5180 Campbells Run Road
Pittsburgh, PA 15205-9731

www.thebradleycenter.org

BRADLEY CENTER SCHOOL REGISTRATION FORM

Date Completed: ____________________

STUDENT'S INFORMATION

Student's Name:	Legal Guardian(s) child lives with:
Student's Date of Birth:	Address:
Student's Email Address:	Parent/Guardian's Email Address:
Student's Cell Phone:	Home Phone Number:
Religion (optional):	Cell Phone Number:
Race (optional):	Work Phone Number:
Student resides with (circle all that apply): Mother Father Other: ______________	

OTHER PARENT/GUARDIAN'S INFORMATION WHO THE CHILD MAY NOT LIVE WITH

Name:	Email Address:
Relationship to the student:	Home Phone Number:
Address:	Cell Phone Number:
	Work Phone Number:

EMERGENCY CONTACT INFORMATION

In an emergency every effort will be made to contact the parent/guardian. Please list three people who can provide transportation and care for your child if you are unavailable. These emergency contacts must have reliable transportation and live in the area.

Name:	**Relationship:**	**Phone Number:**

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ACKNOWLEDGEMENT OF PRACTICES

SAFETY SEARCH AND ESCORTS/PASSIVE RESTRAINTS

I have read the Attendance, Safety Search, and Escorts/Passive Restraints policies of The Bradley Center. I understand and agree to these policies while my student is enrolled in The Bradley Center.

COMMUNITY OUTINGS

Community Based Learning is an essential part of the curriculum at Bradley. I give permission for my student to participate in outings during the school day transported by Bradley staff and in Bradley vehicles.

____
Parent/Guardians Signature

____
Student's Name

____
Date

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BRADLEY CENTER SCHOOL HEALTH INFORMATION, Page 1 of 3

Student's Name:______________________ Date of Birth: ____________

Does your child have any of the following conditions? (Check all that apply.)

	Yes or No	If yes, explain, including how the condition is treated
Food allergies	Y N	
Environmental allergies, including insects	Y N	
Medication Allergies	Y N	
Latex Allergies	Y N	
Other Allergies	Y N	
Heart Conditions	Y N	Explain any restrictions:
Skin Conditions	Y N	
Seizures/ Epilepsy	Y N	Medication: Date of last Seizure:
Asthma	Y N	How often is an inhaler used?
Diabetes	Y N	Which Type?
Hypoglycemia	Y N	
Blood Disorder	Y N	
Sickle Cell Disease	Y N	
Fainting	Y N	
Gastrointestinal Problems	Y N	
Cancer	Y N	
Speech	Y N	
Hearing	Y N	
Vision	Y N	Wear glasses or contacts?
Head Injury/Concussion	Y N	Date of Concussion:
Mobility / Activity Concerns	Y N	
Dietary Restrictions	Y N	
Hospitalizations/Operations	Y N	Date/Type:
Prone to Nosebleeds	Y N	
Eating Disorders	Y N	
Hospitalizations	Y N	Dates/Reasons:

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BRADLEY CENTER SCHOOL HEALTH INFORMATION, Page 2 of 3

Student's Name:________________________ Date of Birth: ____________

Please list all medications the students take outside of school hours.

Medication Name	**Dose**	**Frequency**	**Reason**

Please list all medications the student will need to take during school, including inhalers.

Medicine Name	**Dose**	**Frequency**	**Reason**

** The prescribing doctor and parent must complete an Authorization for Medication During School Hours form and provide the medication in the original prescription bottle. Medication cannot be administered at the school without this form and original prescription bottles.

Medical Professional Contact Information

Doctor's Name	**Phone Number**
Primary Care Doctor	
Dentist	
Psychiatrist	

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BRADLEY CENTER SCHOOL HEALTH INFORMATION, Page 3 of 3

Student's Name:______________________ Date of Birth: ____________

Health Insurance Information

Student's Social Security Number	
Name of Medical Insurance Company	
Group Number	
Policy ID Number	

Medical Emergency Care Authorization
I hereby authorize Bradley Center and/or Paramedics to transport my child to the nearest available emergency room location. If time permits, my first hospital preference is:

Name of Hospital: __________________________

I further authorize the emergency room staff to diagnose and, if necessary, treat my child. I understand The Bradley Center will inform me of the injury/illness as soon as possible.

Date:_________________________ Signature: __________________________
(Parent or Legal Guardian)

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NON-PRESCRIPTION MEDICATION PERMISSION FORM

STUDENT'S NAME:

The following medication may be given to your child as needed only with your written permission. Please initial below all medications/ointments, which you approve in order for them to be administered.

	Alcohol-70%
	Antibiotic Ointment
	Blistex
	Burn Gel
	Hydrocortisone Cream
	Hydrogen Peroxide
	First Aid Cream
	Instant Bandage
	Analgesic spray/gel
	Zinc Oxide (topical that treats cuts, burns, scrapes, and poison ivy)
	Calamine (used for skin rashes with itching)
	Aromatic spirits of ammonia/smelling salts for fainting
	Analgesic spray/gel (temporary relief of pain/sunburn)
	Saline eye wash
	An antihistamine, at manufacturer's recommended dosage, for mild allergic reactions
	Cough Drops
	Sun Screen
	Tylenol/ Acetaminophen*

To be completed by parent/guardian
I authorize The Bradley Center staff to use the above medications and ointments on my child that I have initialed above.

_______________________________ _______________________________

Signature of parent/legal guardian Date

*(Please note, only one dose of acetaminophen will be administered during one single school day. Also, students will not be given acetaminophen more than ten times a school year without a doctor's order from the family physician.)

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PERMISSION TO DISPENSE PRESCRIPTION MEDICATION DURING SCHOOL

Student Name Date of Birth

To Be Completed by Parent/Legal Guardian

I have requested medication to be administered during the school day. I understand the reason which necessities prescribed medication, and I am in full agreement with the aspect of the treatment plan. I further authorize the appropriate staff person at the Bradley Center School to assist my child with the self-administration of the specified medication(s) where a dosage during the school hours is indicated. I understand all medication(s) must be received by Bradley in its original, labeled prescription container. Each different medication must be in its own container. As the parent/guardian, I am responsible for providing the medication to the school for it to be administered. When my child's medication changes, I will provide the school with a new doctor's authorization/order before the new medication will be administered in school.

Parent/Guardian's Signature Date:

The above student is currently being treated for (conditions/diagnosis)

The above named student is currently being prescribed the following medications, which are taken outside of school hours.

Medication	Dose	Time

The above name student is ordered to take the following medications during the school day.

Medication	Dose	Route	Time

Please List Any Special Instructions for Administration.

Physician's Signature Date

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Provision of School Health Services and Mandated Screenings

Please review, sign, and return to school

Please be aware that the Department of Health and Pennsylvania Department of Education require students to have mandated screenings each school year for all students and also grade specific screenings. The results of the screenings will be shared with new student's home district and parents/guardians. Please do not hesitate to contact the school nurse if you have any questions or concerns.

All Grades

- School nurse will complete Immunization Assessment, Grown Assessment, Vision Screening
- Parents will be informed of child's body mass index each year by school nurse.

Medical Exam: Grades 6-11

- Please request your pediatrician/family doctor to complete the school health form. We will also mail you a copy in September.

Dental Exam:

- Please have your dentist complete the school health form. We will also mail you a copy in September.

Hearing Exam: Grades 1, 2, 3,7,11 and special education students in all grades

- School nurse will complete at school.

Scoliosis Exam: Grades 6 and 7

- School Nurse will complete at school with parental consent.

Tuberculosis: Grade 9

- Please request your pediatrician/ family doctor to complete and share results.

I have read and understand the mandated screenings I give consent to the school nurse to complete the required screenings which can take place in school, including the scoliosis screening for 6th and 7th graders that requires a student to be examined privately by lifting the back of their shirt so that the nurse can examine their spine. I further understand the grade level exams that as a parent/guardian I am responsible for having completed.

____________________________ ____________________

(Parent/Guardian Signature) (Date)

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Consent to Share Information to Bradley's Residential Staff

Bradley takes protecting our students' privacy seriously and follows all regulations under FERPA and HIPPA. We only share most information on a need to know basis with our staff. For example, only educational staff who work directly with the student have access to a student's report card, IEP, routine medical information, etc.

Bradley has a strong working relationship with the staff who work in the residential treatment facility, so they assist during times of crisis and often participate in school wide events like assemblies. Due to the acuity of many of our students, we do find it helpful to maintain a list of pertinent medical information and behavioral triggers to share with all staff to ensure our students receive the best care. However, we do need your consent to do so. Examples of this shared information are as follows:

- Students who have inhalers and/or epi pens
- Students who have restraint restrictions
- Students who have a more intense medical need such as diabetes, seizures, etc.
- Trigger/more stressful situations for students examples: prefer male staff over female staff, being asked to go outside, loud noises

Please choose one option.

_____ Pertinent information regarding my child may be shared with all clinical staff employed by Bradley. All employees of Bradley must keep all information confidential per FERPA and HIPPA standards. I can request a copy of the information shared on a broader scope at any time.

_____ Information regarding my child can only be shared on a need to know basis with those working directly with my child.

____ ____________________

(Parent/Guardian's Signature) (Date)

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The Bradley Center
5180 Campbells Run Road, Pittsburgh, PA 15205
Fax: 412-809-0202, Ph: 412-788-8219

Resident Name________________
Date of Birth________________
Medical Record Number__________

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

This Authorization for the use and/or disclosure of the specific personally identifiable health information set forth in this Authorization is made pursuant to the requirements of 45 CFR §164.508. which sets out the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 and authorizes The Bradley Center to obtain the personally identifiable health information specifically referenced in this Authorization.

The following individual or organization is authorized to make the disclosure: ______________________________
The type and amount of information to be used or disclosed is as follows and includes dates from __________ to ____________

Method of Release (must check one): ☐ Verbal only ☐ Copies only ☐ Verbal and Copies

- ☐ Psychological Evaluations
- ☐ Psychiatric Evaluations
- ☐ Psychosocial Evaluations
- ☐ Psychological Tests
- ☐ Academic/ School Reports
- ☐ Other: ______________________________
- ☐ Achievement Tests
- ☐ Treatment Plans
- ☐ Discharge Summaries
- ☐ Medical History/Exams
- ☐ Medication History
- ☐ EKG's
- ☐ Physician Orders
- ☐ Lab Reports
- ☐ Clinical Reviews/ Updates
- ☐ Immunization Report

HIV related information and **Drug and Alcohol** information contained in parts of the record indicated above will be released through this consent unless otherwise indicated: ☐ Do not release

This information is to be disclosed to and used by the following individual or organization:

Name and address: ______________________________

for the purpose of ______________________________

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the record department. If I desire to revoke this Authorization, I may do so by sending a written revocation to The Bradley Center at the following address: 5180 Campbells Run Road, Pittsburgh, PA 15205.

I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: ____________________. **If I fail to specify an expiration date, event or condition, this authorization will expire one year from the date it is executed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information I can contact the Privacy Officer.

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and may no longer be protected.

In certain instances, The Bradley Center will charge a copy fee for release of the records consistent with PA law.

I understand all of the provisions of this Authorization and I wish to execute this Authorization thereby authorizing the use and/or disclosure of the information described above for the purposes described above.

Signature of Resident or
Printed Name and Signature of Personal Representative: ______________________________ Date: ________

Printed Name and Signature of Staff Obtaining Verbal Consent: ______________________________

Printed Name and Signature of Second Staff Member Hearing Consent Obtained: ______________________________

Reason Written Consent Could Not be Obtained and Printed Name of Individual Proving Consent:
____

☐ A copy of the completed and signed Authorization must be given to the Resident or Representative Date: _______ Initials _______
A photocopy of this signed authorization shall have the same effect as an original document

GLOBAL LINKS
Sharing Surplus. Saving Lives.

700 Trumbull Dr.
Pittsburgh, PA 15205
Phone: (412) 361-3424

www.globallinks.org

DATE ________________
This waiver expires 5 years from the date it is signed.

Waiver of Liability and Photo Release

I, ________________________________ (please PRINT name), being O over 18 years of age and competent O under 18 years of age, have agreed to act as a volunteer for Global Links, a non-profit organization, in its charitable endeavors to recover surplus medical equipment and supplies for health care institutions in resource-poor communities.

I understand that any act I do is done by me entirely as a volunteer, rather than as an agent, employee, or independent contractor of Global Links.

I agree that I will not look to Global Links for my personal safety measures even when performing tasks while I am acting as a volunteer. I waive any right to make a claim against Global Links, its employees, its officers or directors for any injury, personal or otherwise, that I may suffer when I am acting as a volunteer.

I agree to defend fully and to indemnify Global Links in any claim that may be made against it for any injury, personal or otherwise, arising from my volunteer activities.

I consent and authorize Global Links to use and reproduce in any form, style or color, together with any writing, any photographs or other likeness of me taken in my capacity as a volunteer and circulated for the purposes of Global Links. This consent and release is given without limitation upon any internal or external use for advertising, promotion, illustration, or any other purpose, in print publication, audio-visual presentation, digital or electronic media or any other medium. I further waive any right to inspect or approve the commercial, advertising or other materials. I agree that such photograph or likeness remains the exclusive property of Global Links. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photograph. I release Global Links from any and all liability related to use and dissemination of my photograph or likeness.

________________________________ ________________________________
Signature Parent/Guardian Signature

________________________________ ________________________________
Street Address Relationship

____
City State Zip

If the above volunteer is under the age of 18, a parent or legal guardian must also sign this waiver of liability.

Global Links collects supplies that have been discarded for a variety of reasons, but nothing should have had patient contact or in any other way be contaminated. Nevertheless, the following precautionary measures are always observed:

1. All volunteers must wear gloves while handling supplies
2. Always keep your hands in view to protect against sharps. (It is best to dump supplies out on the sorting table rather than reaching into a bag to grab handfuls of supplies.)

The Bradley Center School | 2019-2020 CALENDAR

26-30 Clerical Days
Training

AUGUST 2019						
S	M	T	W	Th	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

02 No School
Teachers Off
03 First Day of School

25 **Open House**
27 Early Dismissal

SEPTEMBER 2019						
S	M	T	W	Th	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

14 No School
Teacher In-service

OCTOBER 2019						
S	M	T	W	Th	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

07 Early Dismissal
End of 1st Quarter
08 No School
Clerical Day
27 Early Dismissal
28-29 No School
Teachers Off

NOVEMBER 2019						
S	M	T	W	Th	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

02 No School
Teachers Off
20 Early Dismissal
23-31 No School
Teachers Off

DECEMBER 2019						
S	M	T	W	Th	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

01 No School
Teachers Off
20 No School
Teacher In-service
24 Early Dismissal
End of 2nd Quarter
27 No School
Clerical Day

JANUARY 2020						
S	M	T	W	Th	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

FEBRUARY 2020						
S	M	T	W	Th	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29

14 Early Dismissal
Teacher In-Service
17 No School
Teachers Off

MARCH 2020						
S	M	T	W	Th	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

18 **Open House**
20 Early Dismissal

APRIL 2020						
S	M	T	W	Th	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

1 End of 3rd Quarter
3 Early Dismissal

6 No School
Clerical Day
7-13 No School
Teachers Off

MAY 2020						
S	M	T	W	Th	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

22 Early Dismissal

25 No School
Teachers Off

JUNE 2020						
S	M	T	W	Th	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

11 Early Dismissal
Last Day of School
End of 4th Quarter
12 **Last Day for Teachers**

The Bradley Center School
5180 Campbells Run Road
Pittsburgh, PA 15205
412-788-8219 Phone
412-788-8215 Fax

Regular School Day
8:00am-2:30pm

Early Dismissal
8:00am – 11:30am