Tamassee DAR School
Reaching for the stars

Thank you for your interest in Tamassee DAR School.

Enclosed is an application packet, should you wish to enroll your child into our program. All questions on the application should be answered to the best of your ability. Please print or type all information given. If a particular question does not apply, please write "N/A" in the appropriate place so that we will know that you have read and understood the question.

On page 3 (section 3) entitled "Family," please give information for the children's NATURAL/BIOLOGICAL parents, or legally adoptive parents. DO NOT USE STEP-PARENT INFORMATION in this section.

You are provided "Authorization for Release of Information" forms for your child's *School, Medical, and Mental Health providers* to release information. Please sign and return with the application a completed form for each provider involved in your child's life. If there are multiple medical providers or mental health providers, please complete one for each.

The "Health Information" forms for disclosure of any South Carolina Health and Mental Health records must also be signed and returned.

You may return the application with all documentation to us via mail, email, or fax. Contact information is provided below. After we receive the completed application packet from you, we will request records from any schools and medical agencies. Once we have received and reviewed these records, you will be contacted in regards to the next step in the admission process or for any further questions. If your child is approved for the next step, will set up a date and time for a personal interview to meet with you and your child. If we are unable to accept your child, we will notify you with the reason for denial.

Thank you again for your interest in our program. If we can answer any questions or provide further information, please feel free to call us.

Sincerely,

Erin Cash
Intake/Admissions Coordinator

Mail to: Tamassee DAR School ATTN: Admissions 1925 Bumgardner Dr. PO BOX 8, Tamassee, SC 29686	Email: erinc@tdarschool.org Fax: 864-944-2004 Office: 864-944-3022

Documentation needed ***Before Interview and Intake dates***

Guardians please provide the following documentation for your child

□ Signed Release Forms (included, use separate form for each)

- **Medical—*all medical providers, primary care, dentist, eye doctor, specialist, etc.***
- **Schools—*schools attended current school year***
- **Mental Health—*all counseling locations attended, including residential or inpatient facilities***
- **Any other involved agency or placement**

□ Copy of Student's:

- **Social Security Card**
- **Birth Certificate**
- **Medicaid/Insurance Card**
    - If under a private Insurance, please fully complete Private Insurance Subscriber Information form.

□ Tuberculosis (TB) Test with proof of negative results within the last year

□ Immunization Records – up to date

□ Psychological Evaluation (*if available*)

□ Court or Legal Documentation (*proof of custody – if there has been a change since birth and or the student has been involved with the judicial system*)

Tamassee DAR Admission will request the following with signed release forms.

□ School Records

□ Medical Records

□ Mental Health Records

Private Insurance Subscriber Information

Child's Name:_____ Child's Date of Birth:_____

Primary Insurance Information

**Please provide a copy of the front and back of the insurance card*

Insurance Co. Name	
Effective Date	
Policy #	

Full Name	
Relationship to Student	
Date of Birth	
Social Security Number	

Address	
Phone	

Employer	
Employment Status	
Employer insurance?	

Secondary Insurance Information (if applicable)

** Please provide a copy of the front and back of the insurance card*

Insurance Co. Name	
Effective Date	
Policy #	

Full Name	
Relationship to Student	
Date of Birth	
Social Security Number	

Address	
Phone	

Employer	
Employment Status	
Employer insurance?	

Parent Signature: _____ Date_____

New Student Health History

Student Name: _____ Date of Birth: _____

Primary Care and Dental Health

Primary Care: _____ _____
Health Care Provider's Name Phone

Dental Health: _____ _____
Dentist's Name Phone

Who lives with student?

Name	Relationship	Age

Check if any blood relative(s) has or had any of the following: (*ex: F = Father, M = Mother, B = Brother, S = Sister, GF = Grandfather, GM = Grandmother, A = Aunt, U = Uncle)*

Disease	√	Relationship to Your Child	Disease	√	Relationship to your Child
Asthma			Eye/Ear Disorders		
Allergies			Heart Trouble		
Birth Defects			Anemia		
High Blood Problems			Blood Disorders		
Cancer			Lung Disease		
Kidney/Bladder Problems			Tumors		
Tiberculosis			Cystic Fibrosis		
Seizures			Mental Retardation		
Childhood Death			Muscle Disease/Weakness		
Diabetes			Mental Health		
Death Under 50					

Medications – List medications your child is currently taking and reason– if None, write NONE.

_____

_____

_____

_____

Is your child allergic to any medication(s): If None, write NONE

_____

_____

Has a doctor ever told your child that he/she has a Latex allergy? ( ) Yes ( ) No
Has your child ever experienced itching, swelling or wheezing after contact with Latex (*ex. Blowing up a balloon, after a visit with the dentist, or after surgery?)* ( ) Yes ( ) No
Has your child ever experienced allergic symptoms after eating fruit? Particularly kiwi, bananas, avocados, or tomatoes? ( ) Yes ( ) No

Hospitalizations/Surgeries			**Immunizations**
Year	**Hospital**	**Reason**	Date of Last Tetanus Shot: _____ Hepatitis B Series ( ) Yes ( ) No Date Completed: _____ If born after 1956, have you had a second measles shot? ( ) Yes ( ) No Date: _____

Check (√) if your child had or does have any of the following diseases/problems. Give date of illness, operation, or injury, and date of last treatment.

Alcohol Abuse	Ear Trouble	Meningitis
Amnesia	Eating Disorder	Menstrual Problems
Appendicitis	Encephalitis	Migraine Headaches
Asthma	Exercise Induce Asthma	Mumps
Birth Defects	Eye Trouble	Nervous/Mental condition
Blood Clots	Fainting	Pneumonia
Bronchitis	Frequent Headaches	Recurrent Headaches
Cancer	Gall Bladder Trouble	Rheumatic Fever
Car or Air Sickness	Hearing Defect/loss	Rubella
Chest Pain	Heart Problem	Scarlet Fever
Chicken Pox	Hemorrhoids	Seizure Disorder
Chronic Cough	Hepatitis	Sexually Transmitted Disease
Concussion	Hernia	Sickle Cell Anemia
Convulsions	High Blood Pressure	Sinus Trouble
Diabetes	Hypoglycemia	Stomach/Intestinal Problems
Diphtheria	Kidney Disease	Tuberculosis
Depression	Malaria	Ulcers
Drug Abuse	Measles	

Mental Health

Counselor: _____

Name & Office

_____ _____

Phone Fax

Prescribing Physician/Specialist: _____

Name & Office

_____ _____

Phone Fax

Current or most recent diagnosis(es) for your child-- If None, write NONE.

*primary or most prevalent first.

Diagnosis	Date given	Medications prescribed	Diagnosis professional

Family History

Check if any blood relative(s) has or had any of the following: (*ex: F = Father, M = Mother, B = Brother, S = Sister, GF = Grandfather, GM = Grandmother, A = Aunt, U = Uncle)*

Condition	√	Relationship to Your Child	Condition	√	Relationship to your Child
Alcohol Abuse			Oppositional Defiant Disorder		
Drug Abuse			Bipolar Disorder		
Anger			Borderline Personality Disorder		
Criminal History			Depression		
Physical Abuse			Post-Traumatic Stress Disorder		
Sexual Abuse			Schizophrenia		
ADHD			Suicide		
Anxiety			Other:_____		
Conduct Disorder					

PROVIDER AUTHORIZATION FOR RELEASE OF INFORMATION

Student's Name:_____

Social Security #:_____ Date of Birth:_____

Address:_____

The purpose of this release is to provide two way communication between __Tamassee DAR School__ and the student's medical provider listed below for the development and implementation of care for the above named student and their family or designated guardian.

Name of Medical Provider:_____

Address:_____

Phone:_____ Fax:_____

I request and authorize the above mentioned school to release all information concerning the above named student to: Tamassee DAR School

Address: PO BOX 8, Tamassee, SC 29686

Phone: 864-944-3022

Fax: 864-944-2004

You may withdraw this consent at any time by written notification to Tamassee DAR School. This consent will expire on the listed expiration date.

_____ _____

Date Parent/Legal Guardian Signature

_____

Expiration Date

PROVIDER AUTHORIZATION FOR RELEASE OF INFORMATION

Student's Name:_____

Social Security #:_____ Date of Birth:_____

Address:_____

The purpose of this release is to provide two way communication between __Tamassee DAR School__ and the student's medical provider listed below for the development and implementation of care for the above named student and their family or designated guardian.

Name of Mental Health Provider:_____

Address:_____

Phone:_____ Fax:_____

I request and authorize the above mentioned school to release all information concerning the above named student to: Tamassee DAR School

Address: PO BOX 8, Tamassee, SC 29686

Phone: 864-944-3022

Fax: 864-944-2004

You may withdraw this consent at any time by written notification to Tamassee DAR School. This consent will expire on the listed expiration date.

_____ _____

Date Parent/Legal Guardian Signature

_____

Expiration Date

SCHOOL AUTHORIZATION FOR RELEASE OF INFORMATION

Student's Name:_____

Social Security #:_____ Date of Birth:_____

Address:_____

The purpose of this release is to provide two way communication between __Tamassee DAR School__ and the student's school listed below for the development and implementation of care for the above named student and their family or designated guardian.

Name of School:_____

Address:_____

Phone:_____ Fax:_____

I request and authorize the above mentioned school to release all information concerning the above named student to: Tamassee DAR School

Address: PO BOX 8, Tamassee, SC 29686

Phone: 864-944-3022

Fax: 864-944-2004

You may withdraw this consent at any time by written notification to Tamassee DAR School. This consent will expire on the listed expiration date.

_____ _____

Date Parent/Legal Guardian Signature

_____

Expiration Date

AUTHORIZATION FOR RELEASE OF INFORMATION

Student's Name:_____

Social Security #:_____ Date of Birth:_____

Address:_____

The purpose of this release is to provide two way communication between __Tamassee DAR School__ and the agency listed below for the development and implementation of care for the above named student and their family or designated guardian.

Name:_____

Address:_____

Phone:_____ Fax:_____

I request and authorize the above mentioned agency to release all information concerning the above named student to: Tamassee DAR School

Address: PO BOX 8, Tamassee, SC 29686

Phone: 864-944-3022

Fax: 864-944-2004

You may withdraw this consent at any time by written notification to Tamassee DAR School. This consent will expire on the listed expiration date.

_____ _____

Date Parent/Legal Guardian Signature

_____

Expiration Date

Financial Verification

Student's Name:_____

Verification needed to complete this form

- Last year's tax returns (for all income sources living within your household)
- Last two pay stubs for all working within your household

*I understand that my student's board payment will be set without a discount until all documentation are presented. If you do not have pay stubs or did not file taxes within the last year we will need an official verification notice from the IRS.

Please list any person(s) living in your household:

1.	5.
2.	6.
3.	7.
4.	8.

Annual income for your household: (please list income from all sources including *child support, disability, Social Security Benefits, inheritance, or any other income*)

Parent/Guardian:_____

Parent/Guardian:_____

Student:_____

Other:_____

Other:_____

I understand the information I have given will be used for the sole purpose of determining the amount of board payment for my student. I am stating that the information I have given is true. I agree to contact __Tamassee DAR School__ if my financial circumstances change.

_____ _____

Parent/Guardian Signature Date

_____ _____

Tamassee DAR School Witness Date