



### Instructions & Admission Requirements

Complete and sign the following prior to the transport and placement of your child:

- A. Contract for Services (Must be **notarized**)
- B. Pharmacy Information Sheet
- C. Power of Attorney (Must be **notarized**)
- D. Permission for Release of Medical Records
- E. Permission for Release of School Records
- F. Consent for Release to Insurance Provider
- G. Individual Progress Plan
- H. Interstate Compact
- I. Consent for Treatment & Participation
- J. Consent for Medical Treatment
- K. Child History
- L. Essential Information Form

Please include the following items with admissions paperwork:

- A. Recent Picture of Child
- B. Copy of Child's Birth Certificate
- C. Copy of last physical exam, only if it was within the last three months. If this is not included with initial paperwork, White River will arrange for a physical to be performed by a contracted physician within the first seven days of admission. All costs for such medical examinations and/or procedures will be the responsibility of the parent/guardian.
- D. One Copy of immunization records
- E. One Copy of Insurance Cards, front & back.
- F. Minimum initial payment consisting of the first month's tuition \$3,450.00 plus \$500.00 uniform fee and \$2,500.00 admission fee. These fees totaling \$6,450.00 must be brought with the child at time of placement. Methods of payment are Check or Money Order. Check or Money Order should be made payable to White River Academy.
- G. Clothing Inventory

**WHITE RIVER ACADEMY  
CONTRACT FOR SERVICES**

Enrollment Contract made by, between, and among White River Academy, Inc. A therapeutic school organized and existing under and by virtue of the laws of the State of Utah with its principal place of business at or near 275 West 100 South Delta, Utah 84624 and the undersigned, whether one or more (“client”), for benefit of the child or ward of client (“child”):

Recitals

1. White River Academy operates a facility at or near Delta, Utah for the purpose of providing behavior improvement, 24 hour structure, 24-hour supervision, self esteem and emotional growth services for children with special needs and academics.
2. White River Academy is licensed as a Therapeutic School by the Department of Human Services, Office of Licensing in the State of Utah.
3. Client desires to employ White River Academy for purposes of providing services to child, for the consideration, and subject to the terms contained herein.

NOW THEREFORE THIS CONTRACT

1. GUARDIANSHIP – The Sponsors affirm that they are the legal \_\_\_\_\_ with \_\_\_\_\_ custody of \_\_\_\_\_ (Hereinafter “the child”) whose birth date is \_\_\_\_\_, and that they expressly desire to contract from his admission to the program according to the terms of this agreement. The Program shall be entitled to rely on the representation of either of the above-named Sponsors with respect to the Child, regardless of whether the term “Sponsor” appears in this agreement in the singular or the plural.
2. ADMISSION OF CHILD – Upon the completion of this agreement, the program agrees to review for the admission the above named Child and promises to undertake and provide the following services and facilities: room and board, 24-hour supervision, academic program, emotional growth program, group sessions, all routine progress services, supervised use of recreational equipment and facilities, supervised work projects, clothing and personal amenities, haircuts, postal costs, and incidental allowance expenditures.
3. CONTRACT PERIOD - This agreement will begin the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ and will be effective for a period of one year. This contract shall be renewed automatically on a month-to-month basis at that time, unless either party terminates this agreement by giving written notice to the other parties outlined in section 9.a. 9.b.
4. FINANCIAL PROVISION
  - a. ROOM AND BOARD, SUPPORT, COUNSELING, ACADEMIC CHARGES - The monthly tuition rate for services described under section 2 shall be; \$3,450.00 for the period of to include services listed in section 2 of this contract.
  - b. ADDITIONAL COSTS AND EXPENSES - In addition to the above payment, the Sponsor(s) agree to pay for the following expenses incurred by the Child, which will be billed to the Sponsor(s) monthly as they arise: medical and dental expenses, individual counseling (2 sessions per month of individual counseling are included in the normal monthly tuition, other sessions will be billed at \$85.00 per hour), prescribed medications, airline or other forms of transportation (including admission and discharge travel expenses as well as transport to medical, dental, optical or other non program related appointments) and special testing beyond that which is normally covered by the Program.

- c. PAYMENT SCHEDULE - A payment of six thousand four hundred and fifty dollars (\$6,450.00) consisting of the placement fee of \$2,500.00 plus the tuition at three thousand four hundred and fifty dollars (\$3,450.00) and the uniform fee of five hundred dollars (\$500.00) are due upon admission. All other costs described under 4.b. shall be billed to the Sponsor(s) on a monthly basis. Monthly tuition payments are due on the same day of the month as when your child enters the academy.
- d. ANNUAL RATE INCREASE - The tuition rate described under 4.a. shall be subject to annual increase.
- e. RESPONSIBILITY OF DAMAGE TO PROPERTY BY THE CHILD - Sponsor(s) agree to be financially responsible for the costs of repairing or replacing any program property or personals, or for the replacement of any property belonging to others which may be located at the facility which has been damaged, defaced or destroyed by the Child, or for any damage resulting from injury to third person caused by the Child.
- f. EXPENSES FOR THE ASSISTANCE IN THE RETURN OF A RUNAWAY CHILD – In the event that the Child becomes a run-away, either from program or elsewhere, the Program will use reasonable efforts to assist the Sponsor(s) in finding the child and in obtaining the safe return of the child to the program. An accounting of the expenses incurred by the program while assisting the Sponsor(s) in finding and returning the Child to the program will be made to the Sponsor(s). Sponsor(s) will be responsible for one half of such expenses.
- g. RESPONSIBILITY FOR PERSONAL PROPERTY - The Program is not liable financially or otherwise, for the loss, damage, or theft of any of the Child’s property during their stay.
- h. COSTS OF COLLECTION: ATTORNEY FEES : LATE CHARGES- Sponsor(s) agree to pay for the cost of collection of any amounts due under this agreement, including reasonable attorney’s fees at the rate of 35% of the balance assigned plus the court costs. The Sponsor(s) also agree to pay 18% annum on any unpaid balance that becomes over 60 days past due both during the program process and if any default occurs. If payments are not received on their due date a \$100 fee is assessed and will need to be included with your payment.
- 5. RESPONSIBILITY FOR INJURY OR ACCIDENT - The Program is not liable for any injuries, illness or other damages occurring to the Child during the term of enrollment, including any resulting from the Child’s participating (on or off campus) in programs or activities of the program.
- 6. RESPONSIBILITY FOR LOST, STOLEN OR DAMAGED PERSONAL PROPERTY - The Program is not responsible or liable for any lost, stolen or damaged personal property of the Child during the term of enrollment, including any resulting from the Child’s participating (on or off campus) in programs or activities of the program, nor is the Program liable for any lost, stolen or damaged personal property of the Child which is the result of actions on the part of another Child.
- 7. RELEASE OF RECORDS - The Program shall release the Child’s records to other facilities upon the specific request and written authorization of the Sponsor(s). However, said records shall not be released until all balances owing the program under this contract are paid in full.
- 8. CHOICE OF JURISDICTION, LAW, AND OTHER MATTERS - Sponsor(s) agree to be subject to jurisdiction of Utah Courts in any dispute between the parties of this agreement. The parties agree that Utah law shall govern this agreement. Failure of either party to enforce any term or provision of this agreement shall not constitute or be constructed as a waiver of such term or provision of the right to enforce it. If any provision of this agreement is construed as overbroad as written, the remaining provisions shall remain enforceable according to applicable law.

9. EARLY ENROLLMENT TERMINATION

- a. TERMINATION BY PROGRAM - The Program reserves the right to terminate this agreement at any time upon seven (7) days advance notice to Sponsor(s). In the event of such termination by the Program, the Program shall refund any unused portion of tuition paid.
- b. WITHDRAWEL BY SPONSOR(S) - Sponsor(s) retain the right to terminate the agreement at any time. However in the event that the Sponsor(s) withdraw the child prior to the completion of the service plan, the Sponsor(s) shall pay equal to one months tuition which is deemed equivalent by both parties of this agreement as a reasonable pre-estimate of the probable loses that would be sustained by the program in the event of a withdrawal of a child prior to the completion of the service plan goals. This “loss” amount is not considered by either of the parties to this agreement as a penalty of early withdrawal of the Child. Instead, because the cost of such items as contracted staff salaries, incurred debt reduction, staff schedules, inventories, operation expenses, etc., are so difficult or impossible to accurately estimate the tuition payment equivalent appears to each of the parties as a reasonable estimate of the Programs losses associated with the early withdrawal of the child.

10. THE UNDERSIGNED AGREE(S) - That in the event that other healthcare professional providers, including, but not limited to other hospital(s), furnish services to the child while in the program, the consent(s), assignment(s), guarantee(s), and release(s), herein above set out apply to other providers and services.

11. SCOPE AND MEANING OF AGREEMENT - Sponsor(s) hereby acknowledge that they have read the agreement and that they understand and assent to the provisions. This agreement constitutes the entire agreement between the parties except as may be noted by attached addendum when appropriate.

IN WITNESS WHERE OF, The parties have executed this agreement as of the last day set forth below.

\_\_\_\_\_ signed this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
Signature of sponsor (Father/Guardian)

\_\_\_\_\_ signed this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
Signature of sponsor (Mother/Guardian)

\_\_\_\_\_ signed this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
Signature of financial sponsor other than guardian

\_\_\_\_\_ signed this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
Signature & Seal of Notary:

## White River Academy Pharmacy Information Sheet

Service United Pharmacy  
Delta, Utah

*In the event that a prescription is needed for an individual staying at White River Academy the following information will greatly help the pharmacy staff.  
(Please Print)*

Name of the child: \_\_\_\_\_

Date of birth of the child: \_\_\_\_\_ Gender: \_\_\_\_\_

Does the child's current medical insurance have prescription coverage? \_\_\_\_\_

Name of the insurance carrier: \_\_\_\_\_

Name of the card holder on the insurance: \_\_\_\_\_

Cardholder identification number/Medicaid number: \_\_\_\_\_

Group number: \_\_\_\_\_

Telephone number of the insurance company: (Usually on the back of the insurance card.)

\_\_\_\_\_

Please list all allergies to any medications, prescriptions or over the counter: \_\_\_\_\_

\_\_\_\_\_

Please list all current medications and indicate what it was prescribed for (Over the counter, or

prescription.): \_\_\_\_\_

\_\_\_\_\_

We will do our best to process the prescriptions under your insurance but please understand that some insurance companies do not contract with pharmacies in Utah. Please enclose a copy, front and back, of the current prescription card(s) to help us serve you better.

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**POWER OF ATTORNEY**

KNOW ALL MEN BY THESE PRESENT, that I/we \_\_\_\_\_, and \_\_\_\_\_ the parents(s)/legal guardians (“client”), do hereby certify to White River Academy, that I/we are true and lawful attorney in-fact for

\_\_\_\_\_, (“child”), and that said child is my/our son or legal ward. We hereby execute this Power of Attorney for the purpose of providing custodial care, group, and milieu counseling services in connection with White River Academy. Without limiting or qualifying the general Power of Attorney granted and delegated by Client to White River Academy in the paragraph above, Client specifically grants to White River Academy and its representatives the following powers:

1. To transport the Child from their home to the White River Academy facility and to house the Child in said facility until the Child’s completion of or departure from the Program.
2. To provide or obtain all medical, dental, psychiatric treatment and hospital care and to authorize a physician to perform any and all procedures that may appear to be medically necessary for the well being of the Child.
3. To guide and discipline the Child as deemed necessary and reasonable by White River Academy.
4. To (using C.P.I. methods) physically restrain the Child should he/she become a danger to himself or to anyone else, as deemed necessary by White River Academy.
5. To allow the Child to participate in all activities.
6. To search the person and personal effects of the Child at any time, and seize and confiscate any items deemed by White River Academy to be contraband or counterproductive to the Child’s successful completion of the Program.

This Power of Attorney shall be effective from the date of departure from the Child’s home, beginning \_\_\_\_\_, 20\_\_\_\_\_ and ending upon the Child’s completion of the Program and return to the custody of the Parents/Legal Guardians, unless terminated by Sponsor(s) by withdrawing the Child from the Program prior thereto. I/We have executed this Power of Attorney on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Father/Guardian Signature

\_\_\_\_\_  
Mother/Guardian Signature

Notary:

**PERMISSION FOR RELEASE OF MEDICAL RECORDS**

Attention: \_\_\_\_\_

Recent Psychiatrist/Doctor Name: \_\_\_\_\_

Hospital: \_\_\_\_\_

Street Address: \_\_\_\_\_

City State Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

The above named patient has been accepted into White River Academy. I hereby request the release of his records to their facility. Please include the following:

Current Medical Information

Psychological History

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Parent/Guardian Printed Name

\_\_\_\_\_  
Date of Signature

**White River Academy**  
275 West 100 South  
Delta, UT 84624  
435-864-9008

**PERMISSION FOR RELEASE OF DENTAL RECORDS**

Attention: \_\_\_\_\_

Recent Psychiatrist/Doctor/Dentist Name: \_\_\_\_\_

Hospital/Facility: \_\_\_\_\_

Street Address: \_\_\_\_\_

City State Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Name of Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

The above named patient has been accepted into White River Academy. I hereby request the release of his records to their facility. Please include the following:

Current Medical Information

Current Dental/Orthodontic Treatment Information

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Parent/Guardian Printed Name

\_\_\_\_\_  
Date of Signature

**White River Academy**  
275 West 100 South  
Delta, UT 84624  
435-864-9008

**PERMISSIONS FOR RELEASE OF ACADEMIC RECORDS**

To Principal, Counselors, of \_\_\_\_\_ - \_\_\_\_\_

Most Recent School Name: \_\_\_\_\_

School Address: \_\_\_\_\_

City State Zip: \_\_\_\_\_

Name of Child: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

The above named child has been enrolled at White River Academy. I hereby request the release of his program records to be sent to White River Academy.

Please include the following:

- 1. Transcripts
- 2. Withdrawal grades, including any uncompleted classes
- 3. Health records
- 4. Immunization Records
- 5. Any Counseling Information

Date Requested: \_\_\_\_\_

Sincerely,

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Parent/Guardian Printed Name

**White River Academy**  
275 West 100 South  
Delta, UT 84624  
436-864-9008

## White River Academy

### *Term Schedule / Credit Disbursement / Academic Guidelines*

Term 1 .....	September 1 <sup>st</sup> – October 31 <sup>st</sup>
Term 2 .....	November 1 <sup>st</sup> – December 31 <sup>st</sup>
Term 3 .....	January 1 <sup>st</sup> – February 28 <sup>th</sup>
Term 4 .....	March 1 <sup>st</sup> – April 30 <sup>th</sup>
Term 5 .....	May 1 <sup>st</sup> – June 30 <sup>th</sup>
Term 6 .....	July 1 <sup>st</sup> – August 31 <sup>st</sup>

- **White River Academy** is a special purpose school. Our students attend an average of 50 days of school instruction per term. Students attend school from 8 a.m. to 5 p.m. Monday – Friday. They also attend for a half day on Saturdays. Although we do give our students certain holidays off, we do not follow traditional holiday breaks in our schedule.
- **White River Academy** students are also working on school assignments each evening under the supervision of staff. This helps our students that are behind in subject areas or retaking courses for higher grades.
- **White River Academy** students are **not** given credit for any course of study till all work is completed and turned in. This means that we allow credits to roll over from term to term.

*For ex: If Johnny is working on his Biology 10A and does not finish it in Term 4 he will not be given any credit for this work. He **will** be permitted to continue to work on it and if finished by the end of Term 5 he will receive the full .50 credit. However, he might also be working on Biology 10B in Term 5 and if finished he would receive 1.00 credits in this area of study for Term 5.*

- **White River Academy** does not issue academic credits for work turned in after students withdraw from this facility. This includes students that are withdrawn before their contractual time expires. If partial work is turned in prior to the students withdrawal date the academic staff will determine what, if any, credit has been earned and apply it to the student's transcript.
- **White River Academy** does not release any documents upon departure from program such as; official or unofficial transcripts, birth certificates, or immunization records until the students account is paid in full.

**White River Academy** is accredited through the Northwest Association of Schools

*I have read, understood, and agree to follow these academic instructions and guidelines for White River Academy.*

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**CONSENT FOR RELEASE TO INSURANCE PROVIDER**

I request and authorize the clinical representative of White River Academy, Delta, UT, to disclose a Copy of application, treatment plan information, individual and group therapy and counseling notes, progress notes, psychiatric assessment, psychologist assessment, medication assessment and application to :

\_\_\_\_\_  
(Name/title Organization to which disclosure is made)

For: \_\_\_\_\_  
(Name of child)

This disclosure is made to qualify the above patient to meet requirements of coverage and to obtain program evaluation while attending White River Academy. This consent is subject to written revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate upon the completion of documented discharge of patient.

I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will.

\_\_\_\_\_  
Dated

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Dated

\_\_\_\_\_  
Signature of child/patient

**White River Academy**  
275 West 100 South  
Delta, UT 84624  
436-864-9008

**White River Academy** 275 West 100 South Delta, UT 84624 Ph #: 435-864-9008

RE: Interstate Compact Agreement

Dear Parent or Guardian:

Federal Law requires that children cannot be placed into the care of an agency across state lines without the approval of the Interstate Compact Authorities in each state. This is intended to assure that children are placed into licensed, safe placements and that the state laws in the sending and receiving states are followed. Even parent placements are regulated by this compact agreement, unless placing directly with a relative. I have enclosed a copy of the Interstate Compact Placement Request.

Please follow these steps when completing the form:

1. Complete Section I of the Interstate Compact Placement Request with the vital information.
2. Sign the request in Section III where the X indicates.
3. After you have completed the Interstate Compact Placement Request return it to White River Academy at the above address. We will then forward it to the appropriate state for completion. It is imperative that these forms be completed and returned to White River Academy immediately.

If you have any questions please contact our office at (435) 864-9008

Sincerely,

White River Academy

TO: (Name & Address of Compact Administrator in Receiving State)	FROM: (Name & Address of Compact Administrator in Sending State)
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### INTERSTATE COMPACT PLACEMENT REQUEST

SECTION I - IDENTIFYING INFORMATION					
Notice is given of intent to place:	SEX:	DOB:	ETHNIC GROUP:		
NAME OF MOTHER:		NAME OF FATHER:			
NAME OF AGENCY OR PERSON RESPONSIBLE FOR PLANNING FOR CHILD:			TELEPHONE NUMBER:		
ADDRESS:					
NAME OF AGENCY OR PERSON FINANCIALLY RESPONSIBLE FOR CHILD			TELEPHONE NUMBER		
ADDRESS					
SECTION II - PLACEMENT INFORMATION					
NAME OF PERSON(S) OR FACILITY CHILD IS TO BE PLACED WITH: White River Academy			TELEPHONE NUMBER: 435-864-9008		
Address: White River Academy 275 West 100 South Delta, UT 84624					
<table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none;"> <input type="checkbox"/> FOSTER FAMILY CARE    <input type="checkbox"/> PARENT  <input type="checkbox"/> GROUP HOME CARE    <input type="checkbox"/> RELATIVE (NON-PARENT) RELATIONSHIP  <input type="checkbox"/> RESIDENTIAL TRTMT CTR  <input checked="" type="checkbox"/> CHILD CARING INSTITUTION    <input type="checkbox"/> OTHER: _____  <input type="checkbox"/> INSTITUTIONAL CARE ( ARTICLE VI) </td> <td style="width:50%; border: none; vertical-align: top;"> <p style="text-align: center;">TYPE OF CARE:</p> <input type="checkbox"/> ADOPTION  <input type="checkbox"/> SUBSIDY / IV-E ASSIST.            TO BE COMPLETED IN:  <input type="checkbox"/> SENDING STATE  <input type="checkbox"/> RECEIVING STATE </td> </tr> </table>				<input type="checkbox"/> FOSTER FAMILY CARE <input type="checkbox"/> PARENT <input type="checkbox"/> GROUP HOME CARE <input type="checkbox"/> RELATIVE (NON-PARENT) RELATIONSHIP <input type="checkbox"/> RESIDENTIAL TRTMT CTR <input checked="" type="checkbox"/> CHILD CARING INSTITUTION <input type="checkbox"/> OTHER: _____ <input type="checkbox"/> INSTITUTIONAL CARE ( ARTICLE VI)	<p style="text-align: center;">TYPE OF CARE:</p> <input type="checkbox"/> ADOPTION <input type="checkbox"/> SUBSIDY / IV-E ASSIST. TO BE COMPLETED IN: <input type="checkbox"/> SENDING STATE <input type="checkbox"/> RECEIVING STATE
<input type="checkbox"/> FOSTER FAMILY CARE <input type="checkbox"/> PARENT <input type="checkbox"/> GROUP HOME CARE <input type="checkbox"/> RELATIVE (NON-PARENT) RELATIONSHIP <input type="checkbox"/> RESIDENTIAL TRTMT CTR <input checked="" type="checkbox"/> CHILD CARING INSTITUTION <input type="checkbox"/> OTHER: _____ <input type="checkbox"/> INSTITUTIONAL CARE ( ARTICLE VI)	<p style="text-align: center;">TYPE OF CARE:</p> <input type="checkbox"/> ADOPTION <input type="checkbox"/> SUBSIDY / IV-E ASSIST. TO BE COMPLETED IN: <input type="checkbox"/> SENDING STATE <input type="checkbox"/> RECEIVING STATE				
<input type="checkbox"/> 9 SENDING AGENCY CUSTODY/GUARDIANSHIP <input type="checkbox"/> 9 COURT JURISDICTION ONLY <input type="checkbox"/> 9 UNACCOMPANIED REFUGEE MINOR <input type="checkbox"/> 9 PARENT RELATIVE CUSTODY/GUARDIANSHIP <input type="checkbox"/> 9 PARENTAL RIGHTS TERMINATED TO PLACEMENT <input type="checkbox"/> 9 OTHER: _____					
SECTION III - SERVICES REQUESTED					
INITIAL REPORT (IF APPLICABLE) <input type="checkbox"/> PARENT HOME STUDY <input type="checkbox"/> RELATIVE HOME STUDY <input type="checkbox"/> ADOPTIVE HOME STUDY <input type="checkbox"/> FOSTER HOME STUDY	SUPERVISORY SERVICES <input type="checkbox"/> REQUEST RECEIVING STATE TO ARRANGE SUPERVISION <input type="checkbox"/> ANOTHER AGENCY AGREED TO SUPERVISE <input checked="" type="checkbox"/> SEDNING AGENCY TO SUPERVISE	SUPERVISORY REPORTS <input type="checkbox"/> QUARTERLY <input type="checkbox"/> SEMI-ANNUAL <input type="checkbox"/> UPON REQUEST <input checked="" type="checkbox"/> MONTHLY			
NAME AND ADDRESS OF SUPERVISING AGENCY IN RECEIVING STATE: White River Academy, <b>White River Academy</b> 275 West 100 South Delta, UT 84624 PH#: 435-864-9008					
ENCLOSED: <input type="checkbox"/> CHILD'S SOCIAL HISTORY <input type="checkbox"/> HOME STUDY OF PLACEMENT RESOURCE <input type="checkbox"/> COURT ORDER <input type="checkbox"/> OTHER ENCLOSURES					
SIGNATURE OF SENDER AGENCY PERSON <b>X</b>			DATE SIGNED		
SIGNATURE OF SENDING STATE COMPACT ADMINISTRATOR OR ALTERNATE			DATE SIGNED		
SECTION IV - ACTION BY RECEIVING STATE					
<input type="checkbox"/> 9 PLACEMENT MAY BE MADE <input type="checkbox"/> 9 PLACEMENT SHALL NOT BE MADE	REMARKS				
SIGNATURE OF RECEIVING COMPACT ADMINISTRATOR OR ALTERNATE			DATED SIGNED		
DISTRIBUTION: <input type="checkbox"/> COMPLETE SIX COPIES OF THE FORM <input type="checkbox"/> SENDING AGENCY RETAINS (1) COPY AND FORWARDS FIVE 950 COPIES: <input type="checkbox"/> SEDNING COMPACT ADMINISTRATOR WHO RETAINS ONE (1) COPY AND FORWARDS TO: <input type="checkbox"/> RECEIVING COMPACT ADMINISTRATOR WHO INDICATES ACTION SECTION IV AND FORWARDS ONE COPY TO RECEIVING AGENCY AND TWO COPIES TO THE SENDING COMPACT ADMINISTRATOR WITHIN THIRTY (30) DAYS. <input type="checkbox"/> SENDING COMPACT ADMINISTRATOR RETAINS 1 COPY AND FORWARDS THE OTHER COMPLETED COPY TO THE SENDING AGENCY.					

## INDIVIDUAL SERVICE PLAN

Child Date: \_\_\_\_\_

Parent: \_\_\_\_\_, \_\_\_\_\_

INDIVIDUAL GOALS, CARE, AND SERVICE PLANS are made for each child. Social, academic, emotional, and physical goals are to be included.

Please send your input:

1. Goal in life I desire for my child:

2. Goal upon termination at the program:

3. Objectives to work toward or problems of my child:

**WHITE RIVER ACADEMY**

**CONSENT FOR TREATMENT AND PARTICIPATION**

I/We hereby grant to White River Academy, hereafter referred to as the “Program,” full informed consent, authorization and permission to provide such care, treatment and evaluation, to the minor child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_, as the Program considers to be necessary and appropriate, consistent with the needs of the Child. This shall include consent for securing urgent or emergency medical or dental treatment when, in the opinion of the Program, such treatment is appropriate. Authorization is given for drug screening and Tuberculosis testing. The Program is authorized to provide for hospital care and to authorize a physician to perform any procedures that may be deemed medically necessary for the well being of the Child.

I/We further consent for the Program to release confidential medical and mental health information to those agents whose direct responsibility is to determine medical necessity and/or payment of claims.

I/We understand that the records may contain diagnosis, treatment and prognosis with respect to physical and mental condition, to include record of alcohol and drug abuse, and/or treatment. I/We further give informed consent for the Child to participate in all programs and activities of the program, including, but not limited to, educational programs, work projects, training programs, and various forms of recreation and athletics.

I/We further agree to release the Program, its employee’s and its agent from all liability for any injury to the child caused by any act or omission on their part in the course of such field trips, activities, and leaves; and to indemnify and hold harmless the Program, its medical staff, its employees and its agents from all claims, costs and losses incurred as the result of any act of the Child while on such field trips, activities and leaves. I/We consent to the taking of photographs and to videotape for internal identification and program purposes, as well as for publishing as the primary subject in the child’s personal parent page, as well as unidentified secondary subject in photographs in peer parent pages.

I/We understand that the use of reasonable restraint and/or confinement may be necessary if severity of symptoms or behaviors warrant, in order to protect the Child from harming himself or others or destroying Program property, should such restraints and/or confinements become necessary during the Child’s admission.

I/We understand and agree to indemnify the Program, its employees or agents from any loss due to injury that may occur as a result of such restraint and/or confinement.

\_\_\_\_\_  
(Parent/Guardian)

\_\_\_\_\_  
(Social Security Number)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Parent/Guardian)

\_\_\_\_\_  
(Social Security Number)

\_\_\_\_\_  
(Date)

**WHITE RIVER ACADEMY**

**Consent for Emergency Treatment and/or Emergency Surgery/Dental Care**

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I hereby give to White River Academy permission, after a careful medical examination, to authorize any emergency treatment, surgery, or examination indicated for the benefit of my child's health. I understand I will be consulted by telephone beforehand, if possible, and that I will be kept appraised of special medical needs.

Furthermore, I also hereby give permission to have the above cleaning, fluoride and x-rays done. I understand I will be informed of any special dental needs. I grant permission of any emergency dental care that may require anesthesia, either local or general. I understand that the dentist will bill my insurance (if that information is attached) or bill me directly and my payment will be made directly to the dentist. I agree that I am ultimately responsible for the payment of the dental care but would like the insurance information to be provided to the dentist for initial payment.

\_\_\_\_\_  
(Signature parent/Guardian)

\_\_\_\_\_  
(Signature parent/Guardian)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Relationship to resident)

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip

## Child History

Describe your son's strengths:

Describe your son's Weaknesses:

Has your son ever attempted or discussed suicide?  
If yes, please describe the situation and behaviors:

Yes \_\_\_ No \_\_\_

Has your son demonstrated violence towards self, others or property?  
If yes, please describe the situation and behaviors:

Yes \_\_\_ No \_\_\_

Describe your son's relationship with your family

Has your son used drugs or alcohol?  
If yes, describe, to the best of your knowledge, the substances, frequency  
and when the use began and last occurred:

Yes \_\_\_ No \_\_\_

Describe your son's recent academic performance:

Has your son demonstrated any sexually active behaviors  
(promiscuity or other inappropriate behaviors)?  
If yes, please explain:

Yes \_\_\_ No \_\_\_

Does your son have a history of running away?  
If yes, please explain:

Yes \_\_\_ No \_\_\_



## Medical History

Has your son had a tetanus inoculation within 10 years? Yes \_\_\_ No \_\_\_

Has your son ever been hospitalized for any reason? Yes \_\_\_ No \_\_\_

If yes, please explain:

Does your son have any allergies? Yes \_\_\_ No \_\_\_

If yes, Please explain:

Has your son or any close relatives had any of the following:

Alcoholism/Addictions Yes \_\_\_ No \_\_\_

If yes, who? Describe:

Mental Illness Yes \_\_\_ No \_\_\_

If yes, who? Describe:

Depression Yes \_\_\_ No \_\_\_

If yes, who? Describe:

Bi-Polar Yes \_\_\_ No \_\_\_

If yes, who? Describe:

Kidney Disease Yes \_\_\_ No \_\_\_

If yes, who? Describe:

Cancer Yes \_\_\_ No \_\_\_

If yes, who? Describe:

Heart Disease Yes \_\_\_ No \_\_\_

If yes, who? Describe:

Tuberculosis Yes \_\_\_ No \_\_\_

If yes, who? Describe:

Please list any medical conditions that would pose a concern in your son's placement:

### Medical History (continued)

Has your son had any of the following?

- |  |                                     |
|--|-------------------------------------|
| Yes ___ No ___ Anemia                      | Yes ___ No ___ Measles              |
| Yes ___ No ___ Arthritis                   | Yes ___ No ___ Meningitis           |
| Yes ___ No ___ Asthma                      | Yes ___ No ___ Migraines            |
| Yes ___ No ___ Blackouts                   | Yes ___ No ___ Mononucleosis        |
| Yes ___ No ___ Bladder or Kidney Infection | Yes ___ No ___ Mumps                |
| Yes ___ No ___ Bone Condition              | Yes ___ No ___ Muscle Weakness      |
| Yes ___ No ___ Chicken Pox                 | Yes ___ No ___ Night sweats         |
| Yes ___ No ___ Cluster Headaches           | Yes ___ No ___ Numbness, Tingling   |
| Yes ___ No ___ Convulsions or Seizures     | Yes ___ No ___ Pneumonia/Bronchitis |
| Yes ___ No ___ Cramps                      | Yes ___ No ___ Polio                |
| Yes ___ No ___ Dermatitis                  | Yes ___ No ___ Pregnancy            |
| Yes ___ No ___ Diabetes                    | Yes ___ No ___ Chronic Diarrhea     |
| Yes ___ No ___ Eating Disorders            | Yes ___ No ___ Chronic Constipation |
| Yes ___ No ___ Problems with Sleep         | Yes ___ No ___ Rheumatic Fever      |
| Yes ___ No ___ Epilepsy                    | Yes ___ No ___ Scarlet Fever        |
| Yes ___ No ___ Fainting/ Dizziness         | Yes ___ No ___ Scoliosis            |
| Yes ___ No ___ Fatigue                     | Yes ___ No ___ Stomach Problems     |
| Yes ___ No ___ Frequent Colds              | Yes ___ No ___ Trichotillomania     |
| Yes ___ No ___ Frequent Ear Infections     | Yes ___ No ___ Ulcers               |
| Yes ___ No ___ German measles              | Yes ___ No ___ Venereal Disease     |
| Yes ___ No ___ Heart Disorder              | Yes ___ No ___ Vision Problems      |
| Yes ___ No ___ Dental Problems             | Yes ___ No ___ Hepatitis            |
| Yes ___ No ___ Weight Change               | Yes ___ No ___ Whooping Cough       |
| Yes ___ No ___ Herpes                      | Yes ___ No ___ Other:               |
| Yes ___ No ___ High Blood Pressure         | Yes ___ No ___ Hyperglycemia        |

If yes to any of the above, please explain:

#### Medications – Past and Present

1. Please list all medications your son is currently prescribed.
  
  
  
  
  
  
  
  
  
  
2. Please list all medications your son has been prescribed in the past.

**Medical Insurance Information**

Name of Insured Policy Number Group Number: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Street: \_\_\_\_\_

Address: \_\_\_\_\_

City State Zip: \_\_\_\_\_

**Dental Insurance Information**

Name of Insured Policy Number Group Number: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Street Address: \_\_\_\_\_

City State Zip: \_\_\_\_\_

If White River Academy needs to arrange for refills of your son's prescription please enclose a copy of both sides of your prescription card. Please understand that White River Academy will make every effort to have your insurance billed for your sons prescription, however, some insurance companies do not cover all pharmacies. This information will be provided to the local pharmacy when a request for a prescription is made. If you have any questions please feel free to contact the office.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Policy Holder Date

Note 1. Please include a copy of your son's Immunization Record

Note 2. Please include a copy of the insurance cards (not the card itself)

**Vision Insurance Information**

Name of Insured Policy Number Group Number: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Street Address: \_\_\_\_\_

State, City, & Zip Code: \_\_\_\_\_

**White River Academy  
Consent for Evaluation**

Childs Name: \_\_\_\_\_ Child's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

In order to obtain information for educational services we require your permission to conduct an evaluation. Examples of proposed tests and their purposes are indicated below. It may not be necessary to give all of these tests and we will not give any tests without your consent. Intellectual Tests in this area measure a child's ability to remember what has been seen, heard and the ability to solve problems. They also reflect the learning rate and assist in predicting how well a child will do in Program. Tests such as: Woodcock Johnson-revised: part 1 or Wechsler scales of Intelligence. Academic Tests in this area measure a child's current reading, mathematics, written expression and reading skills. Test such as: Woodcock Johnson-revised: part 2, PACE Pre-tests in math/Language/reading, Kaufman test of educational achievement, or Peabody Individual achievement test-revised. Social/Emotional Tests in this area assess a child's personal independence and social functioning in home, program, and community. They also assess behavioral patterns that may adversely affect educational performance. Tests such as: MMPI Minnesota Multi-physic Personality Inventory, Rorschach, Conner's rating scale, Burk's Behavioral Scale, Sentence Completion, Achenbach, Bender Gestalt, Draw a person, Personal History Inventory or Direct Observation. Vocational/Transition Tests in this area are used to identify career strengths, limitations and interest. They also help to identify present functioning levels of life skills, habits and attitudes relating to vocational performance. Tests such as: Strong Interest Inventory and Substance Abuse Tests in this area identify levels of substance abuse. Tests such as: Substance Abuse Subtle Screening Inventory.

Other Specify: \_\_\_\_\_

This evaluation will be initiated when your written permission is received. You have the right to refuse permission for this Evaluation. All tests will be administered in English. Upon request, you may review or be informed of the results.

- \_\_\_ I DO NOT authorize the evaluation requested for my child.
- \_\_\_ I DO authorize the evaluation requested for my child.
- \_\_\_ I Authorize ONLY the following evaluations for my child.
- \_\_\_ Intellectual
- \_\_\_ Academic
- \_\_\_ Social/Emotional
- \_\_\_ Substance Abuse
- \_\_\_ Other, Specify: \_\_\_\_\_

\_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Date)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(Parent/Guardian Signature) (Date)

### Essential Information Form

STUDENT'S NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

PARENT/GAURDIAN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Wk Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Occupation/Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

PARENT/GUARDIAN (Other than Insured): \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Occupation/Employer: \_\_\_\_\_ Email Address: \_\_\_\_\_

RELATIVE OR FRIEND: \_\_\_\_\_

Emergency Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ state \_\_\_\_\_ Zip \_\_\_\_\_

Relation ship to Student: \_\_\_\_\_ Work Phone: \_\_\_\_\_

First Insurance in Whose Name is Policy Carried: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Policy Number/Social Security #: \_\_\_\_\_ Group # \_\_\_\_\_

Phone Number: \_\_\_\_\_

Second Insurance in Whose Name is Policy Carried: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Policy Number/Social Security #: \_\_\_\_\_ Group # \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Please make sure this form is filled out completely and contains all information requested.**

**PAYMENT ARRANGEMENTS FOR ADDITIONAL SERVICES:**

If other payment arrangements are needed please discuss your payment needs with the receptionist.

Date: \_\_\_\_\_

When did the patient last consult a physician: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Reason: \_\_\_\_\_

\_\_\_\_\_

In consideration of professional services rendered to the above patient. I/we agree to pay your customary charge for these services in full at the time of service, unless other arrangements are made with the doctor and staff. I/we hereby authorize the doctor to receive assignment of insurance benefits and agree to pay any unpaid benefits under legal fees should my account be placed with a collection agency for non-payments. I/we am responsible to my insurance company for the processing of insurance benefits.

Responsible Party: \_\_\_\_\_ Date \_\_\_\_\_

## **ITEMS TO BRING**

Each student will need to bring the following in **(Navy Blue if Possible) 1 Rubbermaid or plastic 18 gallon tubs:**

- 1 pair of sandals without back straps (preferably Crocs however not mandatory)
- 1 pair of sneakers
- 7 pair of socks
- 7 pair of under wear
- 7 white tee-shirts (no logos)
- 2 street shirts (no logos)
- 2 pair of pajamas
- 3 pair of P.E. shorts
- 1 swimming shorts
- 2 Pairs of Athletic pants (sweat pants or other, no baggy pants)
- 1 pair of long pants (no baggy pants)
- 1 set of **navy blue sheets** (twin)
- 1 Comforter (twin)
- 1 set of toiletries (shampoo, soap, toothbrush, toothpaste, deodorant, sun block etc.)
- 1 pillow
- 1 watch (not required)
- 1 water bottle (plastic)
- 2 basic towels
- 2 wash clothes
- 1 Coat suitable for cold weather
- 1 1" 3 ring binder
- 1 2" 3 ring binder
- 1 80 sheet notebook (not spiral bound)
- 15 8.5 x 11 clear sheet protectors

### **These items are not allowed:**

- No type of electronic equipment
- No sleeveless shirts
- No tank tops
- No short shorts
- No jewelry: this includes necklace, bracelets, rings, earrings, etc.(a basic, inexpensive watch is approved)

Please bring only the approved items listed above and take into account what they will be wearing into the facility. Once students are able to show a sufficient amount of progress on service plan goals they will have the option, with parental consent to attend church, at that time they may request for you to send 1 set of church clothes and 1 pair of dress shoes.

Note: This Enrollment Agreement, check, and all copies of necessary documents can be placed in an envelope at the bottom of an 18 gallon tub. Upon admission of your child WRA personnel will

inventory the contents of the tubs and all items will be labeled with your child's initials. **All non-approved items will be donated to the program or mailed back to you at your expense.**

Also note: if you mail the tub via United States Postal Service you need to send it to Attn: White River Academy C/O *your child's name* 275 West 100 South Delta, UT 84624 Ph#: 435-864-9008