DIMENSIONS ACADEMY

Alternative Education

To be completed by parent or guardian.

Date: ______________ Sending School: ______________________________ School ID #: ___________

Student legal name: ____(Goes By)________________

Grade:___________ Date of Birth: ____________________Age: ___________Gender: _____________

Parent/legal guardian name: ____

Address: ____
Street City Zip

Guardian contacts: Home #:__________________Work #:__________________Cell #:_________________

Fax #:_____________________E-mail:_____________________________________

Student contacts: Home #:____________________Cell #:________________E-mail:____________________

Reason for referral: ____

____

____

____

____

____

Other pertinent/background information: (Contact with any social agency such as: JSU, CARS, DHS, DMH, NAIC, DA, MAST, Family Focus, TEAM, Big Bro/Sis, etc.)

____

____

____

SKL 7/2011

DIMENSIONS ACADEMY

PARENT/LEGAL GUARDIAN RESPONSIBILITIES

- Communicate with school staff regarding students concerns, progress, etc
- Support and encourage the child's participation in all aspects of the program
- Participate in scheduled Parent Support Groups
- Attends mandatory meetings

______________________________ ______________________________

Parent/Legal Guardian Signature **Date**

STUDENT PARTICIPATION AGREEMENT

The alternative education program is for high risk youth. All activities are developed to provide personal success. To facilitate a meaningful placement, students will participate in all program components: appropriate education, counseling (group and individual), service learning projects, and job preparation. Each component is regarded as being a significant part of the total program, therefore we expect each participant to make a commitment.

Student Participation Responsibilities

- Attend school on a regular basis
- Complete all assignments
- Participate in all program components
- Dress appropriately
- Refrain from profanity
- Exude enthusiasm
- Respect, accept, and appreciate one another
- Respect other people's property
- Comply with school rules

I understand that continued participation in the program is dependent upon my adherence to the above stated conditions. I am aware that if I do not adhere to these stated conditions, termination from the program may occur.

I am willing to accept these conditions.

______________________________ ______________________________

Student Signature Date

DIMENSIONS ACADEMY - NORMAN NET - APC

Release of Records

I, ____________________________ (Parent/legal guardian, or other ______________)
Give my permission for release of records and/or obtain information regarding:

____
Name of Student Date of Birth

Information released to persons designated on this form shall include, but not be limited to the following:

School records (includes contact with school personnel)
Diagnostic Assessments
History and Physical exam reports
Legal History
Social History
Psychological Evaluation(s)
Progress Reports
Discharge Summary
Aftercare Plan
Other: specify ________________________

This consent shall expire on ________________ or upon the mutually agreed termination of my contact with Dimensions Academy.

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE INCLUDING, BUT NOT LIMITED TO HEPATITIS, SYPHILIS, GONORRHEA, AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS).

I understand that these records are protected under the Federal and State Confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. These confidential education records and information will be maintained in accordance with the Family Educational Rights and Privacy Act. (34 CFR Part 99)

Name of person(s) and/or agencies authorized to release and/or obtain information, please check all applicable:

____Appropriate representative of Department of Mental Health
____Appropriate representative of Norman Addiction Information Center
____Appropriate representative of JSU
____Appropriate representative of DA's office
____Judicial representative
____Other: ____________________

______________________________ ______________
Student Signature Date

______________________________ ______________
Parent/Legal Guardian Signature D.A. Representative

SKL/6/2009

Student Written Essay
(Grades 2 to 12)

Student Name: ______________________________ Date: ______________

Below, in your own handwriting, describe why you think an alternative program is what is needed for your educational placement. Tell us why you have been referred to our program, what areas you found troublesome in your home school, and how you think alternative school will be different. Also, tell us what you plan to do to help yourself be successful while you are with us.

Again, this should be in your own handwriting. If you need more than the space below please use the back or attach another sheet of paper.

OKLAHOMA DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
Consent for Release of Confidential or Protected Information

______________________ ____________ ____________ ______________
(Name of consumer) (Record #) (Date of birth) (Social Security Number)

I authorize: **COCMHC**
Name of Person or Facility Releasing Information

to release to: and ☐**exchange with:** (check if applicable)

Dimensions Academy- Paul Triggestad and Kayla Nicholson
Name of person / facility receiving information

P.O. BOX 400
Address of Person or Facility Releasing Information

1101 E Main St
Address of person or Facility Receiving Info

Norman, OK 73070

Norman, OK 73071

the following information for the following dates of treatment: ______________________ (if known).

Method(s) by which information is to be released: __ Mail __Fax __ Verbal __ Hand carried or given to consumer

In boxes below, I am indicating information to be disclosed from any medical/mental health/substance abuse records:		
__ Psychiatric Evaluation/Assessment	__ Discharge/Aftercare Plan	__ Lab / X-ray reports
__Assessment(s): ______________	__Release/Discharge Summary	__ Medications
__ ______________	__ History & Physical Exam	__ Diagnoses
__ Treatment plan/update	__ Letter of admit/discharge dates	__ Billing/financial info

Other – List specific documents(s) or information: ______________________
The records indicated above ☐can /or☐cannot contain Substance Use Disorder Information. ________ Client Initials

Information is being released for the following purpose: **To provide collaboration and continuity of care.**

I also understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it, and that in any event this authorization expires automatically as follows: Upon final discharge , or if unspecified, one (1) year after the patient's dated signature (below). Revocations should be submitted to the health information department where the information and appropriate revocation forms are kept.

I understand that my records are currently protected by Oklahoma State Statutes and federal privacy regulations including the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 & 164. I understand that my health information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may redisclose the information and it may no longer be protected by the HIPAA privacy law. When applicable, the federal regulations governing the confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, prohibits redisclosure of such information without my specific written consent or when permitted by such regulations.

I understand that the covered entity and/or program seeking this authorization will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I freely and voluntarily give this consent.

I understand that I am entitled to receive a copy of this authorization after it is signed.

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE. *63 O.S. 1-502.2.B, eff. 11/1/2007)*

______________________ /__________ ______________________ /__________
Signature of consumer Date Witness (Optional) Date

______________________ /__________ ______________________
Signature of authorized representative or parent or guardian when required Date Relationship to consumer

I authorize the following parties below to receive confidential or protected information:

_____________ / ______	_____________ / ______
Name of Judge Date	Name of Prosecutor Date
Name of Judge Date	Name of Prosecutor Date
Name of Judge Date	Name of Prosecutor Date
Name of Judge Date	Name of Prosecutor Date
Name of Defense Attorney Date	Name of Coordinator Date
Name of Defense Attorney Date	Name of Coordinator Date
Name of Defense Attorney Date	Name of Coordinator Date
Name of Defense Attorney Date	Name of Coordinator Date
Name of Compliance Officer Date	Name of Treatment Provider Date
Name of Compliance Officer Date	Name of Treatment Provider Date
Name of Compliance Officer Date	Name of Treatment Provider Date
Name of Compliance Officer Date	Name of Treatment Provider Date

A photocopy of this authorization shall be considered as valid as the original.

Name: ______________________ AVATAR ID #: ______________

Central Oklahoma Community Mental Health Center
Child & Family Services

History Form

PLEASE BRING: outpatient medical records, immunization records, school records, letters from teachers, custody or divorce papers if available, and this form to the evaluation.

Name of Child Seeking Services: ______________________

Address: ______________________ Zip Phone: ______________

Date of Birth: ______________ Age: __________ Ethnicity: ______________

Grade: ______________ School: ______________________

Name of Father: ______________________ Age: __________

Occupation: ______________________ Education: ______________

Address: ______________________ zip Phone: ______________

Name of Mother: ______________________ Age: __________

Occupation: ______________________ Education: ______________

Address: ______________________ zip Phone: ______________

Who has legal custody of this child? ______________________

Who referred you to me? ______________________

PRESENTING NEED:

1. Describe your child's needs in your own words.

____

____

____

____

____

Name: ______________________ AVATAR ID #: ______________

2. When did you first become concerned about your child?

____

____

____

____

____

3. Please check if your child has experienced any of the following:

	Never	**Infrequently**	**Occasionally**	**Frequently**	**Always**
Wetting the bed					
Soiling the bed					
Setting fires					
Temper tantrums					
Cruelty to animals					
Fist fights					
Steals and lies					
Cries easily					
Home discipline problem					
Appears nervous					
Behaves impulsively					
Argues with teacher					
Refuses requests					
Destructive behavior					
Sexual behavior					
Special fears or phobias					
Physical complaints					
Cannot delay getting what he/she wants					
Withdrawn or sad					
Daydreams in school					
Skips school after arriving					
Refused to go to school					

Name: ______________________________ AVATAR ID #: ____________________

4. Has your child been seen by a mental health provider for these or similar concerns?
   Yes No

   Describe (who, when, where and why). Was any testing performed? What were the results of the intervention?

   ____
   ____
   ____
   ____
   ____
   ____

5. Describe your child's relationships:
   With parents:

   ____

   With brothers/sisters:

   ____

   With children his/her own age:

   ____

Child's School History

GRADE	NAME OF SCHOOL	CONCERNS THAT YEAR?
Kindergarten		
1st Grade		
2nd Grade		
3rd Grade		
4th Grade		
5th Grade		
6th Grade		
7th Grade		
8th Grade		
9th Grade		
10th Grade		
11th Grade		
12th Grade		

1. Did your child have any difficulty going to school for the first time?

   ____
   ____

2. Has your child ever:

Name: ______________________ AVATAR ID #: ______________

Attended summer school? __________ What year(s)? ______________

Received tutoring? ______________ In what subject(s)? ______________

Been retained? ______________ In what grade(s)? ______________

Been suspended? ________ Why? ______________________

Been placed in a special class? __________ When? ______________

Had IQ or psychological testing by a school? ______________________

Missed school a lot due to health or other reasons? ______________

How does your child's current academic progress compare to last year?

____

____

____

____

Best Subjects	**Worst Subjects**

3. What is your child's current teacher's name? ______________________

Child's Social Activities

1. Hobbies? ______________________
2. Sports, recreational activities? ______________________
3. Clubs? ______________________
4. Interests/talents? ______________________
5. Work experience? ______________________
6. Family activities? ______________________

Name: ____________________ AVATAR ID #: ____________________

Child's Birth, Developmental and Medical History

1. **Prenatal and Birth History**
   - **a.** Were you sick or did you have any complications while you were pregnant with your child?

     ____

     ____

     ____

   - **b.** Did you take any medications during your pregnancy? Y N
     If yes, please list:

     ____

     ____

     ____

   - **c.** Was your child exposed to any of the following during your pregnancy?

Substance	How Much	How Often?
Tobacco		
Alcohol – Beer, Liquor		
Marijuana		
Prescription Drugs: Please Describe		
Cocaine		
Methamphetamine		
Heroin		
Other:		

   - **d.** Was your child born earlier than expected? Y N
     If yes, how much earlier? ____________________
   - **e.** How long was your labor? ____________________
   - **f.** Were anesthetics used? ____________________
   - **g.** Did your child display any evidence of injury or other problems at birth? Y N
     If yes, please describe:

     ____

     ____

     ____

     ____

   - **h.** Did your child have any problems with breathing? Y N
     If yes, was oxygen used? Y N
     If yes, please describe: ____________________

Name: ______________________________ AVATAR ID #: ____________________

i. How much did your child weigh? ________

What was your child's length? ________

2. **Developmental History**

a. At what age did your child crawl? ______________________________

b. At what age did your child walk unattended? ______________________

c. At what age did your child say single words? _______________________

d. At what age did your child talk in short sentences? ____________________

e. At what age was your child toilet trained? __________________________

f. What hand does your child use? _________________________________

g. Would you describe your child as a cuddly baby? ____________________

3. **Medical History**

a. Who is your current doctor/pediatrician? ___________________________

b. Has your child ever had a temperature of 104 degrees or above for more than a few hours? Y N
If yes, how long did it last?

____

____

c. Was a doctor seen about the fever? Y N
If yes, what did he/she say was the matter?

____

____

d. Has your child ever been knocked unconscious? Y N
If yes, for how long? ____

Explain:

____

____

e. Has your child experienced other head injuries that have NOT resulted in loss of consciousness?

____

____

____

f. Has your child ever had a seizure? Y N
If yes, is the child taking medications for these? Y N
If yes, what medications? _______________________________________

Name: ______________________ AVATAR ID #: ______________

____

____

Who is his/her doctor? ______________________

What have you been told about the seizures? ______________

____

____

g. Does your child have allergies? Y N
If yes, what are they? ______________________

____

Does he/she take medications? ______________________

____

If yes, what medications? ______________________

____

Does the medication make your child sleepy? Y N
When does he/she take them? ______________________

Are your child's allergies being treated by a doctor? Y N
Who is his/her doctor? ______________________

h. Has your child ever had meningitis? Y N Age? ____________

i. Has your child ever had encephalitis? Y N Age? ____________

j. Please describe any other serious illnesses/accidents: ____________

____

____

k. Does your child take medications for behavioral or emotional conditions? Y N
If yes, please explain: ______________________

____

Please LIST ALL MEDICATIONS, dosages, and times that your child takes the medications:

____

____

____

____

l. Is there any known history of sexual or physical abuse? Y N

4. **Hearing, Vision, Speech and Immunizations**

a. Does your child have any hearing problems? Y N
If yes, please describe: ______________________

Name: ________________________ AVATAR ID #: ______________

____

At what age were the problems noticed? ______________

Date of last hearing test: ______________

Please describe any professional help with your child's hearing problem: __________

____

b. Has your child ever had earaches or draining ears? Y N
If yes, is it a recurring problem? Y N

c. Has your child ever had tubes in his/her ears? Y N
If yes, how many times? ______________

d. Does your child have any vision problems? Y N
If yes, please describe: ______________

At what age were the problems noticed? ______________

Date of last vision test: ______________

Please describe any professional help with your child's vision problem: __________

____

e. Does your child have any problems with speech? Y N
If yes, please describe: ______________

____

At what age were these first noticed? ______________

How does your child's speech development compare with any brothers or sisters?

____

____

Please describe any professional help with your child's speech problem: __________

____

Please record the dates of your child's immunizations:

Immunization	Date	Date	Date	Date	Date
DTaP/Tdap					
Polio					
HIB					
Hepatitis A					
Hepatitis B					
MMR					
Varicella					
PCV					
MVC					
HPV					

Name: ______________________________ AVATAR ID #: ____________________

Child's Family History:

1. Current marital status of parents (please circle):
   Single Married Separated Divorced Widowed Other

2. Please provide information regarding your child's brothers and sisters:

Name	Age	Sex	Grade	Living at Home?

3. List all people in the household who were not previously mentioned: ____________

4. Is there a family history of medical problems? Y N
   If yes, please explain: ____________

5. Is there a family history of drug or alcohol abuse or dependence? Y N
   If yes, please explain: ____________

6. Has anyone in the family been treated for mental health reasons? Y N
   If yes, please explain: ____________

7. As parents, do you agree about how to raise and discipline your child? Y N
   Please explain: ____________

8. What responsibilities does your child have at home? ____________

9. How often and when do you give money to your child? ____________

Name: ______________________ AVATAR ID #: ______________

____

Do you supervise the use of this money? ______________________

____

10. Does your child become angry often? ______________________

____

If so, how does he or she show it? ______________________

____

____

11. Who usually administers the discipline and how? ______________________

____

____

____

12. Are both parents usually home in the evening? ______________________

____

____

13. When does your child go to bed at night? ______________________

____

Does he/she have to be coaxed? ______________________

____

____

14. Do you have any concerns that your child is using drugs or alcohol? ______________

____

____

15. Has your child had any problems with the police or juvenile authorities? ____________

____

____

Child's Family Culture:

1. Describe your family. What do you know about your family origin? ______________

____

____

____

Name: ______________________________ AVATAR ID #: ____________________

2. Describe some common celebrations or family events that you share with your child: _____
____
____
____
____
____

3. What family traditions do you hope to share with your child as they grow? __________
____
____
____
____

Purpose of Evaluation/Consultation:

Finally, what do you hope to receive from our services? What is it that you would like to see accomplished? Describe your willingness to participate in services. ____________________
____
____
____
____
____

Child's Signature: ______________________ Date: ____________________

Parent's Signature: ______________________ Date: ____________________

PLEASE STOP HERE