DIAKON
WILDERNESS
CENTER

Center Point Day Program

11/30/23

Student:_____ Date of Admission:_____

Item	Notes	Check if Present
Student Photo	Date:	☐
County Authorization	JPO & CYS referrals only	☐
90 Day Authorization	CYS Referrals Only	☐
Intake Memo		☐
Parental Consent	Signed and dated by guardian	☐
Child Rights	Signed and dated by student	☐
Child Rights	Signed and dated by guardian	☐
Medical History	Signed and dated	☐
Physical Exam	Date:	☐
Sickle Cell Consent (if Applicable)	Signed and dated by student & Guardian	☐
Health Assessment:	Signed and dated by student, Staff and Supervisor Date:	☐
Safety Plans (if applicable)	Signed and dated by student, Staff and Supervisor	☐
School Records	Report Card or Student Profile (CAIU)	☐
ISP Documents **ISP Date:_____** **ISP Date:_____** **ISP Date:_____**	ISP Invitation	☐
	ISP Signature Page	☐
	ISP	☐
	ISP Send Out	☐
	Monthly Records	☐
	Discharge Summary	☐

DIAKON ADOPTION & FOSTER CARE
A LUTHERAN FAMILY & COMMUNITY MINISTRY

DIAKON WILDERNESS CENTER
A LUTHERAN FAMILY & COMMUNITY MINISTRY

COUNTY AUTHORIZATION FOR SERVICES & TERMINATION OF SERVICES

Client Name:_____ Placed by County: _____
under the supervision of ***Diakon Child Family & Community Ministries***.

The rate checked below is approved to begin on---------- Start Date: _____

☐ Level I Foster Care - Traditional *(Contract Rate)*
☐ Level II Foster Care - Specialized *(Contract Rate)*
☐ Level III Foster Care - Treatment *(Contract Rate)*
☐ Center Point Day Treatment Program *(Contract Rate)*
☐ Turning Point Evening Program - *(Contract Rate)*
☐ Turning Point Day Program - *(Contract Rate)*
☐ Weekend Alternative Program (min. 10 weekends)
  ☐ *Contract Rate* per day
  ☐ *Contract Rate* (with transportation) per day
☐ Weekend Alternative Program Short Term *(Contract Rate)*
☐ Wilderness Challenge Program (30 days) *Contract Rate* per day Male
☐ Bridge Program - (Contract Rate) per day (anticipated length of stay--)_____days
☐ GPS Monitoring for Traditional Bridge Sat-Sun (Contract Rate)
☐ GPS 7 day a week (Contract Rate)
☐ GPS Intake (Contract Rate)

A. Implementing Services:
Please sign the authorization for services and fax or email to the client's case manager orappropriate Diakon staff. If you have any questions or concerns, do not hesitate to contact me at:

Jason Brode	717-960-6724	BrodeJ@diakon.org
Diakon Executive Director	Phone Number	E-Mail

Thank you for your timely attention to this matter.

I, authorize services to begin for this client on the date and level determined above.

_____
County CYS/JPO Authorized Signature (please print and sign name) Date

B. Termination of Services:
Please sign to authorize termination of services for the above client to be effective on:

_____Date

I authorize services to end for this client on the date listed above.

_____
County CYS/JPO Authorized Signature (please print and sign name) Date

DIAKON WILDERNESS CENTER
A LUTHERAN FAMILY & COMMUNITY MINISTRY
Center Point Day Program

Center Point Contacts
(717) Area Code

Executive Director
Diakon Youth Services (Central Region) : Brode, Jason — 717-960-6742, 717-773-1359 — BrodeJ@diakon.org

Director of Center Point Day Program: Goodhart, Natasha — 717-960-6736, 717-385-8472 — GoodhartN@diakon.org

FAX: 717-258-9408
Office: 717-960-6700

Address:
571 Mountain Road Boiling Springs, PA 17007
Website www.diakon.org/youth-services/

Center Point Day Program Intake Memo

Name:	DOB:	Intake Date:	Start Date:
Address:	City:	State:	Zip Code:
Gender: Male☐ Female☐	SS#	Race: Black ☐ White ☐ Hispanic☐ American Indian☐ Asian☐ Native Hawaiian/Pacific Islander☐	
Language:	Religion:	Phone #:	Email:
Grade:	Regular Ed☐ IEP☐ 504 Plan☐		Credit Recovery: Yes☐ No☐
CAIU Case Manager:		CAIU Services: Social Work☐ SLP☐ OT☐ BC☐ 1:1☐	

Referring Agency Information

Name:		Agency:	
Phone #:		Email:	
Address:	City:	State:	Zip Code:

School District Information:

District:	LEA:	Phone #:	Email:

Guardian Information:

Primary Contact:		Relationship:	
Phone #:		Email:	
Address:	City:	State:	Zip Code:
Secondary Contact:		Relationship:	
Phone #:		Email:	
Address:	City:	State:	Zip Code:

Other Agency Information:

Name:		Agency:	
Phone #:		Email:	
Address:	City:	State:	Zip Code:
Name:		Agency:	
Phone #:		Email:	
Address:	City:	State:	Zip Code:
Name:		Name:	
Phone #:		Phone #:	
Address:	Address:	State:	Zip Code:

Reason for Referral:
Length of Stay:
Goals to Complete:

Educational/Agency History

Prior/Current Offenses/Placements	

Medical Information:

Diagnosis:	Medications:

County Agency Information:

Family Life Services Referral Requests:	D &A counseling/Evaluation Mental Health Counseling/Evaluation	Yes ☐ No☐ Yes ☐ No☐	
Drug Testing:	Weekly ☐ Monthly ☐ Randomly ☐		
Restitution/Fines	Yes ☐ No☐		Amount:
Community Service Hours	Yes ☐ No☐		Hours:
Curfew/Ankle Monitor	Yes ☐ No☐		Time:

Juvenile Probation Information:

Was a YLS Provided? Yes ☐ No☐		**Was a Social History Provided?** Yes ☐ No☐
Assessment of Risk & Needs	**Score**	**YLS Risk Level:**
Prior/Current Dispositions:		
Family Circumstances:		
Educational/Employment Skill Development:		
Peer Relations:		
Substance Abuse:		
Leisure/Recreation:		
Personality/Behavior:		
Attitudes/Orientation:		
Overall		

Child and Youth Services:

Prioritize Main Areas of Focus while Referral is attending Center Point (1=highest; 10=lowest);	Education -	
	Employment -	
	Independent Living Skills -	
	Driver's Permit -	
	Personality/Behavior -	
	Attitude/Orientation -	
	Substance Abuse/ D&A -	
	Family Circumstances -	
	Community Service -	
	Other -	

Other Information

DIAKON YOUTH SERVICES
DIAKON CHILD, FAMILY & COMMUNITY MINISTRIES

Diakon Youth Services Information and Policies

Authorization:

I,_____give my consent for _____
Parent/Guardian Youth
To participate in Diakon's Youth Services Programs.

I give permission for the following:

A. Release of School, Dental and Health records to Diakon's Youth Services programs regarding said child.
B. I understand that my child may be photographed, video or audiotaped while participating in Diakon programs, activities or events. I understand the use of these materials may be used for internal and external communication or publicity/marketing purposes.

*If you ***do not*** give permission for your child to be photographed, audio or videotaped; please initial here:_____.*

C. Transporting my child to and from programming sites and activities. As well as on trips in and out of the state relating to Diakon Youth Service's Programs.
D. Assessing any medical needs and giving appropriate care and/or getting the child any emergency medical attention he/she needs.
E. Diakon Youth Services may take my child for a required physical examination to participate in their programs.

I understand that if my child requires emergency treatment, Diakon Wilderness Center and whomever they designate will immediately take him to a physician for treatment. It is not necessary to obtain my consent when, in the physician's judgment, an attempt to secure my consent would result in the delay of treatment, increasing the risk to my child's health or life.

*****Please initial if you give Diakon permission for the above: _____**

Information-
Child:
Date of birth _____ Present age _____ Male ☐ or Female ☐
Social Security Number _____
Primary spoken language_____(Does youth speak/understand English? - ☐ Yes / ☐ No)
Youth's Primary Care Physician (Name, Address, & Contact Information) _____
_____
Person to be notified in case of illness or injury _____

Insurance Information *(Type/ID #)*_____

Parent's information:
Primary spoken language of parent/guardian_____(Does parent speak/ understands English? ☐ Yes ☐ No
Religious preference/affiliation: _____

Personal Belongings/Clothing Policy:
I thoroughly understand that Diakon is not liable for any lost, stolen, or damaged personal belongings/clothing brought to their programs/sites by my child.

Parent/Guardian Signature_____Date _____

DIAKON YOUTH SERVICES
DIAKON CHILD, FAMILY & COMMUNITY MINISTRIES

Child's Rights

1. A child may not be discriminated against because of race, color, religious creed, disability, handicap, ancestry, sexual orientation, national origin, age or sex. (32a)
2. A child may not be abused, mistreated, threatened, harassed or subject to corporal punishment. (32b)
3. A child has the right to be treated with fairness, dignity and respect. (32c)
4. A child has the right to be informed of the rules of the facility. (32d)
5. A child has the right to communicate with others be telephone subject to reasonable facility policy and written instructions from the contracting agency or court, if applicable regarding circumstances, frequency, time, payment and privacy. (32e)
6. A child has the right to visit with family at least once every 2 weeks, at a time and location convenient with the family, the child and the facility, unless visits are restricted by court order. The right does not restrict more frequent family visits. (32f)
    - For mobile programs, face to face visits are not required. However, mobile programs must provide at least telephone contact between family and children at the once every two weeks interval
7. A child has the right to receive and send mail. (32g)
8. Outgoing mail shall not be opened or read by staff persons. (32g1)
9. Incoming mail from federal, state, or county officials, or from the child's attorney, shall not be opened or read by staff persons. (32g2)
10. Incoming mail from persons other than those specified in 32g2, shall not be opened or read by staff persons unless there is reasonable suspicion of contraband, or other information or material that may jeopardize the child's health, safety or well being, may be enclosed. If there is reasonable suspicion that contraband, or other information that may jeopardize the child's safety may be enclosed, mail may be opened by the child in the presence of a staff person. (32g3)
11. A child has the right to communicate and visit privately with his attorney and clergy. (32h)
12. A child has the right to be protected from unreasonable search and seizure. A facility may conduct search and seizure procedures, subject to reasonable facility policy. (32i)
13. A child has the right to practice the religion or faith of choice or not to practice any religion or faith. (32j)
14. A child has the right to appropriate medical, behavioral health and dental treatment. (32k)
15. A child has the right to rehabilitation and treatment. (32l)
16. A child has the right to be free from excessive medication. (32m)
17. A child may not be subjected to unusual or extreme methods of discipline which may cause psychological or physical harm to the child. (32n)
18. A child has the right to clean, seasonal clothing that is age and gender appropriate. (32o)
19. A child cannot be deprived ofspecific or civil rights. (33a)
20. A child's rights may not be used as a reward or sanction. (33b)
21. A. child's visits with family my not be used as a reward or a sanction. (33c)
22. A child and the child's family have the right to lodge a grievance with the facility for an alleged violation of specific or civil rights without fear of retaliation. (Refer to written grievance procedures). (31e)

The following rights are not applicable to Center Point Day Treatment – 32f, 32g, 32g1, 32g2, 32g3, 32k

This is a copy of the Diakon Youth Services' Child's Rights Document for parental records. These rights have been explained to your child during their orientation to the program.
Should you have any questions or concerns regarding these rights please contact Jason Brode at brodej@diakon.org or 717-960-6724.

Student Signature	Date	Parent/Guardian Signature	Date

Revised: ADS-12/15/17

A copy of this document has been sent for your records.

DIAKON WILDERNESS CENTER
A LUTHERAN FAMILY & COMMUNITY MINISTRY

MEDICAL HISTORY:

To be completed by youth and parent/guardian. Fill in every blank completely.

Many youths over the years who have had a variety of medical/psychological difficulties have attended and successfully completed programs, but we must be aware of these conditions for the youth's benefit. Failure to disclose such information could result in harm to the youth.

If you answer yes to any of the following, please circle the applicable condition.	Yes	No	Explanation
Allergies: List what allergic to and any reactions in section to the right			
Medications (e.g. penicillin, asprin, sulfa, etc.) Foods (e.g. shellfish, nuts, etc.)	☐	☐	
Insect Bites (e.g. bee stings, mosquitoes, etc.)	☐	☐	
Environmental (e.g. hay, grass,, etc.) Other (e.g. wool, acrylic, etc.)	☐	☐	
Medications (e.g. penicillin, asprin, sulfa, etc.) Foods (e.g. shellfish, nuts, etc.)	☐	☐	
Insect Bites (e.g. bee stings, mosquitoes, etc.)	☐	☐	
Head/Neurological Problems: list date of last incident			
Frequent and/or Severe Headaches	☐	☐	
Dizziness	☐	☐	
Fainting	☐	☐	
Seizures/Convultions	☐	☐	
Head Injury/Loss of consciousness	☐	☐	
Numbness/Tingling in arms or legs	☐	☐	
Cardiovascular: list specific disorder/condition			
High or Low Blood Pressure	☐	☐	
Heart Disease, Heart Murmur, Irregular Heart Beat, Chest Pain	☐	☐	
Circulatory Problems, Frostbite, Heat Stroke or Exhaustion	☐	☐	
Bleeding Disorder, Anemia, Sickle Cell	☐	☐	
Eyes, Ears, Nose, Throat and Teeth:			
Vision Impairment: (e.g. blurred vision, double vision, drainage etc.)	☐	☐	
Glasses or contacts	☐	☐	
Hearing Impairment	☐	☐	
Frequent Ear Infections or Difficult with Balance	☐	☐	
Frequent Nosebleeds or Frequent Sinus Infection	☐	☐	
Frequent Sore Throats or Frequent Tonsil Infections	☐	☐	
Braces	☐	☐	
Bleeding Gums	☐	☐	
Missing or Chipped Teeth	☐	☐	
Respiratory: list date of last test or incident			
Chronic cough, Frequent Bronchitis or Pneumonia Bloody Sputum	☐	☐	
History of Asthma (list any inhalers or meds to the right)	☐	☐	
Bloody Sputum	☐	☐	
Positive TB or INH Therapy (dates to the right)	☐	☐	
Gastrointestinal: list date of last incident			
Frequent Nausea or Vomiting	☐	☐	
Frequent Consipation or Diarrhea, Hemorrhoids	☐	☐	
Frequent Heartburn or Stomach Ulcer	☐	☐	
Hernias	☐	☐	
Appendectomy (date)	☐	☐	
Hepatitis or Jaundice	☐	☐	
Special Diet or Eating Disorders	☐	☐	
Urinary: list date of last incident			
Difficulty or Frequent Urinating, Burning or Pain	☐	☐	
Kidney Problems	☐	☐	
Bed Wetting	☐	☐	
Reproductive: list date of last known exam/test			
Sexually Active	☐	☐	
Any past or present STD (e.g. Syphilis, Gonorrhea, etc.)	☐	☐	
Currently Pregnant	☐	☐	
Menstrual Pains	☐	☐	
Lumps in Breasts	☐	☐	
Pain or Swelling in Testes	☐	☐	
Orthopedic: list date of last incident			
Broken Bones or Dislocations	☐	☐	
Back Pain, Scoliosis or Neck problems Sprains	☐	☐	
Osgood Schlatters Disease	☐	☐	
Joint Pain (e.g. shoulder, arm, knee, hip)	☐	☐	
Sprains	☐	☐	

DIAKON WILDERNESS CENTER
A LUTHERAN FAMILY & COMMUNITY MINISTRY

If you answer yes to any of the following, please circle the applicable condition.	Yes	No	Explanation
Other:			
Cancer	☐	☐	
Thyroid or Endocrine Problems	☐	☐	
Motion Sickness	☐	☐	
Fear of Confined spaces or Heights	☐	☐	
Surgery or Sever Illness Requiring hospitalization	☐	☐	
Mental Health:			
Depression	☐	☐	
Hysteria	☐	☐	
Anxiety or Nervousness	☐	☐	
History of Suidial Ideation or Self Harm	☐	☐	
Hyperactivity	☐	☐	
Skin:			
Sun Poioning	☐	☐	
Eczema or Psoriasis	☐	☐	
Sores or Infections	☐	☐	
Rashes	☐	☐	
Family History: (parents, Grandparents, Siblings:			
Heart Attacks	☐	☐	
Diabetes	☐	☐	
Stroke	☐	☐	
Cancer	☐	☐	
Substance Use	☐	☐	
	☐	☐	

Date of Last Physical Exam:	
Date of Last Dental Exam:	
Date of Last Menstrual Cycle:	
Date of Last Pelvic Exam:	

Current Medications:		
Medication	Dosage	Reason for Taking

Have you been in counseling within the last two years:			
If yes, when was counseling terminated:			
Reason for Counseling: Academic☐ Family☐ Mental Health☐ Substance Use☐ Other☐			
Name of Therapist			
Address:	City:	State:	Zip Code:

Does youth use alcohol	Yes☐ No☐	How Much/Often:
Does youth use tobacco	Yes☐ No☐	How Much/Often:
Does youth have substance abuse concerns:	Yes☐ No☐	Describe:
Does use have Chemical Dependency	Yes☐ No☐	Describe:

Youths Current Exercise/Activity; (Please list the activity, frequency and approximate time/distance)
Swimming Ability: Non-Swimmer☐ Cannot Swim over 100 yards☐ Strong Swimmer☐ Current Livesaving Cert☐
Additional Comments:

Parent/Guardian:_____ Date:_____

CONSENT FOR SICKLE CELL TEST:

I_____, voluntarily **consent** to take a sickle cell test
And I understand that if choose to get the sickle cell test it is my financial responsibility.

Consent:_____Date:_____
Student

_____ Date:_____
Parent/Guardian

DECLINE SICKLE CELL TEST:

I_____, voluntarily **decline** to take a sickle cell test.

Decline:_____Date: _____
Student

_____ Date:_____
Parent/Guardian

A copy of this document has been sent for your records.

PHYSICIAN'S MEDICAL EXAMINATION

Diakon Wilderness Center provides some physically challenging activities, which may include hiking/backpacking long distances, canoeing, climbing, and initiatives that include balancing, running, lifting and climbing. Diakon will provide sustainable equipment and ample meals throughout a youth's stay in our programs. ***(Revised 04.20.15)***

NAME:_____DATE:_____APPLICANT'S BIRTHDATE: _

CURRENT MEDICAL PROBLEMS: _____

TODAY'S EXAM: EPSTD: YES_ NO___ROUTINE EXAM: YES_____NO_____Is the Patient free of Communicable Diseases? YES_____NO_____

PRESENT MEDICATIONS: _____

CONTRADITCED MEDICATIONS: _____

ALLERGIES: _____

LMP:_____(if applicable) PREGNANT: YES_____NO _____

OB/GYN EXAM REQUIRED: YES_____NO_____

LABORATORY TESTS REQUIRED: _____

SICKLE CELL SCREENING: YES_____NO _____

DATE OF LAST PPD: _____

IMMUNIZATIONS UP TO DATE:_____ DATE OF LAST TETANUS: _____

HEIGHT:_____ WEIGHT:_____ VISION: OS_____OD _____

TEMP:_____P:_____R:_____BP:_____ AUDIOSCOPE: AS:_____AD: _____

GENERAL APPEARANCE AND STATE OFNUTRITION: _____

HEENT: _____
LUNGS: _____
NECK: _____
EXTREMITIES: _____

HEART: _____

ABDOMEN: _____

DIAGNOSIS AND/OR EMERGENCYTREATMENT: _____

SPECIAL DIETARY NEEDS: _____

MENTAL OR PHYSICAL DISABILITIES: YES_____NO_____ IF YES, PLEASE EXPLAIN: _____

DENTAL PROBLEMS: _____

PRESCRIPTION PROVIDED: YES_____NO_____ SPECIALISTS RECOMMENDED: YES____NO _____

FOLLOW UP DATE:_____ REFERRAL PROVIDED, IF NEEDED: YES_____NO _____

Health Education Completed: YES_____NO_____(Diet/Nutrition_____STD Education_____Effects of Drugs/Alcohol_____)

Is this youth able to participate in a physically challenging program? YES____NO _____

PHYSICIAN'S SIGNATURE: _ DATE: _____

ADDRESS:_____ PHONE: _____

Revised: lmj-11/15/16

A copy of this document has been sent for your records.

DIAKON YOUTH SERVICES
DIAKON CHILD, FAMILY & COMMUNITY MINISTRIES

Nondiscrimination in Services

Admissions, the provision of services, and referrals of clients shall be made without regard to race, color, religious creed, disability, ancestry, national origin, age or sex.

Program services shall be made accessible to persons with disabilities through the most practical and economically feasible methods available. These methods include, but are not limited to, equipment redesign, the provision of aids, and the use of alternative service delivery locations. Structural modifications shall be considered only as a last resort among available methods.

Any residential/client/patient/student (and/or their guardian) who believes they have been discriminated against may file a complaint of discrimination with:

Commonwealth of Pennsylvania Department of
Human Services
Bureau of Equal Opportunity
Room 225, Health & Welfare Building
PO box 2675
Harrisburg, PA 17110

U.S. Department of Health and Human Services
Office for Civil Rights
Suite 372, Public Ledger Building
150 South Independence Mall West
Philadelphia, PA 19106-9111

Pennsylvania Human Relations Commission
Harrisburg Regional Office
333 Market Street, 8th Floor
Harrisburg, PA 17101

Student Signature	Date	Parent/Guardian Signature	Date

A copy of this document has been sent for your records.

DIAKON YOUTH SERVICES
DIAKON CHILD, FAMILY & COMMUNITY MINISTRIES

Court-Mandated Reporter

All Diakon Wilderness Center employees are Court-Mandated Reporters. Therefore, we are obligated to report any confidential issues you may disclose regarding unsafe or abusive home situations of either a physical or sexual nature to your caseworker or probation officer according to the State Childline policies. We will include you in this process as much as possible and work to help you gain control over your situation.

Discipline Policy

As a participant of the Diakon Wilderness Center Programs, you will be expected to abide by rules and to behave appropriately at all times. Inappropriate behavior will be treated with natural and logical consequences, none of which will be intentionally, physically or emotionally abusive.

Search Policy

To ensure a safe environment free of contraband that may put students, staff, volunteers and visitors at risk, you and your belongings will be searched upon arrival to the Diakon Wilderness Center Programs. When enrolled in the Weekend Alternative Program, you will be searched every Friday upon arrival on campus. If, after this initial search, there exists reasonable cause to believe you are in possession of contraband, an additional, more extensive search may be performed. Parent/Guardian and Placing County Agency will be informed prior to the performance of a more extensive search and all search guidelines to be followed will be explained at that time. An incident report will be completed and placed in your file. (*Search Policy Provided*, **signature below acknowledges receipt)**

Emergency Medical Plan

The Diakon Wilderness Center will coordinate transportation for medical services in case of an emergency, based on the necessity of the situation and condition of an injured client, staff member, visitor or volunteer. (*Emergency Transport Policy Provided*, **signature below acknowledges receipt**)

Reporting of Sexual Abuse and Sexual Harassment

Diakon Youth Services will make every effort to assist residents to be safe, to be free of sexual abuse, and to report victimization by other residents or staff. Diakon Youth Services staff shall respond appropriately and timely to allegations of sexual abuse and/or sexual harassment. (*Reporting of Sexual Abuse and Sexual Harassment Policy* can be found at https://www.diakon.org/youth-services/services/weekend-alternative-program/ (**signature below acknowledges understanding**).

Grievance Procedures

If, as a participant of the Diakon Wilderness Center Programs, you have a complaint or concern regarding your personal safety and welfare, you have the following options, in this order:

1. Talk to one or all of your instructors/personal counselors.
2. Complete a grievance form to be reviewed by Program supervisor.
3. Write a request to the Director of the Program requesting a meeting regarding grievance.
4. The Diakon Compliance Hotline can be utilized to file complaints/Grievances. The phone number for the Diakon Compliance Hotline is 1-855-561-7821.

_____	_____	_____	_____
Student Signature	**Date**	**Parent/Guardian Signature**	**Date**

Revised: JB-9/15/19

A copy of this document has been sent for your records.

Overview:**Diakon Privacy and Confidentiality Policy**

At Diakon, we respect our clients and patients and understand that you are concerned about privacy, so we've instituted policies intended to ensure that your personal information is handled safely and responsibly. We are committed to protecting your privacy and the security of the information you entrust with us. While we are not a covered entity or a business associate under the Health Insurance Privacy and Portability Act of 1996 (HIPAA), we strive to provide you with security and privacy protection. This Privacy and Confidentiality Policy ("Policy") discloses our information gathering and sharing practices.

It's Your Personal Information:

You have complete control over who can access the personally identifiable information (name, email, home address, etc.) contained in your record(s). You decide who may have access to your record(s).

How the Information in Your Record is obtained:

The only personally identifiable information that Diakon obtains is information which you voluntarily provide or authorize.

Other healthcare providers may access, contribute to and receive patient care information from records in your account if you grant them permission to do so.

Sharing Your Personal Information:

It's your choice to share the information in your record(s). You can share information with trusted family members and friends, healthcare providers, as required for services you are receiving, and with other individuals to whom you provide access.

You can grant, modify or cancel these privileges at any time.

How Information is used by Diakon:

Diakon will use your personally identifiable information:

- To provide services for you
- To obtain payment from you or your health plan or other third party payor or determine the medical necessity of your treatment;
  - OR
- In connection with our own internal operations in order for us to provide quality services.

How Information is Shared and Disclosed by Diakon:

We do not sell or share personal information about you with other people or nonaffiliated companies, except when we have your permission, or under the following circumstances:

Disclosures to Third Parties Assisting in Our Operations – We may provide your personal information to affiliates, subsidiaries and trusted partners who work on behalf of or with us under confidentiality agreements. These companies may use your personal information to assist us in our operations.

Disclosures Under Special Circumstances – We may provide information about you to respond to subpoenas, court orders or legal process, or to establish or exercise our legal rights or defend against legal claims. We may share information about you when we believe it is necessary to investigate, prevent or take legal action regarding illegal activities, suspected fraud, situations involving potential threats to the physical safety of any person, or as otherwise required by law.

Information Security:

Diakon data is stored in a secure data facility, designed to protect against unauthorized access, use, or disclosure of the information contained within it. Our stringent physical and electronic security measures are regularly reviewed to ensure compliance with our policies and to manage and enhance our capabilities.

We restrict access to nonpublic personal information about you to those employees who need to know that information to provide services to you. We maintain physical, electronic, and procedural safeguards to guard your nonpublic personal information.

Contact Us:

We regularly review our compliance with this Policy. If you have any concerns about how we treat personal information, please contact us at:

Shari VanderGast, JD, LCSW
Senior Vice President/Chief Compliance Officer
Diakon
798 Hausman Road, Suite 300
Allentown, PA 18104
(610) 682-1441

Notification of Changes to this Privacy Policy:

This Policy may be revised from time to time as laws change, and as industry privacy and security practices evolve. We will take reasonable steps to notify you of material changes we make to this Policy. We display an effective date and a latest revision date on the Policy above so that it will be easier for you to know when there has been a change. You are responsible for regularly reviewing this Policy. Your continued use of Diakon constitutes your acceptance of the revised terms.

_____ _____
Student Signature Date

_____ _____
Parent/Guardian Signature Date

Diakon Wilderness Center Search and Seizure Policy and Procedure

3800.32i - A child has the right to be protected from unreasonable search and seizure. Any facility may conduct search and seizure procedures subject to reasonable facility policy.

Policy: The Diakon Wilderness Center will provide an environment that is safe and secure for youth and staff.

Purpose: Establish a criteria and procedure for reasonable search and seizure of youth coming to the Wilderness Center campus.

Criteria:

- Reasonable suspicion of contraband, defined as items contrary to the health, safety, or welfare of youth or staff, being brought onto the campus.
- Reasonable suspicion of theft from the facility, other youth, or stemming from community involvement.
- Youth routinely outside Diakon Wilderness Center staff care, custody and control.

A search will be conducted of the personal belongings of any youth arriving onto the campus entering into the Weekend Alternative Program, Center Point Day Program and/or the Wilderness Challenge program. These routine searches are conducted on Friday check in time in the Weekend Alternative Program and M-F check in times in the Center Point Day Treatment Program. Searches will be conducted of all items carried in, to include bags, outerwear, shoes, hats. Students will be scanned with metal wand scans to ensure they are not concealing weapons that may put other students at risk. Students are also required to turn out pockets and are visually scanned for contraband.

A search may be conducted of a youth or youths under reasonable suspicion of the above criteria while youth is engaged in programming in a Diakon Wilderness Center program. This search will follow the above guidelines. A search may be conducted of the sleeping area of youth under reasonable suspicion of the above criteria.

If more intrusive searches are warranted, these searches will be subjected to parental and county notification prior to the search. Approval must also be given by the Administrator of Diakon Youth Services prior to a more intrusive search being conducted. If reasonable suspicion exists that a student is in immediate possession of dangerous or illegal contraband, and this is creating a danger to the health, safety, or welfare of youth or staff, immediate contact will be made to outside authorities (State Police) prior to any search being conducted internally. A report will be made with the state police and all required documentation will be completed following the resolution of the incident.

A copy of this document has been sent for your records.

DIAKON CHILD, FAMILY & COMMUNITY MINISTRIES-WILDERNESS CENTER

PROGRAM OPERATING PROCEDURE

Subject: **Emergency Transport**
Effective Date: 11/11/2001
Revision Date: 2/6/13

I. Standard: The Diakon Wilderness Center will coordinate transportation for medical services in case of an emergency, based on the necessity of the situation and condition of an injured client, staff member, visitor or volunteer.

II. Operating Procedure: When facing a medical emergency requiring the transport of an injured individual, the following procedures will be followed. In the case of incidents in a wilderness environment, time may become a crucial factor in the response needed to treat an injured individual, therefore a direct care staff is required to use their "best judgment" in guaranteeing the well-being of all concerned and in critical situations should contact emergency support (**911**) directly prior to contacting supervisor.

- Contact the program director or supervisory staff and explain the situation. The program director/supervisory staff will either determine an evacuation/emergency transport to be conducted by Diakon staff or coordinate professional assistance from outside agency.
- If professional emergency assistance is deemed necessary, the supervisory staff will coordinate with direct care staff and responding rescue personnel.
- Diakon staff are responsible for supervising all students in their care and must maintain relevant staff-to-student ratios.
- Supervisory staff will create a log of all events, contacts and responses concerning the injured individual and the care and response being provided. Field staff are responsible for maintaining and turning in all SOAP notes to their supervisor for incident reports.
- Medical Insurance, Medical History, and Consent forms will be accessed from the students file and arrangements will be made to have copies of this information available to outside professionals giving treatment.
- Insurance information, court orders, and consents to treat will be provided to care providers for payment reasons.
- All students in the care of the Diakon Wilderness Center will be accompanied by staff during treatment/assessments
- All emergency contacts will be made by supervisory staff to include county emergency on call workers and youth's listed emergency contact. Arrangements will be made to maintain open contact with family members and transition care, if necessary, to youth's primary care giver.
- Documents/Items which must accompany student in the event of an emergency transport include the following:
    1. Student Emergency Packets
    2. All student specific (prescribed) medication/Medication log.

A copy of this document has been sent for your records.

- If patient receives medical care, return any doctors orders, medication, instructions and paper work to the Program Director / Supervisory staff. All medical paperwork must be copied for students records and originals transferred to patients primary care giver.

III. Medical Protocols

- Emergency treatment of medical conditions and injuries will follow protocols provided in Wilderness Medicine Training Center's First Responder Training, Wilderness First Aid Training (also covered through similar WFA/WFR certification trainings through WMA, SOLO, WMI & RMI) & Basic First Aid and CPR protocols provided by American Heart Association (also covered through similar trainings provided by Red Cross).
- The field staff/direct care staff possessing the highest medical certification will assess the situation and determine what response actions / steps will be taken.
- Situations that require immediate evacuation include (as outlined in Diakon's Emergency Medical Plan policy number DCFM WC 113):
  - ✓ Critical Injuries affecting breathing
  - ✓ Cardiac arrest / distress
  - ✓ Excessive Bleeding (internal and external)
  - ✓ Shock (anaphylactic, volume, toxic, neurogenic)
  - ✓ Heat and Cold injuries (hypo / hyperthermia, heat stroke / heat exhaustion, frostbite)
  - ✓ Loss of consciousness for any period of time
  - ✓ Fall from more than 3 times body height
  - ✓ Whenever epinephrine is given
  - ✓ Fractures / dislocations
  - ✓ Serious burns (hands and face, around limbs, covering 10% of the body
  - ✓ Head injuries
  - ✓ Near drowning (water in the lungs)

IV. Documentation:

- A Diakon Wilderness Center Incident Report must be completed for all medical emergencies treated internal by Diakon staff or when utilizing outside professional assistance.
- A DPW Reportable Incident must be filed via the HCSIS reporting system in instances requiring police, fire, or emergency rescue involvement or when youth receives inpatient treatment at the hospital or outpatient treatment for serious injury or trauma not to include minor injuries such as sprains or cuts.

V. Phone Numbers

- Carlisle Hospital: 717-249-1212
- Holy Spirit Hospital: 717-763-2100
- State Police – Carlisle 717-249-2121
- Mount Holly Police 717-486-7615

VI. References:

- 3800.149(a)

Grievance Form

Complete all sections of this form. Sign it and return to Center for follow-up.

My grievance is:_____

Date issue occurred:_____Location issue occurred:_____

Steps that I have taken to resolve this matter (use other side of sheet if necessary):

_____
_____
_____
_____
_____
_____
_____
_____

Reasons why I feel the issue was not resolved:_____

_____
_____
_____
_____

_____ _____ _____ _____

Complainant's Signature **Date** **Director's Signature** **Date**

Director Review

Comments:

_____

Assistant Administrator Signature/Date

**Signature indicates the matter has been reviewed and resolved.*

Sickle Cell Test Agreement, Release and Waiver of Liability

Revised: lmj-11/15/16

A copy of this document has been sent for your records.

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educational excellence through leadership, partnership, and innovation

AUTHORIZATION TO RELEASE INFORMATION

Student Name: _____
S.S. No. _____ *Date of Birth:* _____

I authorize and request the release of the above named student's records and/or exchange of information regarding services received from:

PROVIDER OF INFORMATION

RECIPIENT OF INFORMATION

CAPITAL AREA INTERMEDIATE UNIT
55 MILLER STREET
ENOLA, PA 17025-1640

I additionally authorize and request the release of the above named student's records and/or exchange of information regarding services received from:

PROVIDER OF INFORMATION

CAPITAL AREA INTERMEDIATE UNIT
55 MILLER STREET
ENOLA, PA 17025-1640

RECIPIENT OF INFORMATION

❖ **THE SPECIFIC INFORMATION TO BE DISCLOSED IS:**

☐ Educational History
☐ Vocational evaluation
☐ Medical records/medication
☐ Other _____
☐ Discharge summary/plans
☐ Probation/police reports
☐ Psychological history and evaluation
☐ Psychiatric history and evaluation
☐ Social/development history

❖ **THE PURPOSE FOR THE DISCLOSURE IS:**

☐ Continuity of care
☐ Other: _____
☐ Case consultation

❖ **SIGNATURE OF STAFF PERSON OBTAINING THE CONSENT:**

Title: Jeremias Garcia
Director, Center Point Day Program (DWC)

This consent is subject to written revocation or orally if the client is unable to write at any time except to the extent that action has been taken in reliance thereon. If not previously revoked, this consent will terminate in twelve months from the date of the client signature below.
I have carefully read and understand the above statements. I voluntarily consent to disclosure of the above information about, or records of my condition to the person/s or agency/s named above. I understand that my records are protected by the Confidentiality of HIV Related Information Act of 148.

_____/_____/_____
Signature of student/customer or responsible person ***Date*** ***Signature of Witness***

☐ *Verbal response given (student/customer physically unable or responsible person to give written consent)A verbal consent requires two (2) witness signatures. I witness that the customer/student (or responsible person) is definitely unable to provide a signature at this time, but understands the nature of the release and freely gives his/her consent.*

_____/_____/_____/_____
Witness *Date* *Witness* *Date*

CAPITAL AREA INTERMEDIATE UNIT
Division of Students Services

Student Name: _____

****

THE FOLLOWING INFORMATION IS REQUIRED FOR PIMS/PDE REPORTING

Section 1: Information in this section needs to be updated manually

Students' Legal Guardian(s): _____

Person(s) who maintains the child's educational rights: _____

Is the student homeless? ☐ Yes ☐ No

Number of years attending U.S. schools _____ Number of years attending PA schools _____

City of Birth: _____ State of Birth: _____

Date moved to PA: _____

Section 2: complete this section if you have not previously submitted this information

Country of Birth: _____

Attended U.S. schools for less than three years? ☐ Yes ☐ No

Date moved to the U.S. _____

Primary Language spoken in the home: _____

What is the student's ethnicity? ☐ Hispanic or Latino ☐ Not Hispanic or Latino

What is the student's race? (Select all that apply)

☐ White
☐ Black or African American
☐ Asian
☐ American Indian or Alaskan Native
☐ Native Hawaiian or Pacific Islander

CAPITAL AREA INTERMEDIATE UNIT
55 Miller Street, Enola, PA 17025-1640
Phone: (717) 732-8400 www.caiu.org

Acceptable Use of the Communications and Information Systems Policy # 815, Social Media Policy # 815.2 and Social Media Administrative Regulation # 815.2-AR-2

Acknowledgment and Consent Form - 2014-15

Students

I have received, read, and understand the Acceptable Use of Communications and Information Systems Policy # 815, Social Media Policy # 815.2, and Social Media Administrative Regulation # 815.2-AR-2 and will comply with them. Someone from the Intermediate Unit has also reviewed them with me and my parent(s)/guardian(s) have reviewed them with me. In addition, I have been given the opportunity to obtain information from the Intermediate Unit and my parent(s)/guardian(s) about anything I do not understand, and I have received the information I requested. If I have further questions, I will ask the Director of Technology Services and my parents/guardians. Additionally, I understand that if I violate the Policies, Administrative Regulation, other Intermediate Unit policies, regulations, rules, or procedures I am subject to the Intermediate Unit's discipline up to and including expulsion and could be subject to ISP and website rules, as well as local, state and federal rules and procedures.

_____
Name of Student

_____
Signature of Student

_____
Date of Signature

Parent(s)/Guardian(s)

As the parent/guardian of a student of the Intermediate Unit, I have received, read, and understand the Acceptable Use of the Communications and Information System (CIS) Policy # 815, Social Media Policy # 815.2, and Social Media Administrative Regulation # 815.2-AR-2. In addition, I reviewed the Policies and Administrative Regulation with my child and answered questions s/he asked. If either the child or I have further questions, I will ask the Director of Technology Services. I agree to have my child comply with the requirements of the Policies, Administrative Regulation, other Intermediate Unit policies, regulations, rules, and procedures. Additionally, I understand that if s/he violates the Policies, Administrative Regulation, other Intermediate Unit policies, regulations, rules, or procedures s/he is subject to the Intermediate Unit's discipline, ISP and website rules, as well as local state and federal laws and procedures.

_____
Name of Parent

_____
Signature of Parent

_____
Date of Signature