



768 Doetown Road • Post Office Box 600  
Rumney, New Hampshire 03266  
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APPLICATION for  
ADMISSION

Please attach a current photo of  
your child here.  
Wallet/passport size preferred.

Student's Name \_\_\_\_\_  Male  Female

Address \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

SS# \_\_\_\_\_

Grade \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_

Present School \_\_\_\_\_

Address \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Contact \_\_\_\_\_

Briefly describe your child's educational successes and challenges:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your child take any current medications? \_\_\_\_\_ If yes, please list all medications below.

1. Name \_\_\_\_\_ Dosages \_\_\_\_\_ Times of day \_\_\_\_\_

2. Name \_\_\_\_\_ Dosages \_\_\_\_\_ Times of day \_\_\_\_\_

3. Name \_\_\_\_\_ Dosages \_\_\_\_\_ Times of day \_\_\_\_\_

Does your child have any current allergies? \_\_\_\_\_ If yes, please describe below.

\_\_\_\_\_  
\_\_\_\_\_

**Parent(s) or Legal Guardian(s)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
Home Phone (\_\_\_\_\_) \_\_\_\_\_ Day Phone (\_\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_  
E-Mail \_\_\_\_\_

**Please provide information below even if you reside at the same address. Phone numbers and email may differ.**

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
Home Phone (\_\_\_\_\_) \_\_\_\_\_ Day Phone (\_\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_  
E-Mail \_\_\_\_\_

**Siblings or other persons living at same residence as child.**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_

**Emergency Contact(s), in case parents or guardians can not be reached:**

1. Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Home Phone (\_\_\_\_\_) \_\_\_\_\_ Day Phone (\_\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_  
2. Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Home Phone (\_\_\_\_\_) \_\_\_\_\_ Day Phone (\_\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_  
3. Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Home Phone (\_\_\_\_\_) \_\_\_\_\_ Day Phone (\_\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_

**Is there anything that you can tell us to help us better understand your child?**

**How did you first learn about The Hunter School?**

## PARENT INVOLVEMENT

At The Hunter School we encourage parent involvement and communication as they are both an important part of your child's support system, as are communications from other members of the family, when appropriate. It is our policy for teachers and house parents to communicate with parents on a weekly basis to provide an update on their child's progress. If your child is admitted to The Hunter School, please place a check mark next to the levels of involvement you would like to have and can commit to in addition to the calls that are a regular part of the program:

E-mail contact \_\_\_\_\_

Face-to-face meetings with staff every 6–8 weeks

Meeting with your child's clinician either by phone or in-person on a periodic basis.

Please check your preference:       Weekly       Monthly       Bi-monthly       As-needed

School visits on a regular basis:

Please check your preference:       Weekly       Monthly       Bi-monthly       As-needed

Other, please describe \_\_\_\_\_

If conflicting schedules necessitate parents/ guardians alternative communication and/visitation schedules, please submit separate sheets for each parent/guardian.

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

**AUTHORIZATION TO RELEASE AND EXCHANGE INFORMATION**  
(Please complete and sign a separate form for each school, physician, psychologist etc.)

CHILD'S NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

Obtain: I, \_\_\_\_\_ (parent/guardian) authorize the Hunter School, by fax, mail or via telephone, to obtain information including educational, medical and/or substance abuse and/or mental health records from:

NAME : \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

Release: I, \_\_\_\_\_ (parent/guardian) authorize the Hunter School, by fax, mail or via telephone, to release information including educational, medical and/or substance abuse and/or mental health records to:

NAME : \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

This information is to be released for the purpose of assessing resident/ student needs and providing comprehensive services.

Additional Reasons for Release: \_\_\_\_\_

Please release the following information:

- \_\_\_ Medical History and treatment/discharge plan                      other (please specify): \_\_\_\_\_
- \_\_\_ Information about benefits/payments I receive
- \_\_\_ Mental Health evaluations, treatment plans, medication and discharge plans
- \_\_\_ Education/psycho education plans
- \_\_\_ IEP or 504 plans
- \_\_\_ Substance use/abuse history

I understand that alcohol/drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 C.F.R. Part 2) and the Health Insurance Portability and Accountability Act of 1996, and cannot be disclosed without my written consent unless provided for in the regulations. I also understand that behavioral health records are confidential and protected from unauthorized disclosure. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it. This consent/authorization shall be valid for one year from the date below and shall expire automatically from the date below.

Signature of parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_

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

Relationship of witness: \_\_\_\_\_