MARGARET HUDSON PROGRAM
Tulsa Campus

Documents and Information Needed to Enroll

The following documents **Must** accompany the Enrollment packet. Please make copies of the original requested documents below or bring the document and Margaret Hudson will make copies. Parents/Guardians, submitting an application does not mean your child is accepted into the program. The child is officially enrolled when she has spent a whole day attending classes.

1. Parent or Guardian
2. Birth Certificate for the Student and Baby
3. Immunization Records for the Student and Baby
4. Social Security Card for the Student and Baby
5. Medical card (T-19, BlueLines, community Care, etc.) for Student and Baby
6. Proof of Pregnancy (Doctor’s letter)
7. Income verification Form & Proof of Income (W-2, paystub, tax return, etc.) for Parent/Guardian if Student does not work.
8. Proof of Address (Current Utility Bill or Lease Agreement etc.)
9. Transcript from Previous School
10. Attendance Record (out-of-district students only)
11. Withdrawal Grades from You Home School
12. MHP-Parent Contract Agreement
13. County Transfer (if applicable)
14. Affidavit of Custodianship (if applicable)
15. Affidavit of Independence (if applicable)
16. Marriage License (if applicable)
MARGARET HUDSON PROGRAM
Tulsa Campus
1136 South Allegheny Avenue
Tulsa, Oklahoma 74112
Phone: 918-833-9860
Fax: 918-833-9875

2015-2016 Schedule

Enrollment and Intake for Returning Students
July 27 - August - 12, 2015

Enrollment and Intake for New Students
August 3 – August 12, 2015

Monday – Thursday 9:00-3:00 & Friday’s 9:00-12:00

Enrollment will resume on August 20th – August 28th for all students and their start date will be September 8th, 2015

***Classes Begin: August 20, 2015***

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MARGARET HUDSON PROGRAM
Admission Application

Name: ___________________________________________ Date of Birth: ____________

I understand that by signing this form I am giving my child permission to continue her education at The Margaret Hudson Program as long as they allow her to attend. I also understand that my child will be receiving all the following services that make up this program. I further understand The Margaret Hudson program is a holistic program and if my child refuses any part of the program she is subject to be returned to her home school.

The services consist of, but are not limited to, the following:
- Academic services
- Care to promote health and prevent illness for adolescent and child
- Care for common illnesses of teenagers and children
- General social service needs and therapeutic groups and counseling
- Care for substance abuse prevention
- Care concerning growth and development
- Human sexuality education and services
- Childcare services
- Coordination and collaborations with other care providers in the community
- WIC/Nutrition services
- Immunizations
- Participation in campus-based mentorship program

I, the undersigned, have read the front and back of this form and agree with all services that may be provided.

_________________________ ____________________________
Parent/Guardian Signature Relationship to Student

_________________________ ____________________________
Student Signature Date

_________________________ ____________________________
Witness Signature Date

EP-1 Academic
Admission Application Continued

Services may include, but are not limited to:

1. Academic Services
   a. Classes required for graduation
2. Care to promote health and prevent illness for adolescents and children
   a. General health information
   b. Physical exams
   c. Health Screening
   d. Developmental screening
3. Care for common illnesses of teenagers and children
   a. Minor acute illness
   b. Cough, colds, stomach aches, and backaches
4. General Social Service needs and Therapeutic Counseling
   a. Depression or sadness
   b. Suicide assessment
   c. Life skills assistance, career planning, and job readiness
   d. Family and martial counseling, child physical and sexual abuse
5. Assessment and referral for substance abuse prevention
   a. Alcoholism and drug abuse
   b. Tobacco
6. Care concerning growth and development
   a. Physical assessment of growth
   b. Counseling about the adolescent growth concerns
7. Childcare Services
   a. Pass Safety test in Child Development class
   b. Student is required to work in all Childcare labs
   c. Student’s parenting skills will be observed while in Childcare labs
8. Human sexuality education and services
   a. Education and counseling on birth control methods
   b. Adolescent-specific family planning clinic services
9. Transportation to appointments through the Margaret Hudson Program van
   a. Scheduled and emergency transportation to appointments
10. Coordinate and collaborate with other community care providers
    a. Verbal and written professional communication to agencies and providers in the community to meet the needs of the adolescent and child.
11. Participation in the campus-based Mentorship Program
    a. One-on-one match of community members and adolescent for support in academics, parenting and enrichment at the campus site.
MARGARET HUDSON PROGRAM-PARENT CONTRACT
2015-2016

The involvement of parents in our program is an essential component of nurturing students and their babies to helping them reach their full potential. We invite you to partner with us to fulfill our vision of Empowering Teen Families for Lifelong Success.

The administration, staff, the parents and students of the Margaret Hudson Program agree that we will share the responsibility for improved student academic and personal achievement. This contract outlines how our program and parents/guardian will each play an important role in building and developing a partnership that will help students achieve.

School Responsibility

We, the staff and administration of the Margaret Hudson Program will:

1. **Provide high-quality instruction in a supportive and effective learning environment that enables students to meet or exceed their academic or personal achievement goals.**
   Supported by administrators, all teachers and staff will:
   - Encourage and support students learning through data-driven decisions resulting in differentiated instructional practices.
   - Maintain high instructional standards that will promote the development of the district’s content standards and benchmarks.
   - Respectfully and accurately inform parents of their child’s progress.
   - Have high expectations for students and be committed to continuous growth for all.
   - Help students resolve conflict in positive ways.
   - Cooperatively work with appropriate staff to support the success of each student and their child.
   - Create a respectful, caring, inclusive, stimulating and safe program/classroom setting.

2. **Hold parent-teacher conferences during which the individual student’s growth and achievement will be discussed within the framework of this contract.**
   - Conferences will be held twice a year (additional conferences may be scheduled based on the individual needs of the student) during the fall and spring semesters. Information about the conferences will be sent home and scheduling will occur on a flexible basis to accommodate parents’ schedules.
   - Conferences can be arranged at a mutually agreed upon time with the teacher and the parent/guardian.
3. Provide parents with frequent reports on their child’s progress. The program will provide the reports as follows:
   - Report cards
   - Progress reports
   - E-mail or phone calls as needed
   - Parent/teacher and support staff conferences and meetings
   - When necessary, documents will be translated and interpreters will be provided for Spanish-speaking parents.

4. Provide parents reasonable access to staff. Specifically, staff will be available for consultation with parents:
   - By phone
   - Through additional conferences as requested
   - E-mail

Parent Responsibilities

We, as parents, will support our students and their child’s learning in the following ways:

   - Reviewing student grades
   - Ensuring child gets to school each day when healthy
   - Ensure that our child arrives on time and ready to learn
   - Demonstrating interest in our child’s well-being by attending school functions and support school activities.
   - Making every effort to attend parent teacher conferences
   - Staying informed about my child’s education and communicating with the program by promptly reading or listening to all notices from the school and responding, as appropriate
   - Seeing that my child is dressed appropriately for school each day.
   - Student Reinforcing appropriate school behavior

Student Responsibilities

As a student, I will share the responsibility to improve my academic and personal achievement.

   - I will follow all rules and regulations of the program.
   - I will complete my assignments in a timely manner and ask for help when needed.
   - I will give all paperwork and information from the program to my parent/guardian who is responsible for my welfare.
   - I will demonstrate respect for myself, other students and adults.
   - I will work cooperatively with my classmates, teachers and support staff.
   - I will model behaviors that promote healthy outcomes for me and my child.

MHP Administration____________________________________ Date_________________________

Parent/Guardian Signature__________________________________________________ Date_________

In signing this contract, I agree to maintain involvement with my child’s education to the best of my ability. If any obstacles or extenuating circumstances hinder and or prevent me from a full commitment, I can offer an explanation to program administration.

Student Signature_________________________________________________ Date_____________
### Intake Form

**Enrollment Date:** ____________________________________________________________________  **Previous MHP Student?**  
☐ Yes  ☐ No

**MHP Enrollment Site:**  
☐ Tulsa  ☐ Broken Arrow  ☐ Outreach

**Name:** ___________________________  
**Last Name:** ___________________________  
**First Name:** ___________________________  
**Middle Initial:** __________

**Address:** ________________________________________________________________________________

**City:** ___________________________________  **State:** ________  **Zip:** __________  **County:** __________

**Home Phone:** ___________________________  **Cell Phone:** ___________________________  **Social Security Number:** ___________________________

**DOB** ______________  **Age:** ____  **Birth Place:** ___________________________  **How many people live in your house:** ______

**Race:**  
☐ White  ☐ African American  ☐ Native American  ☐ Hispanic  ☐ Asian  ☐ Other

**Marital Status:**  
☐ Single  ☐ Married  ☐ Divorced  ☐ Widowed  ☐ Separated

**Last School Attended:** ___________________________________________________________  
**Last Grade COMPLETED:** __________

**Interested in TCC EXCELLEATED program:**  
Yes ☐  No ☐ (ACT score of 19 or above required)

**Are you willing to be added to MHP alumnae database?**  
☐ Yes  ☐ No

**Emergency Contact Name:** ___________________________  
**Relationship:** ___________________________

**Home Phone:** ___________________________  **Cell Phone:** ___________________________

**Currently Live With:**  
☐ Mother & Father  ☐ Mother & Step-Father  ☐ Father & Step-Mother  ☐ Mother Only  
☐ Father Only  ☐ Spouse  ☐ Boyfriend  ☐ Alone  ☐ Foster Parents  ☐ Group Home  
☐ Other (please specify):  
____________________________

**Name of Legal Guardian:** ___________________________  
**Address:** ________________________________________________  
**City** ___________________________  **State:** ________

**Relationship:** ___________________________  **Phone Number:** ___________________________

**Alt. Phone Number:** ___________________________  **Email:** ___________________________

**Your Primary Source of Income:**  
☐ Parent(s)  ☐ Spouse  ☐ Father of Baby  ☐ Self-Supporting  ☐ Public Assistance  
☐ Other (please specify):  
____________________________

**Phone Number:** ___________________________  **Household Annual Income:**  
☐ Under $14,500  ☐ $14,501-$16,399  
☐ $16,400-$23,450  ☐ $23,451-$26,249  ☐ $26,250-$37,500  ☐ Over $37,501

**Type of Medical Insurance:**  
☐ Private Insurance  ☐ Title 19 Medical Card  ☐ Native American  ☐ HMO  ☐ Underinsured

**Reason:** ___________________________

**How were you referred to MHP (please choose at least one):**  
☐ School  ☐ Church  ☐ Parent/Guardian  
☐ Other Relative  ☐ Friend  ☐ Court  ☐ Media  ☐ DHS  ☐ Physician  ☐ Foster Parents  ☐ Planned Parenthood  
☐ MHP Outreach Services  ☐ Other (please specify):  
____________________________

**Social Services Information:** ___________________________
How many children has your mother had? ____________________________________________

How old was your mother when she had her first child? _______________________________

Please check one: Are you the ☐ Oldest ☐ Middle ☐ Youngest or ☐ Only Child

Please answer the following information about the father of your child.

What is the current status of the relationship with the father of your child? Select all that apply. ☐ Involved ☐ No longer involved ☐ Living together

Father of the child’s name: ________________________________________________________

Race: ☐ White ☐ African American ☐ Native American ☐ Hispanic ☐ Asian

Education: ☐ Currently attending school ☐ Where: ___________________________ ☐ High School graduate ☐ GED recipient ☐ College ☐ Tulsa Tech ☐ Trade School ☐ Other (please specify): ___________________________

Grade___________________________

(please specify): ________________________________________________________________

Is he employed? ☐ Yes ☐ No ☐ Don’t Know If yes, where? ______________________________

Child Care Information

What are your plans for Child Care? ☐ MHP Child Care ☐ Other Child Care ☐ Home Child Care

Name of other child care: ___________________________ Phone: _______________________

Will you be receiving child care assistance from the Department of Human Services? ☐ Yes ☐ No

If yes, provide the caseworker name: ___________________________ Phone: _______________________

If no, when do you plan to apply for daycare assistance? ______________________________

Name of children and date of birth:

Child’s Name: ___________________________ DOB ___________________________

Child’s Name: ___________________________ DOB ___________________________

Health Service Information (to be completed by your Margaret Hudson Nurse)

Are you currently: Pregnant? ☐ Yes ☐ No Parenting? ☐ Yes ☐ No

Date of last menstrual period: ___________________________ If pregnant, expected delivery date: ___________________________

Plans for baby: ☐ Parent: ☐ Adoption: ☐ Not sure: Trimester at enrollment: ☐ First ☐ Second ☐ Third

Trimester you began prenatal care: ☐ First ☐ Second ☐ Third: Number of pregnancies (Gravida): ___________________________

Number of children (Para) ________: Where will you go for prenatal care? ☐ Health Department ☐ Private MD/DO

☐ OU Clinic ☐ OSU Clinic ☐ Morton ☐ Planned Parenthood ☐ Indian Health ☐ Other (please specify) _________________

Name of Primary Care Physician: ___________________________ Phone: ________________ you receive WIC?

Yes ☐ No ☐ If yes, where: ___________________________

Administrative Office
PO Box 580637
Tulsa, OK 74158
Website: 222.margarethudson.org

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F: (918) 833-9875

Broken Arrow Campus
751 West Knoxville
Broken Arrow, OK 74012
T: (918) 251-2647
F: (918) 251-266

Tulsa Area United Way
Tulsa Public Schools Emergency Information and Authorization to Administer Non-Prescription Medications

Student’s Name: ___________________________ First Name: ___________________________ Middle Name: ___________________________

Last Name: ___________________________. City: ___________________________. State: ______ Zip: ___________

Address: ___________________________. Phone: ___________________________. Birth Date: ___________. Sex: ☐ Male ☐ Female

Parent/guardian (First Contact): ___________________________. Relationship: ___________________________.

Phones: Home ___________________________. Work: ___________________________. Cell: ___________________________.

Parent/Guardian (Second Contact): ___________________________. Relationship: ___________________________.

Phones: Home ___________________________. Work: ___________________________. Cell: ___________________________.

Please list anyone authorized to pick up your student in the event of illness or injury if you cannot be reached at the above numbers. Only those persons listed will be allowed to pick up your child without additional approval from you.

Name: ___________________________. Relationship: ___________________________. Phone: ___________________________.

Name: ___________________________. Relationship: ___________________________. Phone: ___________________________.

Physician: ___________________________. Phone: ___________________________. Insurance: ___________________________.

Does your student have any potentially life threatening allergies to medicine or anything else? ☐ Yes ☐ No

If yes, explain: ___________________________.

Does your student have any chronic or significant health problems or any physical limitations? ☐ Yes ☐ No

If yes, explain: ___________________________.

Is your student being treated with any prescription medications at home or school? ☐ Yes ☐ No

If yes, list: ___________________________.

I hereby authorize the school nurse, or other school personnel designated to administer medications, to administer acetaminophen (Tylenol), ibuprofen (Advil/Motrin), calcium antacid (Tums), or other non-prescription first aid medications to my student with the following exclusions:

_________________________.

Students in grades 6-12: Students will receive authorization medications at the discretion of school personnel except as excluded by parent/guardian above.

Note: Only a parent or legal guardian may authorize the administration of medications.

Authorization for Treatment

I hereby authorize any physician, surgeon, or dentist on the medical staff of the nearest medical facility, to administer any emergency treatment, procedure or medicine necessary and advisable. I also authorize the use of an ambulance, if necessary, to transport my child. I further agree to pay for all services provided for my child. If this is not satisfactory please list specific emergency instructions in the event that you cannot be reached.

_________________________.

Signature of parent/guardian: ___________________________. Date: ___________________________.

H-14

EP-18 Folder
Alternative Childcare for a sick Child

Staying home may be your only option when your child is so ill that he or she must remain in bed. Margaret Hudson program, however, encourages another option which is to recruit the help of others. The key is to plan ahead. Before your child gets sick ask those people who are closest to you to help out under these circumstances.

Please list below the names, relationship, and phone numbers of two people who will help.

1. Name:_____________________________________________________
   Relationship:_____________________________________________
   Phone:____________________________________________________

2. Name:_____________________________________________________
   Relationship:_____________________________________________
   Phone:____________________________________________________

________________________________________________________________________

Student Signature________________________________________________________________________Date

________________________________________________________________________

Parent/Legal Guardian Signature________________________________________________________________________Date
**Student Pick-Up List**

This form needs to be completed by the parent or legal guardian. Please list below the names and phone numbers of individuals who have permission to pick-up your child from school in the event you are unavailable. Only those listed below will be authorized to pick-up the student from the Margaret Hudson program. The Margaret Hudson Program requires a note from the parent or legal guardian stating a reason the student must leave school early.

Parent/Guardian Name: ____________________________________________________________

Student’s Name: __________________________________________________________________

The following individuals have permission to pick-up the student referenced on this form:

1. ___________________________ Phone: ___________ Relations: ___________
2. ___________________________ Phone: ___________ Relations: ___________
3. ___________________________ Phone: ___________ Relations: ___________
4. ___________________________ Phone: ___________ Relations: ___________
5. ___________________________ Phone: ___________ Relations: ___________

____________________________________________________
Print Name of Parent/Legal Guardian

____________________________________________________
Signature of Parent/Legal Guardian __________________________ Date
Margaret Hudson Program

Attendance Policy

It is the educational philosophy of the Margaret Hudson Program that regular attendance by all students at school is essential and cannot be duplicated by other methods. If a student expects to be absent from school, the student, parent or legal guardian needs to notify the school as soon as possible. Upon returning to school after any absence, the student needs to bring a written note of explanation from a social service or medical agency (Doctor’s appointment, Court or DHS). Failure to abide by this policy will result in an unexcused absence.

Student’s Responsibility

Students will be solely responsible for ensuring the day-to-day affairs of maintaining passing grades, excellent conduct, setting doctor’s appointments, asking for make-up assignments, seeking help when needed, and upholding The Margaret Hudson Program (MHP) rules and regulations to insure the success of each student’s educational, social, and health needs.

Student and Parent/Legal Guardian please sign below to indicate that you have read and understand the Attendance Policy and the Student’s Responsibility.

_____________________________________________  _________________________________________
Print Name of Parent/Legal Guardian                 Print Name of Student

_____________________________________________  _________________________________________
Signature of Parent/Legal Guardian                  Signature of Student

____________________  ________________________
Date                                                  Date

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Broken Arrow, OK 74012
T: (918)251-2647
F: (918) 251-2661
Authorization for Release of Information

Client’s Name: ___________________________________________________________ DOB ______________________

Address: _________________________________________________________________ State: _______ Zip: __________

Phone: __________________________________________________________________ Social Security #: ______________________________

The use and disclosure of Protected Health Information (PHI) not covered by HIPPA Notice of Privacy Practices or the laws that apply to us will be made only with your written authorization.

I hereby release The Margaret Hudson Program, Inc., its staff and collaborating agency from all liability and all claims of any nature whatsoever pertaining to disclosure of information regarding the care and treatment from The Margaret Hudson Program’s above named client.

It is understood that I may revoke this authorization at any time by written request. It is further understood that we are unable to take back any disclosure already made with your authorization and that we are required to retain records of care that are provided you by The Margaret Hudson Program.

I, the undersigned, do hereby authorize The Margaret Hudson Program to release/obtain the following PHI:
_______________________________________________________________________________________________

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<th>Persons/Organization authorized to receive information</th>
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Expiration: This authorization expires (choose one): [ ] One year from the signed date

[ ] On the following specified date: ____________________________

_______________________________________________________________________________________________

Client Signature ___________________________ Date __________________________

_____________________________________________ __________________________

Parent/Legal Guardian Signature Date

EP-10 Health
Margaret Hudson Outreach Program

The Margaret Hudson Program would like to conduct follow-up visits for students who have left the program. The visits would be held six months and one year after the student leaves the program.

Name: ______________________________________ Home Phone: __________________________

Address: __________________________________ Cell Phone: __________________________

City: __________________________ State: __________ Zip: __________________________

Please complete the information requested below. List the people who will always know how to reach you. These people can be parents, grandparents, aunts, uncles, brothers, sisters, etc.

Name: ______________________________________ Phone: __________________________

Address: __________________________________ Cell Phone: __________________________

City: __________________________ State: __________ Zip: __________ Relationship: _____________

Name: ______________________________________ Phone: __________________________

Address: __________________________________ Cell Phone: __________________________

City: __________________________ State: __________ Zip: __________ Relationship: _____________

Name: ______________________________________ Phone: __________________________

Address: __________________________________ Cell Phone: __________________________

City: __________________________ State: __________ Zip: __________ Relationship: _____________

____________________________________________________ __________________________

Parent/Guardian Signature Date

____________________________________________________ __________________________

Student Signature Date

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F: (918) 251-2661

LIVE UNITED
Tulsa Area United Way
MHP Mentor Program

We are pleased to inform you of an opportunity for your child to participate in The Margaret Hudson’s Mentor Program. This program is designed to match approved adults with students who can benefit from the mentor program. When matched, the mentor and student will work together during school time and in the school setting. The mentor will strive to help your child in areas such as grades, attendance, attitudes, special projects, grief, goal setting, self-esteem, and careers.

Parents are asked to support the program by agreeing to talk to your child about the mentoring program and to communicate with your child’s school counselor if you have any concerns regarding the program or your child’s relationship with the mentor.

Please complete the information below to give your permission for your child to participate in the Mentor Program,

Student’s Name: ___________________________________________ Grade: _____________________________

☐ I hereby give permission for my child to participate in the MHP Mentor Program

☐ I do not wish my child to participate in the MHP Mentor Program

I understand that personal liability while on the mentorship assignment is the responsibility of the student and parent. The Margaret Hudson Program, its Board of Directors, employees, and the volunteers of The Margaret Hudson Program are hereby released from responsibility and will not be held responsible in case of accident or injury during the activities of the Mentorship Program.

__________________________________________________________ ___________________________
Parent/Guardian Signature Date

__________________________________________________________
Address City State Zip

__________________________________________________________
Home Phone Number: Cell Phone Number: Work Phone Number:

__________________________________________________________ ___________________________
Student Signature Date

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Live United
Tulsa Area United Way
Field Trip Permission Form

My child has permission to participate in field trips and school activities with the Margaret Hudson Program while enrolled in the program. School rules and policies shall be enforced on all field trips and school activities. The sponsor(s) shall be in attendance with the students during the entire school sponsored trip. TPS owned vehicles (bus, suburban, etc.) will be used to transport the students. The use or possession of alcoholic beverages, tobacco, drugs or medications (other than those listed below) is strictly prohibited. If violated, the parent or guardian will be contacted and the child will be immediately sent home at the expense of the parent or guardian.

Student’s Name: ____________________________________________ Age: __________

Address: ______________________________________________________ City: ______________________

Parent/Legal Guardian Name: __________________________________________ Phone: ______________________

Alternative Phone: _____________________________ If parent cannot be reached, call: _____________________________

My child is presently taking the following medications (list all):

__________________________________________________________________________________________

List any reactions to foods, medication or the environment your child has:

__________________________________________________________________________________________

Health Insurance Company: ________________________________ Policy #: ________________________________

Physician: __________________________________________ Phone: ________________________________

___________________________________________________________ __________________________
Signature of Parent/Legal Guardian/Student 18 or over

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F: (918) 251-2661
Media Release Form

Parent/Guardian Printed Name: ______________________________________________________

Student’s Printed Name: ____________________________________________________________

I hereby give permission to The Margaret Hudson Program to video tape, photograph, make a voice recording, or motion picture of me and/or my minor child, my minor child’s father and any other family member who participates in MHP sponsored activities. Information may be used in connection with internet and educational television programs, subsequent visual and auditory presentations, or to use in a depiction of a regular school activity.

I understand and agree that this will become the exclusive property of The Margaret Hudson Program and that neither my child nor I nor any other family member will receive compensation or remuneration for participating.

Students in DHS custody are exempt from completing this form or participating.

__________________________________________   ____________________________
Parent/Legal Guardian Signature                  Date

__________________________________________   ____________________________
MHP Student Signature                           Date
MHP Student Information Sheet

Last Name: ___________________________________  First Name: ___________________________  Middle Initial: _____

DOB: __________________ Grade: _______  Student ID #: ___________________  Ethnicity: ______________________

Address: __________________________________________ City: __________ State: ______ Zip: _______

Student Phone: ___________________________  Student Social Security #: ___________________________

Student Email Address: ________________________________

**************************************************************************************************

First Contact Name: _____________________________  Relationship: □ Father  □ Mother  □ Grandparent

□ Spouse  □ Sibling  □ Other: _____________________________

Phone (1st call) ___________________________  Check One: □ Home  □ Work  □ Cell

Phone (2nd call): ___________________________  Check One: □ Home  □ Work  □ Cell

Phone (3rd call): ___________________________  Check One: □ Home  □ Work  □ Cell

Email:  

**************************************************************************************************

Second Contact Name: ___________________________  Relationship: □ Father  □ Mother  □ Grandparent

□ Spouse  □ Sibling  □ Other: _____________________________

Phone (1st call) ___________________________  Check One: □ Home  □ Work  □ Cell

Phone (2nd call): ___________________________  Check One: □ Home  □ Work  □ Cell

Phone (3rd call): ___________________________  Check One: □ Home  □ Work  □ Cell

Email:  

**************************************************************************************************

Third Contact Name: ___________________________  Relationship: □ Father  □ Mother  □ Grandparent

□ Spouse  □ Sibling  □ Other: _____________________________

Phone (1st call) ___________________________  Check One: □ Home  □ Work  □ Cell

Phone (2nd call): ___________________________  Check One: □ Home  □ Work  □ Cell

Phone (3rd call): ___________________________  Check One: □ Home  □ Work  □ Cell

Email:

EP-21 Attendance Folder
Student’s Name (Please Print) ____________________________ Date: ________________

Student ID# ________ Current Grade: _____ _____ Pregnant: (if yes how far along?) ________ _____ Parenting

**NOTICE SCHOOL UNIFORMS REQUIRED:** Uniforms will be the responsibility of the parent/guardian and/or student.

**Bottoms:** Black, Khaki, Jeans or maternity pants **(No Cargo Pants):** **Tops, (Short & Long Sleeves):** Polo or Oxford: Any solid color approved by Tulsa Public Schools

Pant Size: (8, 10, 12/S, M, Lg, etc.) Shirt Size: (8, 10, 12/S, M, Lg, etc.)

**TPS Approved Solid Colors for Tops:** White, Black, Gray, Green, Heather Green, Hunter Green, Forest Green, Royal Blue, Powder Blue, Navy Blue, Red, Pink, Burgundy, Maroon and Deep Purple.

________________________________________  ____________________________________
Student Signature: Parent/Guardian Signature:

________________________________________
Date: __________________________

Administrative Office  Tulsa Campus  Broken Arrow Campus
PO Box 580637  1136 S. Alleghany Ave.  751 West Knoxville
Tulsa, OK 74158  Tulsa, OK 74112  Broken Arrow, OK 74012
Website: 222.margarethudson.org  T: (918) 833-9860  T: (918)251-2647
F: (918) 833-9875  F: (918) 251-2661

EP-14 Principal
Media Release Form

Parent/Guardian Printed Name: ____________________________________________________________________________

Student’s Printed Name: __________________________________________________________________________________

I hereby give permission to The Margaret Hudson Program to video tape, photograph, make a voice recording, or motion picture of me and/or my minor child, my minor child’s father and any other family member who participates in MHP sponsored activities. Information may be used in connection with internet and educational television programs, subsequent visual and auditory presentations, or to use in a depiction of a regular school activity.

I understand and agree that this will become the exclusive property of The Margaret Hudson Program and that neither my child nor I nor any other family member will receive compensation or remuneration for participating.

Students in DHS custody are exempt from completing this form or participating.

______________________________  _______________________
Parent/Legal Guardian Signature  Date

______________________________  _______________________
MHP Student Signature  Date
HIPPA PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully and keep for your files.

Note: this is a condensed version of the NOTICE OF HIPPA PRIVACY PRACTICE. Instructions to obtain a copy of the complete NOTICE OF HIPPA PRIVACY PRACTICE is at the end of this notice.

It is the policy of The Margaret Hudson Program (MHP) to keep all of your medical and personal information confidential. We will only use or disclose your information for the following reasons:

- **Treatment**: We will share your medical information with other medical providers who are involved in your care.
- **Reimbursement**: We may use and disclose Protected Health Information (PHI) when it is needed to receive reimbursement for services provided to you.
- **Health Care**: We will use and disclose PHI when it is needed to make sure we are providing you with good service.
- **Other uses or disclosures of your PHI may be made when**:
  - You have given us permission in writing to release part of your information;
  - Ordered to do so by a valid court order;
  - Cases of child abuse or neglect are investigated;
  - Immunization information is needed by schools and childcare centers in which you or your child are enrolled;
  - Business associates of MHP who sign agreements to protect your privacy;
  - Required by state law. For instance, when reporting injuries and disease as required by the Public Health codes or to prevent the spread of diseases such as STD’s.

**You’re Rights:**

You have the right to:

- Request limits on how your information is used or disclosed; however, we are not required to agree to those limits;
- Ask that we not contact you at home;
- Inspect and copy your medical records except in cases involving certain psychotherapy notes;
- Amend incorrect information in your medical record;
- Receive a list of outside persons or organizations to which we release your information;
- Revoke your written permission for release of information;
- Receive a paper copy of this privacy notice.

**Our Responsibilities:**

Federal law requires MHP and its entities to:

- Maintain the confidentiality for your protect health information;
- Provide you with a copy of this notice;
- Abide by the terms of this notice;
- Only change this notice as permitted by federal rules;
- Provide you with a way to file complaints regarding privacy issues.

For further information or a complete copy of this notice, contact: The Margaret Hudson Program – 1136 S. Allegany Ave. Tulsa, OK 74112
**Notice of HIPPA Privacy Practices**

**Student Agreement Form**

**Acknowledgement of HIPPA Privacy Practices** – A complete description of how medical information will be used and disclosed by this program is in our *Notice of HIPPA Privacy Practices*. A condensed version, *HIPPA Privacy Practices*, has been given to you. The complete version is available to you upon request.

I ACKNOWLEDGE THAT I HAVE READ THE *HIPPA Privacy Practices* and acknowledge I have access to a copy of the complete version of The Margaret Hudson Program *Notice of HIPPA Privacy Practices*.

___________________________________________________  ______________________
Student or Responsible Party Signature                      Date

___________________________________________________
Relationship

___________________________________________________
Basis for refusal, if refused

Administrative Office
PO Box 580637
Tulsa, OK 74158
Website: 222.margarethudson.org

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1136 S. Alleghany Ave.
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LIVE UNITED
Tulsa Area United Way

EP-9 Health
Physician’s Report

Application for The Margaret Hudson Program

Note: A physician’s signature is required only if the student is pregnant

Student’s Name: ___________________________________________ DOB: __________________________

Address: __________________________________ City: __________________ State: _______ Zip: __________

Phone: _______________________ Today’s Date: _______________ Age: _________ Grade __________

School: ______________________ Parent’s Name: ________________________________________________

Diagnosis: _______________________________________________________________________________

EDC: ___________________________________________________________________________________

Is the student physically able to participate in a 6-hour instructional program? __________________________

_________________________________________________________________________________________

If not, how long? __________________________________________________________________________

Comments: ______________________________________________________________________________

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Medication Administration Consent Form

To better serve the needs to our students the Margaret Hudson Registered Nurse (RN) requires physician consent to administer medications.

Student Name: _______________________________________________  DOB: ________________________

Allergies: _____________________________________________________________________________________

Health Problems: _________________________________________________________________________________

Physical Limitations: ______________________________________________________________________________

Prescription Medications: ___________________________________________________________________________

Physician’s Name: __________________________________________  Phone: ________________________________

☐ Pregnant Student  ☐ Parenting Student

Please mark all the medications you will allow:

☐ Acetaminophen 325 mg, 1-2 tablets, PO every 4-6 hours PRN for pain/discomfort

☐ Acetaminophen 500 mg, 1-2 tablets, PO every 4-6 hours PRN for pain/discomfort

☐ Ibuprofen 200 mg, 1-2 tablets, PO every 4-6 hours PRN for pain/discomfort

☐ Tums 1-2, PO, PRN for heartburn, indigestion or sour stomach

☐ Robitussin DM, 10-20 ml, PO every 4 hours PRN for cough

☐ Halls Cough Drop, 1 drop PO every 2 hours PRN for sore throat and/or cough

☐ Preggy Pops, 1 pop PO every 2 hours PRN for nausea

☐ Flu vaccine annually

☐ Childhood Immunizations according to CDC & Oklahoma State Department guidelines

☐ Antibiotic ointment, apply topically BID to affected area

☐ Benadryl 25 mg, PO for allergic reaction per anaphylaxis protocol

Physician Signature: __________________________________________  Date: ________________________________

Authorization for Treatment: I hereby authorize any physician, surgeon, or dentist on the medical staff of the nearest medical facility to administer any emergency treatment procedure or medicine necessary and advisable. I also authorize the use of an ambulance, if necessary, to transport my child. I further agree to pay for all services provided for my child. If this is not satisfactory please list specific emergency instructions in the event you cannot be reached.

_________________________________  ________________  __________________
Parent Signature:  Student Signature:  Date: