BENHAVEN 2023-2024

Benhaven Academy
50 North Plains Highway
Wallingford, CT 06492
www.benhaven.org
T: 203 774-0008
F: 203 773-0031

Dear Parents:

Welcome back to school!

Enclosed are updated consent forms and other records that we need for our files. Please be sure to sign forms that require a signature and return to me before or on the first day of school. You may notice that the same information is requested on separate forms – this is because they are required to be filed in separate places according to state procedures. **If you have any changes to your email addresses, phone numbers etc., please let me know as soon as possible**.

There is a health form included for applicable students. According to the Connecticut State Department of Education, all students entering grade 6 or 7 and grade 9 or 10 are required to have a full physical by their physician. If he/she is due for a physical, please have the physician fill out the form and return it to me**. If your child is administered medication during the school day you must send in an updated permission slip from his/her doctor for the new school year (this includes Advil/Tylenol).** Please do not send in medication with your child; it must be brought in by an adult.

Lastly, I've enclosed our 2023-2024 school calendar. Please remember that your child will follow Benhaven Academy and your school district's weather-related closings and/or delays. **Early dismissal is at 1:00p.m. as noted on the calendar.** We have built in two snow days this year, if needed we will close school due to inclement weather. After we have used those two days we will begin to add onto the last day.

Please do not hesitate to call or email me with questions or concerns. We look forward to another successful school year.

Sincerely,

Melissa Soybel

Melissa Soybel
Student Services Facilitator
Melissasoybel@benhaven.org
Enclosures

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EMERGENCY CONTACT PERSONS

(Other than Parents that can pick up child in case of an emergency)

You must identify someone that can arrive within a one-hour time frame

Name: _____

Phone Number: _____

Phone Number: _____

Relationship to Student: _____

Name: _____

Phone Number: _____

Phone Number: _____

Relationship to Student: _____

Name: _____

Phone Number: _____

Phone Number: _____

Relationship to Student: _____

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STUDENT EMERGENCY INFORMATION

Student Name: _____

Address: _____

_____

Parents/Guardian's Names: _____

Parents/Guardian's Phone numbers (list all): _____

_____

Does your child have? ___ Sleep Apnea ___ Heart Problems ___ History of Seizures (Describe)
___ Respiratory Problems

Has your child ever had surgery? If so, for what? Please give dates:

Please List Current Medications:

Medication	Reason	Dosage	Administration During School?	Date Started

Please list any allergies and allergic reactions (if has experienced, reacted to what and at what age?):

Medical Insurance Company: _____

Policy Holders Name #: _____ Policy #: _____

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INSURANCE INFORMATION

Student Name: _____

INSURANCE INFORMATION:

Insurance Company: _____

Policy #: _____

Secondary Insurance (If Any): _____

Policy #: _____

Dental Insurance Company: _____

Policy #: _____

DOCTORS INFORMATION:

Pediatrician Name: _____

Address: _____

Phone #: _____

Psychologist / Psychiatrist Name: _____

Address: _____

Phone #: _____

Dentist Name: _____

Address: _____

Phone: _____

PARENTS/GUARDIAN INFORMATION:

Parents/Guardian Name: _____

Address: _____

Email Addresses: _____

Phone (List All): _____

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AUTHORIZATION FOR EMERGENCY-MEDICAL AND/OR SURGICAL TREATMENT

Student: _____ Date of Birth: _____
Last Name First Name

Allergies: _____

Date of Last Tetanus Shot: _____

This form will be used ***only*** in an emergency situation, ***only*** when a parent or guardian ***cannot*** be readily contacted.

IN CASE OF EMERGENCY, I HEREBY AUTHORIZE _____ (medical facility or personal physician) (and whomever they may designate as their assistants) TO PERFORM ANY EMERGENCY PROCEDURE; OR TO ADMINISTER ANESTHESIA AND/OR TO ADMIT, IF NECESSARY, MY DAUGHTER/SON.

Medical Insurance Co.: _____

Policy #: _____

Policy Holder: _____

Parent/Guardian Signed: _____

Parent/Guardian Print: _____

Address: _____

_____

Phone: _____

Epinephrine Legislation

Public Act 14-176 is designed to protect all students who may experience a life-threatening allergic reaction, for the first time, during school hours. The purpose is to provide emergency first aid to a student who experiences an allergic reaction even if the student has never been diagnosed with a life-threatening allergy and/or does not have a prior written authorization for the administration of epinephrine. This Act allows trained staff, in the absence of the school nurse during regular school hours, to deliver Epi-Pen to a student who presents with signs and symptoms of a severe allergic reaction during regular school hours. Under the revised law, a student's parents or guardian may opt out of having this trained employee administer the Epi-Pen to his/her child as permitted by statute and should submit, in writing to the school nurse, a letter indicating they are opting out of Public Act 14-176. If you have any questions please contact Danielle Castro, RN, Nurse Consultant, Benhaven Academy at 203-774-0008 or dcastro@benhaven.org

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AUTHORIZATION FOR NURSING/MEDICAL SERVICES

Student: _____
Last name First name

Date of Birth: _____

I hereby authorize Benhaven, Inc. and the nursing/medical personnel to take those actions that its professional staff deem appropriate for nursing and medical services (routine or of a monitoring nature).

Parents/Guardians will be kept informed of nursing and medical issues and will be contacted as the need arises.

_____ _____
Signature of Parent/Guardian Date

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PHOTO/VIDEO RELEASE FORM

I hereby give permission for images of my child to be used by Benhaven.

Student name: _____Age: _____

Name of Parent/Guardian if applicable (please print): _____

Individual/Parent/Guardian's Signature: _____

Date: _____

Area	Yes	No
Website		
Social Media		
Email to Families/Staff		
Yearbook		
Newsletter/Mailings		

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CONSENT TO TRANSPORT

I, _____, hereby acknowledge that vehicles belonging to Benhaven are used to transport many of Benhaven's students on community outings and field trips. Expecting that Benhaven will exercise reasonable control and judgment, I give my permission for _____ to be transported by Benhaven staff. I understand that I have a role in determining what means of transportation is most suitable and that I can withdraw this general approval at any time.

_____ _____

Signature of Parent/Guardian Date

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PERMISSION SLIP

I give my permission for official visitors of Benhaven to observe my child _____

with the understanding that the visitors will not reveal my child's identity to individuals not employed by Benhaven.

_____ _____

Signature of Parent/Guardian Date

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EARLY DISMISSAL

Dear Parent/Guardian:

In the event of an early dismissal, if I cannot be reached for notification, I have planned with the person listed below. This person has agreed, in writing, to wait for and accept responsibility for my child until I am able to pick up my child.

_____ _____
Signature of Parent/Guardian Date

PERSON ACCEPTING RESPONSIBILITY:

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

I agree to wait for and accept responsibility for _____ at such time when the parents cannot be reached. I will keep the child until the parent comes for him, provided the school has contacted me before sending the child to me.

_____ _____
Signature of Alternate Person Date

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AUTHORIZATION FOR THE RELEASE OF INFORMATION TO BENHAVEN ACADEMY

I_____, authorize _____
(name of person granting permission) (name and address of person, institution or organization in possession of records) to disclose to Benhaven Academy and _____ (social worker) information/records pertaining to:

_____
(**Name and DOB of person who is the subject of the record**)

Type of information/records to be released (**check all that apply**):

☐ Psychiatric ☐ Psychological ☐ Medical ☐ Education ☐ Medication

☐ Psycho-therapy notes (NOTE: a request for psycho-therapy notes cannot be combined with a request for any other records).

☐ All of the above

☐ Other (**specify**)

The purpose of this authorization/disclosure is to provide information to Benhaven Academy for use in case planning and development/implementation of an educational program or any other purpose for which this information can be lawfully used.

The nature and extent of the information to be disclosed is the entire record unless otherwise specified below: This authorization, if not revoked, will expire on _____ or in one year, whichever occurs first.

_____ _____
Signature of person giving permission or authorized representative Date

Check if this form has been signed by a person other than the subject of the record:

☐ Parent/Guardian ☐ Attorney ☐ Guardian Ad Litem ☐ Other (**explain**)

NOTE: Confidentiality of psychiatric, medical, and behavioral records is required and no information from these specific records shall be transmitted to anyone else without written consent or authorization.

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