Work address:	Email Address:
Are Interpretation Services Needed? ☐Yes ☐ No If Yes, please identify preferred language:	

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Other Parent or Legal Guardian (if contact is approved)	
Name:	
Relationship:	Date of birth:
Home address:	
Home phone:	Cell phone:
Employer:	Work phone:
Work address:	Email Address:
Are Interpretation Services Needed? ☐ Yes ☐ No If Yes, please identify preferred language:	

Referral Source	
Name:	☐JPPO ☐CPSW ☐School
Work address:	
Work phone:	Work fax:
Email address:	
STUDENTS NEXT COURT DATE (if one is scheduled):	
Attorney	
Name:	
Work address:	
Work phone:	Work fax:
Email address:	
Guardian Ad Litem (if applicable)	
Name:	
Work address:	
Work phone:	Work fax:
Email address:	

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School District & Current/Most Recent Educational Placement:	
Responsible School District (LEA):	
School District Address:	School District Phone #:
Educational contacts (e.g., Case Manager, Counselor, SPED Director):	
Special Education Plan: ☐ IEP ☐504 Plan ☐None Current Grade:	
If IEP please indicate Coding: Emotional Disturbance: ☐ Intellectual Disability: ☐ Other Health Impairment: ☐ Specific Learning Disability: ☐ Speech or Language Impairment: ☐ Autism: ☐	
Current/Most Recent School Attended:	
Type: ☐Public school ☐Alternative school ☐GED program ☐Online classes	
School Address:	Phone:

Lead Service Coordinator (MA Students ONLY)	
Name:	
Work Address:	
Email:	
Work phone:	Other contact #:
Students next court date:	**Students next F.C.R. meeting:**

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Ancillary Service Disclosure & Statement of Parental Responsibility

Any service that is not part of the Mount Prospect Academy on-site treatment continuum for a particular program is considered an "ancillary service" for that program. MPA does not cover the cost of ancillary services. Payment for such services is the responsibility of the client's parent/guardian. Examples of ancillary services include, but are not limited to:

- Hospital and Urgent Care visits and hospitalization
- Medical equipment (crutches, splints, hearing aids,
- Doctor's appointments
- Prescription medications
- Specialists (dermatologist, cardiologist, podiatrist, urologist, chiropractor, herbalist, etc.)
- Dental visits, procedures, and appliances
- Psychiatric care and most psychiatric appointments

In order to facilitate continuity of care, we will gladly coordinate services with your child's existing doctor, dentist, psychiatrist, or other specialist whenever possible, but you are responsible for ensuring that payment is made for these services. This includes making sure that your child's medical professionals have accurate insurance policy information on file, and it requires that you pay for any costs associated with treatment including co-payments, deductibles, and out-of-pocket payment for services not covered by your insurance.

To ensure the accuracy of our records and to help facilitate the coordination of ancillary services for your child, please provide your current insurance information below. It is your responsibility to update this information if/when your insurance changes.

Type of insurance (e.g., NH Healthy Kids, Blue Cross):	
Policy number:	Group number (if any):
Subscriber:	Subscriber's date of birth:
Subscriber's SS#:	Subscriber's company:
Insurance company phone:	

ACKNOWLEDGED AND UNDERSTOOD: I understand that Mount Prospect Academy does not pay for ancillary services required by program participants. I agree to pay any charges associated with ancillary services (e.g., medical, dental, and psychiatry) coordinated on my child's behalf by MPA.

Parent / Legal Guardian: _____ **Date:** _____

Parent / Legal Guardian: _____ **Date:** _____

***Copies of active insurance cards (front & back sides) are required for student* admission.**

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Medical and Mental Health Practitioners	
***Primary care physician**:*	
Name of practice:	
Address:	
Phone:	Fax:
Date last seen:	
Dentist:	
Name of practice:	
Address:	
Phone:	Fax:
Date last seen:	
Optometrist (if applicable):	
Name of practice:	
Address:	
Phone:	Fax:
Date last seen:	
Psychiatrist (if applicable):	
Name of practice:	
Address:	
Phone:	
Date last seen:	
Upcoming Appointments:	
*Please identify any upcoming appointments, if scheduled *(include date, time, location & provider)*:	
*Please identify if student is due for any appointments:	

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Medical & Mental Health History

Please identify any current or chronic medical diagnoses:

Please identify any mental health diagnoses:

Does the student have allergies to food, medication, or the environment? ☐Yes ☐ No
If yes, identify and describe:

Does student have an Epi Pen? ☐ Yes ☐ No

Current Medication List

Medication	Dose	Time (AM or PM)

Please identify prescribing practitioner & practice:

_____

_____

Have there been any changes to medication regiment in the last 3 months? Yes ☐ No ☐
If Yes, please describe:

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Informed Consent, Acknowledgement of Limited Confidentiality and Waiver:

I/we understand that effective treatment requires a multi-disciplinary, collaborative approach, and that all persons involved in the student's treatment need to be able to freely and openly discuss the case in order to ensure the development of an effective and comprehensive treatment plan.

I/we understand that initial and ongoing assessments of the student and family will be performed in order to determine treatment needs. In addition, I/we understand that while I/we are under no obligation to answer questions that are asked in connection with these assessments, failure to participate in this process could result in incomplete or inappropriate treatment plans being developed. I/we also understand that the results of all assessment activities, including our level of participation in the assessment process, will be reported to the treatment team and the court. Results will, therefore, be made available to numerous individuals and agencies involved in the student's treatment, as set forth in more detail below.

I/we consent to unrestricted communication between Mount Prospect Academy and agencies that are responsible for the referral of the student to the program. This includes, but is not limited to: the court, the school district, correctional personnel responsible for monitoring and supervising the student, and state agency personnel. I/we also consent to unrestricted communication between Mount Prospect Academy and other individuals and agencies that the staff deems necessary to achieve the purposes stated above.

I/we understand that certain individuals and agencies have a legal right and legal authority to review our records with or without my/our consent. This includes, but is not limited to: state and federal licensing and auditing agencies, and courts through a subpoena.

We understand that laws require Mount Prospect Academy to report certain infectious diseases and acts of suspected abuse and neglect towards children, the disabled, and the elderly. We also understand the obligation of the agency to inform the proper authorities if the behavior of a student or a family member presents a clear and imminent danger to themselves or to another.

We acknowledge that this waiver and consent is signed voluntarily in an effort to support the treatment purposes set forth above. This authorization will expire in one calendar year unless otherwise indicated.

_____	_____	_____	_____
Signature of Student	**Date**	**Signature of Witness**	**Date**
_____	_____	_____	_____
Signature of Parent/Guardian	**Date**	**Signature of Witness**	**Date**

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Student: _____ Date of Birth:_____

Consent/Release of Liability

Please initial and sign below

____I give Mount Prospect Academy permission to perform educational, psychological, and/or psychiatric testing deemed necessary to formulate an appropriate treatment plan for my child/ward.

____I give Mount Prospect Academy permission to conduct random drug testing of my child/ward in the event that substance use/abuse is suspected.

____I give permission for my child/ward to participate in athletic activities with the understanding that Mount Prospect Academy shall not be held liable for any injury that may result from participation.

___ I understand that Mount Prospect Academy does its best to ensure that all student belongings are kept safe and secure. Upon admission, an inventory of belongings is taken. I agree to notify Mount Prospect Academy when additional belongings are sent, and I agree to keep items of high monetary and sentimental value at home whenever possible. In the event that my child/ward brings an item back to campus that is not allowed or that MPA believes should not be stored in my child/ward's room, that item will be held in a locked area until it can be returned home. MPA strictly prohibits the lending, borrowing, or trading of personal items.

____I acknowledge that Mount Prospect Academy cannot be held responsible for lost or stolen items.

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

MOUNT PROSPECT
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Consent for the Release of Confidential Information Relating to Alcohol and Drug Abuse- Federal Law 42 U.S.C.A.

I, _____ (student) authorize Mount Prospect Academy to disclose information about my treatment and current and previous substance use to my treatment team. The treatment team may include, but is not limited to: my parent(s)/guardians, referring agencies, school districts, and the court. The purpose of the disclosure authorized in this consent is to maximize my treatment, not to be punitive.

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 C.F.R. Part 2) and the Health Insurance Portability and Accountability Act of 1996 (45 C.F.R. Pts. 160 and 164), and that they cannot be disclosed without my written consent unless otherwise provided for in the regulations. I further understand that I may revoke this consent at any time (except to the extent that action has been taken in reliance on it), and that if not revoked earlier or otherwise indicated, this authorization will automatically expire in one calendar year.

I understand that I might be denied services if I refuse to consent to a disclosure for the purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I have been provided with a copy of this form.

_____	_____	_____	_____
Signature of Student	**Date**	**Signature of Witness (required)**	**Date**

MOUNT PROSPECT
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Medical Authorization

Student: _____ Date of Birth:_____

I _____ (parent/guardian) hereby authorize Mount Prospect Academy:

	Initial
to procure and administer any medical, dental, surgical, or mental health treatment deemed to be necessary to restore health to the above-named individual in the event of an emergency	
to arrange routine medical, dental, optical, and mental health examinations for the above-named individual	
to secure any tests, treatments, and immunizations considered necessary or proper for the welfare of the individual or the group with whom he is associated. This includes, but is not limited to: blood tests, urine tests, skin tests, and drug screens	
to administer yearly influenza vaccinations	
to administer any medications ordered by the school physician or the student's personal physician	

The New Hampshire state law (RSA 200) requires a physician's written order and the authorization of a legal guardian in order for a nurse to administer medical preparations, exclusive of hallucinogens and narcotics. In the absence of a nurse, a medical assistant or another trained staff member will administer oral medications.

I understand that in the event of a medical or mental health emergency, Mount Prospect Academy will make every attempt to contact me and keep me fully informed. I also understand that as the parent or guardian of the above-named individual, I still retain the right and responsibility to sign hospital admission forms and surgical permits if I can be located. If I cannot be located, I authorize Mount Prospect Academy to proceed with obtaining treatment so that no unnecessary delays occur.

I understand that it is my responsibility to notify Mount Prospect Academy of any changes to my contact information. I acknowledge that if I do not notify the agency of changes, staff members may not be able to locate me in the event of a medical or mental health emergency.

A photocopy of this release shall be considered as effective and valid as the original.

***Individual boxes in chart above must be initialed for student admission.**

_____ _____ _____ _____

Signature of Parent/Guardian **Date** **Signature of Witness (required)** **Date**

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STANDING MEDICATION ORDERS

Student:_____ Date of Birth:_____

Allergic Reaction**:**
Diphenhydramine (Benadryl) **-** 50 mg every 4 hrs, maximum 300 mg/day
Epi-Pen 0.3 mg (autoinjecter)- inject into outer thigh for severe allergic reaction and seek immediate medical attention.

Allergy Symptoms:
Chlor-trimaton (non- drowsy antihistamine) - 1 tab every 4 hrs, maximum 6/day

Athletes Foot**:**
Clotrimazole (Lotrimin) - apply to clean dry feet and apply clean dry socks to cover.
Tolnaftate (Tinactin) - apply to clean dry feet and apply clean dry socks to cover.

Constipation**:**
Raisins / Prune juice - twice daily
Magnesium Hydroxide (Milk of Magnesia) – 4800 mg at bedtime

Cough**:**
Guaifenesin & Dextromethorphan Syrup (Robuitussin) **-** 10 ml every 4 hrs, maximum 60 ml/day
Cough Drops (menthol) **-** 1 every 2 hrs, maximum 12/day

Diarrhea**:**
Bismuth Subsalicylate (Pepto-Bismol) - 30 ml every 4 hrs, maximum 120 ml/day
Loperamide HCL (Imodium) – 4 mg after first loose stool, 2 mg after subsequent loose stool, maximum 8 mg/day

Dry Lips**:**
Lip Balm – as needed
Cerumen Build up:
Debrox Ear Drops- use as directed.

Heartburn/Indigestion**:**
Aluminum Hydroxide (Alamag) – 20 ml 4 x daily, maximum 80 ml/day
Calcium Carbonate (Tums) – 1000 mg every 4 hrs, maximum 7500 mg/day;
Bismuth Subsalicylate (Pepto-Bismol) - 30 ml every 4 hrs, maximum 120 ml/day.

Itching**:**
Calamine – apply to affected area as needed.
Diphenhydramine gel/spray (Benadryl) – apply to affected area, maximum 4 x/day
Medicated Body Powder (Gold Bond) – apply to affected area, maximum 4 x/day

Minor Cuts:
Bactine – antiseptic
Bacitracin – infection prevention

Nasal Congestion**:**
Saline spray - 3 times a day as needed.

Pain/Fever**:**
Acetaminophen (Tylenol) **-** 650 mg every 4 hrs, maximum 4000 mg/day
Ibuprofen - 400 mg every 4 hrs, maximum 3200 mg/day

Sun Exposure**:**
SPF 30 Sunscreen – apply before exposure and every 30 mins while exposed
Aloe Vera – apply to affected area as needed
Lidocaine HCL 2.0 – apply to affected area, maximum 4 x/day

_____ _____

Signature of Parent/Guardian Date

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Policy on the Use of Photographs and Videos

Policy

Photographic and digital images and video of students may be collected for security reasons, educational purposes, and for use in promotional materials (e.g., program brochures, website, news stories). Images of students including those captured on film, video, or digital camera, are subject to privacy laws and may not be disclosed outside of the Company without signed authorization from the student's parent or legal guardian, except as required by law.

Security Photography/Video:

Parent/guardian permission is not required for the use of video surveillance for security and staff training purposes. However, security images may not be distributed outside of the program without parent/guardian permission except as permitted by law. Video surveillance must follow strict guidelines governing where and how such surveillance is allowed.

Educational Photography/Video:

Videotaping, filming, or photographing students while participating in school activities sometimes is used as an instructional tool. Faculty are mindful that photographing students without adequate preparation and justification may disrupt the planned instructional process and should be avoided. Examples of allowable activities include:

- Videotaping a mock interview so that the student/class can review and critique
- Photographing activities in the classroom throughout the semester to show students how much they have achieved during an end-of-year slideshow
- Using photographs from a fieldtrip as the basis for a class project (e.g., to illustrate a student's story about the fieldtrip)
- Documenting a faculty member's performance for critique

Parent/guardian permission is not required to use images within the program for educational purposes. However, permission must be secured before such images can be released beyond the program. For example. If a student incorporates digital images of a peer into a class art project, he/she may not take that project home unless the parent/guardian of the peer featured in it has authorized the use/release of their child's photographs.

Public Events

Because school grounds (e.g., playgrounds, athletic fields, parking lots) cannot be effectively shielded from the public, no assurance can be provided to students or parents that they are protected from photographing, filming or videotaping while using such facilities. In addition, program participants voluntarily take part in public and/or newsworthy events such as assemblies, plays, concerts, athletic contests, and community-based outings. The Company cannot be held responsible for photographs and videos that may be taken by members of the public during these events, nor can the company control how images captured by the public may be used.

Permission to use Photographs/Video

I authorize MPA to videotape, photograph, or film my student and use the images for reasons other than education, security, and training purposes. This includes the use of digital images in promotional materials. This authorization is valid for one year and may be revoked in writing at any time. Expiration or revocation of authorization does not apply retroactively, and images used pursuant to this authorization may remain in the public domain even after this permission expires.

_____	_____	_____
Parent/Guardian Name (Print)	**Signature**	**Date**

Physical Restraint

Mount Prospect Academy is committed to maintaining a safe environment for all. Sometimes residents become agitated and are unable to effectively self-regulate, which poses a safety concern for themselves and others. MPA faculty are trained to recognize when a situation is escalating and diffuse it before aggression or self-harm occur. In the event that a youth becomes physically aggressive and injury is possible, Therapeutic Crisis Intervention (TCI) may be used to prevent the youth from causing injury by physically managing the youth. MPA maintains compliance with RSA 126-U as well as Senate Bill 396. A physical management is used as a last resort when other interventions and de-escalation efforts are ineffective. MPA utilizes a trauma informed care approach to treatment and prohibits the use of seclusion as a punitive response to behavior. Please review the family intake guide or speak directly with a treatment team member for further information.

Off Campus Programming/Trips

The Mount Prospect Academy residential treatment programs often engage in community-based programming. Faculty-to-student supervision while off campus is maintained at least a 1:4 ratio at all times. Students have the opportunity to participate in day trips, overnight wilderness adventures and other scheduled programming and activities. The overarching goal of off-campus programming is to encourage positive leadership abilities while developing new skills that will aid in the transition process upon discharge.

I understand that my student will be transported via public transportation or by a properly insured vehicle driven by a licensed faculty member for all program activities.

I understand that I will be notified in advance of any overnight trips, and that additional permissions may be required for participation in such trips. Unless otherwise specified, overnight trips will occur in the student's home state.

I understand that the same standards for on-campus behaviors apply to-off campus programming as well. Cell phones and other contraband (e.g., tobacco products, lighters, alcohol and illicit substances) are strictly prohibited. The student's belongings will be searched prior to the trip and may be searched again at any subsequent point during the trip. Personal searches will be conducted according to the agency's search policy and procedures.

By signing below, you are acknowledging you understand the above and agree to its content.

_____	_____	_____
Parent/Guardian Name (Print)	**Signature**	**Date**
_____	_____	_____
Witness Name (Print)	**Signature**	**Date**

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Student Name: _____

Program: _____

NOTICE OF HIPAA PRIVACY PRACTICES

This Notice of Privacy Practices provides information about how Mount Prospect Academy, referred to herein as "the Company" may use and disclose **Protected Health Information (PHI)** about your child or legal ward. The Notice describes your rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

You have the right to review this document before signing, and a copy will be provided to you upon request.

By signing this form, you consent to the Company's use and disclosure of PHI about your child or legal ward for treatment, payment, and operational purposes.

I, the undersigned, acknowledge that:

- I have the legal authority to sign this document;
- My child or legal ward's Protected Health Information may be disclosed by the Company, or used for treatment, payment, or company operations (e.g., recordkeeping, state and federal reporting, and billing);
- I have had the opportunity to review this Notice of Privacy Practices and HIPAA Release Form and agree to the terms herein;
- The Company reserves the right to change this Notice of Privacy Practices and HIPAA Release Form at any time, without notice;
- I may revoke this consent in writing at any time, and all future disclosures will then cease. Such revocation shall not affect any disclosures already made in reliance on my prior consent;
- I have the right to request that the Company restrict how my child or legal ward's PHI is used or disclosed for treatment, payment, or organizational operations. However, the Company is not required to agree to my requested restriction;
- I may request, in writing, access to my child or legal ward's PHI;
- I may request, in writing, a log of my child's PHI disclosures (log does not include disclosures made for treatment, billing, and business continuity purposes);
- If I believe that the confidentiality of my child or legal ward's PHI has been breached as per HIPAA guidelines, I have a right to file a complaint and the incident will be investigated;
- The Company may condition treatment upon execution of this consent form.

_____	_____	_____
Parent/Guardian Name (Print)	**Signature**	**Date**

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NOTICE OF PARENT/GUARDIAN RIGHTS UNDER THE FAMILY EDUCATION RIGHTS AND PRIVACY ACT (FERPA)

The Family Educational Rights and Privacy Act (FERPA) affords authorized parents and legal guardians of students, with certain rights with respect to their student's education records:

1. **The right to review and inspect** their student's education records within 45 days of request. Requests must be made, in writing, to the Director of Academics, and should identify the record(s) the parent/guardian wishes to inspect.

2. **The right to request an amendment** of any education record(s) that they believe are inaccurate, misleading, or otherwise in violation of the student's privacy rights under FERPA. Requests for an amendment should be made in writing and submitted to the Director of Academics. If MPA decides not to amend the record as requested, we will notify yu in writing of our decision.

3. **The right to provide written consent** before Personally Identifiable Information (PII) is disclosed. An eligible parent or guardian has the right to provide written consent before MPA discloses PII from their student's education records, except to the extent that FERPA authorizes disclosure without consent.

   MPA may, and from time to time does, disclose education records without prior written consent from the student's parent or guardian when authorized by FERPA, including to MPA staff who have legitimate educational interests in the student. "Legitimate educational interests" include performing a task or engaging in an activity related to (i) one's regular duties or professional responsibilities, (ii) a student's education, (iii) the discipline of a student, (iv) a service to or benefit for a student, (v) measures to support student success, and (vi) the safety and security of the campus.

4. **The right to file a complaint.** An eligible parent or guardian has the right to file a complaint with the U.S. Department of Education concerning alleged failures by MPA to comply with the requirements of FERPA.

When does FERPA permit disclosure of PII without consent? FERPA permits the disclosure of PII from students' education records, without consent, if the disclosure meets certain conditions found in §99.31 of the FERPA regulations. Except for disclosures to MPA staff (as defined above), disclosures related to some judicial orders or lawfully issued subpoenas, disclosures of directory information, and disclosures to the student, §99.32 of FERPA regulations requires the institution to record disclosures. Clients have a right to inspect/review the record of disclosures.

I acknowledge that I have read and understand my rights under FERPA:

_____	_____	_____
Parent/Guardian Name (Print)	**Signature**	**Date**

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Student Name: _____

Program: _____

AUTHORIZATION FOR RELEASE OF INFORMATION
PROTECTED HEALTH INFORMATION (PHI) AS DEFINED BY HIPAA,
AND PERSONALLY IDENTIFIABLE INFORMATION (PII) AS DEFINED BY FERPA

I, the undersigned, give permission for the Company to share my child or legal ward's confidential information with the following individual(s). This authorization is valid for one year unless I notify the Company in writing that the authorization has been revoked.

Complete a separate form for each authorized recipient.

Student Name:
Authorized Recipient: Name: _____ Mailing Address: _____ Phone: _____ e-Mail: _____
Date Range of Information to be Disclosed: ____/____/____ through ____/____/____
Information to be Disclosed*: □ Education Records □ Treatment Plan (May contain medical, clinical, and health information) □ Monthly/Weekly Progress Reports (May contain medical, clinical, and health information) □ Discharge Summary □ Other (please describe)
Authorization - *request is invalid unless signed below by parent/guardian who is authorized to approve the requested disclosure(s). Do not sign a blank form.*

_____	_____	_____
Parent/Guardian Name (Print)	**Signature**	**Date**
_____	_____	_____
Witness Name (Print)	**Signature**	**Date**

*MPA is prohibited by law from disclosing the following information without the client's expressed written permission or a court order: individual or family therapy notes, substance use disorder (alcohol/drug) diagnosis or treatment information, HIV/AIDS diagnosis or treatment information, sexually transmitted disease diagnosis or treatment information.

** We are prohibited from disclosing third party information to you. For example, if you would like a copy of an Individual Education Plan (IEP) provided to us by your child's sending school, you will need to ask the sending school for a copy directly.

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Student Name: _____

Program: _____

Permission to Make Routine Disclosures

Initial all that apply, and sign below:

____ I authorize MPA to communicate with my student's sending school and to disclose and receive education-related information as necessary to facilitate continuity of educational services. Educational materials include, but are not limited to: transcripts, attendance records, and Individual Education Plans.

____I authorize MPA to disclose and receive the following ***non-education information*** with my child's sending school: disciplinary reports, medical and clinical information, and family/community information.

____ I authorize MPA to communicate with my student's General Practitioner as necessary to facilitate continuity of medical care and medication management. Materials that may be disclosed include: medical records, scripts for medication, treatment plans. (some medical facilities require their own disclosure authorization form be signed as well)

Practice/Facility:_____
Physician Name: _____
Phone Number: _____Fax Number_____
e-mail _____
Address: _____

____ I authorize MPA to communicate with my student's therapist /psychiatrist as necessary to facilitate continuity of mental health care and medication management.

Practice/Facility:_____
Physician Name: _____
Phone Number: _____Fax Number_____
e-mail _____
Address: _____

____ I authorize MPA to communicate with my student's attorney and to provide any/all documentation requested in accordance with all applicable law.

Attorney Name: _____
Phone Number: _____Fax Number_____
e-mail _____
Address: _____

_____	_____	_____
Parent/Guardian Name (Print)	**Signature**	**Date**
_____	_____	_____
Witness Name (Print)	**Signature**	**Date**

MOUNT PROSPECT
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Student Name: _____

Program: _____

CONSENT TO USE ELECTRONIC COMMUNICATION

As the parent/guardian of a Mount Prospect Academy client, you have the option of receiving communication about your child via electronic media. This information may include Protected Health Information (PHI), as defined by the Health Insurance Portability and Accountability Act (HIPAA), and Personally Identifiable Information (PHI) as defined by the Family Education Rights and Privacy Act (FERPA).

Electronic communications can be a valuable asset in the treatment process (e.g., e-mail, text, Instant Message, or cell-phone updates on your child's progress, or videoconferencing for family therapy). However, before authorizing us to communicate with you electronically, you must be aware of the risks inherent in electronic communication:

1) Use of any electronic communications to discuss sensitive information can increase the risk of such information being disclosed to third parties.
2) Despite reasonable efforts to protect the privacy and security of electronic communication, it is not possible to completely secure information.
3) Employers and online services may have a legal right to inspect and keep electronic communications that pass through their system.
4) Electronic communications can introduce malware into a computer system, and potentially damage or disrupt the computer, networks, and security settings.
5) Electronic communications can be forwarded, intercepted, circulated, stored, or even changed without the knowledge or permission of the sender and recipient.
6) Even after the sender and recipient have deleted copies of electronic communications, back-up copies may exist on a computer system.
7) Electronic communications may be disclosed in accordance with a duty to report or a court order.
8) Email, text messages, and instant messages can more easily be misdirected, resulting in increased risk of being received by unintended and unknown recipients.
9) Email, text messages, and instant messages can be easier to falsify than handwritten or signed hard copies. It is not feasible to verify the true identity of the sender, or to ensure that only the recipient can read the message once it has been sent.

10) Videoconferencing using services such as Skype or FaceTime may be more open to interception than other forms of videoconferencing.

Encryption: As an added security measure, Mount Prospect Academy will encrypt client PHI that is sent by e-mail unless a parent or guardian* authorizes us to do otherwise. Encryption is a process of converting information or data into a code to prevent unauthorized access. If you receive information via encrypted e-mail, you will not be able to access the content of the e-mail until you have gone through a multi-step de-encryption process that includes entering a document-specific passcode that we will provide you. Encryption secures sensitive information while in transit, but we cannot be responsible for what happens to the information once you have received it.

** Note that state employees who are paid to serve as a client's guardian may not opt to receive PHI via unencrypted e-mail. This is because agencies that provide paid guardianship services also are covered by HIPAA and, as such, cannot legally waive the encryption requirement.*

Consent:

I acknowledge that I have read and fully understand the security limitations for use of the electronic communication services described above, I accept the risks associated with the following forms of communication, and I understand that I may revoke this consent at any time by providing written notice to Mount Prospect Academy.

I authorize the following methods of Electronic Communication:

□ Encrypted E-mail

□ Unencrypted E-mail (this option cannot be selected by state employees paid to serve as a client's guardian)

□ Text messaging

□ Instant Messaging

□ Cell Phone

□ Videoconferencing

Client Name:	**Date:**
Parent/Guardian Name (Print):	**Signature:**