Rockdale Recovery High School

Application for Admission

STUDENT INFORMATION

Name: First _____Middle_____ Last _____

DOB:_____ Age: _____ Gender: _____ Grade: _____

SASID#: _____ Social Security Number: _____

Current Address: _____ City _____

State _____ Zip _____

Place of Birth: City _____ State _____

Student Phone Number: (H) _____ (C)_____

Home School (Name/Address): _____

_____

School Contact (Name/Role):_____

School Contact (Phone/Email):_____

Parent/Guardian 1

Relationship to Student: _____

Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

E-Mail: _____

Lives with student: YES ☐ NO ☐

Should receive mail: YES ☐ NO ☐

Parent/Guardian 2

Relationship to Student: _____

Name: _____

Address:_____

City, State, Zip: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

E-Mail: _____

Lives with student: YES ☐ NO ☐

Should receive mail: YES ☐ NO ☐

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Step Parent / Other Guardian (If Applicable) 1

Relationship to Student: _____

Name:_____

Agency (if applicable):_____

_____

Address: _____

City, State, Zip: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

E-Mail: _____

Lives with student: YES ☐ NO ☐

Should receive mail: YES ☐ NO ☐

Step Parent /Other Guardian (If Applicable) 2

Relationship to student: _____

Name: _____

Agency (if applicable):_____

_____

Address: _____

City, State, Zip: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

E-Mail: _____

Lives with student: YES ☐ NO ☐

Should receive mail: YES ☐ NO

Describe custody arrangements (if any):

EMERGENCY CONTACT INFORMATION

1st Emergency Contact

Relationship to Student:

Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

E-Mail: _____

Can receive student: YES ☐ NO ☐

Can dismiss student: YES ☐ NO ☐

2nd Emergency Contact

Relationship to Student:

Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

E-Mail: _____

Can receive student: YES ☐ NO ☐

Can dismiss student: YES ☐ NO ☐

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MEDICAL/CURRENT PROVIDER INFORMATION

Collateral Role	Contact Name	Agency Name	Telephone/Fax
Department of Children and Families Caseworker (DCF)			
Probation Officer (PO)			
Primary Care Physician			
Dentist			
Individual Therapist			
Psychiatrist			
In-Home/Family Therapist			
Intensive Care Coordinator (ICC)			
Therapeutic Mentor (TM)			
Family Support Partner (FSP)			
Other:			
Other:			

Psych/Subst. Use Disorder Diagnosis(es): _____

_____

Allergies: _____

Medical Conditions: _____

Important Medical History: _____

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STUDENTS: Please tell us why you would like to attend the Recovery High School, including your level of commitment to recovery. You may uses a separate piece of paper:

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TREATMENT INFORMATION List all treatment programs attended.

Admission Date	Discharge Date	Type of Treatment	Agency Name and Address	Agency Contact Name / # / Role	Reason for Placement	Complete: Yes or No	If no, explain why not:

*Types of treatment may include: inpatient psychiatric hospitalization, (intensive) community based acute residential treatment (CBAT/ICBAT), inpatient detox services, residential treatment programs (substance abuse and/or behavioral/mental health), outpatient detox services, outpatient therapy, psychiatry/medication management, intensive-home therapy, family therapy, intensive outpatient programs/structured outpatient addiction programs, medication assisted treatment programs, etc. ***If necessary please make a copy of this document and continue on a second page.***

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Central Massachusetts Collaborative

CONSENT AUTHORIZING DISCLOSURE OF CONFIDENTIAL SUBSTANCE USE STUDENT RECORDS

Student Name: _____ DOB: _____

I, _____ (parent / guardian), hereby authorize and request the release, exchange, disclose all records including records related to evaluation and/or treatment for substance use, including but not limited to, all written reports and recommendations to CENTRAL MA COLLABORATIVE (CMC**)** from the following agencies /schools:

_____

_____

Phone Number: _____ Fax Number: _____

Please forward information to: **Rockdale Recovery High School, Principal or Clinician**

121 Higgins Street, Worcester MA 01606

F: 508-854-4984

The information that may be disclosed, obtained and / or exchanged through this authorization includes the following type of information checked below.

FROM OUTSIDE AGENCIES:

√ Verbal interactions between CMC and _____

√ Electronic communication including but not limited to fax and email between CMC and the above named entity.

√ Treatment records: Intake/Admission/discharge summary, Emergency Mental Health reports, and additional evaluations.

√ All mental health records, including clinical records created or received by the sending institution.

√ Information pertaining to the diagnosis and treatment of substance abuse

FROM SCHOOLS:

√ Academic records including: attendance, transcripts, birth certificate, discipline, grades to date, immunization/health records, 504 plan, ELL records, standardized testing (i.e.: MCAS, MAPS, PARRC).

√ Psychological or Neuropsychological evaluations

√ Academic/Achievement and Itinerant evaluations, (i.e.: OT, PT, Speech, LD)

√ Individualized Education Plan

√ Other specific information: _____

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I understand that my substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically upon completion of the evaluation from Central MA Collaborative.

"This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2).The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§2.12 (c)(5) and 2.65."

I have carefully read the above, had the opportunity to request clarification on items I may not understand, and fully consent to the disclosure of the above-stated information to the parties indicated.

Parent(s)/Guardian(s) Signature:

_____

Date: _____

_____
Initials of student

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Referral Process for Interested Students

After receiving a referral, the principal (or designee) will make direct contact with the parent/guardian or student to answer preliminary questions and to schedule an enrollment meeting and tour.

• All applicants need to have an adult who is willing to co-sign paperwork and should accompany them to their first visit to Rockdale Recovery High School. (Applicants over 18 should still bring a family member with them.)

Needed Documents for Enrollment Meeting / Tour:

- Application for Admission including Narrative Essay
- Social Security Card / Birth Certificate
- Consent for the Release of Confidential Information, for all service providers affiliated with the prospective student. (DCF worker, probation officer, psychiatrist, treatment program, etc.)
- School Records including: attendance records, behavior records, IEPs/504s (if applicable)

Enrollment Interview / Tour

1) Principal, guidance counselor, and Recovery Clinician will have reviewed transcript and academic records to ensure needs can be met at RRHS.

2) Student and family will receive a tour of the school and discuss the following topics:

• RRHS History/Recovery High School movement.
• Collaboration with sending schools.
• Facilities
• Class size & gender/age make-up
• Academic schedule and program tracks (special education vs. AP)
• Class content
• Standardized Testing (MCAS & SATs)
• College & Career Planning
• Lunch options
• Extra-curricular activities
• Recovery Programming/Supports (groups, meetings, counselor, drug testing)
• Relapse Policy
• Parent involvement (quarterly parent/guardian night)
• Special education accommodations
• Attendance requirements.
• On-line credit options

3) Students will be interviewed by Recovery Clinician to assist with determining whether student is eligible for enrollment.

*****Students may be accepted, conditionally accepted, or denied.**
*A student who is conditionally accepted may be asked to fulfill certain conditions (e.g. complete a period of out-patient counseling, inpatient treatment, ect.) prior to starting RRHS. ***denied students may apply again in the future as circumstances change*

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