Valley West School

269 Moore St.
Chicopee, MA 01013
(413) 592-6069

ADMISSION AGREEMENT

I have read, understand, and agree to all of the policies and procedures contained in the ***Valley West School Parent/Student Handbook*** as they pertain to my child _____.

I understand and agree that my child is responsible for following the rules, regulations, and policies of Valley West School.

The ***Valley West School Parent/Student Handbook*** can be found on our website www.valleywestschool.com under the Parents tab.

_____
Signature of Parent/Guardian Date

_____
Signature of Student Date

I understand and agree to the hazing policy contained within the handbook.

_____
Signature of Parent/Guardian Date

_____
Signature of Student Date

Valley West School

269 Moore Street, Chicopee, MA 01013 www.valleywestschool.com
phone 413.592.6069 fax 413.598.8430

2022-2023 EMERGENCY FORM

Please fill in the following information and return it to school prior to the first day of school year..
This information is important in case of illness, or emergency, during school or an emergency dismissal from school.
NO STUDENT WILL BE ALLOWED IN SCHOOL WITHOUT A SIGNED EMERGENCY FORM.

Please refer to https://www.doe.mass.edu/covid19/ for current COVID19 screening guidelines.

Student's name: _____ Birthdate: _____ Grade: ____
First Middle Last

Address: _____ City: _____ Zip code: _____

Parent/Guardian 1: _____ Relation: _____

Home #: _____ Cell #: _____ Work #: _____

(Please note: Parent/Guardian 1 will be contacted regarding student absences)

Parent/Guardian 2: _____ Relation: _____

Home #: _____ Cell #: _____ Work #: _____

Custody: _____ Living Arrangement: _____

Email of Parent/Guardian 1: _____ Email of Parent/Guardian 2: _____

Student's physician: _____ Phone #: _____ Date last visit: _____

Student's dentist: _____ Phone #: _____ Date last visit: _____

Student's therapist: _____ Phone #: _____ Date last visit: _____

Student's psychiatrist: _____ Phone #: _____ Date last visit: _____

Please list all medications that your child takes. **Please notify health office of any medication changes!**

_____

_____

Please circle the following that affect your child: Heart Condition Diabetes Asthma Seizure Disorder ADD ADHD
Migraines Depression Allergies Positive COVID19 test date_____ Other_____
Allergies: Y or N *To what? (Food, insects, medication, environment)* Specify_____
Procedure_____ Epi-pen _____ Inhaler_____

I agree to have my son/daughter brought to the nearest hospital, E.R. or crisis center for evaluation and treatment, in the event of a medical/psychiatric emergency, which cannot be handled in the school setting. I give permission for the exchange of information with any of my child's service providers for the purpose of referral, diagnosis and treatment. I give consent to Valley West School to request a copy of my child's physical and immunization record from the sending school or physician's office. I give permission to the school nurse to share this information with the appropriate school personnel.

Signature of Parent/Guardian_____Date_____ **OVER**

2022-2023
Parent/Guardian Authorization for Over the Counter Medication

When students have a minor injury or health issue during school hours they may be helped by over the counter medications. Valley West's School Physician has approved the administration of the medications listed below provided a nurse has assessed the student's condition, current medication profile, allergies, and need for medication. Please complete and return this permission form to the Health Office **crossing out any individual medication or topical preparation that you do not give permission to be used.** Please update the Health Office promptly of any changes in medications, allergies, or health conditions. No medications will be given unless current signed consent from parent/guardian is on file at school. Telephone permission cannot substitute for a signed, dated consent.

Student's Name (please print): _____ Date of Birth: _____

Allergies to food, medications, insect bites/stings, latex, or other? _____

Has your child ever been prescribed an Epi-Pen for an allergy? _____

List all medications your child takes including those taken outside of school hours: _____

_____

Circle any of the following that affect your child: Heart Condition Diabetes Asthma Seizure Disorder ADD ADHD Migraines Depression Positive COVID19 test date___ Other _____

Acetaminophen 325mg – Over 12 years old- Two tabs every 4-6 hrs, NTE 12 tabs/24 hrs. Under 12 years old -Use children's strength product. Follow package directions for age and weight.	**Antacid liquid** (Aluminum hydroxide 400mg/simethicone 40mg Magnesium hydroxide 400mg per 5ml) – Over 12 years old- 10 to 20ml between meals. NTE 120 ml/24hrs. Under 12 years old - only as directed by child's MD.
Ibuprofen 200 mg – Over 12 years old-One to two tabs every 4-6hrs. NTE 6 tabs/24 hrs. Under 12 years old- Use children's strength product. Follow directions for age/weight.	**Antacid tablets** (Calcium Carbonate 1000 mg/tablet). Over 12 years old- Chew 2-3 tablets as heartburn symptoms occur. NTE 7 tabs/24 hours. Under 12 years old -only as directed by child's MD.
Diphenhydramine 25 mg – for localized allergic reaction. Over 12 years old- 1 to 2 tabs. For 6-12 yrs old - one tab.	**Cough drops** – menthol/eucalyptus (one drop per hour) or menthol/Benzocaine (one drop every 2 hours).
Diphenhydramine Cream – for localized itching	**Lip Balm** – for chapped lips
Hydrogen Peroxide – superficial skin/wound care	**Calamine Lotion** – for mild, localized insect bites & rashes
Isopropyl Alcohol 70% – superficial skin/wound care	**Oral-jel** (IC 10% Benzocaine oral anesthetic) – for tooth/gum pain
Triple Antibiotic Ointment – (bacitracin zinc, neomycin sulfate, polymixin B) signs of superficial wound infection	**Sun Screen** – as requested by student prior to going outside.
Hydrocortisone cream 1% – minor skin irritations.	**Insect Repellent** – as requested by student
Alcohol based Hand Sanitizer-(at least 60% Ethyl Alcohol)- for cleaning hands as alternative when handwashing with soap and water is not available. Dispense enough product onto your palm to thoroughly cover your hands. Rub hands together briskly until dry. Children under 6 years old should be supervised during use and application of hand sanitizer.	

Emergency Treatment

Poisoning- Treatment as directed by Poison Control 1-800-222-1222
Allergic Reaction - Diphenhydramine HCl 25-50mg
***Anaphylactic Reaction-** Epi-Pen Jr 0.15mg for child under 60 lbs. Epi-Pen 0.3mg for child/adult over 60 lbs.
***Opioid Overdose** – Naloxone intranasal 2 mg (1mg/1ml) initial dose for individuals ≥ 44lbs or ≥ 5 years of age.
*When Epi-Pen or Naloxone are administered 911 must be called to transport patient via ambulance to Emergency Room

I give my permission for the school nurse, or their designee, to administer the medications approved by the school physician. I have crossed out any product that I do not want my child to receive. I give my permission for my son/daughter to be transported via ambulance to the nearest Emergency Room in the event of a medical emergency that cannot be handled in the school setting.

School Physician
Dr. Kristen Deschene

MD 8/20/22
Physician Signature & Date

Signature of parent/guardian: _____ Date: _____

Relationship to student: _____

Signature of student (if 18 years): _____

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Permission to Pick-Up

In an attempt to follow appropriate safety protocol please provide the names of anyone who is allowed to pick up the following student:

Student Name: _____

Parent/Guardian: _____

PERSON ALLOWED TO PICK UP

NAME/PHONE NUMBER	RELATION

Signature of Parent/Guardian:_____ Date: _____

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Release of Information Form

I, hereby give permission to the following agencies and/or providers to communicate, furnish, or receive all information regarding my child _____ as requested or provided by Valley West School:
(NAME and DATE OF BIRTH)

AGENCY/PROVIDER/OTHER	PHONE NUMBER

_____ _____

Parent/Guardian Signature **Date**

Except for the provisions in Section 7.3, no information in a student's record shall be disseminated to a third party without the specific informed written consent of the eligible student and his/her parent, or either one, as applicable, under the rules in Section 1 of these regulations. When granting consent, the eligible student and his/her parent, or either one, as applicable, shall have the right to designate which portions of the student record shall be disseminated to any third party.

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_____ I hereby **give** permission for my child to be photographed while at Valley West School. I understand that these pictures may be displayed on our school website and included in the Valley West School yearbook.

_____ I **do not give** permission for my child to be photographed while at Valley West School.

CHILD'S NAME: _____

DATE: _____

PARENT/GUARDIAN
SIGNATURE:_____