NEW INDEPENDENCE ACADEMY

Declaring Independence for our Students

APPLICATION

STUDENT INFORMATION

Last Name: _____First Name: _____

Preferred Name: _____

Birth Date: _____Sex: _____

Address: _____County:_____

City: _____State: _____Zip:_____

MEDICAL INFORMATION

Please note that the student's immunization records, or waiver and medical diagnosis form must be on file at the school before the child is admitted to class.

Doctor's Name: _____Phone:_____

Medical Diagnosis: _____

Secondary Diagnosis: _____

Allergies: _____

Medications: _____

Dentist: _____Phone:_____

New Independence Academy
PO Box 125
Pikeville, NC 27863
(919) 288-2429

STUDENT'S INFORMATION

To be answered by the student

What is your favorite subject?

What is your least favorite subject?

What do you like to talk about with other kids?

What do you do to get exercise?

Do you like animals?

Would you like to participate in horseback riding?

What do you do in your free time?

What are some things that distract you during school?

What would you like to do when you finish school?

What are some of your favorite books?

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PARENT INFORMATION

PARENT/GUARDIAN #1

Last Name: _____First Name: _____

Relationship to the student: _____

Address: _____County:_____

City: _____State: _____Zip:_____

Main Contact Phone _____Secondary Number: _____

Email address: _____

Occupation: _____

PARENT/GUARDIAN #2

Last Name: _____First Name: _____

Relationship to the student: _____

Address: _____County:_____

City: _____State: _____Zip:_____

Main Contact Phone: _____Secondary Number: _____

Email address: _____

Occupation: _____

EMERGENCY CONTACTS

Parents will always be the first contact for emergencies. Please list alternate family members or friends in case we cannot get in contact with the parent/guardian.

Name:_____ Phone number:_____

Relationship to student: _____

Name: _____ Phone number: _____

Relationship to student: _____

SIBLINGS

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

OTHER FAMILY MEMBERS/KEY PEOPLE IN THE STUDENT'S LIFE:

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

AGREEMENT OF PARTIES:

New Independence Academy does not discriminate on the basis of race, age, color, sex, national origin, physical or mental disability, or religion.

New Independence Academy intends to:

- Develop critical thinking skills for the student's learning.
- Foster increased social skills with measurable results.
- Build self-confidence in each student through positive reinforcement of their strengths.
- Prepare the student for today's world through digital learning.
- Enhance the child physical, mental and emotional well-being.
- Conduct all discussion with the child and parent(s) or legal guardian(s) in a respectful tone.

The parent(s) or legal guardian(s) agrees to the following:

- The student is medically diagnosed with high functioning autism.
- The parent will participate as a partner in the child's continuum of education.
- All communication for the child's learning experience should be directed first to the teacher, then to the director.
- Any concerns that may possibly arise will always be handled in a professional manner, in a private setting.
- The parent will practice positive reinforcement of the student's strengths as a basis for a learning experience.

Signature of Parent/Guardian: _____

Date: _____

Signature of NIA Director: _____

Date: _____

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Emergency Authorization for Medical Treatment/Release of Information to Treating Facility

I, _____, being the responsible

legal guardian of _____, do hereby authorize New Independence Academy to seek, authorize and consent to medical treatment or care necessary for my child.

Additionally, I authorize New Independence Academy to release information to and receive information regarding my child from any treatment facility and/or emergency personnel relevant to the safety of my child.

In the case of an injury, serious illness or life threatening event involving my child while attending New Independence Academy or a related activity, I understand that the following procedure will be followed:

1. New Independence Academy staff will call the parent/guardian to come and get the student so that they may be taken to receive the appropriate medical attention.
2. If we are unable to reach the parent/guardian, we will try to reach an alternate person(s) listed on the emergency information form.
3. If we cannot reach anyone, we will take the child to the nearest medical facility, or if feasible to the child's medical facility.
4. In the event of a serious or life threatening situation requiring immediate action, New Independence Academy staff will use their judgment to either call 911, or to take the child to the nearest hospital.

I understand that New Independence Academy does not assume financial responsibility for emergency medical for students. The treating medical facility will be asked to bill the parent/guardian for any charges incurred.

Insurance Information:

_____ _____
Name of Insurance Company Policy Number

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Date

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Notice of Medication Requirements

Effective from:_____to_____

Parents/Guardians:

As part of your child's enrollment into New Independence Academy, we will require that you complete the medication forms given to you during the intake process. Please complete this form, even if your child will not be given medication during school hours. If the student's medication is changed or dosage is altered, it is the responsibility of the parent to inform the school.

If your child is on any medication, please ensure that the forms are signed by the physician. If your child is to receive any medication during school hours, these medications must be given to the school prior to your child's start date. You may bring these medications with your child on his/her initial day. If the school has not received necessary medication, your child will not be allowed to start in the school program.

If your child comes to school without his/her medication or if we have not received the appropriate forms stating your child is not on medication, we will call and request that your child is picked up and taken home until those forms are filed at the school. There are no exceptions to this policy. Please read the attached **Student Medication Requirements**. If you have any questions or concerns, please see the school's director.

I have read the above notice and understand that my child will be sent home if New Independence Academy does not have the necessary medical forms and medication needed on or before his/her start date.

_____ _____

Parent/Guardian Signature Date

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Notice & Authorization of Medication to be Given During School Hours

Student's Name: _____DOB:_____

This form is to be signed by the physician AND parent if the medication is to be given during school hours and if there are any changes to the medications. Please take this form to your physician, who will list all necessary medications. Please sign and return to New Independence Academy. Notify the school immediately if there are any changes.

1. Name of medication: _____

Dosage: _____ Time(s) Given: _____

How medication given: _____

Reason medication given: _____

Side effects that may impact student's learning or behavior:
_____

2. Name of medication: _____

Dosage: _____ Time(s) Given: _____

How medication given: _____

Reason medication given: _____

Side effects that may impact student's learning or behavior:
_____

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3. Name of medication: _____

Dosage: _____ Time(s) Given: _____

How medication given: _____

Reason medication given: _____

Side effects that may impact student's learning or behavior:
_____

This will serve as a prescription for the individual named above:

Prescribing physician: _____Phone:_____

Signature of Physician_____

Date:_____

I authorize New Independence Academy staff to administer the above medication(s) to my child as specified above. The authorization is valid from: _____to _____
(no more than a year). I give consent to the director to communicate with the child's physician and counsel the school personnel on the possible side effects of my child's medication

_____ _____
Signature of Parent/Guardian Date

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Drop-off/Pick-up Authorization Form

Effective from: _____to _____

Child's Name: _____ DOB: _____

Male: _____ Female: _____ Age: _____

I hereby give permission for the following adults (18+) to drop off and/or pick up my child in the event that I am unable to do so. These adults will then be responsible for my child upon pick up.

Name: _____Phone:_____

Name: _____Phone:_____

Name: _____Phone:_____

Name: _____Phone:_____

Name: _____Phone:_____

Name: _____Phone:_____

(Optional)

You may provide an emergency password in the event that someone other than the above listed adults need to pick up your child. We will ask the adult for the password and if they are unable to provide it, we will not release your child to them.

Password: _____

_____ _____

Parent Signature Date

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Allergy Form

Child's Name: _____DOB:_____

Parent's Name:_____

Please list your child's allergies (food/beverage/contact) below:

_____
_____
_____
_____

List any medications taken for above allergies:

Do you authorize emergency treatment if necessary? ____Yes ____No

Physician's Name: _____

Physician's phone: _____

Parent signature: _____

Date: _____

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Consent Waiver and Release

Student's Name: _____Age:_____

Event: _____

Parent/Legal Guardian: _____

Address: _____

City: _____ Zip Code: _____ Phone: _____

To be signed by the parent or guardian:

I hereby give permission to New Independence Academy and to other news media entities to prepare, use, reproduce, publish, or exhibit my name, picture, portrait, likeness, or voice or any or all of them for use by the news media or the New Independence Academy in their news and public relations programs and website. Any photograph, photo transparency, drawing or other illustrative graphic material, audio-visual illustration, news report, story or article may be used without my prior examination of the finished product.

I have crossed out, dated and initialed any exceptions to this consent waiver and release form.

I hereby waive my rights to privacy in connection with consent given above and I hereby release, discharge and agree to hold harmless all the parties to whom this consent is given from any liability whatsoever and agree that this consent and waiver will not be made the basis of a future claim of any kind.

Signed: _____Relationship:_____

Witness:_____ Date:_____

THERAPEUTIC RIDING PROGRAM

It is important for the family to understand that there are potential risks in horseback riding. However, New Independence Academy feels the benefits to your child outweigh the risk.

Stepping Stones Stables is the provider of the riding program at New Independence Academy. Stepping Stones Stables and NIA require a Hold Harmless Agreement be on file for each student in order for them to participate. New Independence Academy and Rosewood Worship Center are, hereinafter, considered the sponsor of the program. The school adheres to the North Carolina General Statute Chapter 99E: Under North Carolina Law, an equine activity sponsor or equine professional is not liable for the injury or death of a participant in equine activities resulting exclusively from the inherent risk of equine activities.

LIABILITY RELEASE:

I, _____ the parent/legal guardian of

_____ (student's name) would like my child to participate in the therapeutic horseback riding program at New Independence Academy. I further agree to waive and release all claims against Stepping Stones Stables, New Independence Academy, and Rosewood Worship Center, their instructors, therapists, aids, volunteers, and employees for any and all injuries and/or losses my child may sustain while participating in equine activities in compliance with North Carolina Statute Chapter 99E.

Signature: _____ Date: _____

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Nondiscrimination Policy

It is the policy and commitment of New Independence Academy that it does not discriminate on the basis of race, age, color, sex, national origin, physical or mental disability, or religion.

Equal Employment Opportunity
New Independence Academy is committed to a policy of equal employment opportunity and does not discriminate in the terms, conditions, or privileges of employment on account of race, age, color, sex, national origin, physical or mental disability, or religion or otherwise as may be prohibited by federal and state law. Any employee, board member, volunteer or client who believes that s/he or any other affiliate of New Independence Academy has been discriminated against is strongly encouraged to report this concern promptly to the School Director and/or Board of Directors.

Discriminatory Harassment
Harassment or intimidation of a client, staff person or guest because of that person's race, age, color, sex, national origin, physical or mental disability, or religion is specifically prohibited and may be grounds for termination. Harassment and intimidation includes abusive, foul or threatening language or behavior. New Independence Academy is committed to maintaining a workplace that is free of any such harassment and will not tolerate discrimination against staff members, volunteers or students. Issues of discriminatory treatment, harassment, or intimidation on any of these bases should immediately be reported to the School Director and/or Board of Directors or immediate supervisor and, if substantiated, prompt action will be taken.