ENROLLMENT DOCUMENTS

The following forms need to be reviewed and/or completed before your son can be enrolled:

- Packing List (3 pages)
- Wiring instructions
- UHSAA Sports Consent and Pre-Participation Physical Evaluation (2 pages)
- Interstate Compact (3 pages)
- School information
- Dental and Orthodontics forms

Please send, fax, or email the above documents to:

Telos Academy
870 West Center
Orem, UT 84057

Fax: 801-426-8825

Email: acarroll@telos.org
or
jhamel@telos.org

Telos Packing List

Dear Parents:

This is a detailed list of everything your son will need while at Telos. Your son will need all the items on the required list. Those items that you do not have, or do not want to send, will be purchased by our staff out of the money you deposit into the trust account. Receipts and documentation will be provided for all purchases. **We do not consider it to be an inconvenience to shop with your son after admission.** It gives us an informal chance to interact with him. Also, we have bulk buying power to purchase items at a significant discount. We especially discourage you from purchasing a bike for your son; we can get quality discounted bikes here, and it is very important that the fit be appropriate.

Please do not send anything that is not included on this list. Items that are not acceptable will be shipped back to you at your expense. Telos does not have room in the facility to store additional items.

Also, please label your son's personal belongings (especially musical instruments) before sending them. We will label them here if they arrive without any labeling.

Required items:

Items listed in the application for admission

- Completed application (online)
- Copies of prior testing/assessment
- Family physician contact information
- Immunization record
- List of current medications
- Medical insurance card
- Dental insurance card

Regular clothing

- Two pair comfortable shoes
- One collared dress shirt
- Ten shirts; these must not have any printed material that is inappropriate (music groups, sexual, derogatory, etc.). These can be t-shirts, long sleeve, collared, etc.
- Eight pairs of conservative denim jeans or knee-length shorts
- Three pair pajamas
- Winter coat (fall to spring)
- Light jacket
- One hoodie
- Ten pairs of socks and underwear
- A conservative belt
- Shower sandals
- One casual sandal (Flip Flops, Chaco, Teeva, etc)

Other

- Swim trunks
- Journal (any size)
- Two bath towels
- Two wash cloths
- One set twin sheets with pillowcase
- One comforter
- One or two pillows

- One mattress cover/protector

Optional seasonal items
- Two hats or beanies
- One pair of snow gloves
- One pair snow pants
- One snow appropriate footwear
- One snowboard/ski boots
- Either skis or snowboard allowed—only one please
- Snowboard/ski helmet
- One pair ski goggles
- One skateboard/longboard *with wrist guards and helmet (required)*

Other optional items:
- Electric razor (to be stored in the nurse's station)
- Blanket
- Musical instruments
- Religious books
- Contacts/eyeglasses/sunglasses
- Pictures of family members or approved friends (no glass in the frame)
- One conservative bracelet, necklace, and/or ring
- Personal hygiene items (non-aerosol) *
- Cheap waterproof sports watch
- Mattress topper

Banned items:
- All items not included above
- Personal money
- Cell phones
- Earrings
- Any clothing that brings undo attention, is ragged, or in any way affiliated with subculture: drug, music, anarchy themes, etc. No OF (Odd Future), HUF, Rip & Dip, or Rick and Morty brands.
- Straight razors
- Pocketknives or other weapons
- Computer games
- Headsets or personal radios/iPods
- Glass items
- Aerosol items (deodorants, colognes, etc.)

Please bring at least a 7-day supply of all current medication.

All medications, including over the counter medications, acne treatments and inhalers, will be reviewed by the nursing staff and should be packed separately.

Telos does not permit any food or beverages (other than water) to be stored or consumed on the residential floors. Telos provides all meals and snacks. If you have concerns about food options and availability, please discuss options during the admission process. If concerns occur after admission, please discuss them with your son's primary therapist.

Supplements, including protein powder, are treated as medications and will require approval by our medical director prior to administration. Please do not send protein powder or other muscle building supplements without prior approval. Any non-approved supplements will be returned to you at your expense.

*Items containing alcohol are not permitted. (This includes hairspray, cologne, hand sanitizer, after shave, body spray, etc... Please check the ingredients of all items prior to purchase to be sure items do not contain alcohol.)

Mouthwash, dental floss, and nail clippers are supplied by Telos and are kept in the nurse's station. Please do not send floss sticks or cotton swabs.

*Telos provides all hygiene related items like deodorant, soap, toothbrush, shampoo, laundry detergent, etc.

Swim/Bike/Run Equipment

Below you will find the fitness equipment your son will need during his stay at Telos. Shopping for athletic equipment can be frustrating and expensive. We are happy to take care of all equipment purchases through our in-house endurance sports shop. Unless you request otherwise, we will charge all required items to your son's trust account. If you are not interested in having Telos manage the acquisition of your son's gear, please let the admissions team know.

801-769-3576
T3TRIATHLON.COM
INFO@T3TRIATHLON.COM

EACH STUDENT WILL RECEIVE THE FOLLOWING GEAR PACKAGE:

		RETAIL
SWIM	Mesh swim gear bag	$22
	Goggles	$30
	Hand paddles	$20
	Swim jammers	$35
	Swim cap	$8
BIKE	Fuji Roubaix Road Bike	$1269
	Water Bottle Cage	$15
	Pedals	$25
	Bike bag with tools & spare tube	$75
	Safety light	$10
	Water bottle	$12
	Safety vest	$26
	Helmet	$55
	Sunglasses	$70
	Triathlon race kit	$199
RUN	Gym shorts & shirts (includes 2 shorts, 3 shirts & running pants)	$230
	2 pairs of wicking socks	$28
	Shoes (Trail & Road)	$226
	Handheld water bottle	$28
	Running jacket	$65
	Hat and/or visor	$25
	Watch	$60
	Transition triathlon backpack	$80
	USAT Membership & entries to 3 triathlons	$250
	Winter apparel (August-February)	$200
	Summer (March-July) admission package subtract $200	
		$3053

YOUR COST
$2800

T3 Endurance Sports is your one stop shop for all your student's gear. All items are "coach approved." Bike is serviced at no charge while student is enrolled (non-warrantied parts extra.) package includes required USAT membership and entries into 3 T3 Sponsorsed Races.

Frequently Asked Questions

Why do we have a shop?

In 2006 we opened our own retail shop in order to provide discounts and carry the brands, gear, and merchandise that are specific to our needs for the boys to be successful in the triathlon program.

Why shop at T3 Endurance Sports?

-We provide a discount to all students and families on high quality products that we carry in the shop.
-We purchase merchandise from our high quality vendors to fit the specific needs of our boys, coaches, employees, and general public.
-We are able to quickly fix and warranty bikes, apparel, etc since all students will be directly dealing with T3 Triathlon rather than an outside retailer.
-We are able to expedite warranty issues, exchanges, and servicing of bikes.
-We offer intern positions and jobs for our anthem boys. The intern position can also receive school credit.

Does my son really need all of this gear?

Yes, every item that is on the required gear list will be used by your son on a weekly basis. This will also ensure that your son is adequately equipped to be successful in the triathlon program. The gear list is derived from the triathlon coach's requests to ensure your sons safety, lack of injury and success in the program.

My son has gear at home, can I send it?

Yes, but we do recommend that you get the gear that is specified by the coaches. If you are choosing to send some gear/bike/shoes etc for the triathlon program, please only do so if you've coordinated with Shaun Christian (Head Triathlon coach) to ensure that the gear is sufficient for our specific needs.

What happens to the gear/apparel and bike once my son completes the program and leaves Telos?

-Your son's bike will be boxed up by T3 and shipped home. We encourage this option, as we want your son to continue with his cycling.
-Your son's gear will be sent home along with all of his other personal items by the residential staff.

What are the USAT, CLUB, and race fees?

The USAT fees are an annual membership that allows your student to participate in a USAT sanctioned race, which is a personal insurance for that race day. Most races that we participate in are USAT sanctioned.
-All boys are enrolled into T3's USAT Sanctioned Youth Club to provide a secondary means of liability coverage during their workouts. For example: Whether we have a morning run, weekend bike ride or their P.E. swim workout, the members of the Youth Club (your son) can be covered in the event of injury during these activities.
-Race Fees: These fees cover their registration to participate in 3 T3 sponsored races annually. This will also cover the cost of 3 open water swim clinics as well as wetsuit rentals.

Will my son be participating in the triathlon program? I'm not sure if he will be...

YES! Every able-bodied student will participate in the triathlon program. It is a requirement of Telos, a part of our therapeutic program as well as academic program.

What if my son is neither an athlete nor knows how to swim or bike?

Most of our students fall into the beginner category. Our coaches specialize in teaching beginners to learn to swim, bike, and run with correct form and technique. Our classes are small (5-8 students) and staffed with two coaches. This allows us to coach students of varied ability levels. This also allows us to coach the non-swimmer or biker one-on-one. Our head coach is a USAT Level II coach, USA cycling Level I coach, USAT Youth Level I coach, and a certified Crossfit instructor. He has coached at all ability levels from our beginner athletes to pro athletes.

Wiring Instruction for Telos

For instructions contact:

Weston Curtis
801-426-8800 Ext 126
wcurtis@telos.org

UHSAA

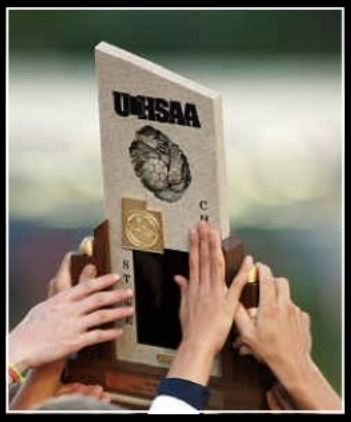
High School Sports

LEARN MORE

Visit the UHSAA Website

www.uhsaa.org

Winning takes a complete command of the fundamentals. Then it takes desire, determination, discipline, and self-sacrifice. —Jesse Owens



Phone: 801-566-0681
Fax: 801-566-0633

ATTENTION: Students & Parents/Guardians

The Utah High School Activities Association has been the leadership organization for education-based athletics and fine arts activities since 1927. Along with music, forensics, and theatre, the UHSAA sponsors ten sports for girls and ten sports for boys. To participate, students must be eligible according to UHSAA standards. The purpose of this flyer is to provide you with some information on the eligibility rules and the Transfer Rule. It is important to KNOW THE RULES!

To be eligible to compete:

- You must be a 9th –12th Grader
- You must be a full-time student
- You must earn a 2.0 GPA the grading period prior to trying out.
- You cannot earn more then one F; (an "NG" or "I" is calculated as an F)
- You cannot turn 19 years old before Sept. 1 the year you intend to play.

If you attend a charter, home, private, online or alternative high school , you may only participate in extracurricular activities at the school within whose boundaries your parents or legal guardians reside or at the public school from which you withdrew for the purpose of home schooling or to attend the charter or private school. **Charter and private school students may only be eligible at a public school for sports not offered at their school.**

UHSAA Sports

- Baseball
- Basketball (G/B)
- Cross Country (G/B)
- Drill (G)
- Football
- Golf (G/B)
- Soccer (G/B)
- Softball (G)
- Swimming/Diving (G/B)
- Track & Field (G/B)
- Volleyball (G)
- Wrestling

UTAH HIGH SCHOOL ACTIVITIES ASSOCIATION

UHSAA

LEARN MORE

For more info:

Visit the UHSAA

Website

www.uhsaa.org

Follow us on

Twitter

Facebook

Phone Apps

PHONE: 801-566-0681

How do you establish your initial eligibility?

Students establish their initial eligibility when they attend high school for the first time OR when they tryout and are selected as a member of a high school team.

When a 9th grader from a junior high school tries out for and is selected as a member of a high school team (Freshman, Sophomore, JV or Varsity), they have established their eligibility at that high school and are not eligible at another high school. An unsuccessful tryout does not establish a student's initial eligibility; however, it does end a student's sport season preventing them from trying out for the same sport at a different high school that same school year.

Students and parents/guardians are encouraged to learn the rules, consider their options and carefully "choose" where they want to establish their initial eligibility.

What happens if you transfer schools?

According to the UHSAA Transfer Rule, a student transferring from one high school to another high school is NOT ELIGIBLE TO COMPETE in UHSAA athletics (at any level) for twelve months from the first day of attendance at the new school. The Transfer Rule also applies to students transferring to an alternative high school or transferring in from out-of-state.

If a student enrolls at a new school during the summer, they will not be eligible for activities until the following school year, sitting out from one summer to the next.

Can the UHSAA waive the ineligibility?

The UHSAA has the discretion to waive the period of ineligibility when a student transfers to a new school as the result of a bona fide change of residence, recent divorce or documented hardship. The change of residence shall be into the established attendance area of the high school to which the transfer is made. A hardship is defined "as an unforeseeable, unavoidable, and uncorrectable act, condition or event which causes the imposition of a severe and non-athletic burden upon the student and/or his/her family." In the case of a bona fide change of residence or recent divorce, parents or legal guardians must submit a completed "Change of Residence" application, required signatures and supporting documents to the UHSAA office. In the case of a hardship, a completed "Hardship Waiver" application, required signatures and third party documentation must be submitted for review. A "Change of Residence" or "Hardship" application can be submitted to the UHSAA after the student has enrolled at the new school or upon proof of enrollment during the summer. Allow 4-6 weeks for a final decision to be made and the family and school will notified by the UHSAA. A student is ineligible to compete for their new school until they have sat out 12 months or they have been notified by the UHSAA their transfer application was approved. Ineligible students are allowed to practice.

GO TO UHSAA.ORG & CLICK ON TRANSFER TAB TO DOWNLOAD APPLICATIONS.

UTAH HIGH SCHOOL ACTIVITIES ASSOCIATION

HEADS UP CONCUSSION IN HIGH SCHOOL SPORTS

A FACT SHEET FOR **PARENTS**

What is a concussion?

A concussion is a type of traumatic brain injury. Concussions are caused by a bump or blow to the head. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious.

You can't see a concussion. Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If your child reports any symptoms of concussion, or if you notice the symptoms yourself, seek medical attention right away.

What are the signs and symptoms of a concussion?

If your child has experienced a bump or blow to the head during a game or practice, look for any of the following signs of a concussion:

SYMPTOMS REPORTED BY ATHLETE	SIGNS OBSERVED BY PARENTS/GUARDIANS
• Headache or "pressure" in head • Nausea or vomiting • Balance problems or dizziness • Double or blurry vision • Sensitivity to light • Sensitivity to noise • Feeling sluggish, hazy, foggy, or groggy • Concentration or memory problems • Confusion • Just "not feeling right" or "feeling down"	• Appears dazed or stunned • Is confused about assignment or position • Forgets an instruction • Is unsure of game, score, or opponent • Moves clumsily • Answers questions slowly • Loses consciousness (even briefly) • Shows mood, behavior, or personality changes

How can you help your child prevent a concussion or other serious brain injury?

- Ensure that they follow their coach's rules for safety and the rules of the sport.
- Encourage them to practice good sportsmanship at all times.
- Make sure they wear the right protective equipment for their activity. Protective equipment should fit properly and be well maintained.
- Wearing a helmet is a must to reduce the risk of a serious brain injury or skull fracture.
  - However, helmets are not designed to prevent concussions. There is no "concussion-proof" helmet. So, even with a helmet, it is important for kids and teens to avoid hits to the head.

What should you do if you think your child has a concussion?

SEEK MEDICAL ATTENTION RIGHT AWAY. A health care professional will be able to decide how serious the concussion is and when it is safe for your child to return to regular activities, including sports.

KEEP YOUR CHILD OUT OF PLAY. Concussions take time to heal. Don't let your child return to play the day of the injury and until a health care professional says it's OK. Children who return to play too soon—while the brain is still healing—risk a greater chance of having a repeat concussion. Repeat or later concussions can be very serious. They can cause permanent brain damage, affecting your child for a lifetime.

TELL YOUR CHILD'S COACH ABOUT ANY PREVIOUS CONCUSSION. Coaches should know if your child had a previous concussion. Your child's coach may not know about a concussion your child received in another sport or activity unless you tell the coach.

If you think your teen has a concussion:
Don't assess it yourself. Take him/her out of play.
Seek the advice of a health care professional.

It's better to miss one game than the whole season.

For more information, visit **www.cdc.gov/Concussion**.

April 2013

This form certifies that you have received and read the information above on concussions.

Participant & Parental Disclosure and Consent Document

PLEASE NOTE: It is the responsibility of the parent/guardian to notify the school if there are any unique individual problems that are not listed on Health Examination Form A or B.

Complete this portion

_____ _____
Name of Student *School*

Is the student covered by health/accident insurance? ❑Yes ❑No

_____
Name of health insurance provider

If no insurance provider, explain _____

_____

_____

_____

CONSENT FORM

Parent or Guardian Statement of Permission, Approval, and Acknowledgement:

By signing below, I the parent or legal guardian of the above named student do:

- Hereby consent to the above named student participating in the interscholastic athletic program at the school listed above. This consent includes travel to and from athletic contests and practice sessions.
- Further consent to treatment deemed necessary by health care providers designated by school authorities for any illness or injury resulting from his/her athletic participation.
- Recognize that a risk of possible injury is inherent in all sports participation. I further realize that potential injuries may be severe in nature including such conditions as: fractures, brain injuries, paralysis or even death.
- Acknowledge and give consent that a copy of this form will remain in the student's school. I agree that if my student's health changes and would alter this evaluation, I will notify the school as soon as possible but within no longer than 10 days.
- Hereby acknowledge having received education including receiving written information regarding the signs, symptoms, and risks of sport related concussion. I also acknowledge that I have read, understand and agree to abide by the UHSAA Concussion Management Policy and/or the policy of the school listed above. http://www.uhsaa.org/SportsMed/ConcussionManagementPlan.pdf

_____ _____
Parent or Guardian Name *Parent or Guardian Signature*

_____
Date

Student Statement

By signing below I acknowledge:

- This application to compete in interscholastic athletics for the above school is entirely voluntary on my part and is made with the understanding that I have not violated any of the eligibility rules and regulations of the Utah High School Activities Association.
- My responsibility to report to my coaches and parent(s)/guardian(s) illness or injury I experience.
- Having received education including receiving written information regarding signs, symptoms, and risks of sport related concussion. I also acknowledge my responsibility to report to my coaches and parent(s)/guardian(s) any signs or symptoms of a concussion.

_____ _____
Signature of Student *Date*

THIS FORM MUST BE ON FILE AT THE MEMBER HIGH SCHOOL PRIOR TO PARTICIPATION.

Pre-Participation Physical Evaluation

Health History

Date of Exam_____

Name_____Age_____Sex_____Date of Birth_____

Grade_____School_____Sport(s)_____

Address_____City_____State_____Phone_____

Personal Physician_____

In case of emergency, contact:

Name_____Relationship_____Phone(H)_____Phone(W)_____

Explain "Yes" answers below
Circle questions you don't know the answers to

Complete this portion

	Yes	No
1. Have you had a medical illness or injury since your last check-up or sports physical?	☐	☐
• Do you have an on-going or chronic illness?	☐	☐
2. Have you ever been hospitalized overnight?	☐	☐
• Have you ever had surgery?	☐	☐
3. Are you currently taking any prescription or non-prescription (over the counter) medications or pills or using an inhaler?	☐	☐
• Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?	☐	☐
4. Do you have any allergies (for example, to pollen, medicine, food or stinging insects)?	☐	☐
• Have you ever had a rash or hives develop during or after execise?	☐	☐
5. Have you ever passed out during or after exercise?	☐	☐
• Have you ever been dizzy during or after exercise?	☐	☐
• Have you ever had chest pain during or after exercise?	☐	☐
• Do you get tired more quickly than your friends do during exercise?	☐	☐
• Have you ever had racing of your heart or skipped heartbeats?	☐	☐
• Have you had high blood pressure or high cholesterol?	☐	☐
• Have you ever been told you have a heart murmur?	☐	☐
• Has any family member or relative died of heart problems or of sudden death before age 50?	☐	☐
• Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month?	☐	☐
• Has a physician ever denied or restricted your participation in sports for any heart problems?	☐	☐
6. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)?	☐	☐
7. Have you ever had a head injury or concussion?	☐	☐
• Have you ever been knocked out, become unconcious, or lost your memory?	☐	☐
• Have you ever had a seizure?	☐	☐
• Do you have frequent or severe headaches?	☐	☐
• Have you ever had numbness or tingling in your arms, hands, legs or feet?	☐	☐
• Have you ever had a stinger, burner, or pinched nerve?	☐	☐
8. Have you ever become ill from exercising in the heat?	☐	☐
9. Do you cough, wheeze, or have trouble breathing during or after activity	☐	☐
• Do you have asthma?	☐	☐
• Do you have seasonal allergies that require medical treatment?	☐	☐

	Yes	No
10. Do you have any special or corrective equipment or devices that aren't usually used for your sport or position (examples: knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid, etc.)	☐	☐
11. Have you had any problems with your eyes or vision?	☐	☐
• Do you wear glasses, contacts, or protective eyewear?	☐	☐
12. Have you ever had a sprain, strain or swelling after injury?	☐	☐
• Have you broken or fractured any bones or dislocated any joints?	☐	☐
• Have you had any other problems with pain or swelling in muscles, tendons, bones or joints?	☐	☐

If yes, check appropriate box and explain below.

☐Head	☐Elbow	☐Hip
☐Neck	☐Forearm	☐Thigh
☐Chest	☐Wrist	☐Knee
☐Shoulder	☐Hand	☐Shin/calf
☐Upper Arm	☐Finger	☐Ankle
		☐Foot

13. Do you want to weigh more or less than you do now?	☐	☐
• Do you lose weight regularly to meet weight requirements for your sport?	☐	☐
14. Do you feel stressed out?	☐	☐

15. Record the dates of your most recent immunizations:
Tetanus_____ Measles_____
Hepatitis B_____ Chickenpox_____

FEMALES ONLY

16. When was your first menstrual period?_____
When was your most recent menstrual period?_____
How much time do you usually have from the start of one period to the start of another?_____
How many periods have you had in the last year?_____
What was the longest time between periods in the last year?_____

EXPLAIN ANY YES ANSWERS HERE

_____
_____
_____
_____
_____
_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Student_____ Signature of Parent_____ Date_____

Please fill out highlighted areas and return to Telos with your enrollment documents.

ICPC 100A
REV. 05/2019; EFF. 01/2020

One form per child; please type

INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN REQUEST

TO: UTAH **FROM:**

Complete this portion

SECTION I—IDENTIFYING DATA

Notice is given of intent to place—Name of Child:			Ethnicity: Hispanic Origin: ☐ Yes ☐ No ☐ Unable to determine/unknown
Social Security Number:	ICWA Eligible ☐ Yes ☒ No	Title IV-E Eligible ☐ Yes ☒ No ☐ Pending	Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ Black or African American ☐ White
Sex:	Gender:	Date of Birth:	
Name of Parent 1:			Name of Parent 2:
Name of Agency or Person Responsible for Planning for Child:			Phone:
Address:			Email Address (optional):
Name of Agency or Person Financially Responsible for Child:			Phone:
Address:			Email Address (optional):

SECTION II—PLACEMENT INFORMATION

Types of Care Requested:
- ☐ Public Placement ☐ Private Placement
- Subsidy: ☐ IV-E ☐ Non IV-E ☐ Pending ☐ None
- ☐ Adoptive Home: Finalizing in: ☐ Sending State ☐ Receiving State ☐ Pending
- ☐ Foster Family Home
- ☐ Group Home Care
- ☐ Child-Caring Institution
- ☒ Residential Treatment Center
- ☐ Parent
- ☐ Institutional Care—Article VI Adjudicated Delinquent
- ☐ Relative (Not Parent) Relationship: _____
- ☐ Other: _____

Current Legal Status of Child:
- ☐ Sending Agency Custody/Guardianship
- ☐ Parent Relative Custody/Guardianship
- ☒ Court Jurisdiction Only
- ☐ Protective Supervision
- ☐ Parental Rights Terminated—Right to Place for Adoption
- ☐ Unaccompanied Refugee Minor
- ☐ Other: _____

Name of Person(s) or Facility Child is to be placed with: TELOS RESIDENTIAL TREATMENT	Soc. Sec # (optional): Soc. Sec # (optional):
Address: 870 WEST CENTER, OREM, UT 84057	Phone: 801-426-8800
If placement is with an agency (e.g., adoption, public, etc.) other than a residential treatment facility (RTF), please identify the foster or adoptive resource where the child will reside.	
***Name(s) of Prospective Adoptive or Foster Resource:** X	Soc. Sec # (optional): Soc. Sec # (optional):
Address:	Phone:

SECTION III—SERVICES REQUESTED

Initial Report Requested (if applicable):
- ☐ Adoptive Home Study
- ☐ Foster Home Study
- ☐ Parent Study
- ☐ Relative Home Study

Supervisory Services Requested:
- ☐ Request Receiving State to Arrange Supervision
- ☐ Another Agency Agreed to Supervise
- ☐ Sending Agency to Supervise
- ☐ Other _____

Supervisory Reports Requested:
- ☐ Semi-Annually
- ☐ Quarterly
- ☐ Monthly
- ☐ Other: _____

Name and Address of Supervising Agency in Receiving State:

Enclosed: ☐ Child's Social History ☐ Court Order ☐ Financial/Medical Plan ☐ Other Enclosures ☐ Home Study of Placement Resource ☐ ICWA Enclosure ☐ IV-E Eligibility Documentation

Complete

Signature of Sending Agency or Person:	Date:
Signature of Sending State Compact Administrator, Deputy, or Alternate:	Date:

SECTION IV—ACTION BY RECEIVING STATE PURSUANT TO ARTICLE III(d) of ICPC

☐ Placement may be made ☐ Placement shall not be made

Remarks:

Signature of Receiving State Compact Administrator, Deputy or Alternate:	Date

DISTRIBUTION: See 100A Instructions

ICPC 100B
REV. 05/2019; EFF. 01/2020

One form per child; please type

INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN
REPORT ON CHILD'S PLACEMENT STATUS

TO: UTAH	FROM:

SECTION I—IDENTIFYING INFORMATION

Complete

Child's Name:	Birthdate:
Parent #1's Name:	Parent #2's Name:
Name of Resource: TELOS	
Address: 870 WEST CENTER, OREM, UT 84057	
Type of Care: RESIDENTIAL TREATMENT CENTER	

SECTION II—PLACEMENT STATUS

☒ Initial Placement of Child in Receiving State — Date Child Placed in Receiving State:

☐ Placement Change — Effective Date of Change:

SECTION III—COMPACT PLACEMENT TERMINATION

☐ Adoption Finalized ☐ In Sending State ☐ In Receiving State ☐ Court Order Attached

☐ Child Reached Majority/Legally Emancipated

☐ Legal Custody Returned to Parent(s) ☐ Court Order Attached
Name:

☐ Legal Custody Given to Relative ☐ Court Order Attached
Name: Relationship:

☐ Legal Custody Given to Other (specify)_____ ☐ Court Order Attached
Name: Relationship:

☐ Treatment Completed

☐ Sending State's Jurisdiction Terminated with the Concurrence of the Receiving State

☐ Unilateral Termination

☐ Child Returned to Sending State

☐ Child Has Moved to Another State

☐ Proposed Placement Request Withdrawn

☐ Approved Resource Will Not Be Used for Placement

☐ Other (Specify):

Date of Termination:

SECTION IV—SIGNATURES

Complete

Person/Agency Supplying Information:	Date:
Compact Administrator, Deputy, or Alternate:	Date:

DISTRIBUTION: See 100B Instructions

ACCEPTANCE LETTER
FINANCIAL PLAN
MEDICAL PLAN
PLACEMENT DISRUPTION AGREEMENT

Date: _____.

ICPC Office for the State of _____.
(STUDENT HOME STATE)

Dear Compact Administrator:

_____ has been accepted for admission into Telos Residential
(STUDENT NAME)

Treatment Center located at 870 W Center St, Orem, UT as of _____.
(DATE OF ADMISSION)

Student Date of Birth: _____

Name(s) of Parent(s)/Guardian(s): _____

Address of Parent(s)/Guardian(s): _____

In compliance with ICPC Regulation 4, the Financial Plan is as follows:

The child's placement in our program is being funded by:

☐ Family's private funds.

☐ Family's health insurance.

☐ Combination of private funds and insurance.

☐ Other: _____

Also in compliance with ICPC Regulation 4, the parent(s)/guardian(s) will be responsible for providing medical coverage for this child.

In the event that there is a disruption in placement, the parent(s)/guardian(s) would be responsible for the child's return to your State.

Best regards,

_____
(SIGNATURE OF PARENT/GUARDIAN)

_____
(SIGNATURE OF TELOS REPRESENTATIVE)

SCHOOL INFORMATION

MOST RECENT SCHOOL

Name:

Address:

Phone number:

Fax:

Email:

Attendance dates:

PREVIOUS SCHOOLS

Name:

Address:

Phone number:

Fax:

Email:

Name:

Address:

Phone number:

Fax:

Email:

Name:

Address:

Phone number:

Fax:

Email:

Barry Family Dental Group

WELCOME TO OUR OFFICE — THE INFORMATION REQUESTED ON THIS GET-AQUAINTED FORM IS IMPORTANT FOR OUR RECORDS AND YOUR HEALTH. PLEASE FILL OUT COMPLETELY.

PATIENT INFORMATION

Patient's Name _____ (full name) Birth Date _____ Age _____

Address _____ City State Zip Phone _____ SS# _____

Marital Status: (Please Circle) Single Married Divorced Widowed Separated Full Time College Student? ___ School Name _____

RESPONSIBLE PARTY INFORMATION

Name _____

Relationship to Patient _____ Social Security No. _____ Date of Birth _____

Home Address _____ Phone _____

Employer _____ Occupation _____

Business Phone _____

Spouse's Name _____ Soc.Sec # _____ Date of Birth _____

Spouse's Employer _____ Phone _____

Name(s) of other family members seen by us previously? _____

Name of nearest relative not living with you _____

Address _____ Phone _____

Whom may we thank for referring you? _____

INSURANCE INFORMATION

PRIMARY INSURANCE SUBSCRIBER INFO:

_____
LAST FIRST M SS#

_____
BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

_____
EMPLOYER DENTAL INS. CO

_____
ADDRESS/PHONE# OF INSURANCE CO GROUP #

SECONDARY INSURANCE SUBSCRIBER INFO:

_____
LAST FIRST M SS#

_____
BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT

_____
EMPLOYER DENTAL INS. CO

_____
ADDRESS/PHONE# OF INSURANCE CO GROUP #

ASSIGNMENT AND RELEASE OF INFORMATION

I hereby authorize my insurance benefits be paid directly to the dentist and I am financially responsible for services not paid within 45 days. I further authorize the dentist to release any medical or dental information requested.

SIGNED _____ Date: _____

If patient is under 18:

I hereby grant permission for dental work to be performed on this minor and will assume all responsibilities connected with such treatment.

_____
Signature of Parent or Guardian

DENTAL-MEDICAL HISTORY

Please answer each of the following questions for our records and your dental history.

Name of Medical Doctor _____ Phone _____

1. Do you have, or have you had, any of the following diseases or problems? Circle if yes.

Taken Phen-Fen	Tuberculosis	Any Blood Disorder
Rheumatic Fever	Abnormal Bleeding	Epilepsy
Abnormal Heart Condition	Diabetes	Anemia
Any Allergies	Hepatitis, Jaundice,	Cancer
Sinus Trouble	Liver Disease,	Stroke
Asthma	Rheumatism or Arthritis	Glaucoma
Fainting Spells or Seizures	Stomach Ulcers	Pacemaker
	Kidney Trouble	AIDS

2.	Are you in pain?	Yes	No
3.	Are you now, or have you been under the care of a physician during the past two years?	Yes	No
4.	Are you presently using any prescription drugs?	Yes	No
5.	Have you ever experienced any ill effects from Novocain, Penicillin or other drug?	Yes	No
6.	Have you ever experienced any unfavorable reaction to dental treatment?	Yes	No
7.	Are your teeth sensitive to heat or cold, sweet or sour?	Yes	No
8.	Do you have a problem with bleeding gums?	Yes	No
9.	Do you have a problem with food wedging between your teeth?	Yes	No
10.	Do you have frequent bad breath or an unpleasant taste in your mouth?	Yes	No
11.	Have you ever had a problem with thumbsucking, nailbiting, or tongue chewing?	Yes	No
12.	Do you clench or grind your teeth or get headaches often?	Yes	No
13.	Do you wake up with sore muscles in your face or neck?	Yes	No
14.	Do you have any allergies?	Yes	No
15.	Have you received any type of artificial joint replacement (hip, knee, etc.)?	Yes	No
16.	Are you currently taking, or have you in the past, any medications for osteoporosis? (Fosomax, Actonel, Boniva, etc.)	Yes	No

If any of the above answers are yes, please explain:

_____

_____

Women: Are you pregnant?_____

When did you visit a dentist last? _____ Last Cleaning? _____

How often do you brush your teeth? _____ How often do you floss? _____

Are you happy with the appearance of your teeth? _____

Color? _____ Shape? _____ Position? _____

If you could change anything about your teeth, what would it be? _____

_____

AGREEMENT FOR EXTENSION OF CREDIT

In accordance with the Federal Truth-In-Lending Act which requires all doctors to give their patients information in connection with extension of credit, please be advised of the following policies which apply in this office. The responsible party agrees to:

1. Pay the doctor at the time treatment or service is received or by previous arrangements.
2. That if payments are extended beyond 90 days from the date of first billing to pay 1.75% per month on the unpaid balance (annual rate of 21%).
3. Allow our office to obtain your credit rating.

I/we agree to pay cost and/or reasonable attorney's fees if any delinquent balance is placed with an agency or attorney for collection or suit.

Barry Family Dental Group

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available upon request. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Office Manager/Financial Manager

Telephone: (801) 226-0441/226-0442 Fax: (801)226-4754

E-mail: info@teethrock.com

Address: 165 North 400 West #A-2 Orem, UT 84057

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I give my permission for Barry Family Dental Group to disclose my dental health information to a family member, friend or other person to the extent necessary to help with my healthcare or with payment for my healthcare. Yes ____ No ____

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

BARRY FAMILY DENTAL GROUP

Financial Policy:

Our options for payment are as follows:

- 5% discount for payment at time of service.*
- Credit card (Visa, MasterCard, American Express, Discover)
- In-house financing up to 60 days.
- Care Credit financing (upon approved credit)
  - Greater than $300 can finance for 3-6 months at no interest
  - Greater than $300 can finance for 12-18 months at no interest
    * Processing fees will apply to the 12-18 month plans.
  - Greater than $1500 can finance for up to 60 months at 9.9% interest

Billing:
Our office sends billing statements at the beginning of each month. Payments are due by the 20th of every month. Our billing statement lists a balance, an estimated insurance portion and an estimated patient portion. The patient portion is expected in full unless prior arrangements have been made with the Accounts Manager. Balances older than 90 days will be subject to finance charges at 21% APR.

Insurance:
Our office files insurance claims and accepts insurance checks as a service to our customers. We do expect an estimated patient portion to be paid on the date of service even if a patient has insurance coverage. We cannot provide exact estimates since the amount of coverage your insurance provides is strictly a function of the policy selected by your employer. We cannot guarantee your insurance will cover your services even if we pre-authorize. Please stay in contact with your insurance company regarding your procedures to help ensure payment. Any balance remaining after insurance pays is due the 20th of the next billing cycle. The patient accepts responsibility to pay in full immediately if their insurance company has not paid within 45 days of service. If you overpay due to our estimates, we would be happy to hold the credit on your account or reimburse you.

Other Information:
- Our office gives a 10% discount to all seniors over 62.*
- We do charge returned check fees ranging from $5.00 to $20.00 depending on the amount of the check.
- Broken or missed appointments with less than 24 hours notice will be subject to a $25.00 fee.
- If it becomes necessary to refer an account to the collection agency, we may charge a collection fee of 30% of the balance owing.
- I grant permission to telephone me at home or work to discuss matters related to this form.
- This agreement supersedes any other agreement and by signing this agreement any arbitration/mediation agreements previously signed are null and void.

* Courtesy discounts are not applied to any dental services that are eligible for a contracted insurance write off. Discounts cannot be combined.

Thank you for reviewing our policies. We make every effort to explain your costs and avoid misunderstandings so that we can focus on your dental health. If you have any questions, please ask. We are here to serve you. At any time, please feel free to request copy of this document.

I have read, understand, accept, and agree to abide by the terms stated above.

Responsible Party _____ Date _____

FRANDSEN ORTHODONTICS

Date _____

Patient's Name _____
FIRST MIDDLE LAST NICKNAME

Home Address _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ E-mail _____

Patient's Age _____ Birthday _____ Sex: M F
MONTH DAY YEAR

School _____

Number of other children in family _____

Other children currently in treatment _____

Father's name _____ Occupation _____

Employed by _____

Business address _____ Business phone _____

Mother's name _____ Occupation _____

Employed by _____

Business address _____ Business phone _____

Emergency contact _____ Phone _____

Person responsible for account _____ S.S.# _____

Referred by _____

Family Dentist _____

Insurance Carrier _____ Subscriber ID# _____

Address _____ Group# _____