



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

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

Parent(s): Married _____ Divorced _____ Separated _____ Single _____ Remarried _____

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

BIOGRAPHICAL INFORMATION CONTINUED

Please list names and ages of siblings: Name _____ Age _____ Name _____ Age _____
Name _____ Age _____ Name _____ Age _____

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 _____

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 _____

MEDICAL INFORMATION CONTINUED

Name of Policy Holder _____ DOB _____ SSN _____

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	<input type="checkbox"/> yes	<input type="checkbox"/> no	Type/Frequency _____
	Hearing impairment	<input type="checkbox"/> yes	<input type="checkbox"/> no	Aid required _____
	Speech impairment	<input type="checkbox"/> yes	<input type="checkbox"/> no	Therapy/Frequency _____
	Visual impairment	<input type="checkbox"/> yes	<input type="checkbox"/> 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 _____

Achievement/Academics

Date _____ by whom _____ address/phone _____

Vocational Assessment

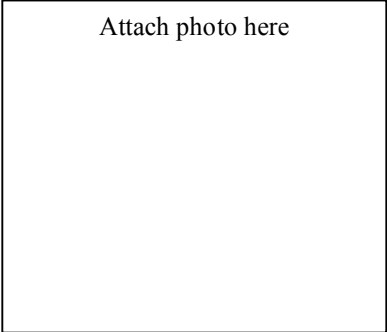
Date _____ by whom _____ address/phone _____

Please attach a current photo to the application.

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. All 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 responsibilities _____

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 _____

MEDICAL EXAMINATIONS AND TREATMENT

I hereby authorize the performance of medical examinations/evaluations deemed necessary for the evaluation and treatment for _____ (student's name). I understand I will be advised in advance of such examinations/evaluations unless the attending physician recommends the immediate performance of a particular procedure.

Parent/Guardian Signature _____ Date _____

I hereby authorize any representative of The King's Daughters' School to execute the medical consent forms necessary to obtain emergency treatment for _____ (student's name) if, in the opinion of the attending physician, 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 also understand that the services of a qualified specialist will be used as a situation requires and allows.

Parent/Guardian Signature _____ Date _____

I hereby authorize any representative of The King's Daughters' School to obtain mental health services, treatment and evaluations as needed for _____ (student's name).. The representative has approval to sign for medications prescribed in order to fill prescriptions for my child while he/she is enrolled. I understand I will give consent for the use of any medications prior to the initial administration and that I will be notified of any changes.

Parent/Guardian Signature _____ Date _____

Do you authorize immunizations or other preventative measures deemed necessary by the attending physician?

Yes _____ No _____ Requests _____

Do you give consent to our writing and sharing of communications* with you regarding the applicant's medical and other care while enrolled? (This includes, mailings, emails, and telephone conversations, etc.) Yes ___ No ___

**Note: The King's Daughters' School does not release any information regarding your child to outside sources without your approval. A request to do so must be in writing. The School does, however, provide information to attending physicians, funding sources and other entities according to state and federal rules and regulations as required or requested for the necessary treatment, service delivery and the agency's licensure compliance, etc.*

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 _____ 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)

Hometown Media Release (Optional):

Name of Hometown Newspaper _____ Address _____

Parent/Guardian _____ 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 NEW 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 _____

MEDICATION ORDERING

KDS will transfer ALL medications (prescription & over-the-counter) to Bi-Lo Pharmacy, who provides Medication-On-Time packaging for KDS. If you have questions regarding your insurance coverage through Bi-Lo, please contact Bi-Lo at 877-668-2456. Bi-Lo will bill you directly for any fees associated with your student's medication. This form must be filled out completely and submitted with the application packet. KDS will submit this enrollment form to Bi-Lo once your student enrolls. This is a separate agreement between Bi-Lo and the financially responsible party, not KDS.

Bi-Lo Pharmacy Enrollment Form

Bi-Lo Pharmacy
9213 Lee Hwy, Chattanooga, TN 37422
Phone: 877-668-2456/ Fax: 877-279-2770

RESIDENT INFORMATION

FACILITY NAME: The King's Daughters' School

RESIDENT NAME: _____

ADMISSION DATE: _____ ROOM NUMBER: Main Campus/Center for Autism

DATE OF BIRTH: _____ SEX: _____

SOCIAL SECURITY #: _____

MEDICARE ID #: _____

(SUBMIT COPY OF FRONT & BACK OF MEDICARE CARD)

MEDICINE ALLERGIES: _____

PRIMARY DOCTORS: _____

DOES RESIDENT HAVE PRESCRIPTION INSURANCE: _____

(IF SO, WE NEED A COPY OF ALL INSURANCE CARDS)

FINANCIALLY RESPONSIBLE PARTY INFORMATION

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: (HOME): _____ (WORK): _____

I, THE UNDERSIGNED, CERTIFY THAT I ACCEPT RESPONSIBILITY FOR PAYMENT OF THE PHARMACY ACCOUNT OF THE PATIENT NAMED ABOVE. IF THIS OBLIGATION SHOULD GO INTO DEFAULT, I UNDERSTAND I WILL BE RESPONSIBLE FOR ANY FEES INCURRED IN THE COLLECTION PROCESS.

SIGNATURE: _____ DATE: _____



THE KING'S DAUGHTERS' SCHOOL

412 W. 9TH STREET

COLUMBIA, TN 38401

(931) 388-3810 / (931) 388-0405 FAX

Dear Parent(s),

Enclosed, please find a copy of the 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:

- A copy of the applicant's birth certificate
- A copy of the Social Security Card
- A copy of any insurance cards
- An immunization record
- Most recent physical examination, dental screening and visual exam
- Most recent Individual Education Plan (IEP)
- Current Psychological Examination depicting any diagnoses

In addition, at the time of enrollment, **a month's worth of prescribed medications and refill prescription** will need to be obtained for 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,

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.