welcome

TO WATERFORD COUNTRY SCHOOL

WATERFORD COUNTRY SCHOOL
LEVINE EDUCATION PROGRAM
78 Hunts Brook Road | Quaker Hill, CT 06375
860.442.9454 | admissions@waterfordcs.org

Levine Education Center Expectations

Welcome to Waterford Country School!

Your education is extremely important to us. We will do ***Whatever It Takes*** to make learning rewarding and meaningful. We have the following expectations for all students:

- We expect that you will come to school every day, on time.
- We expect that you will do your best every day.
- We expect that all your interpersonal interactions will be respectful.
- We expect that you will refrain from bringing in any electronic items or toys to school. If you use these items during your transportation, we expect that you will hand them in as you enter each day. This includes cell phones, headphones, music devices, gaming devices, flash drives, cameras, etc. Your logged-in items will be returned to you directly as you leave to your transportation home.
- We expect that you will refrain from bringing candy, soda, coffee or "junk food" to school.
- We expect that you will dress appropriately for the school environment. Specifically, cropped shirts, low cut tops, low riding pants or other attire that does not appropriately cover the body are not allowed. Also not allowed is any printing that includes association with inappropriate language, behavior, tobacco, alcohol, illegal substances or actions, or things of questionable nature. Please refer to the student dress code policy for additional information.

  Please keep in mind that some of your classes require you to transition outdoors; therefore, dress appropriately for weather conditions.

I am very excited about this school year and looking forward to working with you.

Rachel Newer, LCSW
School Principal

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OUR APPROACH

We believe that children will do well if they can and if they aren't doing well, it is up to us (the staff) to develop conditions under which they can be successful. Most of our children struggle because they have not developed the skills or emotional competence to self-regulate their behavior when flooded with emotions. Our role is to assist the students during the struggle and walk them through to a positive outcome.

CARE (Creating Conditions for Change) was designed by Martha Holden from the Residential Child Care Project of Cornell University. CARE is a research-based model we use to help young people who are struggling make positive changes in their lives. Everyone at WCS is trained in this milieu model from the top Administrators and Teachers to even support staff at the agency who do not work directly with children.

CARE is based on the following six principles:
RELATIONSHIP BASED A good relationship is the most important part of the treatment process. We want to create a strong positive relationship with youth and their families. We want people to feel safe, heard and respected. We want to create the best possible conditions for people to grow and succeed.
DEVELOPMENTALLY FOCUSED Every youth is unique and special. We individualize our services to every child's specific needs – to their specific developmental level.
FAMILY INVOLVED Families are important and know their children best. We value family input and recognize that the best treatment happens when we are all working together. We want families to be a part of our Team and participate as much as possible in all aspects of programming.
COMPETENCE CENTERED We want youth to experience success. We want to help them develop whatever skills are necessary to live healthy, engaged lives in their communities.
TRAUMA INFORMED We know that family members living apart from one another can be a very traumatic experience. We also know that many children and families have experienced trauma in their lives as well. We want to make sure youth, adults, and families feel as safe and comfortable as possible so that WCS can be a place of healing.
ECOLOGICALLY ORIENTED Our surroundings can help us grow and change. We work to make our environment both emotionally and physically safe, supportive, friendly and caring for youth and families.

We are committed to doing "whatever it takes" to help all our young people and their families build on their strengths, enhance their family relationships and move forward towards a strong and positive future.

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21A

Day Student Information and Health Questionnaire

Student's Name _____
First Middle Initial Last

Home Address _____

Date of Birth _____ Grade:_____ Gender:_____

Prior School _____

Referring District _____

Contact Person _____

Race *(check applicable)*:	**Hispanic Indicator** *(check applicable)*:
☐ American or Alaska Native ☐ Asian ☐ African American ☐ Pacific Islander ☐ Caucasian ☐ Multi-Racial	☐ Hispanic ☐ Non-Hispanic

	Parent/Guardian Primary	**Parent/Guardian Secondary**	**Emergency Contact**
Name			
Relationship to Student			
Phone			
Email			
Mailing Address			
Physical Address (if different)			

DO NOT CONTACT (Name & Reason) _____

Other agencies/providers currently involved in the student's life? (DCF Worker, Parole Officer, IOP, PHP)
If yes, please list:

Name/Title _____

Phone _____ Email _____

Day Student Information and Health Questionnaire (Continued)

Does the student have an outside therapist or psychiatrist? ☐ Yes ☐ No

If yes, please indicate the following:

Therapist/Psychiatrist Name _____

Address _____
Phone _____
Email _____

Pediatrician
Name _____ Phone Number _____
Current Medications _____
Any Medications taken during school hours (8:30am-3:15pm) _____

Does the student have a history of any medical conditions listed below?

	YES	NO	UNSURE
Diabetes			
Heart Condition			
Seizure Condition			
Lung (Asthma)			
Food Allergies			

If yes, please explain:

_____
_____

List allergies and reactions:

_____
_____

Anaphylaxis/Life Threatening? ☐ Yes ☐ No

If yes, explain:_____

Epi-pen required? ☐ Yes ☐ No

Signature of Parent/Guardian _____ Date _____

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Photo/Video Release Form

I hereby grant Waterford Country School, Inc. permission to use pictures/video that Waterford Country School staff takes of my child [or in which my child may be included with others] to publish individually or in conjunction with other photographs. I hereby grant permission to Waterford Country School, Inc. to photograph my child during school activities to use the photographs and printed materials without compensation or approval rights.

(Please check all applicable boxes)

- ☐ I grant permission for *internal* publications and displays such as the yearbook, bulletin boards, school slideshows, etc.
- ☐ I do *NOT* give permission for my child's photo to be shared internally or externally for any reason.

Photos taken will not be used for marketing or fundraising purposes or published online.

Printed Name of Student _____

Signature of Parent or Guardian _____

Date _____

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School Field Trip Consent Form

_____ (name of student), as a student at Waterford Country School, will have opportunity to participate in off-grounds field trips. These field trips are typically planned in advance by the teacher and administration.

Every effort will be made to communicate the scope and nature of the field trip well in advance. In the event that we have an unexpected opportunity or an opening becomes available for your child to attend a trip, you would be contacted via telephone for verbal permission to attend.

The special education program has appropriate procedures to ensure whenever any staff member, or any other individual acting on behalf of the program, including staff from contracted providers of transportation, operated a vehicle for the purpose of transporting students on behalf of the program, the vehicle's operator is properly licensed to operate that class of vehicle being operated, and has been trained to care for the student(s) being transported.

The special education program ensures that, whenever students are transported on behalf of the program, the utilized vehicle is in compliance with each applicable mandate that has been disseminated by the Department of Motor Vehicles.

Any and all limitations or restrictions regarding the child's participation in activity trips or modes of transportation are hereby specified:

_____

_____

_____

_____ _____

Parent/Guardian Signature Date

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Consent for Participation in Follow-Up Studies

I hereby give permission for my child, _____, to be included in Waterford Country School's discharge and follow-up studies. I realize that the studies are conducted for the sole purpose of supporting program evaluation and enhancement, and understand the following to be true:

- My child will not be identified in any documentation produced by the study.
- My decision to participate shall in no way affect the services provided to my child or family.
- The study consists of one or two contacts after discharge/graduation to ascertain the status of my child.
- I may withdraw my consent at any time.

Parent/Guardian Name (printed): _____

Parent/Guardian Signature: _____

Date: _____

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OUTDOOR EDUCATION RELEASE OF LIABILITY

Disclosure: Waterford Country School (WCS) Adventure Programs involve a variety of programs that often include warm-ups, games, group initiative problem solving, high and low ropes course elements and other rigorous physical adventure activities.

All participants are encouraged to consider their personal health and physical condition prior to participation in any program. Such participation involves physical exertion. The participant, being aware of any conditions predisposing them to injury or illness, and in consideration of inherent physical exertion, may wish to seek the advice of a physician prior to participation or may choose not to participate at all. The level of participation in these program activities is always completely up to the individual. Yet there is a risk, which must be assumed by each participant, that they may suffer an emotional or physical injury or disability.

A certified member of the Outdoor Education staff will supervise each program and will do everything possible to provide a suitable, safe and enjoyable experience. (The Director reserves the right to issue new or modified existing rules or regulations that are deemed essential to the success of the overall program.)

Policy for participation in all WCS Adventure Programs requires that every participant have health/accident insurance coverage. In addition, certain health/medical information must be made known to the instructor(s) conducting programs so that they are prepared to respond appropriately if the need arises. This information will be held in confidence. This completed form must be returned to Waterford Country School for the individual to be permitted to participate in any activities.

Activity

☐ Student at WCS	☐ Ropes Challenge Course	☐ Mobile Farm Visit
☐ Camp Cuheca camper	☐ Farm/Animal Interaction	☐ Farm Volunteer

Participant's Information

Name: _____ Date of Birth: _____

Health Insurance Company: _____

Agent Address: _____ Policy # _____

Applicant's Address: _____

Home Phone: _____ Cell: _____ Work: _____

Group/Organization (if applicable): _____

WATERFORD COUNTRY SCHOOL

Do you have any limiting physical disabilities or handicaps (temporary or permanent)? ☐ No ☐ Yes

If yes, identify and explain:

_____

Are you currently taking medication (prescribed or otherwise, e.g. cold medicine)? ☐ No ☐ Yes

If yes, please list what you are taking and why:

_____

_____

Do you have any allergies, reactions to medications or any other medical special condition? ☐ No ☐ Yes

If yes, identify and explain:

_____

Release of Liability

I understand that part of the Waterford Country School Adventure Program may be physically or emotionally demanding. I affirm that my health is good and that I am not under a physician's care for any undisclosed condition that bears upon my fitness to participate in these activities. I recognize the inherent risk of injury, serious disability or death in WCS Adventure activities. I understand that each participant must assume the risk of physical injury that could result from any of these activities. I hereby release Waterford Country School, Inc., its staff members and Board of Trustees from all liability for any injury to me resulting from my or my child/ward's participation in WCS adventure activities.

Applicant's Signature: _____ Date: _____

I hereby give my permission for my child to participate in the above activity.

Parent/Guardian Signature (for applicants under age 18):

_____ Date: _____

Relationship to Applicant: _____

STUDENT MEDICAL INFO MUST BE RECEIVED

PRIOR TO START OF SCHOOL

PLEASE SEND COMPLETED HEALTH & MEDICAL INFO TO:

WCS NURSING

Email: nursing@waterfordcs.org

Fax: 860-440-4372

Phone: 860-442-9454 x4815

State of Connecticut Department of Education
Health Assessment Record

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part 1) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part 2) and the oral assessment (Part 3).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, licensed pursuant to chapter 378, physician assistant, licensed pursuant to chapter 370, a school medical advisor, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

Please print

Student Name (Last, First, Middle)	Birth Date	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity ❑ American Indian/ Alaskan Native ❑ Hispanic/Latino	❑ Black, not of Hispanic origin ❑ White, not of Hispanic origin ❑ Asian/Pacific Islander ❑ Other
Primary Care Provider		
Health Insurance Company/Number* or Medicaid/Number*		
Does your child have health insurance? Y N Does your child have dental insurance? Y N	If your child does not have health insurance, call **1-877-CT-HUSKY**	

* If applicable

Part 1 — To be completed by parent/guardian.
Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Hospitalization or Emergency Room visit	Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocations	Y	N	Fainting or blacking out	Y	N
Allergies to medication	Y	N	Any muscle or joint injuries	Y	N	Chest pain	Y	N
Any other allergies	Y	N	Any neck or back injuries	Y	N	Heart problems	Y	N
Any daily medications	Y	N	Problems running	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	N	Bleeding more than expected	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	N	Problems breathing or coughing	Y	N
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	N
Any problems with speech	Y	N	Dental braces, caps, or bridges	Y	N	Asthma treatment (past 3 years)	Y	N
Family History						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)				Y	N	Diabetes	Y	N
Any immediate family members have high cholesterol				Y	N	ADHD/ADD	Y	N

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any **medications** your child will need to take **in** school:

*All medications taken in school require a separate **Medication Authorization Form** signed by a health care provider and parent/guardian.*

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian Date

To be maintained in the student's Cumulative School Health Record

Part 2 — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name _____ Birth Date _____ Date of Exam _____

❑ I have reviewed the health history information provided in Part 1 of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider under Connecticut State Law

***Height**_____in. /_____% ***Weight**_____lbs. /_____% **BMI**_____/_____% **Pulse** _____ ***Blood Pressure**_____/ _____

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
*Gross Dental			Arms/Hands		
Lymphatic			Hips		
Heart			Knees		
Lungs			Feet/Ankles		
Abdomen					
Genitalia/ hernia					
Skin					

***Postural** ❑ No spinal abnormality ❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made

Screenings * According to Bright Future's Periodicity Schedule

***Vision Screening**

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑ Referral made

***Auditory Screening**

Type:	Right	Left
	❑ Pass	❑ Pass
	❑ Fail	❑ Fail

❑ Referral made

	Date
***History of Lead Level** ≥**3.5** µg/dL ❑ No ❑ Yes **Results:**	
***Speech** (school entry only)	
***HCT/HGB:**	

TB: High-risk group? ❑ No ❑ Yes PPD date read: Results: Treatment:

*IMMUNIZATIONS

❑ Up to Date or ❑ Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

Asthma ❑ No ❑ Yes: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent ❑ Exercise induced
*If yes, please provide a copy of the **Asthma Action Plan** to School*

Anaphylaxis ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Unknown source

Allergies *If yes, please provide a copy of the **Emergency Allergy Plan** to School*
History of Anaphylaxis ❑ No ❑ Yes Epi Pen required ❑ No ❑ Yes

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II **Other Chronic Disease:**

Seizures ❑ No ❑ Yes, type:

❑ This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.
*Explain:*_____
Daily Medications (*specify*): _____
This student may: ❑ **participate fully in the school program**
❑ participate in the school program with the following restriction/adaptation: _____
This student may: ❑ **participate fully in athletic activities and competitive sports**
❑ participate in athletic activities and competitive sports with the following restriction/adaptation: _____

❑ Yes ❑ No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.
Is this the student's medical home? ❑ Yes ❑ No ❑ I would like to discuss information in this report with the school nurse.

Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number

Part 3 — Oral Health Assessment/Screening

Health Care Provider must complete and sign the oral health assessment.

To Parent(s) or Guardian(s):

State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

Student Name (Last, First, Middle)	Birth Date	Date of Exam
School	Grade	❑ Male ❑ Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination	**Visual Screening**	**Normal**	**Referral Made:**
Completed by: ❑ Dentist	Completed by: ❑ MD/DO ❑ APRN ❑ PA ❑ Dental Hygienist	❑ Yes ❑ Abnormal (Describe) _____ _____ _____ _____ _____	❑ Yes ❑ No

Risk Assessment	**Describe Risk Factors**	
❑ Low ❑ Moderate ❑ High	❑ Dental or orthodontic appliance ❑ Saliva ❑ Gingival condition ❑ Visible plaque ❑ Tooth demineralization ❑ Other _____	❑ Carious lesions ❑ Restorations ❑ Pain ❑ Swelling ❑ Trauma ❑ Other _____

Recommendation(s) by health care provider: _____

_____

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

_____

Signature of Parent/Guardian Date

_____

Signature of health care provider DMD / DDS / MD / DO / APRN / PA/ RDH Date Signed Printed/Stamped ***Provider*** Name and Phone Number

Student Name: _____ **Birth Date:** _____ HAR-3 REV. 3/2024

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) Note: *Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP	*	*	*	*		
DT/Td						
Tdap	*				Required 7th-12th grade	
IPV/OPV	*	*	*			
MMR	*	*			Required K-12th grade	
Measles	*	*			Required K-12th grade	
Mumps	*	*			Required K-12th grade	
Rubella	*	*			Required K-12th grade	
HIB	*				PK and K (Students under age 5)	
Hep A	*	*			See below for specific grade requirement	
Hep B	*	*	*		Required PK-12th grade	
Varicella	*	*			Required K-12th grade	
PCV	*				PK and K (Students under age 5)	
Meningococcal	*				Required 7th-12th grade	
HPV						
Flu	*				PK students 24-59 months old – given annually	
Other						

Disease Hx of above _____ (Specify) _____ (Date) _____ (Confirmed by)

Religious Exemption: _____

Religious exemptions must meet the criteria established in Public Act 21-6: https://portal.ct.gov/-/media/SDE/Digest/2020-21/CSDE-Guidance---Immunizations.pdf.

Medical Exemption: _____

Must have signed and completed medical exemption form attached.
https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/infectious_diseases/immunization/CT-WIZ/CT-Medical-Exemption-Form-final-09272021fillable3.pdf

KINDERGARTEN THROUGH GRADE 6

- DTaP: At least 4 doses, with the final dose on or after the 4th birthday; students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after the1st birthday (children 5 years and older do not need proof of vaccination).
- Pneumococcal: 1 dose on or after the 1st birthday (children 5 years and older do not need proof of vaccination).
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the1st birthday or verification of disease.**

GRADES 7 THROUGH 12

- Tdap/Td: 1 dose of Tdap required for students who completed their primary DTaP series; for students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are required, one of which must be Tdap.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Meningococcal: 1 dose
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the 1st birthday or verification of disease.**
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.

HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES

- August 1, 2017: Pre-K through 5th grade
- August 1, 2018: Pre-K through 6th grade
- August 1, 2019: Pre-K through 7th grade
- August 1, 2020: Pre-K through 8th grade
- August 1, 2021: Pre-K through 9th grade
- August 1, 2022: Pre-K through 10th grade
- August 1, 2023: Pre-K through11th grade
- August 1, 2024: Pre-K through 12th grade

** **Verification of disease:** Confirmation in writing by an MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.

Note: The Commissioner of Public Health may issue a temporary waiver to the schedule for active immunization for any vaccine if the National Centers for Disease Control and Prevention recognizes a nationwide shortage of supply for such vaccine.

~~Initial/Signature of health care provider – MD / DO / APRN / PA~~ ~~Date Signed~~ ~~Printed/Stamped ***Provider*** Name and Phone Number~~

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PHYSICIAN'S STANDING ORDERS / DAY STUDENTS

Cross out medications you do not want administered.

Name	Date of Birth	Allergies

MEDICATION	INDICATION	DOSE	FREQUENCY
Acetaminophen	Pain, Temperature 100.4 and above	____4-5yo 240 mg (7.5 mL) ____6-8yo 320 mg (10mL) ____9-10yo 400mg (12.5mL) ____11yo 480mg (15mL) ____12years-adult 650 mg	Every 4hrs. PO PRN
Ibuprofen	Pain, Temperature 100.4 and above Muscle discomfort sprains/strain Menstrual discomfort	____4-5yo 150 mg (7.5 mL) ____6-8yo 200 mg (10mL) ____9-10yo 250mg(12.5mL) ____11yo 300 mg (15mL) ____12years-adult 400 mg	Every 6hrs. PO PRN
Cough drop	Dry Cough/irritated throat	5yo-adult 1 lozenge **Do not give under 5 yrs. old**	Every 2 hrs. PO PRN
Calcium carbonate tablets	Indigestion	12 years-adult (2)500mg tabs **Do not give under 12 yrs old**	Q4hrs PO PRN

***Indicate dosage for Acetaminophen and Ibuprofen for children less than 12 years old.**

MD Signature_____

Date* _____

***Order expires one year after above date unless otherwise noted**

Parent Signature_____

Date_____

7/17/2025 JR/DR