PARENT/GUARDIAN
INFORMATION/CONSENT PACKET

MAIL OR FAX TO:

Lakeside Academy
Attn: Admissions
3921 Oakland Dr.
Kalamazoo, MI 49008
Phone: 269-381-4760
Fax: 269-381-5332

christopher.behnke@sequelyouthservices.com

Please have paperwork completed prior to admission

Intake Checklist

Name of Student: ____________________ Gender: __________ Program: __________

Date of Birth: ______ / ______ / ______ Date of Admission: ______ / ______ / ______

Referring Agency: ____________________ Referring Worker: ____________________

Responsible Agency: Worker Telephone #: ____________________

Primary: ____________________ Worker E-mail: ____________________

Billing Address: ____

Billing Contact: ____________________ E-mail: ____________________

Secondary: ____________________ Treatment Coordinator: ____________________

Assigned Dorm: ____________________ Rate per day: ____________________

Referral Packet Requirements

To be completed by Lakeside Academy Staff

- [ ] Intake interview and risk assessment documentation
- [ ] YLS Score: _____ ☐ Low ☐ Moderate ☐ High — Safety Interview Score: _____ ☐ Low ☐ Moderate ☐ High — Self Report Score: _____ ☐ Low ☐ Moderate ☐ High
- [ ] MAYSI-2 Total Score: _____ AD _____ DA _____ SI _____ TE _____ AI _____ SC _____ TD _____

L=Low C=Caution W=Warning

- [ ] Case Plans Due: Initial: _____ / _____ / _____ Updated: _____ / _____ / _____
- [ ] Information from Referring Worker Sheet
- [ ] Initial Clothing Inventory
- [ ] Print Face Sheet & Student Statement Requirements

Following Items Required from Referring Worker

- [ ] Copy of court order documenting offenses for which the adjudication/placement has occurred.
- [ ] Next court hearing: _____ / _____ / _____ ___ : ___ am / pm @ ____________
- [ ] Copy of Birth Certificate
- [ ] Copy of Social Security card # ____________________
- [ ] Copy of Immunization records
- [ ] Copy of Medicaid/Insurance card # ____________________
- [ ] Program consent forms signed by parent/guardian and student
- [ ] Approved contact list completed
- [ ] Court reports, i.e. probation officer reports, police reports, etc.
- [ ] Reports from previous placements
- [ ] Mental health assessments/reports
- [ ] GED (16 or older) ☐ High School Diploma

TO PARENTS AND GUARDIANS:

COMPREHENSIVE MENTAL, PHYSICAL, AND EMOTIONAL HEALTH CARE REQUIRES A THOROUGH REVIEW OF THE CHILD'S HEALTH BACKGROUND. PLEASE COMPLETE THIS NOW AS MUCH AS POSSIBLE. THE REGISTERED NURSE WILL REVIEW IT WITH YOU LATER DURING THE ADMISSION AND CLARIFY ANY QUESTIONS. PLEASE INFORM THE NURSE OF ANY OTHER SIGNIFICANT HEALTH PROBLEMS.

THANK YOU FOR YOUR ASSISTANCE.

STUDENT NAME: ______________________________ **ALLERGIES:** FOOD ______________________________

DRUGS ______________________________

OTHER ______________________________

YES	NO	**EYE/EAR/NOSE/THROAT**
		EYE INJURIES ______________________________
		FREQUENT EYE INFECTIONS ______________________________
		EAR INFECTIONS ______________ TUBES: R L WHEN PLACED ________ REMOVED? Y N WHEN ______
		EAR DISCHARGE ______________ RINGING IN EARS ______________
		NASAL FRACTURE ______________ DEVIATED SEPTUM ______________
		CHRONIC NOSEBLEEDS ______________________________
		SINUS TROUBLE ______________________________
		FREQUENT COLDS ______________________________
		FREQUENT TONSILLITIS/STREP THROAT ______________________________
		SWOLLEN GLANDS ______________________________
		MOUTH/TONGUE: BLEEDING/SORES ______________________________
		OTHER: ______________________________

		RESPIRATORY
		ASTHMA/WHEEZING/SHORTNESS OF BREATH ______________________________ AGE OF ONSET ______________ CURRENT TREATMENT ______________ ______________________________
		TUBERCULOSIS ______________ VALLEY FEVER ______________
		WHOOPING COUGH ______________________________
		PNEUMONIA ______________ BRONCHITIS ______________
		CHRONIC COUGH ______________ COUGHING BLOOD ______________
		OTHER: ______________________________

		CARDIOVASCULAR
		EKG (WHEN/WHERE) ______________________________
		IRREGULAR HEART BEAT ______________________________
		CHEST PAIN ______________________________
		CONGENITAL HEART DISEASE ______________________________
		RHEUMATIC FEVER ______________________________
		OTHER: ______________________________
		EXERCISE INTOLERANCE ______________________________

		HEMATOLOGY
		BLOOD TRANSFUSIONS ______________________________
		INTRAVENOUS DRUG USE ______________________________
		DRUG REACTIONS ______________________________
		BLEEDING DISORDERS ______________________________
		ANEMIA ______________________________
		SICKLE CELL TRAIT/ANEMIA ______________________________

YES NO **GASTROINTESTINAL**

- CHRONIC INDIGESTION ______
- CHRONIC NAUSEA VOMITING ______
- ANOREXIA/BULEMIA ______
- ULCERS ______
- ABDOMINAL PAIN ______
- HEPATITIS ______
- GALL BLADDER ______ BLOODY STOOLS ______
- CHRONIC CONSTIPATION/DIARRHEA ______
- LAXATIVE USE ______
- SOILING/ENCOPRESIS ______

ENDOCRINE

- THYROID DISORDER ______
- DIABETES ______
- OTHER ______

NEUROLOGIC

- EEG (WHEN/WHERE) ______ X-RAY (WHEN/WHERE) ______
- MRI (WHEN/WHERE) ______ CAT SCAN (WHEN/WHERE) ______
- SEIZURES ______
- HEAD TRAUMA/LOSS OF CONSCIOUSNESS ______
- DIZZINESS/FAINTING ______
- WEAKNESS/PARALYSIS ______
- BRAIN TUMOR ______
- MIGRAINE/CHRONIC HEADACHES (FREQUENCY, PREVIOUS EVALUATION AND TREATMENT) ______

GENITAL/URINARY

- ENURESIS/BED WETTING ______
- INCONTINENCE ______
- PAINFUL/DIFFICULT/FREQUENT URINATION ______
- KIDNEY DISEASE/BLOOD IN URINE ______
- FREQUENT URINARY TRACT INFECTIONS ______
- DISCHARGE ______
- HISTORY OF SEXUAL ABUSE ______
- SEXUALLY ACTIVE ______ # OF PARTNERS ______
- SEXUALLY TRANSMITTED DISEASES ______

MUSCULO-SKELETAL

- SCOLIOSIS ______
- FRACTURE/BROKEN BONES ______
- BACK PROBLEM ______
- JOINT PROBLEMS ______
- OTHER ______

DERMATOLOGY

- RASH ______
- ACNE/TREATMENT ______
- PSORIASIS ______

CHILDHOOD/INFECTIOUS DISEASE

- CHICKEN POX (AGE) ______
- MEASLES (AGE) ______
- MUMPS (AGE) ______
- RUBELLA (AGE) ______
- TUBERCULOSIS (AGE) ______
- OTHER: ______

OTHER HEALTH PROBLEMS - PAST OR PRESENT

____

____

____

____

PREVIOUS
HOSPITALIZATIONS______________________________

____

____

SURGERIES______________________________________

____

MEDICAL HISTORY/FILE LOCATION

DOCTOR______________________ TOWN______________________

HOSPITAL______________________ TOWN______________________

PSYCHIATRIC/PSYCHOLOGY______________ TOWN______________________

** REMINDER: A COPY OF THE CHILD'S IMMUNIZATION RECORD MUST BE
MAILED TO LAKESIDE ACADEMY IF NOT BROUGHT IN AT ADMISSION.***
YOU MAY OBTAIN THIS FROM YOUR CHILD'S SCHOOL OR
PEDIATRICIAN IF YOU CANNOT FIND THIS RECORD AT HOME.

INFORMATION PROVIDED BY:

NAME	RELATIONSHIP	DATE

REVIEWED BY NURSE ______________________ DATE/TIME______________

____

LAKESIDE ACADEMY MEDICAL/DENTAL INSURANCE INFORMATION

Student Information: Current status

Name:	SS#:	DOB:
Address:	City:	State/Zip:
Home Phone:	Program:	ID#:

Notify in case of emergency

Name:	Address:	Phone#:

Guarantor Information (Parent/Guardian responsible for bills)

Name:	SS#:	Relationship to student:
Address:	City:	State/Zip:
Employer:	Home Phone:	Work Phone:
Employer Address:	City:	State/Zip:

Is the student covered by any private insurance? yes no HMO_____ PPO_______

____

Name of Current Physician & Phone #

Insurance Information (Primary) Check services provided: __medical___dental___vision__prescription__mental health

Name of Insurance Company:	
Person who carries policy (subscriber):	
Subscriber's DOB: SS#:	
Relationship to student:	Policy #:
Address of Insurance Company:	Phone #:
City/State:	Zip:

Secondary Insurance Company

Company:	Subscriber:	Policy #:
Address:	City:	State/Zip:

Dental:

Company:	Subscriber:	Policy #:
Address:	City:	State/Zip:

DOES YOUR INSURANCE REQUIRE PREAPPROVAL BEFORE HOSPITALIZATION OR TREATMENT? PHONE NUMBER FOR APPROVAL PROCESS:_____________________________

CONSENT TO MEDICAL/DENTAL CARE: I voluntarily consent to medical/dental care which is determined to be necessary or beneficial in the professional judgment of my physician. This includes routine diagnostic procedures and medical/dental treatment by authorized agents and employees of the facility, and by their staff. I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE TO ME AS TO THE EFFECT OF SUCH EXAMINATIONS OR TREATMENT OF MY CONDITION.

FINANCIAL AGREEMENT: I, the undersigned, as the guarantor, agree that in consideration for the services rendered do hereby assign payment directly to the medical/dental/optical/pharmacy/laboratory providers, see attached sheet, otherwise payable to me, but not to exceed regular and customary charges for said services. I hereby agree to pay any and all charges that exceed or that are not covered by my insurance coverage.

UNIFORM ASSIGNMENT AND RELEASE OF INFORMATION AUTHORIZATION: I hereby authorize and direct the ___________________________________, having treated me, to release information to government agencies, insurance carriers who are financially liable for medical/dental payments for services rendered, and to permit representatives thereof to examine and make copies of all records relating to such care and treatment. I also authorize the release of my records related to the care of the student to Lakeside Academy to ensure appropriate care is provided.

Date	Parent/Guardian Signature	Relationship

SCHOOL DISTRICT WORKSHEET

STUDENT NAME____

DOB_____________________ SS#_____________________

SCHOOL INFORMATION

Current Grade__________

Name and address of the school district where student resides:

____

____

____

Telephone _____________________________

CONTACT PERSONS

Director of Special Education_____________________________

Principal_____________________________

School Counselor_____________________________

Teacher_____________________________

SCHOOL HISTORY

Was the student ever in Special Education?_____________________________

If so, when?_____________________________

If so, what?_____________________________

Learning Problems? Attention____ Reading____ Spelling____ Speech____ Behavior____

Does the school district know of placement?_____________________________

Parent/Guardian Signature_____________________________ Date________

LAKESIDE ACADEMY

APPROVED MAIL/TELEPHONE/VISIT LIST

PLACING WORKER AND/OR PARENTS: Please complete the following information for our records:

I hereby acknowledge that I have read, understand and agree to the conditions contained in the Lakeside Academy Mail/Telephone/Visitation Policy. I understand that resident and parent visitation cannot be disallowed unless there is court documentation that indicates visitation is detrimental to the resident. R 400.4142.

______________________________ ______________________________

Parent/Guardian **Date** **Placing Worker** **Date**

____

Student **Date**

Please list all approved contacts including parents/guardians

---

The following persons are APPROVED for contact with:

Name:______________________ **Telephone#:**______________
Address:______________________
Relationship:______________________

APPROVED FOR:
telephone contact mail contact on-campus visits off-campus visits

REASON:______________________

Name:______________________ **Telephone#:**______________
Address:______________________
Relationship:______________________

APPROVED FOR:
telephone contact mail contact on-campus visits off-campus visits

REASON:______________________

All parties have read and agree with the above listed names

If additional space is necessary please use the back of this form

LAKESIDE ACADEMY
PERSONAL ITEMS LIST
CLOTHING NEEDS

MALES (Minimums)	Quantity
T-SHIRTS	10
POLO SHIRTS	2
DRESS SHIRT	1
SWEATSHIRTS	2
SWEATPANTS	1
JEANS	3
SLACKS or KHAKI'S	2
ATHLETIC SHORTS	2
SOCKS	10 pair
UNDERWEAR	10
BELT	1
TENNIS SHOES	1
COAT	1 (seasonal)
JACKET	1 (seasonal)
STOCKING CAP	1 (seasonal)
GLOVES	1 pair (seasonal)
BOOTS	1 pair (seasonal)

FEMALES (Minimums)	Quantity
T-SHIRTS	10
POLO SHIRTS	2
DRESS SHIRT	1
SWEATSHIRTS	2
SWEATPANTS	1
JEANS	3
SLACKS or KHAKI'S	2
ATHLETIC SHORTS	2
SOCKS	10 pair
UNDERWEAR / BRAS	10 / 5
BELT	1
TENNIS SHOES	1
COAT	1 (seasonal)
JACKET	1 (seasonal)
STOCKING CAP	1 (seasonal)
GLOVES	1 pair (seasonal)
BOOTS	1 pair (seasonal)

All clothing should be brought with the student upon admission or be with the student when our staff pick them up.

Lakeside Academy staff will send home any clothing deemed inappropriate or not on the needs list.

DO NOT SEND EXPENSIVE JEANS, COATS, JEWERLY (WATCHES), VIDEO GAMES, ETC… IF DAMAGED OR LOST, THEY WILL NOT BE REPLACED.

Lakeside Academy
3921 Oakland Drive
Kalamazoo, MI 49008

Lakeside Academy is a residential placement managed and operated by Sequel Youth and Family Services and located at the aforementioned address. The following information and consents are required in order to provide quality services and to meet federal, state and accreditation standards. .

General Information:
Student's Legal Name: ______________________________
Date of Birth:______________(Please attach a certified copy of the Birth Certificate)
Social Security Number:__________________ (Please attach a copy of the card)
State: ____________________ County: ________________________

Medical Information:
Medical Conditions, medications or allergies that ___________________ may have:

____

____

____

____

Medical Insurance/Medicaid Information (check those that apply):

☐ **Private Insurance Plan**
Parent(s) or guardian if you or your child possesses a private health plan, please completes the Medical Care Information below. ***Also, please provide a copy of the front and back of the insurance plan card.***

Policy Holder's Name as it appears on the card: ____________________________

Policy Holder's Date of Birth: __________Relationship to Student: ______________

Policy Holder's ID Number: ______________Group Number: __________________

Employer's Name and Address:______________________________________

____

Name and Address of Insurance Company:____________________________

____

This Policy Covers (check those that apply):

☐ Major Medical ☐ Eye Care ☐ Dental ☐ Prescriptions

☐ **Medicaid (Title XIX)** **Title XIX Number:** ________________

Parent(s) or guardian Please send a copy of the most recent Title XIX card you have received. If you receive cards in the future, please forward them to us to ensure the utmost quality of care for your child/ward.

I state that the information given is correct to the best of my knowledge. I also give authorization for payment of hospital benefits directly to the hospital and medical benefits directly to the physician(s). I agree to pay any and all hospital, medical, pharmacy, co-pays and deductibles that exceed or that are not covered by my medical insurance, Title XIX or State Medical Coverage that are a result of care for my child/ward.

Legal Parent/ Guardian Sign here: ________________________________

☐ **Consent to Treatment**

I apply and consent to such psychiatric, psychological, mental health, medical, medical screening and follow-up, diagnostic, immunizations, substance abuse, emergency and routine hospital treatment, as professionals contracting with Lakeside Academy may prescribe. I am aware the practice of medicine and mental health is not an exact science and I acknowledge that no guarantees have been made to me regarding the results of treatment or examinations.

Legal Parent/ Guardian Sign here: ________________________________

Student Sign here: ____

☐ **Reciprocal Authority for Release and/or Exchange of Information**

I authorize the release and/or exchange of all necessary information (written or verbal) to and among the service providers listed below, as well as, other providers contracting services for the purpose of providing educational, residential and/or temporary shelter care to my child/ward. All information shared/requested shall be on a "need to know" basis and comply with the Privacy Practices (HIPAA) of Lakeside Academy. Providers include: Lakeside Academy, Department of Human Services (to include any past child abuse reports), Juvenile Court Services or other placing agency(s), Youth Attorney, Guardian ad Litem and the child's resident school.

Legal Parent/Guardian Sign here: ________________________________

Student Sign here: ____

☐ **Consent to Travel and Participate**

Note: This consent allows full participation in athletic, educational and recreational activities while a student at Lakeside Academy. These activities may be on or off the Lakeside Academy campus. Further, occasionally activities may extend to locations outside the State of Michigan (for each instance of travel outside of the State of Michigan, separate consents will be needed by parent/guardian and Placing Agency Representative).

Consent: I understand that all activities involve the risk of injury. I consent/request my child/ward be given the opportunity of participating in interscholastic sports, off campus activities, field trips, etc.

Legal Guardian/Parent Print Name here: ______________________________

Legal Guardian/Parent Sign here: ____________________________________

Student Print Name here: ____

Student Sign here: ____

Placing Agency Representative: _____________________________________

☐ **Consent for Media Release**

As an integral part of Lakeside Academy, we encourage involvement in the various academic, athletic and education opportunities offered on campus. At times, various media may request pictures and/or interviews with students as recognition of an individual or group accomplishment. For any media request, the home area or reason for placement will not be released. This consent allows for such media purposes. For each specific event a separate consent will be needed by parent/guardian and Placing Agency Representative.

Legal Guardian/Parent Print Name here: ______________________________

Legal Guardian/Parent Sign here: ____________________________________

Student Print Name here: ____________ ______________________________

Student Sign here: _________________ ______________________________

Placing Agency Representative: _____________________________________

I have read and understand the information above. I understand I can terminate or modify consent to any or all by way of written form to Lakeside Academy.

Legal Guardian/Parent Print Name here: ______________________________

Legal Guardian/Parent Sign here: ____________________________________

Student Print Name here: ____

Student Sign here: ____

Placing Agency Representative: ______________________________________

Parent Consultation

Student's Name____ Date: __________
Parent Completing Consultation: ____

Please complete this consultation to the best of your knowledge. It is extremely important that Lakeside Academy has the input on your family dynamics and your perspective of your child. If you have information you feel will be helpful in understanding and rehabilitating your child that is not included in this consultation, please include that information on the space provided on the back of this form. Thank you.

Describe the makeup of your household (include names, ages and relationship to your son).

Would you describe your home environment as structured or unstructured? (Include daily expectations you have for your child, household rules, etc.)

How do you reward your child for positive behavior?

How do you discipline your child for negative behavior?

How much time are you at home? (Include what hours of the day)

How much time do you spend with your child and how is this time spent?

What do you see as your child's strengths?

Positive interests?

What do you see as your child's weaknesses?

Negative interests?

Do you see your child as a leader or a follower? Positive or negative?

What goals do you have for your child while at Lakeside Academy?

Long term goals for your child?

What is the plan for your child's living arrangements upon discharge from Lakeside Academy?

List significant people in their life that may be positive role models or influences (name and relationship).

Additional comments.

Parental Consultation Substance Abuse

Are you aware of any substance use by your child?

Are you concerned that your child may be abusing drugs or alcohol? If so, why?

If so, what do you want to see your child learn about or change concerning their drug and/or alcohol use?

Are you aware of any resources that are available within the community that could help your child stay drug and alcohol free?

What are your goals for your child dealing with their substance abuse?

Is there a history of drug or alcohol abuse within your family?

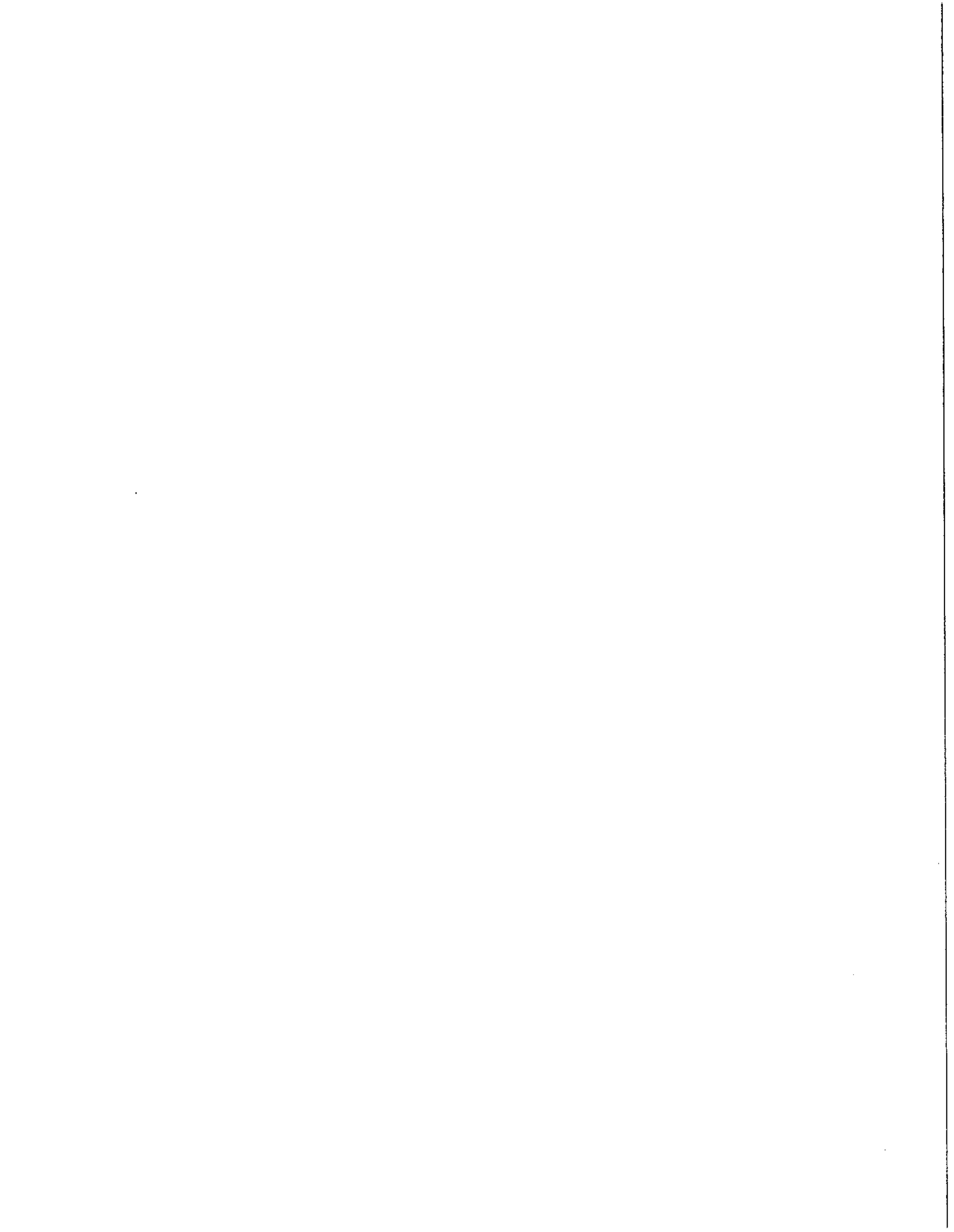
Additional comments.

Lakeside Academy Clothing Inventory **Student Name:** ______________________ **DOA:** ___________

Living Unit: ______________________

Please do NOT send blue or red clothing items

DATE:													
	Required												
Underwear	10												
Socks	10												
Athletic Shorts	2												
Swim Suit	1												
Sleep Wear	1												
T - Shirts	10												
Polo Shirts	2												
Dress Shirts	1												
Shirts (other)													
Sweatshirts	2												
Sweatpants	1												
Cargo Shorts	2												
Jeans	3												
Slacks	2												
Belt	1												
Sneakers	1												
Hiking/Winter Boots	1												
Shoes													
Jacket (Spring/Fall)	1												
Jacket (rain)	1												
Coat (winter)	1												
Ski Cap	1												
Gloves	1												



Student Rights:

Students have a variety of rights while at Lakeside Academy. Their individualized program will include risk and need assessments, specific and measurable goals and various treatment modalities. Lakeside Academy students will have access to medical care, psychological care, therapeutic services, education, recreation and supervision by trained staff.
Students have the right to file a grievance (confidential or anonymous) against any procedure, condition or person if they feel that any of their rights have been violated.

Protection from Mistreatment - Students have the right to be protected from acts or threats of harm or mistreatment from peers and/or staff including cruel and severe discipline. Unacceptable approaches to working with children include:

- Intimidation (verbal or non-verbal)
- Harassment (all forms)
- Corporal Punishment (hitting or striking a child)
- Ridicule, Humiliation, Teasing and/or Hazing (denying rest, meals, or forcing students to perform any degrading act or acts)
- Sexual abuse, contact, harassment
- Bribery (enlisting a student's cooperation through promises of money, drugs, or other items)
- Using work as a punishment and/or forced physical exercise
- Using an Emergency Safety Intervention as a punishment
- Retaliation for reporting staff or student's inappropriate actions
- Punishment by peers
- Group punishment or discipline for individual behavior
- Unwarranted use of invasive procedures or activities as a disciplinary action (e.g. invading a child's right to privacy, forcing a child to participate in an activity, unwarranted restriction of contact between a child and his/her family for "disciplinary" purposes).

While the aforementioned list of prohibited interventions is not all inclusive, staff would be best served to understand that discipline is a proactive process meant to teach appropriate behaviors and values; discipline is NOT to be delivered in anger or in retaliation to a misbehaving student.

Staff members who witness other employees exercising practices defined as punitive and unacceptable by this policy are expected to immediately report such infractions to their supervisor. Staff engaging in any of the aforementioned unacceptable approaches may expect supervisory action up to and including termination. Staff members who witness, and then fail to report, other employees who have engaged in any of the aforementioned "unacceptable approaches" may expect supervisory action, as well, up to and including termination. Approved Emergency Safety Physical Intervention procedures can be used only to protect students from injuring themselves or others. Please note: there may be times where damaging property and/or a serious disruption in the milieu may meet or exceed this definition.

External Contacts and Visitation - Students are permitted to communicate with their approved contacts which include; family/guardians, public officials, court officials, referring worker and their attorneys. Mail, telephone, video conference and visitation are available for students and families. If there is reasonable suspicion of contraband,

incoming mail may be opened in front of the students by a member of the Lakeside Academy Management Team. Mail, which is not a threat to the safety and security of Lakeside Academy staff or students, will be given to the student. Students have the right to visit parents/guardians unless regulated by the court. Visits may be terminated whenever they become inappropriate and/or dangerous. If someone is prohibited from visiting, there first must be consultation with the referring agency and the justification must be documented in the student's file. There must be a written plan (identified in the student's Treatment Plan) in place outlining all visits and their locations.

Confidentiality - Information regarding students and their families are kept confidential and released only with proper authorization as mandated by state licensing and law.

Education and Recreation - Students have the opportunity to meet their basic educational (as outlined by state education regulations) and recreational needs. In addition, students have access to recreational opportunities and equipment, including regular outdoor exercise (unless prohibited by severe weather conditions).

Equal Treatment - Students have the right to not be discriminated against because of race, language, religion, political, national or social origin, property, birth, gender, sexual orientation or other status. There is equal access to programs and services for all students.

Freedom of Expression - Students have a right to express their ideas and opinions with limitation. Harassing statements, negative peer connections (including colors, signs and or language), past (or future) illegal behavior (or discussion unless specifically part of a treatment modality led by an employee) are expressions which are considered detrimental to treatment and growth. Expression would also need to meet accepted campus and societal norms (wearing appropriate fitting and styled clothing, being quiet during sleeping hours, utilizing appropriate table manners, etc...).

Individualized Treatment - Based on information gathered from; admissions, discussions with probation officers (or referring agency worker) and parents/guardians (as available), risk and need assessments, student interviews and observations individualized treatment plans are developed for each student within 30 days of admission. This process involves the collaboration of the treatment team. Each plan is reviewed and revised at a minimum of every 90 days. Revised plans will be completed as a result of a new YLS being administered. Updated risk assessments determine the student's treatment. Each student will have a copy of their current treatment plan to provide guidance while working on and achieving treatment goals.

Medical and Dental Care - Intake procedures include an initial health screening. Within one week of admission the student receives a physical examination by a licensed medical practitioner. Routine and ongoing care is provided as required (state regulations) and as needed.

Basic Needs - Students have the right to be provided with the necessities of daily life (adequate seasonal clothing, adequate sleep, shelter and nutritional food) while at Lakeside Academy. Students may not be denied any essential program services.

Orientation - Students will receive an orientation to Lakeside Academy. Upon admission each new student will meet his/her "primary counselor" and Big Brother or Big

Sister. Daily life, expectations, student rights, student safety (PREA), key individuals, basic needs (clothing), recreation and The Lakeside Charter School will be addressed. Phase Packets, behavior expectations (including behavior management, Levels of Intervention and Emergency Safety Procedures), weekly ratings, status (Orientation, Pledge, Titan, Dorm Executive, and Campus Executive) will be discussed.

Personal Appearance - Students may wear personal clothing as long as it fits (does not sag), looks appropriate, is in good repair and is free from offensive language, gestures, symbols or slogans. Some students may be prohibited from wearing past gang colors. Students will daily demonstrate good hygiene with appropriate haircuts.

Religious Freedom
Students have the right to hold any religious belief. However, the right to express or exercise these beliefs by word or action is subject to the security and individual treatment needs. Students will not be compelled to attend religious services or education.

Vote - Students may register to vote if they are 18 years of age or over. The Lakeside Academy staff will help if a student desires to exercise his right to vote.

Student Signature: ______________________________
Date

Parent/ Guardian Signature: ______________________________
Date

Referring Agency Signature: ______________________________
Date

Lakeside Academy Staff Signature:______________________________
Date

Lakeside Academy

PREVENTING SEXUAL ASSAULT

Student Orientation Packet

THIS PART OF YOUR ORIENTATION TO LAKESIDE ACADEMY IS ABOUT PREVENTING SEXUAL ABUSE AND RAPE. AS REQUIRED BY THE PRISON RAPE ELIMINATION ACT (PREA) LAKESIDE ACADEMY WILL NOT TOLERATE SEXUAL ABUSE OR ATTEMPTED SEXUAL ABUSE OF ITS STUDENTS.

What is Inappropriate Sexual Activity at Lakeside?

Sexual activity of any type is prohibited at Facility. Students must not engage in sexual activity with any person. Staff, volunteers, and contractors that work with students at Facility are prohibited by law and policy to engage in any type of sexual activity with students, or sexually harass students, and will be held fully accountable for any violations of policy and state law.

Zero Tolerance Policy

Zero tolerance means that sexual acting out, sexual assault, and sexual activity of any type is not allowed and will not be tolerated at Lakeside. Personnel at Lakeside supervise students vigilantly to prevent sexual assault. Any occurrence of sexual assault or attempted sexual assault will be reported, investigated, and the perpetrator held accountable.

Reporting Sexual Assault, Attempted Assault, Threats, or Sexual Acting Out Behavior

It is the responsibility of all students of Lakeside to immediately report sexual assault, attempted sexual assault, threats, sexual harassment, or sexual exploitation if it occurs or *if it is suspected to have occurred.* Students reporting will be fully protected from retaliation, including retaliation from staff if staff is suspected of sexually inappropriate behavior or sexual assault.

Students must report violations or suspected violations to any staff, supervisor, or administrator, or may report to someone outside of the facility by calling Children's Protective Services at 1-888-444-3911. Reporting can be done verbally or in writing. Students are encouraged to report directly and immediately to staff so that immediate steps may be taken to keep students safe from sexual assault and/or investigate an actual occurrence. Reports may also be made through use of the Student Grievance System. It is the responsibility of all residents and all personnel at Lakeside to maintain safety at all times.

Preventing sexual assault in institutions is a responsibility that the personnel at Lakeside take extremely seriously. While students are encouraged to report even suspected violations, students are cautioned that knowingly making a false allegation against another person is a legal violation. This means that a student that intentionally lies when accusing someone of sexual assault and/or related

sexually inappropriate behavior will receive consequences that could include criminal charges. Report truthfully.

Help and Counseling for Victims of Sexual Assault

Lakeside has policies in force that require that a victim of sexual assault receive medical attention, counseling, is kept safe from further victimization and protected from retaliation, and is supported in helping to hold perpetrators accountable. If a student believes or suspects he has been victimized or is in danger of being victimized, or believes that another student has been victimized or is danger of being victimized, it must be reported. Keeping the issue a secret might keep a victim or potential victim of sexual assault from getting the help that is needed.

How to Help Keep Yourself and Others Safe

Keep yourself and others from falling victim to sexual assault by:

- Following the rules of the program
- Don't keep secrets—Talk about what is happening in your treatment group
- Don't isolate with another student—Keep your activities out in the open
- Don't trade food or goods with other students
- Never accept a gift or promise from another student in return for not telling on the student or not bringing up group and student issues
- Always report and discuss issues with your staff and treatment group
- <u>Don't enter into romantic relationships with other students</u>—It is strictly prohibited and could increase the chances of inappropriate behavior or sexual assault

TALK ABOUT IT!

Sexual Abuse
is *NEVER* OK

Report sexual abuse:

- **Tell or Write Staff or Counselors**
- **File a Grievance**
- **Contact a Family Member or Worker**
- **Call Children's Protective Services: 1-888-444-3911**

Student Signature Sheet for PREA Orientation

I received orientation on the Prison Rape Elimination Act expectations at Lakeside Academy on (date) __________. I understood the information that was presented.

Student Printed Name ________________________________

Student Signature ___________________________________

Date _____________

Staff Presenting Orientation Printed Name

____

Staff Signature ___________________________________

Date _______

NOTICE OF PRIVACY PRACTICES

"THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY."

A. **Introduction:**

As part of your health care, ______________________________ (the "Facility") originates
(Name of Facility)
and maintains numerous medical, billing, and other related records which contain information identifying you and describing your health history, symptoms, test results, diagnosis, treatment, and any plans for future care. This notice describes how this information may be used and disclosed by the Facility, as well as your rights and the Facility's duties with respect to such information.

B. **Your Health Information Rights:**

Although all records relating to the treatment you receive at the Facility are the property of the Facility, you have the following rights with respect to your health information:

- the right to request restrictions on certain uses and disclosures of your health information as provided by 45 C.F.R. 164.522. The Facility is not required to agree to any requested restriction.
- the right to obtain a copy of this Notice upon request.
- the right to inspect and obtain a copy of your health information as provided in 45 C.F.R. 164.524.
- the right to amend your health information as provided in 45 C.F.R. 164.526.
- the right to obtain an accounting of disclosures of your health information as provided in 45 C.F.R. 164.528. A Request for Accounting of Disclosures of Health Information must be made on the Facility's form. Copies of these forms are available at the Facility.
- the right to receive confidential communications of your health information as provided in 45 C.F.R. 164.522(b), as applicable.
- the right to receive notifications of breaches of unsecured PHI as provided in 45 C.F.R. 164.520(b)(1)(v)(A)).

You may exercise any of these rights by contacting the Facility representative listed below.

C. **Facility Responsibilities:**

The Facility is required by law to maintain the privacy of your health information and to provide you with a notice as to the Facility's legal duties and privacy practices with respect to your health information. The Facility is also required to abide by the terms of this Notice, as it may be revised from time to time.

The Facility reserves the right to change the terms of this Notice and to make any revisions to the Notice effective for all your health information that the Facility maintains. Should the Facility change the terms of this Notice it will either hand-deliver or mail you a revised notice as well as post the revised notice in an area accessible to residents.

D. **For More Information or to Report a Problem:**

If you have questions or would like additional information, you may contact

________________________________ at __________________________

(Name of Contact) (Phone Number)

If you believe your privacy rights have been violated, you can file a complaint with

________________________________ at __________________________

(Name of Individual) (Address)

or with the Secretary of the Department of Health and Human Services without fear of retaliation for filing a complaint. All complaints must be in writing.

E. **Use and Disclosure of Your Health Information.**

As a general rule, the Facility may use or disclose your health information in the following ways:

Treatment: The Facility will use your health information in the provision and coordination of your healthcare. We may disclose all or any portion of your health information to other health care providers who have a legitimate need for such information in your care and continued treatment. The Facility also may disclose your health information to people outside the Facility who may be involved in your medical care after you leave the Facility, such as family members, clergy, and others used to provide services that are part of your care.

Family/Friends: In certain situations, the Facility may release health information about you to a friend or family member who is involved in your medical care, or to someone who helps pay for your care

Payment: The Facility may release health information about you for the purposes of determining coverage, billing, claims management, medical data processing, and reimbursement. Your health information may be released to an insurance company, third party payer or other entity (or their authorized representatives) involved in the payment of your medical bill and may include copies or excerpts of your medical record which are necessary for payment of your account. For example, a bill sent to a third party payer may include information that identifies you, your diagnosis, and the services and supplies provided to you. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the

purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Routine Healthcare Operations: The Facility may use and disclose your health information during routine healthcare operations, including, but not limited to, quality assurance, utilization review, medical review, internal auditing, accreditation, certification, licensing or credentialing activities of the Facility.

Facility Directory: In certain situations, the Facility may use your name and location in the Facility for directory purposes. This information may be provided to people who ask for you by name.

Business Associates: The Facility may disclose certain health information about you to business associates. A business associate is an individual or entity under contract with the Facility to perform or assist the Facility in a function or activity which necessitates the use or disclosure of health information. Examples of business associates, include, but are not limited to, consultants, accountants, lawyers, medical transcriptionist and third-party billing companies. The Facility requires the business associate to protect the confidentiality of your health information.

Marketing: The Facility may disclose certain contact information to a third party to provide marketing materials and information to you.

Regulatory Agencies: The Facility may disclose your health information to a health oversight agency for activities authorized by law, including, but not limited to, licensure, certification, audits, investigations and inspections. These activities are necessary for the government and other health oversight agencies to monitor the healthcare system, government programs, and compliance with civil rights.

Law Enforcement/Litigation: The Facility may disclose your health information for law enforcement purposes as required by law or in response to a valid subpoena or court order.

Public Health: As required by law, the Facility may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Victims of Abuse: The Facility may disclose your health information to government authorities, such as social services authorities or protective agencies, if the Facility reasonably believes that you are a victim of abuse, neglect, or domestic violence.

Workers Compensation: The Facility may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Required by Law: The Facility will disclose medical information about you when required to do so by law.

Coroners, Medical Examiners, Funeral Directors: In the event of your death, the Facility may release your health information to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. The Facility may also release your health information to funeral directors as necessary to carry out their duties.

Organ Procurement Organizations: Consistent with applicable law, the Facility may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

Research: The Facility may disclose your health information to researchers when their research has been approved by an institutional review board that has reviewed the research purpose and established protocols to ensure the privacy of your health information. Before disclosing any of your health information we will verify that the researchers have obtained your consent to participate in the study.

Appointment Reminders/Treatment Alternatives: The Facility may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): The Facility may disclose to the FDA health information relative to adverse events with respect to food supplements, products, and product defects, or post- marketing surveillance information to enable product recalls, repairs, or replacement.

Avert Threat to Health or Safety: The Facility may disclose your health information if the Facility in good faith believes that disclosure is necessary to prevent serious harm to an individual or the public.

Government Functions: When appropriate, the Facility may disclose health information to serve certain governmental functions. The entities who may receive this information include, but are not limited to the military, intelligence agencies, and correctional institutions.

Fundraising: The Facility may contact you as part of our fundraising efforts.

Other Uses: Any other uses or disclosures of your health information will be made only with your written authorization. You may revoke an authorization, in writing, at any time except to the extent that the Facility has relied on your authorization.

F. The following uses and disclosures require authorization from you:

- Most uses and disclosures of psychotherapy notes (where applicable).
- Uses and disclosures of PHI for marketing purposes; and
- Uses and disclosures that constitute the sale of PHI.

G. **Confidentiality of Substance Abuse Treatment Records.**

Federal regulations (42 C.F.R. Part 2) provide special protection for the confidentiality of certain alcohol and drug abuse treatment records. To the extent that the Facility maintains any records or other health information about you that is protected from disclosure by these regulations, the Facility will only disclose such information as permitted by these regulations.

H. **Mental Health Care Treatment Records.**

State law and/or regulations may provide special protection for mental health care treatment records. To the extent that the Facility maintains any records or other health information about you that is protected from disclosure by such state law and/or regulations, the Facility will only disclose such information as permitted by state law and/or regulations.

I. **Effective Date:**

The effective date of this notice is ______________________, ____________.

I acknowledge that I have been provided a copy of the Facility's "Notice of Information Practices" which provides a description of the manner in which the Facility may use and disclose my protected health information. If I have any questions, I know that I have the right to contact Sequel and ask the Privacy Officer about my concerns.

______________________________ ______________
Signature of Resident Date

____
Resident's name (please print)

______________________________ ______________
Signature of Parent or Guardian Date

______________________________ ______________
Signature of Witness Date

Lakeside Academy Clothing Inventory **Student Name:** ______________________ **DOA:** ___________

Living Unit: ______________________

Please do NOT send blue or red clothing items.

DATE:													
	Required												
Underwear	10												
Socks	10												
Athletic Shorts	2												
Swim Suit	1												
Sleep Wear	1												
T - Shirts	10												
Polo Shirts	2												
Dress Shirts	1												
Shirts (other)													
Sweatshirts	2												
Sweatpants	1												
Cargo Shorts	2												
Jeans	3												
Slacks	2												
Belt	1												
Sneakers	1												
Hiking/Winter Boots	1												
Shoes													
Jacket (Spring/Fall)	1												
Jacket (rain)	1												
Coat (winter)	1												
Ski Cap	1												
Gloves	1												