Evans Home Admission Application

www.evanshome.org - (540) 662-8520

Please don't leave any blanks when completing this form – use "NONE" or "Unknown" as appropriate

CHILD'S INFORMATION

First Name		Middle Name		Last Name	
Date of Birth		**Place of Birth**			
Social Security Number		**Religious Preference**			
Gender		**Race**			
Height		**Weight**			
Eye Color		**Hair Color**			
Marks/Scars/Tattoos					

BIOLOGICAL MOTHER

Full Name			
Address			
Date of Birth		**Marital Status**	
Social Security Number		**Race**	
Home Number		**Cell Number**	
Email Address		**Work Number**	
Is Spouse a Step Parent	☐ Yes ☐ No	**If Yes, Name**	

BIOLOGICAL FATHER

Full Name			
Address			
Date of Birth		**Marital Status**	
Social Security Number		**Race**	
Home Number		**Cell Number**	
Email Address		**Work Number**	
Is Spouse a Step Parent	☐ Yes ☐ No	**If Yes, Name**	

SIBLINGS

Name	Age	Sex	Address	Phone Number

Revised 2-9-18

REFERRAL SOURCE

Is this child in the custody of a biological parent/adoptive parent/family member or friend of the family? ☐ Yes ☐ No	If Yes, complete below: If No, skip to next section:
Parent/Guardian Name	
Address	
Home Number	
Work Number	
Cell Number	
Email Address	

Is this child in DSS Custody? ☐ Yes ☐ No	If Yes, complete below:
Placing Agency Name	
Case Worker Name	
Address	
Office Number	
Cell Number	
Fax Number	
Email Address	
Supervisor Name	
Supervisor Phone #	
Permanency Plan	

Is FAPT involved regarding funding? ☐ Yes ☐ No	If Yes, complete below:
FAPT Locality	
Case Manager	
CSA Coordinator	
Address	
Office Number	
Cell Number	
Fax Number	
Email Address	

REASON FOR REFERRAL

Why is your child being referred for admission to this facility?

INSURANCE INFORMATION

Medicaid	☐ Yes ☐ No	**Medicaid Number**	
Insurance Company			
Policy Number		**Group Number**	
Policy Holder's Name		**Policy Holder's DOB**	
Policy Holder's Relationship to Child		**Policy Holder's Social**	

CURRENT MEDICAL SERVICE PROVIDERS (**please fill in all fields**)

PRIMARY CARE PHYSICIAN

Physician Name	
Physician Number	
Physician Address	

DENTIST

Dentist Name	
Dentist Number	
Dentist Address	

MENTAL HEALTH THERAPIST

Therapist Name	
Therapist Number	
Therapist Address	

PSYCHIATRIST/MED. MANAGMENT

Psychiatrist Name	
Psychiatrist Number	
Psychiatrist Address	

GOALS OF PLACEMENT: Specify the goals you would like the Evans Home to assist your child in accomplishing

1	
2	
3	
4	
5	

What are the tentative transition/discharge plans for this child?

PHYSICAL HEALTH

Allergies	☐ Yes ☐ No	**If yes, please explain:**
Any Known medical conditions, Illnesses, Medical Care Required or Physical Limitations	☐ Yes ☐ No	**If yes, please explain:**
Any History of Substance Abuse	☐ Yes ☐ No	**If yes, please explain:**
Any Nutritional/Dietary Needs	☐ Yes ☐ No	**If yes, please explain:**
Any Medical/Dental Follow Up Needed	☐ Yes ☐ No	**If yes, please explain:**
Any Immunization Needs?	☐ Yes ☐ No	**If yes, please explain:**
Do the child's parents or siblings have any serious illness or chronic condition?	☐ Yes ☐ No	**If yes, please explain:**
Does child wear braces?	☐ Yes ☐ No	**If yes, please list orthodontist contact info:**
Does the child have any issues with bed wetting/toileting?	☐ Yes ☐ No	**If yes, please explain:**
Has this child ever been hospitalized for any illness or injury?	☐ Yes ☐ No	**If yes, please explain:**
Has this child ever had any neurological care?	☐ Yes ☐ No	**If yes, please explain:**
Please rate your child's personal hygiene skills:	☐ 1-Excellent ☐ 2- Good	☐ 3-Needs Prompting ☐ 4-Doesn't Know How ☐ 5-Doesn't Remember ☐ 6- Doesn't Care

CURRENT MEDICATIONS

(Check N/A if this is not applicable to your child.) ☐ **N/A**

Medication Name	Dose	Frequency	Prescribing Physician
Is youth compliant with medications?	☐ Yes ☐ No	**If no please explain:**	

EDUCATION

Current Grade		
Current School		
School Contact Name		
School Contact Phone Number		
Any Vocational/Independent Living Needs?	☐ Yes ☐ No	**If yes, please explain:**
Is this child in Special Education?	☐ Yes ☐ No	**If yes, please explain:**
Does this child have an IEP?	☐ Yes ☐ No	**If yes, what is the Eligibility Category?**

If your child has an IEP, we are required to notify your child's previous school system of placement with us. Please write the name of the superintendent of the resident's home locality and their phone number below.

Superintendent's Name		**Phone Number**	

PLACEMENT HISTORY (Please list all previous hospitalizations, foster and residential placements)

Foster Placement/Facility	Start Date	End Date	Successful? If No, explain why

CLINICAL HISTORY

Is this child currently at risk for harming self or others?	☐ Yes ☐ No	**If yes, please explain behavior:**
Has this child sexually offended against others?	☐ Yes ☐ No	**If yes, please explain:**
Has this child ever been the victim of sexual abuse	☐ Yes ☐ No	**If yes, please explain:**
Is there a current Psychological evaluation?	☐ Yes ☐ No	**If yes, please list the IQ Scores on the row below:**

FULL SCALE IQ		**VERBAL IQ**		**PERFORMANCE IQ**		**WORKING MEMORY**	

Is there a family history of mental illness?	☐ Yes ☐ No	**If yes, please explain:**
Is there a family history of substance abuse?	☐ Yes ☐ No	**If yes, please explain:**
Is this child currently on Probation?	☐ Yes ☐ No	**If yes, please explain the charges:**
If child is on probation, please list the name of the probation officer:		**Probation Officer Name:** **Probation Officer Phone Number:**

DSM-IV DIAGNOSIS (Check N/A if this is not applicable to your child.) ☐ **N/A**

AXIS				
I				
II				
III				
IV				
V				
GAF:	Current:		Highest in past year:	

STRENGTHS

Please list your child's strengths, interests, skills and talents?	

THERAPEUTIC NEEDS

Are there any current therapy needs?	
Please list any past therapy or counseling provided to this child.	

PROTECTION NEEDS

Are there any protection needs? Any threats or vulnerabilities we need to be aware of?

SIGNIFICANT BEHAVIORS

Are there any other significant behaviors not previously noted? And is there a current risk for these behaviors?

BEHAVIOR IN THE LAST 7 DAYS

Please describe your child's behaviors of the last seven days as well as where the behaviors are occurring and their frequency.
What interventions, if any, have been effective in addressing these behaviors?

ASSESSMENT OF CHILD'S BEHAVIOR & SUPPORT NEEDS (Check all descriptions that apply)

POSITIVE ATTRIBUTES

	Adaptable		Gets along well with others
	Calm/ Even Tempered		Clear communicator
	Creative		Easygoing/Friendly
	Empathetic		Energetic
	Expressive		Independent/Mature
	Flexible		Hard Working
	Honest		Manages time well
	Nurturing		Open-minded
	Organized		Polite
	Problem Solver		Resourceful
	Responsible		Self-confident
	Sense of Humor		Supportive
	Seeks out positive relationships		Truthful
	Recreational Interests		Demonstrates concern for others

CHALLENGING BEHAVIORS

	Aggression-Verbal (cursing, yelling, screaming, threats, tantruming, whining, crying)		Aggression- Physical (hitting, head butting, scratching, spitting, biting, punching, kicking hitting, choking, attacking)
	Self-Injury- (ie: cutting, head banging, scratching/picking skin, throwing self to floor)		Self-Harm- Suicidal
	Non-compliance (defiance, bickering, refusing to follow directions, passive when a request is made)		General disruptions (hyperactivity, talking out, overly loud, distracting others, arguing)
	Physical Ticks (gestures, hand flicking, mouthing, body rocking)		Verbal Ticks (unusual vocalizations, repeated words,
	Inappropriate Sexualized behavior (public masturbation or groping)		Property Destruction (damaging anything in the physical environment)
	Stealing		Resistant to authority figures
	Sexually Active		Sexually predatory* please explain
	AWOL/ Running Behaviors		Moody/ Negative Attitude
	Social withdrawn (Primarily plays alone, Doesn't respond to peers attempts to play)		Easily Agitated/ Overwhelmed/ Overstimulated
	Substance abuse history/susceptible to substances		Eating Disorders (anorexia, bulimia, and binge eating, extreme emotions, attitudes, & behaviors surrounding weight and food issues)
	Smoking/ Use of Tobacco Products		Fire Setting
	Intentionally isolating/excluding other children		Manipulative behaviors (minimizing, Never accepting blame, gas lighting, blame shifting)

PERSPECTIVE ON PLACEMENT CHANGE

What is your child's attitude toward transition to the Evans Home?
What is your child's attitude toward their present home or foster situation?
How does the child's family feel about the transition to the Evans Home?

EXPECTED FAMILY INVOLVMENT

What is/was the reason for removal from family of origin?		
Is there a history of abuse, neglect or exploitation in the Child's/Family's past?	☐ Yes ☐ No	**If yes, please explain:**
Will there be visitation with family members?	☐ Yes ☐ No	**If yes, please detail the frequency, location and with whom the visits will be:**

APPROVED CONTACTS (please list the individuals allowed to have contact with this child)

Name	Relationship to Child	Phone Number	Visitation Parameters (Phone, Face to Face,

INDIVIDUALS BARRED FROM HAVING CONTACT WITH CHILD

Name	Relationship to Child	Phone Number	Reason for Restriction

EMERGENCY/ ON CALL/ AFTER HOURS CONTACT

Name	
Relationship to Child	
Phone Number	
Address	

APPLICATION COMPLETED BY:

Name	
Relationship to Child	
Date	

THE FOLLOWING DOCUMENTATION IS REQUIRED FOR ADMISSION TO THE EVANS HOME:

- Proof of Legal Guardianship/Court Documentation
- Physical Examination (see attached medical forms)
- Tuberculosis Screen/Test completed (see attached medical forms)
- Current Individualized Education Plan (I.E.P.)
- Birth Certificate (please bring original for copying)
- Social Security Card (please bring original for copying)
- Health Insurance Verification (current insurance card)
- Up to date Immunization Records
- Any Psychological Evaluations or other mental health treatment records
- Discharge Summaries from prior foster placements/residential facilities
- Current treatment plan/progress reports from any mental health services/placements
- A minimum of 7 days' worth of medication- if your child is on medication; as well as the scripts to fill the medication for the future.

FOR INTERNAL USE ONLY		
After careful review of this application and all required admissions documentation, this child appears to be suitable for placement at the Evans Home for Children.		
SIGNATURE	**POSITION**	**DATE**
	PROGRAM DIRECTOR	
	EXECUTIVE DIRECTOR	

Evans Home Placement Agreement

www.evanshome.org - (540) 662-8520 - 330 E. Leicester St., Winchester, VA 22601

I/we, the parent(s)/legal guardian, agree that, _____, for whom I/we have legal custody, shall be placed with the Henry & William Evans Home For Children (hereinafter known as EH or Evans Home), which shall stand in *loco parentis* to provide care, maintenance, education and guidance while this agreement remains in effect. However, legal custody of the above-named resident shall remain with the undersigned parent(s), legal guardian or placing agency. This agreement shall be in full force and effect until such time as it is in the child's best interest that other plans be made or termination from the program.

Parties agree to terms of placement including the rights and responsibilities stated below.

THE EVANS HOME SHALL:

1. Provide supervision and case management services consistent with the EH program.
2. Provide a nutritionally sound, safe and clean environment for the resident.
3. Be responsible for making sure the resident receives routine medical/dental care and treatment. Obtain permission for planned and special medical/dental care. EH shall act immediately in medical/dental emergencies, obtaining necessary and timely services and notifying the parent/legal guardian within 24 hours.
4. Support the resident academically by providing educational assistance through study time and coordinating with the school regarding any additional services.
5. Notify the Legal Guardian of extended absences that include overnight trips, camps and conferences. Notification may not be routinely provided for day trips.
6. Provide the resident with the opportunity to actively participate in a wide variety of community based activities.
7. Develop an Individual Service Plan (ISP) that will address the resident's strengths and needs; current level of functioning; goals, objectives and strategies established; projected family involvement; projected date for accomplishing each objective; status of the projected discharge plan; and, estimated length of stay. This plan will be reviewed every month and revised quarterly and more often, if needed. Written reports will be provided to the legal guardians and other pertinent parties.
8. Offer attendance to religious services and activities on a **voluntary** basis only. The choice for off-campus faith experiences are strictly up to the child.

In the case of parent/guardian non-cooperation with the EH program or policies, a member of the Administrative Team will attempt reconciliation with the parent/guardian. In the event this effort does not resolve the difficulty, EH may terminate the resident's placement. EH also retains the right to discharge the resident any time his/her behavior poses an immediate threat to him/herself, to peers, to staff or to EH property. When possible, EH agrees to give the Legal Guardian a minimum of 48 hours' notice for discharge.

THE EVANS HOME FOR CHILDREN IS GRANTED FULL AUTHORITY TO:

1. Authorize normal medical/dental treatment as well as Emergency medical/dental, surgical treatment and/or hospitalization that may be necessary and to proceed with obtaining such treatment in emergencies even if the Guardian cannot be notified in advance. The parent(s)/legal guardian will be responsible for any expenses. This includes full authority to admit the resident for emergency in-patient psychiatric care.

2. Screen incoming and outgoing mail as clarified below:
   a. **Incoming Mail** - All incoming mail from persons not on the approved list must be opened in front of staff. Threats, inappropriate language, contraband, and/or inappropriate pictures as well as sexual comments will not be tolerated in outgoing or incoming mail. Note that the resident may receive mail, unopened, from persons on his/her approved list without staff witnessing it being opened.
   b. **Outgoing Mail** - If staff believe there is valid reason to inspect such outgoing mail, such inspection may be done on a case-by-case basis but only after receiving approval from the Parent/Legal Guardian. Note that the resident may send mail to persons on his/her approved list without staff inspecting it.

3. Screen incoming and outgoing telephone calls as clarified below:
   a. A list of parent/guardian approved friends/family will be provided to staff.
   b. Only the names on this list may be called by the resident at the designated times. (*please be aware that we are only able to control the phone calls made here at the Evans Home. If a resident borrows a peers phone at school, or from family members during visits, etc, we will not be held responsible for the calls made under those conditions)

4. Authorizes the Evans Home to file a missing person's report on the child if he/she has eloped without permission.

THE PARENT/ LEGAL GUARDIAN SHALL AGREE TO & COMPLY WITH THE FOLLOWING EVANS HOME POLICIES AND PROCEDURES:

PROGRAM:

1. Agree to encourage the resident to comply with the EH program and to cooperate with those attempting to help him/her.
2. Agrees to pay a **daily** rate of: $75.00. This rate does not include therapy sessions, medications or supplies not covered by Medicaid (diapers, multivitamins, lactaid, etc.).

3. Agree to abide by all guidelines and regulations of the Evans Home including attending meetings to develop service, educational and behavior plans as well as conduct progress reviews.

4. Agrees to meet the resident's clothing needs by providing a clothing allowance of a minimum of $350 per year separate from the daily rate. Further agrees that if such funding provisions are not made in advance, arrangements will be made with EH staff to take the resident shopping to meet clothing needs. Following such shopping, I/we will reimburse EH promptly once presented with a copy of the store receipt.

5. Agrees that the child's attendance at seminars, workshops or other Agency planned activities will be arranged with the Evans Home in advance so that they do not conflict with the child's daily schedule or EH activities.

6. Acknowledges that the anticipated **minimum** length of stay at the Evans Home is 30 days (barring any subsequent decisions made by the placing agency, the Evans Home or by court order).

7. Agrees that unless it has been previously agreed upon, the child is expected to participate in Evans Home holiday activities.

8. Agrees to allow the resident to go to staff members' homes with the group for the purpose of scheduled recreational activities.

9. Understands that the Evans Home provides a variety of trips and outings (some which may leave the state) to enrich residents' lives and help build competencies. I/we understand that while caring for and providing services to the resident, the Evans Home will transport him/her to various events and locations. Having been informed of this service during review of this agreement, I/we hereby give permission for the Evans Home to transport the resident as part of the program. We agree to allow the resident to participate and relinquish all claims against the Evans Home or its staff if an accident should occur.

10. Agrees to visit the resident on a regular basis and work in conjunction with the Evans Home staff and the resident on a transition plan as well as an appropriate discharge plan. The Guardian is required, as per their legal responsibility, to address any issues resulting from the transition.

11. Agrees to comply with the following procedures regarding family contact/visitation:

    a. All Visits, whether they be hourly, day long or overnight, will be scheduled in advance with EH Staff. During that discussion a start date/time as well as an end date/time will be established as well as other parameters prior to the visit taking place.

    b. Any change in the visitation plans should be communicated to the EH staff immediately so that they can plan accordingly.

    c. Any on campus visits will be evaluated for safety/appropriateness and approved by the Program Director/Executive Director. On campus visits are for special circumstances only.

    d. Each resident will be allowed 2- ten-minute telephone calls each day. It is further understood that the resident may receive extra telephone calls if others are not waiting and based on staff availability and the residents' behavior.

    e. Visitation with individual family members must be approved by the Guardian.

    f. The Evans Home reserves the right to prohibit visitation at the home to protect any resident from disruptive, harmful or otherwise negative influence.

    g. The Guardian will provide an approval list that specifies which person(s) may/may not have contact with the child by mail, phone or e-mail.

12. Agrees to confer with the Evans Home Program Director regarding any plans for the residents' temporary absence from the facility prior to making such plans. Agrees to take into consideration activities planned by the facility for the resident before permitting such absences.

13. Understands that in the interest of preventing the introduction of contraband (i.e. materials such as X-rated movies, games or books, weapons, unapproved cell phones, tobacco products, alcohol, unauthorized or illegal drugs, lighters, inhalants, sharp objects, or any other items that are prohibited), residents returning to campus from home visits, or at the discretion of residential staff on duty, are subject to having their bags, clothing, and other items searched. Residents' rooms shall be searched regularly and randomly, with or without probable cause. If a resident is suspected of possession of illegal substances or other contraband which may be harmful to the resident, other residents, or staff, staff will request that the resident turn their pockets inside, take off shoes and show the inside of bags/belongings. If a resident refuses or staff continues to be concerned about possible possession, staff will call the police department who will provide a pat down search.

14. Agrees that in the event of an accident or the death of the resident while in care of the Evans Home I/we will not bring suit against the Evans Home if reasonable and prudent care and supervision have been maintained. If

the resident should become deceased while being cared for by the Evans Home, I/we agree to be responsible for all expenses.

15. Acknowledges receipt of a copy of the grievance procedure explained to and provided to the child.

16. Understands that the Evans Home for Children cannot assume responsibility for loss or damage to clothing, eyeglasses, and other valuable or personal items (including items left behind if a resident absconds (goes AWOL from the Evans Home).

17. Understands that the Evans Home for children uses Audio/video monitoring. Audio/video monitoring may be used in the common area of the residence hallways & possibly outside areas. Monitoring is prohibited in the bedroom and bathroom areas.

MEDICAL:

1. Agrees to make sure the resident has completed both a physical & tb screen/test prior to admission

2. Agrees to provide the resident with Virginia Medicaid or equivalent medical/dental insurance for the resident and to be responsible for all non-covered expenses including, but not limited to, the following: medical, dental, optical, medications, vitamins, and psychological evaluation or services. This includes reimbursement to the Evans Home when necessary.

3. Agrees to be contacted regarding any medical, dental or optical needs that the resident may have. I/we will take care of non-covered expenses including co-payments.

4. Authorizes the Evans Home to have access to the results of all medical and psychiatric care for the purpose of supporting and or fulfilling treatment orders, and arrange follow up care as recommended by the medical provider.

5. Authorizes the Evans Home to have any medical tests or immunizations administered that have been omitted according to the attached medical form, and to bill the Guardian for said tests and immunizations not covered by Medicaid. The same authorization is hereby given for any dental work not completed before admission and to bill the Guardian for said dental work.

EDUCATION:

1. Register the resident in the local public school system **PRIOR** to admission date
2. Contact the resident's previous school system and inform them that the resident will be attending Winchester City Public Schools.

PLEASE NOTE: If you are placing a child in our group home and the legal guardian/s reside outside the Winchester City Area, you will most likely be required to pay a separate yearly tuition for the time period that your child is attending Winchester City public schools while at our facility. For more information please contact Judy McKiernan Lead Student Support Specialist at (540) 974-4104. This only applies to private placements.

By signing this agreement, I am acknowledging that I am the resident's legal guardian. I am confirming that I have the authority to place the resident at the Evans Home for Children and have provided documentation to that effect.

Legal Guardian: _____

Legal Guardian: _____

Evans Home Representative: _____

Date: _____

Evans Home Medical Agreement

www.evanshome.org - (540) 662-8520

Residents Name	

The undersigned Agency acknowledges that final acceptance of an applicant at Henry and William Evans Home is contingent upon satisfactory results of a complete medical examination, including fulfillment of the immunization requirements, and a dental checkup. The undersigned agency also agrees to the following:

1. Agrees to make sure the resident has completed both a physical & tb screen/test prior to admission

2. Agrees to provide the resident with Virginia Medicaid or equivalent medical/dental insurance for the resident and to be responsible for all non-covered expenses including, but not limited to, the following: medical, dental, optical, medications, vitamins, and psychological evaluation or services. This includes reimbursement to the Evans Home when necessary.

3. Agrees to be contacted regarding any medical, dental or optical needs that the resident may have. Agrees to take care of non-covered expenses including co-payments.

4. Authorizes the Evans Home to have access to the results of all medical and psychiatric care for the purpose of supporting and or fulfilling treatment orders, and arrange follow up care as recommended by the medical provider.

5. Authorizes the Evans Home to have any medical tests or immunizations administered that have been omitted according to the attached medical form, and to bill the Guardian for said tests and immunizations not covered by Medicaid. The same authorization is hereby given for any dental work not completed before admission and to bill the Guardian for said dental work.

6. Authorizes normal medical/dental treatment as well as Emergency medical/dental, surgical treatment and/or hospitalization that may be necessary and to proceed with obtaining such treatment in emergencies even if the Guardian cannot be notified in advance. The parent(s)/legal guardian will be responsible for any expenses. This includes full authority to admit the resident for emergency in-patient psychiatric care (in emergency situations only). The legal guardian will be notified within 24 hours if not sooner regarding emergency medical treatments.

SIGNATURES

Agency Representative/ Legal Guardian	
Evans Home Representative	
Date	

(Revised 3-22-17)

Evans Home Clothing Agreement

www.evanshome.org - (540) 662-8520

CHILD'S INFORMATION

Residents Name	

The undersigned Agency hereby acknowledges that _____ (Child) is to have adequate, acceptable clothing brought with him/her to the Henry and William Evans Home at the time of placement, as per the Evans Home clothing list.

This agency hereby authorizes the Henry and William Evans Home to purchase necessary clothing or replace clothing as necessary due to wear/tear, outgrown or inadequate for the child's needs. Said items of clothing to be billed to this Agency.

The Henry and William Evans Home agrees to use good judgment in making any necessary purchases of clothing and to confer with the Agency before making said purchases.

Recommended Clothing List:

Boys	Girls
8 pairs of underwear	8 pairs of underwear
8 undershirts	3 bras (if appropriate)
2 sets of pajamas	2 sets of pajamas
8 t-shirts (any style)	8 t-shirts
2 long sleeved casual shirts	2 long sleeved casual shirts
8 jeans/pants	8 jeans/pants
1 dressy outfit (shirt, pants, shoes)	1 dressy outfit (shirt, pants, dress, skirt, shoes)
8 pairs of socks	8 pairs of socks
1 bathing suit (seasonal)	1 bathing suit (seasonal)
2 sweaters or sweatshirts (seasonal)	2 sweaters or sweatshirts (seasonal)
1 winter coat	1 winter coat
1 spring or light jacket	1 spring or light jacket
1 pair of sneakers	1 pair of sneakers
1 pair of shoes	1 pair of shoes
1 pair of slippers/house shoes	1 pair of slippers/house shoes

SIGNATURES

Agency Representative/ Legal Guardian	
Evans Home Representative	
Date	

(Revised 3-22-18)

Evans Home Emergency Medical Data Sheet

www.evanshome.org - (540) 662-8520

Please don't leave any blanks when completing this form – use "NONE" or "Unknown" as appropriate

CHILD'S INFORMATION

Full Name			
Date of Birth		**Social Security Number**	
Any Medication Allergies (if known)			
Any Other Allergies (bee sting, food, etc?)			

EMERGENCY CONTACT

Full Name			
Address			
Cell Number		**Work Number**	
After Hours Contact		**Email Address**	

INSURANCE INFORMATION

Medicaid	☐ Yes ☐ No	**Medicaid Number**	
Insurance Company			
Policy Number		**Group Number**	
Policy Holder's Name		**Policy Holder's DOB**	
Policy Holder's Relationship to Child		**Policy Holder's Social**	

PRIMARY CARE PHYSICIAN

Physician Name	
Physician Number	
Physician Address	

DENTIST

Dentist Name	
Dentist Number	
Dentist Address	

List any significant past and current medical conditions	
List any History of Substance Abuse	

* All House Parents have the Carezone App installed on their phones with the current medication list as well as the placement agreement and medical authorization. They may also access it through carezone.com or they may call the houseparent on duty.

(Revised 3-22-17)

Evans Home Resident Face Sheet

www.evanshome.org - (540) 662-8520

Please don't leave any blanks when completing this form – use "NONE" or "Unknown" as appropriate

ADMISSION DATE:					
First Name		**Middle Name**		**Last Name**	
Medicaid/Insurance #					
Date of Birth		**Place of Birth**			
Social Security Number		**Race:** ☐ White (includes Arabian) ☐ Black (includes Jamaican, Bahamians, Carribeans not of Hispanic descent) ☐ Hispanic (incl. Mexican, Puerto Rican, Central/South American or Spanish origin) ☐ Asian & Asian American (includes Pakistani, Indians, & Pacific Islanders) ☐ American Indian (includes Alaskans) ☐ Other: (please explain)_____			
Gender					
Religious Preference					
Last known residence					

Reason for Referral to the Evans Home

Legal Guardian Name			
Address		**Home Number**	
Work Number		**Cell Number**	
Email Address			

DSS/Placing Agency Name			
Address		**Home Number**	
Work Number		**Cell Number**	
Email Address			

Emergency Contact Name			
Address		**Home Number**	
Work Number		**Cell Number**	
Email Address			

FOR OFFICE USE ONLY	
DISCHARGE DATE:	
Reason for Discharge:	
Name of person to whom Resident was discharged:	
Address of person to whom resident was discharged	
Forwarding Address of Resident (if known)	
Forwarding Phone Number of Resident	

Revised 2-9-18

Consent To Exchange Information- Educational

www.evanshome.org - (540) 662-8520

Authorization for the release of confidential information

I understand that different agencies provide different services and benefits. Each agency must have specific information in order to provide services and benefits. By signing this form, I am allowing agencies to exchange certain information so it will be easier for them to work together effectively to provide or coordinate these services.

As such, I, _____, the legal guardian/parent, of _____
Name of Parent/Legal Guardian *Resident's Name*

hereby give my permission to _____
Name of Person/School/Organization

_____
Address of Person/School/Organization

to release the following records/reports to the **Evans Home for Children**, 330 E. Leicester St., Winchester, VA 22601. (Office: 540-662-8520) (Fax: 540-662-4224)

REQUESTED RECORDS (except drug or alcohol abuse diagnoses or treatment information)

✓	Educational Assessments	✓	Current School Transcript		Criminal Justice Records
✓	Tri-annual Evaluation		Medical Records		Employment Records
✓	Current I.E.P.		Medical Diagnoses		Financial Information
✓	Most recent report card		Mental Health Diagnoses		Benefits/Services Needed, Planned and or Received
✓	Cumulative Records		Psychological Records		Assessment Information
✓	Immunization Records		Psychiatric Records		Medication Management

ANY ADDITIONAL INFORMATION TO EXCHANGE: (Write In)

ANY OTHER AGENCIES ABLE TO EXCHANGE THIS INFORMATION:

Person/ Agency Name		**Person/ Agency Name**	
Person/ Agency Name		**Person/ Agency Name**	

PURPOSE FOR EXCHANGING INFORMATION: (Check all that apply)

	Service Coordination & Treatment Planning		Eligibility Determination

TYPE OF INFORMATION TO BE SHARED: (Check all that apply)

	Written Information		In Meetings or By Phone		Computerized Data

I want to share additional information received after this consent is signed: ☐ YES ☐ NO

This consent is good until 30 days after the resident's discharge from the program. I understand what information has been requested and I further understand that the provision of services is contingent on the release of this information. I voluntarily consent to the release of this information and I understand that I can withdraw this release at any time.

Signature of Parent/Legal Guardian: _____Date: _____

Consent To Exchange Information- Medical

www.evanshome.org - (540) 662-8520

Authorization for the release of confidential information

I understand that different agencies provide different services and benefits. Each agency must have specific information in order to provide services and benefits. By signing this form, I am allowing agencies to exchange certain information so it will be easier for them to work together effectively to provide or coordinate these services.

As such, I, _____, the legal guardian/parent, of _____
Name of Parent/Legal Guardian *Resident's Name*

hereby give my permission to _____
Name of Person/School/Organization

_____
Address of Person/School/Organization

to release the following records/reports to the **Evans Home for Children**, 330 E. Leicester St., Winchester, VA 22601. (Office: 540-662-8520) (Fax: 540-662-4224)

REQUESTED RECORDS (except drug or alcohol abuse diagnoses or treatment information)

	Educational Assessments		Current School Transcript		Criminal Justice Records
	Tri-annual Evaluation	✓	Medical Records		Employment Records
	Current I.E.P.	✓	Medical Diagnoses		Financial Information
	Most recent report card		Mental Health Diagnoses	✓	Benefits/Services Needed, Planned and or Received
	Cumulative Records		Psychological Records	✓	Assessment Information
	Immunization Records		Psychiatric Records	✓	Medication Management

ANY ADDITIONAL INFORMATION TO EXCHANGE: (Write In)

ANY OTHER AGENCIES ABLE TO EXCHANGE THIS INFORMATION:

Person/ Agency Name		**Person/ Agency Name**	
Person/ Agency Name		**Person/ Agency Name**	

PURPOSE FOR EXCHANGING INFORMATION: (Check all that apply)

	Service Coordination & Treatment Planning		Eligibility Determination

TYPE OF INFORMATION TO BE SHARED: (Check all that apply)

	Written Information		In Meetings or By Phone		Computerized Data

I want to share additional information received after this consent is signed: ☐ YES ☐ NO

This consent is good until 30 days after the resident's discharge from the program. I understand what information has been requested and I further understand that the provision of services is contingent on the release of this information. I voluntarily consent to the release of this information and I understand that I can withdraw this release at any time.

Signature of Parent/Legal Guardian: _____Date: _____

Consent To Exchange Information- Psychological/Psychiatric

www.evanshome.org - (540) 662-8520

Authorization for the release of confidential information

I understand that different agencies provide different services and benefits. Each agency must have specific information in order to provide services and benefits. By signing this form, I am allowing agencies to exchange certain information so it will be easier for them to work together effectively to provide or coordinate these services.

As such, I, _____, the legal guardian/parent, of _____
Name of Parent/Legal Guardian *Resident's Name*

hereby give my permission to _____
Name of Person/School/Organization

_____
Address of Person/School/Organization

to release the following records/reports to the **Evans Home for Children**, 330 E. Leicester St., Winchester, VA 22601. (Office: 540-662-8520) (Fax: 540-662-4224)

REQUESTED RECORDS (except drug or alcohol abuse diagnoses or treatment information)

	Educational Assessments		Current School Transcript	✓	Criminal Justice Records
	Tri-annual Evaluation		Medical Records		Employment Records
	Current I.E.P.		Medical Diagnoses		Financial Information
	Most recent report card	✓	Mental Health Diagnoses	✓	Benefits/Services Needed, Planned and or Received
	Cumulative Records	✓	Psychological Records	✓	Assessment Information
	Immunization Records	✓	Psychiatric Records	✓	Medication Management

ANY ADDITIONAL INFORMATION TO EXCHANGE: (Write In)

ANY OTHER AGENCIES ABLE TO EXCHANGE THIS INFORMATION:

Person/ Agency Name		**Person/ Agency Name**	
Person/ Agency Name		**Person/ Agency Name**	

PURPOSE FOR EXCHANGING INFORMATION: (Check all that apply)

	Service Coordination & Treatment Planning		Eligibility Determination

TYPE OF INFORMATION TO BE SHARED: (Check all that apply)

	Written Information		In Meetings or By Phone		Computerized Data

I want to share additional information received after this consent is signed: ☐ YES ☐ NO

This consent is good until 30 days after the resident's discharge from the program. I understand what information has been requested and I further understand that the provision of services is contingent on the release of this information. I voluntarily consent to the release of this information and I understand that I can withdraw this release at any time.

Signature of Parent/Legal Guardian: _____Date: _____

STANDING ORDER FOR OTC MEDICATIONS

Standing Order for medication **MUST** be signed by a medical doctor.

The following non-prescription medications may be stocked for use at the Evans Home for Children and are used on an **as needed** basis to manage illness and injury.

Please CROSS THROUGH the name of any medication that should **NOT** be used on the following resident.

RESIDENTS NAME	

ACHES, PAINS, FEVERS AND HEADACHES			
	MEDICATION	DOSAGE	Max in a 24 Hr. Period
	Acetaminophen (Tylenol)	(2) 500mg tabs every 4 hours	(8) 500mg tabs
	Ibuprofen (Advil, Motrin)	(1) 200mg tab every 4-6 hours (2) 200mg tabs may be used if pain persists	(6) 200mg tabs
	Naproxen (Aleve)	(1) 220mg tab every 8-10 hours	(3) 220mg tabs in 24 hrs
	Jr. Strength Ibuprofen	Use as directed on label based on weight and age	As directed on label

ALLERGIES, COLDS, COUGHS, SORE THROATS			
	MEDICATION	DOSAGE	Max in a 24 Hr. Period
	Diphenhydramine (Benadryl)	(1-2) 25mg tabs every 4-6 hours	(6) 25mg tabs
	Loratidine (Claritin, Alavert)	(1) 10mg tab in the morning	(1) 10mg in 24 hours
	Fexofenadine (Allegra)	(1) 180mg tab in the morning	(1) 180mg in 24 hours
	Cetirizine (Zyrtec)	(1) 10mg tab in the morning	(1) 10mg in 24 hours
	Phenylephrin hci (Sudafed PE)	(1) 10 mg tab every 4 hrs (12 & up only)	(6) tablets in 24 hours
	Guaifenesin (Mucinex)	(1-2) 600 mg tab every 12 hrs	(4) tablets in 24 hours
	Fluticasone (Flonase)	1-2 puffs per nostril in the morning (no more than 3-5 day period at a time)	1-2 puffs per nostril in 24hr
	Oxymetazoline HCl (0.05%) (Sinex, Afrin)	(2-3) sprays in each nostril every 10-12 hrs (no more than 3-5 day period at a time)	(4-6) sprays in 24 hours
	Antihistamine eye drops (Visine-A)	1-2 drops in affected eye up to 4 times a day	If condition lasts longer than 72 hrs. call doctor.
	Dextromethorphan HBr, USP (20 mg), Guaifenesin, USP (400 mg) (Robitussin DM)	10 ml every 4 hours (use measuring cup) (12 & up only)	(6) 10ml in 24 hours
	Cough Drops	(1) drop/lozenge every 2 hours	No maximum

UPSET STOMACH, CONSTIPATION, DIARRHEA			
MEDICATION		DOSAGE	Max in a 24 Hr. Period
	Loperamide Hcl (Imodium)	(2) tablet after the first loose stool (12 & up only. For younger follow box instructions) (1) tablet after each subsequent loose stool	(4) tablets in 24 hours
	Calcium Carbonate (Tums)	(2-3) 1000mg tablets as symptoms occur	(7) tablets in 24 hours
	Lactase Enzyme (Lactaid)	(1) tablet with first bite of dairy food	Use every time dairy is digested
	Bismuth subsalicylate (Pepto Bismol)_	(2) tablespoon (30ml) of Pepto liquid	(8)doses (240ml or 16 tbsp) in 24 hours
	Polyethylene Glycol (Miralax)	Fill one capful (17grams) Stir And dissolve in any 4 to 8 ounces of beverage (cold, hot or room temperature) then drink. Use once a day.	Use once in 24 hours
	Rehydration Fluids (Pedialyte)	Begin with small frequent sips every 15 minutes, increasing serving size as tolerated. Continue for as long as diarrhea is present.	To maintain proper hydration, 1-2 liters (32 to 64 fl oz) of Pedialyte may be needed per day.

SKIN ABRASIONS, RASHES & ITCHING			
MEDICATION		DOSAGE	Max in a 24 Hr. Period
	Diphenhydramine (Benadryl)	(1-2) 25mg tabs every 4-6 hours	(6) 25mg tabs
	1% Hydrocortisone Maximum Strength Cream Hydrocortisone Cream (Cortaid, Cortizone)	Apply cream to affected area not more than 3 to 4 times daily.	Apply cream to affected area not more than 3 to 4 times daily.
	Calamine Lotion	Apply cream to affected area not more than 3 to 4 times daily.	Apply cream to affected area not more than 3 to 4 times daily.
	Antibiotic Cream (Bacitracin, Double Ointment, Polysporin)	Apply a small amount of this product (an amount equal to the surface area of the tip of a finger) on the area 1 to 3 times daily	1-3 times daily

	OTHER AILMENTS		
	MEDICATION	DOSAGE	Max in a 24 Hr. Period
	Melatonin	(1) 3mg tablet at bedtime	(1) 3mg tablet in 24 hours
	Motion Sickness (Dramamine)	**Children 12 Years and Over:** Take 1 to 2 tablets every 4-6 hours. **Children 6 to Under 12 Years:** Give 1/2 to 1 tablet every 6-8 hours.	Do not take more than 8 tablets in 24 hours, or as directed by a doctor. Do not give more than 3 tablets in 24 hours, or as directed by a doctor.
	Aloe Vera	Aloe gel may be applied liberally as needed.	Use as directed on the package, unless instructed differently by your doctor
	Lice Shampoo or Cream (Nix or Elimite)	Use as directed on the package.	Use as directed on the package, unless instructed differently by your doctor.

If at any time the minor condition being treated worsens or lasts longer than 3-5 days, the residents physician will be contacted immediately.

PHYSICIANS NAME	
PHYSICIANS ADDRESS	
PHYSICIANS SIGNATURE	
DATE	

EVANS HOME PHYSICAL EXAM REPORT

Please don't leave any blanks when completing this form – use "NONE" or "Unknown" as appropriate

Child's Name		**Date of Exam**	

Immunizations administered today (***If none were administered please write NONE***)

TB SCREENING/ TB TEST-
PLEASE SEE ATTACHED FORMS AND FILL OUT ACCORDINGLY

Does the child appear to be free from communicable disease? ☐ **YES** ☐ **NO**

Height				
Weight				
Blood Pressure				
Heart Rate				
Allergies				
Handicaps				
Chronic Conditions				
Nutritional Requirements (*including special diets*)				
Restrictions on activities				
Hearing	Right Ear		Left Ear	
Vision	Right-W/O Glasses		Left-W/O Glasses	
	Right-With Glasses		Left-With Glasses	
Color Discrimination				
General Physical Condition				
Follow Up Appointment *(Only if needed)*				
Recommendations				

Physician's Signature (PLEASE SIGN NAME)	
Physician's Phone Number	

VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment
www.vdh.virginia.gov

Virginia Department of Health TB Control Program
TB Risk Assessment Form (TB 512)

Patient name (L,F,M): _____ DOB: _____ Race: ____ Sex: ____

Address: _____ Social Security Number: _____

City, State, ZIP: _____ Home/Work #: _____

Cell #: _____ Language: _____ Patient Pregnant: ___No ___Yes; If Yes, LMP: _____

Country of Origin: _____ Year arrived in US (if applicable): _____ Interpreter needed: ___No ___Yes

I. Screen for TB Symptoms (Check all that apply)

___None (Skip to Section II, "Screen for Infection Risk")
___Cough for ≥ 3 weeks → Productive: ___YES ___NO
___Hemoptysis
___Fever, unexplained
___Unexplained weight loss
___Poor appetite
___Night sweats
___Fatigue
Evaluate these symptoms in context

Pediatric Patients (≤ 6 years of age):
___Wheezing
___Failure to thrive
___Decreased activity, playfulness and/or energy
___Lymph node swelling
___Personality changes

II. Screen for TB Infection Risk *(Check all that apply)*

Individuals with an increased risk for acquiring latent TB infection (LTBI) or for progression to active disease once infected should have a TST. Screening for persons with a history of LTBI should be individualized.

A. Assess Risk for Acquiring LTBI
The Patient…
___is a current high risk contact of a person known or suspected to have TB disease: Name of Source case: _____
___has been in another country for - 3 or more months - where TB is common, and has been in the US for ≤ 5 years
___is a resident or an employee of a high TB risk congregate setting
___is a healthcare worker who serves high-risk clients
___is medically underserved
___has been homeless within the past two years
___is an infant, a child or an adolescent exposed to an adult(s) in high-risk categories
___injects illicit drugs or uses crack cocaine
___is a member of a group identified by the health department to be at an increased risk for TB infection
___needs baseline/annual screening approved by the health department

B. Assess Risk for Developing TB Disease if Infected
The Patient…
___is HIV positive
___has risk for HIV infection, but HIV status is unknown
___was recently infected with *Mycobacterium tuberculosis*
___has certain clinical conditions, placing them at higher risk for TB disease: _____
___injects illicit drugs (determine HIV status): _____
___has a history of inadequately treated TB
___is >10% below ideal body weight
___is on immunosuppressive therapy (this includes treatment for rheumatoid arthritis with drugs such as Humira, Remicaid, etc.)

History of BCG / TB Skin Test / TB Treatment:

History of prior BCG: ___NO ___YES → Year: _____
History of prior (+) TST: ____NO ___YES
Date of (+) TST _____ Reading: ____mm
CXR Date: _____ CXR result: ___ABN ___WNL
Dx: ___LTBI ___Disease
Tx Start: _____ Tx End: _____
Rx: _____
Completed: ___NO ___YES
Location of Tx: _____

III. Finding(s) *(Check all that apply)*

___Previous Treatment for LTBI and/or TB disease
___No risk factors for TB infection
___Risk(s) for infection and/or progression to disease
___Possible TB suspect
___previous positive TST, no prior treatment

IV. Action(s) *(Check all that apply)*

___Issued screening letter ___Issued sputum containers
___Referred for CXR ___Referred for medical evaluation
___Administered the Mantoux TB Skin Test
___Draw interferon-gamma release assay
___Other: _____

TST Placed	TST Read
Arm: ___Left ___Right Date/Time _____ POS#:_____	Date/Time _____ Induration _____mm POS#:_____

IGRA Type used: ___T-Spot ___QFT-G-IT

Date/Time drawn: _____

Result: ___Pos ___Neg ___Borderline/Indeterminate

Screener's signature:_____

Screener's name (print):_____

Screener's title:_____

Date: _____ Phone #:_____

Comments: _____

- I hereby authorize the doctors, nurses, or nurse practitioners of the Virginia Department of Health to administer the Tuberculin Skin Test (PPD) or draw blood for an IGRA test from me or my child named above.
- I agree that the results of this test may be shared with other health care providers.
- The Deemed Consent for blood borne diseases has been explained to me and I understand it.
- I acknowledge that I have received the Notice of Privacy Practices from the Virginia Department of Health.
- I understand that:
  - this information will be used by health care providers for care and for statistical purposes only.
  - this information will be kept confidential.
  - medical records must be kept at a minimum for 10 years after my last visit, 5 years after death; for minor children, 5 years after the age of 18, or 10 years after the last visit, whichever is greater.

X _____ Date: _____

Virginia Department of Health
REPORT OF TUBERCULOSIS SCREENING

DATE _____

Name _____ Date of Birth _____

To Whom It May Concern:

The above named individual has been evaluated by _____
(Name of health dept./facility)

Tuberculin Skin Test (TST)

Date given: _____ Date read: _____

Results: _____mm ___ Negative ___ Positive

The individual listed above has no symptoms compatible with active tuberculosis. The individual is free of tuberculosis in a communicable form.

Signature _____ Date _____
(MD or Health Department Official)

Address _____ Phone _____

City, State, Zip _____

Interferon Gamma Release Assay Alternative test for the tuberculin skin test (TST)

Date drawn _____ Time drawn _____

Result: ___Neg ___Pos ___Indeterminate ___Borderline

The individual listed above has no sympotms compatible with active tuberculosis. The individual is free of tuberculosis in a communicable form.

Signature _____ Date _____
(MD or Health Department Official)

Address _____ Phone _____

City, State, Zip _____

Chest X-Ray – No active disease

Date of Chest x-ray _____

___ No evidence of active tuberculosis

The individual listed above has no symptoms or radiographic findings compatible with active tuberculosis. The individual is free of tuberculosis in a communicable form.

Signature _____ Date _____
(MD or Health Department Official)

Address _____ Phone _____

City, State, Zip _____

Chest X-Ray – Abnormal Report

Date of Chest x-ray _____

___ Chest x-ray abnormal, active tuberculosis to be ruled out

Active tuberculosis cannot be ruled out in the individual listed above. The individual should be referred to a physician or health department for further evaluation.

Signature _____ Date _____
(MD or Health Department Official)

Address _____ Phone _____

City, State, Zip _____

REPORT OF TUBERCULOSIS SCREENING

DATE _____

Name _____ Date of Birth _____

TO WHOM IT MAY CONCERN:

The above named individual has been evaluated by _____.
(Name of health dept/facility)

_____ A tuberculin skin test (PPD) is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis, risk factors for developing active TB or known recent contact exposure.

_____ The individual has a history of a positive tuberculin skin test (latent TB infection). Follow-up chest x-ray is not indicated at this time due to the absence of symptoms suggestive of active tuberculosis.

_____ The individual either is currently receiving or has completed adequate medication for a positive tuberculin skin test (latent TB infection) and a chest x-ray is not indicated at this time. The individual has no symptoms suggestive of active tuberculosis disease.

_____ The individual had a chest x-ray on _____ that showed no evidence of active tuberculosis. As a result of this chest x-ray and the absence of symptoms suggestive of active tuberculosis disease, a repeat film is not indicated at this time.

Based on the available information, the individual can be considered free of tuberculosis in a communicable form.

Signature _____ Date _____
(MD or Health Department Official)

Address _____ Phone _____
_____
_____

Evans Home Rate Sheet

www.evanshome.org - (540) 662-8520

Effective from July 1, 2019 to June 30, 2020 **Henry & William Evans Home for Children** 330 E. Leicester St. Winchester, VA 22601 **Phone:** (540) 662-8520 **Fax:** (540) 662-4224		
Program Director-Admissions	LaMishia Allen, M.S.W.	LaMishia.Allen@evanshome.org
Executive Director	Marc Jaccard	Marc.Jaccard@evanshome.org
Business Office- Billing	Liz Brenner	evans@evanshome.org

RESIDENTIAL PROGRAM RATE		
SERVICE	**DAILY RATE**	**VIRGINIA MEDICAID ELIGIBLE**
Residential Room and Board	$41.25	No
Daily Supervision	$20.25	No
Administrative Case Management	$3.75	No
Other Residential Services	$9.75	No
RESIDENTIAL DAY PER DIEM	**$75.00**	Bundled Rate

The Evans Home for Children is **NOT** a treatment facility, therefore, all other services, including but not limited to, individual/family counseling, medication management, visitation, medical services, dental services, speech and hearing/OT, group counseling, drug testing, etc. would be delivered by local community providers.

Evans Home WHAT TO BRING WITH YOU list

EVERYDAY CLOTHING

- 8 pairs of jeans/ pants
- 8 t-shirts
- 2 long sleeved casual shirts
- 8 pairs of socks
- 8 pairs of underwear/panties
- 2 sets of sleepwear (pajamas)
- 1 pair of slippers/house shoes
- 2 sweatshirts/hoodies/sweaters
- 1 pair of sweatpants/joggers
- 1 light weight jacket
- 1 winter coat
- 1 pair of gloves
- 1 knitted cap/hat for the winter
- 1 swimsuit/swim trunks
- 1 pair of tennis shoes (sneakers)

DRESS CLOTHING

- 1 Long sleeved dress shirt/ blouse
- 1 pair dress socks/pantyhose
- 1 pair dress shoes
- 1 pair dress pants/ skirt or dress
- 1 belt
- 1 tie

ITEMS THAT WILL BE PROVIDED FOR YOU:

- Wash Cloths & Bath Towels
- Bed Sheets
- Pillows & Blankets
- Hygiene Basket
- Hygiene Products (body wash, deodorant, toothbrush toothpaste, etc)
- Alarm Clock
- Hair Brush/Combs
- Laundry Basket

PROHIBITED ITEMS

- No Cell Phones
- No Wi-Fi capable equipment (i.e.: IPad, IPod, Tablets, Personal Computers/Laptops, Video Equipment, etc.)
- No controlled substances (illegal drugs, or drugs without a prescription)
- No toxic glue, paint, spray paint, aerosol cans of any kind or airbrush guns
- No matches, lighters or cigarettes
- No boomerangs or sling shots
- No guns, knives or other weapons
- No fireworks
- No clothing with profanity, violent/sexual content, symbols of gang or their colors, drugs or alcohol reference
- No music CD's with profanity, violent/sexual content (ie: parental advisory cds)

It is the responsibility of the Evans Home to provide a safe and secure environment for the residents and staff. Provisions of such an environment require ensuring that items which would prove a threat to the safety and well-being of students and staff are not allowed on campus. To that end student searches are conducted in accordance with our policy, prior to admission, after visits off campus and at staff discretion.

Revised 3-24-17

VIRGINIA DEPARTMENT OF EDUCATION

CERTIFICATE OF ENROLLMENT
PUBLIC, PRIVATE, AND HOMESCHOOL

A certificate of enrollment must be issued by an authorized school official, and must provide the student's residential (street) address as it appears on the permanent record. A post office box is not acceptable as a residential address. Photocopies of this form are not valid. All signatures must be in blue ink to verify this is an original.

SCHOOL:		**SCHOOL DIVISION:**	
STUDENT'S LEGAL NAME:	**LAST:**	**FIRST:**	**MI:**
DATE OF BIRTH (MONTH/DAY/YEAR):			
STUDENT'S RESIDENTIAL ADDRESS:	**STREET** ***(PO BOX NOT ACCEPTABLE)*****:**		**APT#:**
CITY:	**STATE:**	**ZIP CODE:**	
AUTHORIZED SCHOOL OFFICIAL'S SIGNATURE: (PLEASE USE BLUE INK)		**DATE:**	
SCHOOL OFFICIAL'S PRINTED NAME:		**SCHOOL PHONE NUMBER:**	

I CERTIFY THAT THE NAME, ADDRESS, AND DATE OF BIRTH CONTAINED ABOVE ARE ACCURATE.

PARENT/LEGAL GUARDIAN'S SIGNATURE: (PLEASE USE BLUE INK)	**DATE:**
PARENT/LEGAL GUARDIAN'S PRINTED NAME:	
PARENT/LEGAL GUARDIAN'S DRIVER'S LICENSE OR DMV-ISSUED IDENTIFICATION NUMBER:	
STUDENT'S SIGNATURE: **(PLEASE USE BLUE INK)**	**DATE:**

PLEASE NOTE:

If this form is issued to a minor, a parent or guardian must sign this form.

This form may be subject to federal and state laws and regulations depending upon its use. In addition, fraudulently obtaining, altering, counterfeiting, forging or otherwise tampering with this form or falsifying information contained herein in order to obtain a photo-identification card, learner's permit, driver's license or birth certificate may be a criminal offense.

Revised January 2015