OCEAN ACADEMY
STUDENT EMERGENCY UPDATE SHEET

STUDENT NAME:_____ DOB:_____

ADDRESS:_____ S.S.#_____

_____ HOME PHONE #:_____

PARENT/GUARDIAN:_____ CELL #:_____

EMAIL ADDRESS:_____

EMPLOYER:_____ WORK #:_____

EMPLOYER ADDRESS:_____

INSURANCE CO:_____ ID#_____

CARD HOLDER'S NAME_____ DOB: _____

CARD HOLDER'S SS#_____

HEALTH PROBLEMS/MEDICATIONS

CHRONIC HEALTH ISSUES:_____

PRESENT MEDICATION(S):_____

MEDICATION ALLERGIES OR OTHER ALLERGIES:_____

EMERGENCY CONTACT PEOPLE

1) NAME:_____ 2) NAME:_____

RELATIONSHIP: _____ RELATIONSHIP: _____

ADDRESS:_____ ADDRESS:_____

_____ _____

PHONE #:_____ PHONE #:_____

CELL #:_____ CELL #:_____

PHYSICIAN INFORMATION

FAMILY PHYSICIAN OR CLINIC USED: NAME:_____

ADDRESS:_____PHONE #:_____

PSYCHIATRIST:_____PHONE #:_____

SIGNATURE:_____**DATE**_____

NO PRESCRIPTION MEDICATIONS WILL BE DISPENSED IN THE SCHOOL WITHOUT SPECIFIC WRITTEN INSTRUCTIONS FROM YOUR PHYSICIAN.
PLEASE REFER TO OCEAN ACADEMY HANDBOOK.

7/15/10

OCEAN ACADEMY
160 Atlantic City
Bayville, NJ 08721

PERMISSION TO OBTAIN EMERGENCY MEDICAL TREATMENT

NAME: _____ **DOB:** _____

I hereby give my permission to the staff of Ocean Academy School to obtain emergency medical treatment in the event my child receives accidental injury or appears to be in an acute medical crisis. It is understood that the staff will attempt to contact me prior to obtaining such treatment and will take my child to the nearest medical facility to receive treatment.

_____ _____
Signature of Parent / Guardian Date

_____ _____
Witness Date

PERMISSION FOR CHILD TO TRAVEL

I understand that some of the Ocean Academy curriculum and activities require that the program staff transport students to various locations. I hereby give permission to the Ocean Academy staff to transport my child at their discretion to and from any location in connection with program curriculum and activities. It is understood that the staff will take all reasonable precautions to safeguard my child. I hereby hold harmless the staff from any damage or liability should my child by involved or injured in an accident or mishap while being transported.

_____ _____
Signature of Parent / Guardian Date

_____ _____
Witness Date

EMEREGENCY CONTACT

Name: _____ Phone #: _____

Address: _____ Relationship: _____

Medical Conditions: _____

Allergies: _____

Ocean Academy

Custody Alert

The legal custodial parent or court-ordered guardian for _____ is _____

(Student) (Parent/Guardian)

The following people MAY NOT have legal access to the child or the child's records without written permission from the custodial parent.

Name	Relationship	Address	Phone
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

_____ Check here if there are NO custody problems concerning your child and sign below.

The School must be notified of any changes occurring ot the information of this form

_____ _____

Parent/Guardian's Signature Date

Bright Harbor Healthcare

Building Better Tomorrows, One Life at a Time
687 Atlantic City Blvd, Bayville, NJ 08721

AUTHORIZATION TO OBTAIN/DISCLOSE PROTECTED HEALTH INFORMATION AND/OR SUBSTANCE USE DISORDER (SUD) INFORMATION

THIS FORM MUST BE COMPLETED IN FULL

Consumer Name: _____ Date of Birth: ____/____/

Address: _____ State: _____ Zip Code: _____

I hereby authorize Bright Harbor Healthcare to ☐ **obtain** ☐ **disclose** the information below to:

Name of Person/Provider: _____ Telephone: _____

Address: _____ Relationship to Consumer: _____

Information may be faxed to the receiver: ☐ Yes ☐ No

The information to be used by the above is for the following purpose:
CONTINUING CARE _____ ATTORNEY/LEGAL _____ INSURANCE _____ OTHER _____

Range of Service: ____/____/____ to ____/____/____

Information to be shared:

☐ Psych. Assessment /Eval	☐ Psych. Meds	☐ All of my SUD info
☐ Treatment Plan	☐ SUD Meds	☐ None of my SUD info
☐ Psychiatric Notes	☐ Medical Labs	☐ SUD History
☐ Biopsychosocial Assessment	☐ SUD Lab Results	☐ SUD Discharge Summary
☐ Discharge Summary	☐ Billing Information	☐ Complete Medical Record Release

☐ Other: _____

Note: Bright Harbor Healthcare is not legally permitted to disclose information contained in the record that is from a source outside of the agency.

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above.

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Privacy Officer. I can also revoke consent verbally over the phone. In this instance, BHH staff will place me on speaker phone and identify two BHH staff persons as witnesses to the verbal revocation of prior consent. This will be documented and I will be responsible to follow up with that same revocation in writing at next point of contact. I understand the revocation will not apply to the extent that Bright Harbor Healthcare has already taken in reliance on this authorization. This authorization will automatically expire at discharge unless I otherwise specify that this authorization will terminate on the following date or concurrently with the following event or condition:

_____

I understand that authorizing the sharing of this protected health information and/or SUD information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment, or eligibility in benefits. I understand I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524 and 42 CFR Part 2. I understand that any disclosure of information carries with it the potential for an un-authorized re-disclosure and the information may not be protected by federal confidentiality laws. If I have questions about disclosure of my personal information, I can contact the Privacy Officer at 732-349-1977.

Date: ___/___/___ Consumer Signature: _____

Witness: _____ Witness: _____

(Two witnesses are required for verbal consent)

Legal Representative: _____
Circle One: Parent / Legal Guardian / POA / Healthcare Proxy – (ATTACH THE DOCUMENT OF AUTHORITY)

ATTACHMENT TO ADMINISTRATION OF MEDICATION POLICY

Dear Parent/Guardian:

SCHOOL YEAR: 2024-2025

1. All Permission to Medicate forms must be stamped by the prescribing doctor, as well as signed and dated.
2. The school nurse will give no medication, prescription or non-prescription, to a student, unless it is received in the ORIGINAL CONTAINER and accompanied by a written physician and parent/guardian request.
3. All medications are to be held in the school nurse's office, with the parent/guardian assuming the responsibility for delivering such and picking up unused amounts when no longer needed.
4. PRESCRIPTION MEDICATION must be in the original pharmacy-labeled container.
5. Opportunities must be provided for student/parent/physician/school nurse communications.
6. Your child's physician may be consulted by the school nurse whenever necessary to discuss medications being given to students, including long-term use and possible abuse of any over-the-counter medications.
7. No student will be allowed to medicate himself/herself during school hours, except as otherwise specified and documented as per Physicians Certification.

PERMISSION TO MEDICATE

Bright Harbor Healthcare/Ocean Academy requires an authorization form signed by the physician and the parent/guardian of any student who must receive medication during the school day/school activities.

Name of Student: _____

Name of Physician: _____

Name of Medication: _____

Dose: _____ Route: _____ Time Given: _____

Illness: _____

Signature of Parent/Guardian: _____ Date: _____

Signature of Physician: _____ Date: _____

THIS FORM MUST BE RETURNED TO THE SCHOOL NURSE

OCEAN ACADEMY

I, _____, hereby give my permission to the
(parent/guardian)
Staff of Ocean Academy to take photographs/video tape, of my child for various school purposes:

PLEASE INITIAL:

School Newspaper _____

Social Media (School Account) _____
(Twitter, Facebook, Instagram)

Bulletin Boards _____

Yearbook _____

Website _____

Creation of school video for _____
educational purpose

_____ _____
Name of Student Student's Signature

_____ _____
Parent/Guardian's Signature Date

BEHAVIOR CONTRACT

NAME:_____**DOB:**_____

The purpose of this written agreement is to outline the school's expectations regarding student behavior.

1. Ocean Academy will provide a quality and challenging educational experience. Students and families must be willing to participate in psychiatric and therapeutic counseling services.

2. Student Responsibilities:
   A. To treat everyone with respect and care as an individual
   B. To attend class regularly
   C. To be cooperative and not be disruptive
   D. To study and do your work
   E. To learn and master the required material

3. Students must follow the school's rules as written in the handbook. No physical contact is permitted. Fighting and assaults will lead to police intervention. Weapons, drug and alcohol violations can lead to police involvement and possible termination from school.

4. It is understood that admission to the program is probationary for the first thirty school days and that all aspects of student performance and behavior will be evaluated for suitability for continued enrollment.

5. It is understood that a change in behavior and attitude will be necessary in order to improve school performance. This means setting goals and being receptive to new ideas and points of view that will be processed in counseling and therapy.

6. The student and parents are responsible for being aware of all school rules and policies that are in the student and parent handbook.

PLEASE SIGN BELOW THAT YOU HAVE READ AND UNDERSTAND THIS CONTRACT.

DATE OF AGREEMENT_____

AGREED TO & ACCEPTED BY PARENT(S)/GUARDIAN_____

AGREED TO & ACCEPTED BY STUDENT_____

AGREED TO & ACCEPTED BY SCHOOL REPRESENTATIVE_____

OCEAN ACADEMY

Computer Contract

_____
(Name)

Use of computer equipment and electronic and internet services

Ocean Academy has made a substantial investment in technology for the benefit of its students and wants to foster responsible use of its equipment and services. Consequently unauthorized use of equipment and services is expressly prohibited.

The internet is an unregulated medium, which offers a wealth of material that can be enriching to users of all ages. However, it also accesses material that is inappropriate or illegal for school activity or students. Ocean Academy (O. A.) will make every effort to prevent access to inappropriate sites, but it is the student who is responsible for his/her behavior.

Inappropriate use of the computer system in any way will result in the following:

- Warning
- Suspension of privilege to use the computer system
- Disciplinary action

As the parent/guardian of my son/daughter, I permit my son/daughter to use the Ocean Academy computer system. I recognize it is impossible for Ocean Academy to restrict access to all inappropriate websites. Therefore, I will not hold O. A. responsible for my son/daughter actions while on the computer. I hereby give permission to O. A. to issue an account for my son/daughter to use O. A.'s computer system.

_____
Parent Signature Date

_____
Student Signature Date