The King's Daughters' School

412 West 9th Street
Columbia, TN 38401
Phone (931) 388-3810
Fax: (931) 388-0405
www.tkds.org
info@tkds.org

Dear Parent(s),

Thank you for your interest in The King's Daughters' School.

Enclosed, please find an Application for Admission to The King's Daughters' School. In order to evaluate the application for admission, the following must be submitted along with the completed application:

- Most recent Individual Education Plan (IEP)
- Current Psychological Examination depicting any diagnoses
- Any relevant medical information.

Remaining paperwork, along with **two-four weeks' worth of prescribed medications and refill prescriptions**, can be brought to KDS upon enrollment.

We look forward to working with you in the near future. If you have questions, please do not hesitate to contact the school. We'll gladly help you throughout the enrollment process.

Sincerely,

David H. Craig, Ph.D., Executive Director

Shauna Bryant, Assistant Executive Director

Please read the following pages carefully and sign accordingly. If you have any questions concerning these pages, please feel free to contact the school at 931-388-3810.

The King's Daughters' School

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Thank you for considering The King's Daughters' School. The following information will help us learn about your child. *PLEASE PRINT ALL ITEMS*.

Date of Application _____ Anticipated Date of Admission _____

Biographical Information

Child's Name _____ Date of birth _____ Age _____

Social Security Number _____ Place of birth _____ Gender: M ☐ F ☐

Race _____ Religious Preference _____ Languages Spoken _____

Father's Name _____ Home phone _____

Address _____ Cell Phone _____

City, State, Zip Code_____ Business Phone_____

Place of employment _____ Email address_____

Job Title or Position_____ Work email_____

Mother's Name _____ Home phone _____

Address _____ Cell Phone _____

City, State, Zip Code_____ Business Phone_____

Place of employment _____ Email address_____

Job Title or Position_____ Work email_____

Guardian's Name_____ Home phone_____

Address_____ Cell Phone_____

City, State, Zip Code_____ Email Address_____

Relationship to Applicant_____ Work Email_____

Place of Employment_____ Job Title or Position_____

Applicant's legal competency status: Parents are applicant's guardian ☐ Legally Competent ☐

Court appointed guardian ☐ Limited guardianship ☐

For students age 18 & over, guardianship/conservatorship papers are required. Please include a copy with this application.

Parent(s): Married_____ Divorced_____ Separated_____ Single_____ Remarried_____

If parents are divorced, who has legal custody of applicant?_____

Please list names and ages of siblings: Name_____ Age____ Name_____ Age____

Name_____ Age____ Name_____ Age____

Biographical Information Continued

Person(s) financially responsible for tuition and related costs _____

Billing Address: Source/Name _____

Address_____

Address_____

City/State/Zip_____

Telephone_____

Email Address_____

Emergency Contact Information

Please indicate a person other than parent or guardian as an emergency contact.

Name _____ Relationship _____

Address _____ Home phone _____

City, State, Zip Code_____ Business or cell phone _____

Educational Information

Please list all schools and facilities the child has attended, beginning with the most recent.

Name of school/facility_____ Dates attended_____

Location_____ Reason Left_____

Name of school/facility_____ Dates attended_____

Location_____ Reason Left_____

Medical Information

Medicaid/Major Medical Insurance Number _____

Medical Billing is to be forwarded to _____

Name of Policy Holder_____ DOB_____ SSN_____

Who will be handling the following medical appointments/needs: Routine medical/physicals: ☐ KDS ☐ Family

Psychiatric/Med mgmt: ☐ KDS ☐ Family Dental: ☐ KDS ☐ Family

Vision: ☐ KDS ☐ Family Other: _____ ☐ KDS ☐ Family

Does the applicant have any restrictions due to a health-related disorder? If yes, please explain.

_____

_____

Has the applicant ever had major surgery or illnesses? If yes, please explain.

_____

_____

Does the applicant have any particular dental problems? If yes, please explain.

_____

_____

Food Allergies:_____ Explain_____

Does the applicant receive social security benefits? Yes____ No____ *If yes, please provide a copy of the benefit letter for the applicant's file.*

Does the applicant receive supplemental security benefits? Yes___ No___ *If yes, please provide a copy of the benefit letter for the applicant's file.*

Medical Diagnosis (please specify):

Axis I:_____ Date of Last Psychological Exam_____

Axis II:_____ Full Scale IQ_____

Axis III:_____ By Whom:_____

Axis IV:_____ Age of Initial Diagnosis_____

Axis V: _____

Early Developmental History_____

_____

Does the applicant have:	Seizure disorder	☐ yes	☐ no	Type/Frequency_____
	Hearing impairment	☐ yes	☐ no	Aid required_____
	Speech impairment	☐ yes	☐ no	Therapy/Frequency_____
	Visual impairment	☐ yes	☐ no	Glasses_____

Other Types of Services/Therapies requested_____ Frequency_____

Diagnostic information

Please list previous assessments (attach reports and immunization record):

Physical/Health Exam

Date_____ by whom _____ address/phone _____

Dental Exam

Date_____ by whom _____ address/phone _____

Auditory Screening/Exam

Date_____ by whom _____ address/phone _____

Speech/Language Exam

Date_____ by whom _____ address/phone _____

Adaptive Behavior

Date_____ by whom _____ address/phone _____

Vocational Assessment

Date_____ by whom_____ address/phone_____

Please attach a current photo to the application.

Attach photo here

Height _____ Weight _____

Eye Color _____ Hair Color _____

Identifying marks_____

Current Medications

Please list medications currently prescribed*:

Medication and Dosage	Reason for prescription
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I give my permission/consent for the medications listed to be administered as prescribed.

Signature_____ Date_____

Please list any medication allergies_____

*TKDS is authorized to administer medication in accordance with physician's orders as prescribed. Written parental consent will be requested prior to any medication changes or adjustments. Over-the-counter medications are only administered according to the physician's Standing Orders; vitamins or any other over-the-counter medication that is regularly administered will require doctors' orders. All prescription medications must be provided through an authorized Medication-On-Time pharmacy and must be legal in the United States (See Bi-Lo Pharmacy Enrollment Form, last page). **Emergency medications (for acute illness or injury) are filled at Walgreens Pharmacy. To ensure that your insurance and billing are handled, we suggest setting up an Express Pay Account for your child at Walgreens. You may do this by going to www.walgreens.com: click on Pharmacy; under Convenience Services, Click on Express Pay.*

Personal comments

Please list any specific concerns or objectives you would like to see addressed.

_____

_____

_____

List any special interest or hobbies the applicant has_____

Describe the socialization, learning, daily living skills, self-help and habits of the applicant:

In the home_____

_____

In school_____

_____

In responsiblities_____

_____

Behavioral problems_____

_____

Speech and Communications_____

_____

Aggression or other potential risks to others_____

_____

Coping and Self-Management_____

_____

In Motor Skills_____

_____

How did you hear about King's Daughters' School? _____

The King's Daughters' School does not discriminate on the basis of race, color, religion, sex or national origin in our admissions, services or employment practices.

Consent for Assessments and Evaluations

Assessments and evaluations are a critical component in making determinations regarding a child's needs and eligibility for special education services. To successfully examine the performance of a child, The King's Daughters' School's educational, residential and other trained professionals review all records, observe the child, and make recommendations necessary to develop an Individual Program Plan and/or an Individual Education Plan that best suits the child's needs. The following assessments and/or evaluations have been selected to evaluate the needs of_____ (student's name):

- ☐ Sensory screening *(assessment of visual acuity, hearing acuity, and speech/language ability)*
- ☐ Educational evaluation *(assessment of current academic levels, including strengths and weaknesses)*
- ☐ Intellectual evaluation *(assessment of potential for learning)*
- ☐ Adaptive/developmental evaluation *(assessment of daily living skills, social and self help skills, and developmental age)*
- ☐ Speech/language evaluation *(assessment of articulation, fluency, voice and/or language)*
- ☐ Vocational Assessments *(assessments of pre-vocational and vocational performance abilities)*
- ☐ Classroom Observations *(assessments of performance/behaviors within a class room setting)*
- ☐ Additional Data as needed for re-evaluation purposes *(any assessment need for re-evaluations)*
- ☐ Functional Behavioral Assessment
- ☐ Adaptive Technology

Please refer to the parental rights prior to authorizing your permission and obtain a copy of *Rights of Children with Disabilities and Parent Responsibilities.* I have read and understand my rights in regard to the proposed assessments and evaluations and:

- ☐ I give my permission for evaluation ☐ I do not give my permission for evaluation
- ☐ I request a conference to discuss this evaluation before granting permission

I've reviewed and understand the attached brochure concerning the *Rights of Children with Disabilities and parent responsibilities.* ☐ Yes ☐ No

Your signature shall not be construed as consent for placement in any special education program. When the assessment(s) is completed, you will be invited to an IEP team meeting in order to discuss the findings, determine your child's eligibility for special education services and, if needed, plan an appropriate educational program for your child. For questions, please contact the Director of Educational Services.

Parent/Guardian Signature_____ Date_____

The King's Daughters' School

Authorization for medical examinations and treatment

Client:_____ DOB:_____

Parent/Guardian (please print):_____

Please initial to grant authorization:

_____I hereby authorize the performance of medical examinations/evaluations deemed necessary as recommended by a licensed healthcare provider for his/her health and well-being.

Do you authorize immunizations or other preventative measures deemed necessary by the healthcare provider?
Yes_____ No_____ Requests_____

_____I hereby authorize a representative of The King's Daughters' School to execute the medical consent forms necessary to obtain emergency treatment, if, in the opinion of the healthcare provider, such treatment, including hospitalization, surgical treatment and/or anesthesia, is warranted. I understand that, if an acute condition/illness requiring such treatment arises, I will be notified as soon as possible.

_____I hereby authorize a representative of The King's Daughters' School to obtain mental health services, treatment and evaluations as needed while he/she is enrolled. The representative has approval to fill, sign for, pick up, and request prescribed medications through an authorized pharmacy or healthcare provider.

_____ I understand I will be contacted regarding consent for the use of any recommended psychotropic medication(s) prescribed and that no psychotropic medication will be administered without my consent.

_____I hereby authorize the administration of prescribed medications for the well-being, prevention, routine treatment, and general care as recommended by a licensed healthcare provider.

_____I grant permission for the administration of over-the-counter (OTC) medications by KDS staff as recommended by the prescribing provider or KDS Standing Orders (Please reference the Student and Parent Handbook).

The King's Daughters' School

Authorization for Medical Examinations and Treatment, Continued

Client:_____ DOB:_____

Parent/Guardian (please print):_____

_____I understand due to licensing rules and regulations, that no medication (except as outlined in the KDS Standing Orders) may be administered without a prescription by a licensed healthcare provider. I also understand KDS staff are not able to administer samples, herbals, supplements, or other forms of home remedies or alternative medicine.

Communication/Release of Protected Health Information

KDS maintains confidentiality of individuals served and is HIPPA compliant with protected health care information. KDS requires your approval for release of such information between attending health care professionals, the individual served, and communications with you. Information released is only between treating healthcare providers, legal guardians, authorized KDS staff and governing entities.

_____I hereby consent to the writing and sharing of communications regarding medical and other care while enrolled with members of the treatment team (This includes mailings, emails, and telephone or other electronic conversations, etc.).

Please list other individuals authorized to receive this information: _____

_____I hereby consent for the writing and sharing of communications with attending healthcare providers regarding medical and other care while enrolled with members of the treatment team (This includes mailings, emails, and telephone or other electronic conversations, etc.).

Parent/Guardian Signature_____ Date_____

Authorization to ride in Automobile

I give permission for _____ (student's name) to ride as a passenger in an automobile, van, or other vehicle operated by a licensed King's Daughters' School employee or volunteer.

Parent/Guardian Signature_____ Date_____

Parental Rights

I understand I have a right to:

- Inspect and review all of my child's educational/residential records that are collected, used and maintained at The King's Daughters' School
- Request explanations and interpretations of the records
- Request that The King's Daughters' School provide copies of the records
- Have a representative inspect and review records
- Require The King's Daughters' School to keep a record of persons obtaining access to my child's records (except access by parents and authorized staff) including the name of the individual, the date access was given, and the purpose for which the individual is authorized to use the records
- Request that the school amend any information that I believe is inaccurate or misleading or violates the privacy rights of my child
- Confidentiality of any personally identifiable information
- Give consent when personally identifiable information is to be disclosed to anyone other than the staff or the school
- Be informed when personally identifiable information collected, maintained, or used is no longer needed to provide services to my child
- Obtain an independent evaluation of my child and information about where an independent evaluation may be obtained
- A written notice prior to the initiation of any change in the identification, evaluation or placement of my child, including a full explanation of all procedural safeguards available to me (the notice will include a description of action proposed and any records, reports, or procedures used as a basis for the proposed action)
- Written consent prior to the conducting of any preplacement evaluations
- Request that The King's Daughters' School assist me in obtaining an alternate placement to meet the needs of my child
- Request a change in my child's Individual Program Plan (IPP)

Parent/Guardian_____ Date_____

Personal Property Liability

I understand that The King's Daughters' School cannot assume any responsibility for loss or damage due to personal property identified with _____ (student's name) on or off The King's Daughters' School grounds. It is suggested that such personal property be covered under the family's homeowner's policy and/or any personal property floater coverage the family maintains.

Parent/Guardian_____ Date_____

Media Release consent

I hereby give my permission for _____ (student's name) to

yes ☐	no ☐	be mentioned by name to exemplify The King's Daughters' School's programs and/or activities (newsletter, website, newspaper, articles, etc.)
yes ☐	no ☐	appear in photographs taken to exemplify The King's Daughters' School's programs and/or activities (newsletter, website, newspaper, articles, etc.)
yes ☐	no ☐	appear in photographs on the KDS Facebook page (KDS admin control content)
yes ☐	no ☐	make public appearances (in person or on the radio and/or television)

Parent/Guardian Signature_____ Date_____

Visitation Consent

Please list any visitation sources, or restrictions regarding phone contact, letters and email or in person visitation. Identify any parties granted permission to visit with your child. Please note the relationship of any parties to the child.

Restrictions_____

Visitation Approval_____

Telephone/Email Contact_____

Acceptance of Ne w Student & Parent Handbook

I/We have read the New Student & Parent Handbook for The King's Daughters' School. I/We understand that this handbook is not comprehensive. I/We and my child accept the policies as outlined in the book, including the policies on behavior modification techniques and physical holding/restraint.

Parent/Guardian_____ Date_____

Phone 877-684-9987

Fax 877-455-5550

PATIENT PAYMENT GUARANTEE

RESIDENT NAME: **FAILITY**

Middle Tennessee Pharmacy Services (referred to herein as "Pharmacy") agrees to provide to the resident all pharmaceutical services as needed.

Pharmacy will maintain a current drug profile on the resident, and provide delivery service and 24-hour emergency service.

In consideration for the agreement of the Pharmacy to provide medications and supplies to the above patient on an open account, (I,/We) do hereby unconditionally guarantee payment to the Pharmacy for all medications and supplies purchased from the same and supplied to the above named patient while a resident at the above name Facility.

(I, We) understand that all bills are due upon receipt. If not paid within 30 days of billing date, a 1.5% finance charge (18% per annum) will be assessed. (I, We) also agree to pay any legal fees and court costs incurred in the collection of this account.

I authorize any holder of medical and /or insurance information about me to disclose such information to the Pharmacy. I further authorize the Pharmacy to disclose any medical and / or insurance information concerning me in its possession: (1) to other professional personnel involved in my care such as my physician, a registered nurse, a pharmacist or other such professional personnel; and (2) to any insurer or other third-party payer who may be responsible for payment or Pharmacy services.

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y Services a

Insured's Name:

Insurance Company Name: Social Security#

ID# Group #

Insurance Company Phone# Date of Birth

Insurance Company Address

****RESPONSIBLE PARTY SIGNATURE REQUIRED****

Responsible Party (print): Relationship to Resident:

Responsible Party (sign):

Address:

City: State: Zip:

Telephone Number: ( ) Alternate Telephone Number( )

Witness: Date:

MTPS LLC

Credit Card Consent

Resident Name: _____

Last First Middle Initial

Facility Name: _____ Customer Number: _____

I authorize **Middle Tennessee Pharmacy Services** to charge my credit card for the balance of charges not paid by my insurance company.

☐ This service only, not to exceed $_____.

Cardholder's Name: _____

Type of card (circle) Visa/ Mastercard / American Express / Discover

Card Number:

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Expiration Date:

☐ ☐ ☐ ☐

Cardholder's Billing Address:

_____

CVN*:

☐ ☐ ☐

*Card Verification Number. Found on back of card, need only last 3 digits.

I understand that this form is valid for the time period selected above unless I cancel the authorization through written notice to Guardian Pharmacy.

Cardholder Signature:_____ Date:_____

Note that balances will be charged after statements have been received by customers to allow for the communication of any issues/concerns. Guardian will automatically process payments in accordance with instructions outlined above before the next statement is generated unless otherwise instructed.

MIDDLE TENNESSEE PHARMACY SERVICES, LLC
661 EAST LANE ST.
SHELBYVIILE, TN 37160
877--684-9987
middtnps@yahoo.com

Please accept this as your authority to pay against my account each month a draft drawn by Middle Tennessee Pharmacy Services, LLC for our prescription drug bill. The amount of this draft will vary according to the amount of prescriptions. I understand that my account will be drafted on the due date as stated on the bill. This authority is to remain in full force and effect until Middle Tennessee Pharmacy Services, LLC has received written notice from me of its termination in such time and in such manner as to afford Middle Tennessee Pharmacy Services, LLC a reasonable opportunity to act on it. This information will be used by Middle Tennessee Pharmacy Services, LLC only for the processing of monthly statements and will be kept strictly confidential.

Automatic Bank Draft Authorization Form

Name:
Address:
City:
State:
Zip:
Telephone:
Patient Name:
Bank Name:
City:
State:
Zip:
ABA Transit/Routing Number:
Bank Account Number:
Account Type (Checking or Savings):

Attach a voided check to this form.
Mail this form **and a voided check** to: Middle Tennessee Pharmacy Services, LLC
661 East Lane St.
Shelbyville, TN 37160

Printed Name:_____

Signature:

_____Date:_____