BRUNSWICK
COMMUNITY COLLEGE

BRUNSWICK INTERAGENCY PROGRAM

TO: Potential BIP Student

SUBJECT: INTAKE FORMS

Enclosed you will find forms to be completed as a part of Brunswick Interagency Program Admissions process.

Please read and complete the forms to the best of your knowledge. If you have any questions or concerns, please feel free to contact us. Once you have completed the forms, please call to set-up an appointment and tour our facility.

We are also requesting documentation to verify that the Intellectual/Developmental Disability occurred prior to age 22. This can be a Psychological or an IEP from their previous school, Medical Insurance (Medicaid, Medicare or other insurance), the students State ID, Social Security Card and if the student is not their own legal guardian please bring the original court documentation. Copies will be made during your scheduled appointment.

Transportation may be requested and will be submitted to BTS (Brunswick Transit System) after the Admissions process is completed.

Thank you and we look forward to seeing you and your student.

Brunswick Interagency Program
(910) 755-7364
www.brunswickcc.edu

BRUNSWICK
COMMUNITY COLLEGE

BRUNSWICK INTERAGENCY PROGRAM
SOCIAL HISTORY

STUDENT'S NAME: _____ AGE: _____ MARITAL STATUS: _____

ADDRESS: _____

PLACE OF BIRTH: _____ DATE OF BIRTH: _____

SOCIAL SECURITY # _____ RACE: _____

MOTHER'S NAME: _____ EMPLOYER: _____

FATHER'S NAME: _____ EMPLOYER: _____

LIVING ARRANGEMENTS: _____

IN HOUSEHOLD _____ EDUCATION: _____

RELIGION: _____ VOCATION: _____

CHILDREN: _____ SIBLINGS (Number, Age, Sex) _____

IINCOME: (Work, Social Security, Disability): _____

I.Q/DIAGNOSIS: (Measure used, see Psychological for further detail):

_____

_____

_____

PHYSICAL DESCRIPTION (Height, Weight, etc.):

_____

_____

_____

_____

LIMITATIONS:

_____

_____

_____

_____

MENTAL STATUS:

BEHAVIOR ISSUES:

SEXUAL BEHAVIOR/MALADAPTIVE/DIVIENT BEHAVIOR:

SOCIAL SKILLS:

DEVELOPMENTAL HISTORY:

CHILDHOOD DISEASES:

ILLNESSES AND ACCIDENTS (Recurring):

SPECIAL RESTRICTIONS:

MEDICATION AND ANY SIDE AFFECTS:

****

Place of Interview: _____ DATE: _____

Source of Information: _____

Intake Person's Signature: _____ Title: _____

BRUNSWICK COMMUNITY COLLEGE

BRUNSWICK INTERAGENCY PROGRAM

SCREENING AND FINANCIAL EVALUATION FORM

DEMOGRAPHIC INFORMATION

Name: _____ Client # _____

Address: _____ Marital Status _____

City: _____ State: _____ Zip Code: _____

Maiden Name: _____ Nickname: _____

Date of Birth: _____ Home # _____ Cell #_____

Social Security # _____

Guardian/Responsible Person: Name _____ Address _____

****

INSURANCE INFORMATION (Please provide a copy of all Insurance Cards)

Primary Insurance# _____ Name: _____ Group# _____

Policy # _____ Employer: _____

Policy Holder Name: _____ Relationship: _____

Social Security # _____ Date of Birth: _____

Secondary Insurance# _____ Name: _____ Group# _____

Policy #: _____ Employer: _____

Policy Holder Name: _____ Relationship: _____

Social Security # _____ Date of Birth: _____

INCOME SOURCE

Source	Employer	Yearly Income
_____	_____	_____
_____	_____	_____

Total # of Dependents _____ Total Family Income _____

Verification: _____

PLEASE NOTIFY THE STAFF WHEN THERE IS A CHANGE IN YOUR FINANCIAL STATUS.

Acknowledgement: By my signature, I certify that these statements are true to the best of my knowledge and I agree to pay the fee for services as determined above.

_____ _____

Guardian/Client/Student Date

_____ _____

Interviewer Date

BRUNSWICK COMMUNITY COLLEGE

BRUNSWICK INTERAGENCY PROGRAM

NORTH CAROLINA Division of Mental Health, Developmental Disabilities and Substance Use Service

Name of Individual:	**Date Completed:**
Individual's Support Coordination Agency:	

I. Risk Assessment Tool

Situational (situations, systemic issues, mental health issues, or circumstances with caregivers, family, friends or others that create the potential for risks.

Please Check	RISK ISSUES	Why is this issue a particular risk to this person?	
		Current	Within (5) Years
	Loss of caregiver of close family member		
	Loss of someone significant		
	Loss of natural supports		
	Social isolation by caregiver		
	Refusal of critical services (by the individual or the guardian)		
	Unavailable or unreliable staffing		
	Significantly compromised hygiene or appearance (especially if a change from usual)		
	Incapacitated caregiver		
	History of neglect or abuse		
	Pregnancy and parenthood		
	Compromised communication skills		
	Loss of home		
	Eviction		
	Frequency moves for seemingly unjustified reasons		
	Difficulties with relationship with landlord		
	Dangerous or threatening neighbors		

Environmental (environmental issues that create the potential for risk

Please Check	RISK ISSUES	Why is this issue a particular risk to this person?	
		Current	Within (5) Years
	Unsanitary living conditions		
	Home is in significant disrepair		
	Necessary environmental modifications not completed		

	Necessary equipment in disrepair, broken or lost	
	Unmet equipment needs	
	Equipment not being available for use	

Behavioral (personal behaviors or lifestyle choices that are considered dangerous or potentially dangerous to self or pose a risk to others)

Please check	RISK ISSUES	Why is this issue a particular risk to this person?
		Current Years / Within five (5)
	Self -injury	
	Aggression or violence towards others	
	Assault	
	Stealing	
	Excessive self-stimulatory	
	Making significant threats to the safety of others	
	Destruction of property	
	Refusal of Necessary services	
	Poor compliance with treatments or supports	
	Elopement	
	Social Isolation	
	Compromised communication skills	
	History of poor decision-making despite being well-informed	
	Risky sexual behavior	
	Predatory behavior	
	Excessive fascination with children or sexual abuse of children	
	History of sexually aggressive or dangerous behavior	
	Fascination with fire or history of fire setting	
	Frequent job changes	
	Suicidal ideation or attempt	
	Substance abuse	
	Contacts with EMS or law enforcement (i.e. unnecessary calls to or create situations to cause others to call)	
	Criminal justice involvement	
	Multiple requests for crisis services	

Medical (Health related risks)

Please Check	RISK ISSUES	Why is this issue a particular risk to this person?
		Current / Within (5) Years
	Multiple medical or psychiatric hospitalization in a year	
	Multiple visits to the emergency room (whether admitted or not)	
	A person living alone or with little support who takes multiple medications	

	Taking three or more medications for a chronic medical condition, including a psychiatric diagnosis with reduced supports	
	Medical benefit loss	
	Poor follow through on post hospitalization discharge orders	
	Significant changes in health or mental status	
	Significant changes in sleeping or eating patterns	
	Significant number of medical visits or a significant increase in medical visits	
	Unmet medical needs (i.e. appointments not scheduled, follow-up appointments missed)	
	Information shared with medical personnel by support staff is inadequate (i.e. reason for referral)	
	Poor compliance or non-compliance with medical regime	
	Refusal of services	
	Inability to tolerate a medical examination/procedure	
	Multiple falls/fractures	
	Mobility impairment	
	Significant weight gain or loss	
	Swallowing disorders	
	History of choking and/or aspirations	
	Skin breakdown	
	Obesity	
	Compromised communications skills (especially in relation to being able to indicate physical pain)	
	PICA	
	Lifestyle choices that negatively affect health (i.e. smoking, drinking when contraindicated by medications)	

Financial risks (mismanagement of finances by self or others or loss of income			
Please Check	**RISK ISSUES**	**Why is this issue a particular risk to this person?**	
		Current	**Within (5) Years**
	Loss of job		
	Loss of benefits or significant reduction in benefits		
	Indebtedness		
	Loaning money to others		
	Excessive gambling		
	Financial housing cost		

Other risks (Identified risks not otherwise mentioned above			
Please Check	**What is the issue?**	**Why is this issue a particular risk to this person?**	
		Current	**Within (5) Years**

II. Summary of Incident Reports

Reportable Incidents (summarize by type of incidents, the number of reportable incidents, or attach other printout summary of reportable incidents)		
TPYE OF INCIDENT	**Number of Incidents**	**COMMENTS**

Other explanatory Information:

Individuals participating in the completion of this tool.

Name

Title:

_____ _____

_____ _____

_____ _____

BRUNSWICK
COMMUNITY COLLEGE

Brunswick Interagency Program

HEALTH ASSESSMENT

Name: _____ School: Brunswick Interagency Program/BCC

Address: _____ City: _____ State: _____

Date of Birth: ___/___/_____ Age: ____ Phone# _____

Name of Insurance: _____ ID# _____

Name of Insurance: _____ ID# _____

Allergies (if any): _____

Current Medications/ Dosage:

_____

_____

Please check all that apply

Yes	No		Yes	No	
___	___	Heart Disease	___	___	Diabetes
___	___	Seizures/Epilepsy	___	___	Asthma
___	___	Hearing Loss	___	___	Heat Stroke
___	___	Serious Head Injury/Concussion	___	___	Special Diet
___	___	Major Surgery/Serious Illness	___	___	Free Bleeder
___	___	Visual Impaired/Wears glasses	___	___	Chest Pains
___	___	Bone/Joint Pain	___	___	Tobacco Use
___	___	Emotional/Psychiatric Behavior	___	___	Sickle Cell Disorder

Other Medical Conditions:: _____

_____

_____

Blood Pressure ____/____ Weight_____ Height_____

Date of Physical: _____

Physician's Name: _____ Phone#: _____

Physician's Signature: _____

Address: _____ City: _____ State: _____

*Note: **This Form needs to be completed and signed by your physician****

Updated 1/31/2024

BRUNSWICK
COMMUNITY COLLEGE

Written Consent Permission Form to Release Confidential Information

If a student wishes Brunswick Community College to share his/her educational records with his/her parents/guardians this form must be signed.

Please print clearly, except where signatures are required. Unreadable names will be disregarded.

I. _____ ID# _____
(Print student full name) (Social Security# or BCC ID#)

Date Signed: _____ Expiration Date: _____

authorize representatives of Brunswick Community College to release any and all information contained in all BCC educational records as indicated below.

I understand that all Brunswick Community College educational records may/will be shared with my parent(s) or legal guardian(s) via the designated Brunswick Community College representative(s) and the Office of Student Services.

My parent(s)/legal guardian(s) are:

Name: _____

Relationship: _____
(Print parent/guardian full name)

Name: _____

Relationship: _____
(Print parent/guardian full name)

Student Signature: _____

Updated 6/2022

BRUNSWICK
COMMUNITY COLLEGE

BRUNSWICK INTERAGENCY PROGRAM
50 College Road. NE
Bolivia, North Carolina 28422

Consent for Release of Information

CLIENT:

DATE:

REOCRD NUMBER:

I hereby authorize Dr. _____ to release specified information in my patient records to: BRUNSWICK INTERAGENCY PROGRAM.

For Specific: Establishing eligibility and updating information for the records.

The doctrine of informed consent has been explained to me and I understand the contents to be released, the need for the information, and that there are statues and regulations protecting the confidentiality of authorized information, I hereby acknowledged that this consent is truly voluntary and is valid until such request is fulfilled. I further acknowledge that I may revoke this consent at any time except to the extent that action based on this consent has been taken.

_____ Client

_____ Witness

OR

_____ Legal Appointed Representative

_____ Date

BRUNSWICK
COMMUNITY COLLEGE

BRUNSWICK INTERAGENCY PROGRAM
50 College Road, NE
Bolivia, North Carolina 28422

Consent for Release of Information

CLIENT:

DATE:

REOCRD NUMBER:

I hereby authorize _____ to
(Name of Provider)
release specified information in my patient records to: BRUNSWICK INTERAGENCY PROGRAM.

For Specific: Establishing eligibility and updating information for the records.

The doctrine of informed consent has been explained to me and I understand the contents to be released, the need for the information, and that there are statues and regulations protecting the confidentiality of authorized information, I hereby acknowledged that this consent is truly voluntary and is valid until such request is fulfilled. I further acknowledge that I may revoke this consent at any time except to the extent that action based on this consent has been taken.

_____ Client

_____ Witness

OR

_____ Legal Appointed Representative

_____ Date

BRUNSWICK
COMMUNITY COLLEGE

BRUNSWICK INTERAGENCY PROGRAM
50 College Road, NE
Bolivia, North Carolina 28422

Consent for Release of Information

CLIENT:

DATE:

REOCRD NUMBER:

I hereby authorize _____ to
(Name of School)
release specified information in my patient records to: BRUNSWICK INTERAGENCY PROGRAM.

For Specific: Establishing eligibility and updating information for the records.

The doctrine of informed consent has been explained to me and I understand the contents to be released. the need for the information, and that there are statues and regulations protecting the confidentiality of authorized information, I hereby acknowledged that this consent is truly voluntary and is valid until such request is fulfilled. I further acknowledge that I may revoke this consent at any time except to the extent that action based on this consent has been taken.

_____ Client

_____ Witness

OR

_____ Legal Appointed Representative

_____ Date

BRUNSWICK COMMUNITY COLLEGE

BRUNSWICK TRANSIT SYSTEM, INC. TRANSPORTATION INFORMATION

- Transportation to Brunswick Interagency Program (BIP) is available through Brunswick Transit System Inc. (BTS)
- If you wish to access this service, complete the attached form and return to Jessica Thornton in the main office at BIP
- The cost of this service is a **FLAT RATE** of $65.00 per month, billed by BIP, **regardless** of the number of days per week the service is provided.
- Payment can be made by Cash, Check, or Money Order. Payments by check or money order **MUST** be payable to Brunswick Interagency Program (BIP).
- If you have any questions or concerns about transportation fees, please contact Jessica Thornton at (910) 755-7375
- Seating is limited, so please be consistent with your ridership. Not riding BTS for 30 calendar days or more could result in the loss of your seat.
- Call Brunswick Transit System (BTS) to cancel any ride AT LEAST 2 hours in advance to avoid "NO SHOWS" that could potentially cost you your seat Three (3) "NO SHOWS" in 30 days can result in suspension of service.
- Brunswick Transit System (BTS) contact number is (910) 253-7800.
- Once you are a passenger, please share any safety concerns with your driver and with a representative from Brunswick Interagency Program at (910) 755-7364 or Chad Cumber, Director of BIP at (910) 755-7394.

Chad Cumber, Director, BIP
cumberc@brunswickcc.edu
(910) 755-7394

Jessica Thornton, BIP Transportation
thorntonj@brunswickcc.edu
(910)755-7375

BTS
BRUNSWICK TRANSIT SYSTEM

PASSENGER TRANSPORTATION REQUEST Date of request:_____

Please use this form for ***recurring (subscription)*** passenger requests. All requests must be submitted to BTS for authorization and scheduling. **Submitting any form does not guarantee scheduling.**

Responsible Agency: _____

Person submitting request: _____Telephone: _____

Passengers Last Name: _____First Name: _____ MI: _____

Pick-up address (House/Apt/Trailer number and road name):

_____

_____

Special Directions: _____

_____

Telephone Number: _____ Other Number: _____

Is a lift van required? Yes____ No____ Is an attendant or other assistance provided? Yes____ No____

If a wheelchair will be used, please specify if it is standard, motorized, extended, etc. (to determine space requirements):_____

BTS follows all Federal and State laws governing transportation of children. Parents are responsible for federally approved child seats where applicable.

Destination: _____Complete Address: _____

_____

_____

Days of the week transportation is requested: (Circle appropriate days):

Monday Tuesday Wednesday Thursday Friday

Arrival Time: _____Departure Time (if applicable): _____

Date transportation will begin: _____Date transportation will end:_____

Initials: BIP_____ BTS___

BRUNSWICK
COMMUNITY COLLEGE

BRUNSWICK INTERAGENCY PROGRAM

I, _____ am the legal guardian of

_____ as adjudicated by law. I will submit a copy of formal documentation to the Brunswick Interagency Program within 30 days of my signature.

_____ _____

Parent or Guardian Date

_____ _____

Witness Date

I. _____ am my own legal guardian.

_____ _____

Witness Date

BRUNSWICK
COMMUNITY COLLEGE

Privacy Statement

Notice to individuals receiving services from Brunswick Interagency Program about how your medical information is protected, used and disclosed. Please review carefully.

All individual and family information provided during screening, admission and service is considered confidential. The disclosure of Protected Health Information (PHI) is governed by North Carolina General Statute 122C and the Health Insurance Portability and Accountability Act of 1966 (HIPPA), as well as any other applicable federal or state laws.

Exchange and use of PHI between BIP staff for the purpose of education and employment services will be permitted and based on •need to know" guidelines and positional authority.

Disclosure of PHI outside of Brunswick Interagency Program is permitted when you or your legal representative signs a written authorization, or when you give your verbal authorization in an emergency situation. Any authorization for disclosure may be revoked at any' time, except to the extent that action has been taken in reliance on it.

You have the right to request restriction of the disclosure of your PHI, except when Brunswick Interagency Program is required to do so. Under the following specific conditions. disclosure of information outside Brunswick Interagency Program is permitted/required by' law and professional ethics without your specific authorization:

- When there is a medical or psychiatric emergency involving the health/safety or others.
- When the BIP staff are required by law to report instances of neglect or abuse of a child or disabled adult.
- When the BIP is responding to a court order.
- When the BIP is required by North Carolina Administrative Code to disclose physician information due to an incident which would cause health risk to other persons.

You also have other rights related to the use and disclosure of PHI in your medical record. These include:

- Right to request your medical record be designated as a "secure" file
- Right to inspect and request a copy of your medical record.
- Right to request amendment of any section of your medical record.
- Right to receive an accounting of disclosures that have occurred with your medical record.

Each disclosure of PHI will be documented in the medical record. You have the right to request an accounting of these disclosures. The program may mail or email information to you regarding appointment reminders, schedules or other information about community services that might be of interest to you. If you are interested in receiving information from the program, please let me know.

BIP reserves the right to change this notice and to make the new notice effective for all PHI maintained in hard copy or electric format. Revisions to the NOTICE OF PRIVACY PRACTICES will be made available to the BIP office for distribution to all individuals receiving services and their families.

Brunswick Interagency Program recognizes the importance of confidentiality, and your right to be fully informed of all regulations regarding PHI. If you feel your privacy rights have been violated, you may contact the Secretary of The North Carolina Department of Health and Human Services (DHHS) at 20001 Mail Service Center, Raleigh, NC 27699-2001, or (919) 733.4534; or the United States Secretary of Health and Human Services at 200 Independence Ave. SW, Washington; DC 20201, or (877) 696.6755. Provision of services will not be affected by the filing of any complaint.

If you are interested in learning more about any of the rights identified in this document, please

Contact Chad Cumber, Director, BIP

Revised 7/2025

BRUNSWICK
COMMUNITY COLLEGE

Acknowledgment of receipt of
NOTICE OF PRIVACY PRACTICES

I, _____, do hereby acknowledge receipt of a copy of the Notice of Privacy Practices, Policies and Procedures.

_____

Signature of Individual

_____

Date

IN THE EVENT THIS REQUEST IS MADE BY THE INDIVIDUAL'S PERSONAL REPRESENTATIVE:

_____ _____

Signature of Personal Representative Date

_____ _____

Legal Authority or Personal Representative Date

BRUNSWICK
COMMUNITY COLLEGE

BRUNSWICK INTERAGENCY PROGRAM

CLIENTS RIGHTS

Client Rights forms will be completed upon admission to the program apprising students of their rights and shall be placed in his/her chart. The form will be signed by the student and/or parents/guardian following explanation of rights.

As a student of services, the following are your rights:

- You have the right to dignity, privacy and humane care.
- You have the right to be free of mental and physical abuse, neglect and exploitation.
- You have the right to treatment, including medical care and habilitation, regardless of your age or disability. The treatment you receive will be age appropriate.
- You will be offered the most appropriate and least restrictive or intrusive service alternative to meet your needs.
- You have the right to be involved in the development of an individualized treatment plan, also known as your person-centered plan.
- You will be notified in advance of all potential risks and benefits of treatment
- You have the right to be free from unnecessary or excessive medications.
- You have the right to refuse treatment at any time.
- You CANNOT be treated with electroshock therapy, experimental drugs or procedures, or undergo surgery (unless it is an emergency surgery) without your written permission.
- The use of physical restraint or seclusion CANNOT be used at BIP.
- You have the right to dispose of property.
- You have the right to make purchases.
- You have the right to vote.
- You have the right to marry and divorce.
- You have the right to a discharge plan prior to being discharged. You will receive a copy of the plan.
- No corporal punishment may be inflicted on any student at BIP.
- No demeaning, shaming or degrading language or activities will be used for punishment or behavior modification.
- No unnecessary punitive restrictions.
- No forced physical exercise to eliminate behaviors.
- No peer punishment or group punishment for individual behavior.
- No punitive work assignments.

Brunswick Interagency Program has an active "P.E.T" which is our "Participant Empowerment Team." This group of self-advocates recruit new members on an annual basis. For specific dates and meeting times, please inquire with the program director.

BRUNSWICK
COMMUNITY COLLEGE

BRUNSWICK INTERAGENCY PROGRAM

As a participant, or the legal responsible person for a participant of Brunswick Interagency Program, I have received a copy of the Client Rights pamphlet. I have been informed of the facts concerning my rights.

_____ _____

Participant's Name Chart Number

_____

Participant/Legal Responsible Person

_____

Witness

_____

Date

BRUNSWICK
COMMUNITY COLLEGE

BRUNSWICK INTERAGENCY PROGRAM
CONSENT FOR EMERGENCY MEDICAL TREATMENT

NAME: _____ DOB: _____

MID#: _____ RECORD# _____

In case of emergency, accident or illness, I give my consent for the staff to provide and/or obtain emergency medical treatment.

Physician's Name: _____ Phone # _____

DIAGNOSIS: _____

ALLERGIES (if any): _____

CURRENT MEDICIATIONS: (if any)

_____ _____

_____ _____

_____ _____

Emergency Contact Name: _____ Relationship: _____

Phone Number: Cell: _____ Work: _____

I fully understand the above statement that has been read and explained to me by the member of the BIP staff.

_____ _____

Client Date
(If under 18 Parent/Guardian must sign)

_____ _____

Parent/Guardian Signature Date

_____ _____

Witness Date

Updated 6/2022

BRUNSWICK COMMUNITY COLLEGE

Brunswick Interagency Program

Grievance Procedure

If you feel you are not being treated fairly, talk to your instructor and/or staff member. If after talking with these people you have not solved your problem, you may go to the Director. He or she will give you an answer within five (5) days after receiving a written report from your instructor or counselor.

In the event that a satisfactory agreement is not met with the Director, you may appeal in writing to the Vice President for Community and Continuing Education within thirty (30) days after receiving the written decision from the Director. The Human Rights Committee will consult all appropriate parties and will render a written decision within thirty (30) working days. The decision of the Human Rights Committee will be final.

If you feel that the matter has not been satisfied to your satisfaction you can contact the Governor's Advocacy Council for Persons with Disabilities at 1.800.821.6922.

As a participant, or legally responsible person for a participant of Brunswick Interagency Program, I have received a copy of the Grievance Procedure. I have been informed of the facts concerning any grievances that may arise.

_____

Participant's Name

_____

Participant/Legally Responsible Person

_____

Witness

_____

Date

Updated 9/30/2024

BRUNSWICK
COMMUNITY COLLEGE

BRUNSWICK INTERAGENCY PROGRAM

CONSENT FOR EMERGENCY MEDICAL TREATMENT

NAME: _____ DOB: _____

MID# _____ RECORD# _____

In case of emergency, accident or illness I give my consent for the staff to provide and/or obtain emergency medical treatment.

Physician's Name: _____ Phone Number: _____

DIAGNOSIS: _____

ALLERGIES (if any): _____

CURRENT MEDICATIONS:

_____ _____

_____ _____

_____ _____

Emergency Contact Name: _____ Relationship: _____

Phone Number: Cell _____ Work: _____

I fully understand the above statement that has been read and explained to me by the member of the BIP staff.

_____ _____

Client Name Date

(If under 18 Parent/Guardian must sign)

_____ _____

Parent/Guardian Signature Date

_____ _____

Witness Date

Revised 2/18/2020

BRUNSWICK INTERAGENCY PROGRAM

CONSENT FOR TREATMENT

Consumer: _____ DOB: _____

MID# _____ RECORD# _____

Brunswick Interagency Program's service philosophy is that people with intellectual and developmental disabilities are respected and included in community life. They can direct their own lives and are able to live, learn, work, and worship successfully in their communities.

We provide an educational/vocational program that enables individuals with developmental disabilities to develop to their full potential, become more independent, and fully participate in their communities.

OUR APPROACH TO DELIVERING SERVICES ARE TO:

- Encourage life-long learning
- Ensure academic excellence
- Establish a positive learning environment
- Provide opportunities for learners to develop to their ultimate potential
- Provide long term support for learners
- Provide person-centered support

Brunswick Community College is an equal opportunity college and is committed to full compliance with the U.S. Civil Rights Act of 1964. It is the policy of the college not to discriminate on the basis of race, sex, color, age, national origin, religion, political affiliation, or handicap with regard to its students, employees, or applicants for admission or employment. Any complaints alleging failure of this college to follow this policy should be brought to the attention of the College's Affirmative Action Officer.

The General Admission Policy of Brunswick Community College is applicable. All applicants will be screened for eligibility prior to admission. Admission screening will include a Needs Assessment and the availability of services prior to admission consideration. Individuals who do not have a developmental disabilities diagnosis are given information about medical and/or mental health professionals who can provide them with psychological testing (screening, triage, and referral 1-866-875-1757).

Background information available in a pre-admission process shall include:

1. Developmental and medical history
2. Previous psychological testing results
3. Social and family history
4. Previous program history
5. Other diagnostic and collateral information that may be relevant to the provision of services

Applicants will be carefully evaluated during the pre-admission process to ensure that the program can be adapted to meet their individual programmatic and developmental needs and to ensure that appropriate plans and safeguards are developed for successful integration. Applicants shall also meet the following criteria for admission

A. All applicants shall not be less than seventeen (17) years of age or have been excluded from the public school system. They should also possess the maturity to function with other adults. The applicant must be diagnosed with a developmental disability.
B. Applicants shall possess certain skills and attributes:
   1. The ability to utilize toilet functions independently
   2. Possession of good personal hygiene skills or the ability to acquire sound hygiene skills
   3. The ability to feed self
   4. The ability to communicate needs in some fashion and the ability to follow simple verbal instructions
   5. The desire to learn and participate in a structured developmental setting
   6. Current physical
   7. Social security card
C. The Intake Specialist will notify the applicant, family members and referring agency of the screening results.

Please sign below to indicate that you have read the Consent for Treatment and fully understand the information shared. Your signature indicates that you are consenting to services and agree to uphold all term established in this contract. Individuals have the right to withdraw from treatment at any time. Your decision to participate/not participate will be respected.

_____ _____

Consumer/Legally Responsible Party's signature Date

_____ _____

Witness Date

I wish to withdraw my consent for treatment.

_____ _____

Consumer/Legally Responsible Party's signature Date

_____ _____

Witness Date

Revised 2/18/2020

Updated Athlete Registration Form
Frequently Asked Questions

Special Olympics

Special Olympics has made significant changes to its athlete registration process, transitioning from the Athlete Medical Form to a more streamlined system comprised of an updated Athlete Registration Form and a new Renewal Form. This change makes the registration process easier for athletes and families by removing the barrier of getting a physical examination prior to participation. The Athlete Registration Form still ensures that essential health information is collected and the Renewal Form provides annual updates. Special Olympics continues to encourage all athletes to have yearly physical examinations by a licensed provider to detect or prevent new health issues and manage existing ones.

How is the new Athlete Registration Form different?
The new form has been simplified removing some confusing questions and medical jargon. It focuses on essential information. The two-page health history is now the only requirement; no sports physical conducted by a medical professional is required for participation.

How is the release/waiver form different?
The updated form contains the same information about using an athlete's likeness and confirming requests about emergency care. It now also includes the communicable disease waiver (the previous COVID waiver language) and a section about Atlanto Axial Instability.

Is an Emergency Medical Care Refusal Form still required if someone has objections to medical treatment or does not consent to blood transfusions?
Yes that information is noted on the release/waiver form but the additional form should also be completed.

Will athletes ever be required to complete a sports physical?
Athletes who travel to competitions outside of North Carolina will be provided with a medical form that must be completed which includes getting a sports physical.

Why will there be a requirement for an annual health history renewal?
The new form is only good for one year versus the previous three years. The new requirement eliminates a major barrier requiring a licensed medical practitioner's physical examination and signature. At the same time, the new registration form benefits Programs by providing more current information about athletes across all categories and benefits athletes by providing the most current health information in support of their overall participation. Many of our athletes have changes in their health and medications annually and it is in their best interest – and ours – to have updated information.

What are the Athlete Registration Form requirements for sports participants in schools and community partner programs? (i.e., Unified Champion Schools, colleges, Parks & Recreation, Boys & Girls Clubs)
For activities and competitions that are operated by the school or partner organization, the Athlete Registration Form is encouraged, but not required. The Special Olympics Athlete Registration Form and annual renewal policy is required for participation in activities and competitions that are operated by a Special Olympics Program. In other words, the Athlete Registration Form is required for participants from schools and community organizations that attend competitions operated by Special Olympics.

Are there certain responses to the health history or medication in the new Athlete Registration Form that would require the Program to recommend further attention prior to participation, including the completion of the Athlete Medical Form by a medical practitioner?
For health and safety reasons, Programs, coaches and medical staff may advise an athlete to consult a physician before pursuing participation based on the information reported on the Athlete Registration Form.

How will we be able to verify if someone qualifies for Special Olympics if we don't have a medical professional completing the form?
The purpose of the athlete participation packet was never to verify/confirm a diagnosis of an intellectual disability and it did not have such a question (it simply asked for associated diagnoses and the current form still has that question). Special Olympics relies on outside professionals to provide that diagnosis to the athlete and/or their family and we rely on the information they provide to us.

What is the potential impact on MedFest? How will MedFest be marketed moving forward?
Even though Special Olympics will not require a licensed medical practitioner's signature to participate, an annual physical exam is strongly encouraged to promote overall athlete health. MedFest will remain as a program aimed at providing athletes the opportunity to see a physician as well as an opportunity to train physicians to care for individuals with IDD. We will increasingly highlight overall health activities and education including our program SO Good (formerly Partner Up Power Up), offer additional health screenings as able, and showcase sports participation at MedFest events.

Will there continue to be a supplemental form for athletes with Atlantoaxial Instability?
Language specific for athletes with Atlantoaxial Instability has been added to the waiver section of the registration form.

Does an athlete have to complete the full form every year?
The renewal process for continuing athletes has been greatly simplified with a new renewal form. The waiver only has to be completed once. The renewal form will ask for any personal information updates and then if the athlete indicates any changes to health history, they will have the chance to provide those.

Will there be an option for the form to be completed electronically?
Yes! We are in the process of creating a fillable pdf of the form but even more exciting is the development of completing this form full online. This does mean that the forms will come into a central SONC account which will then be shared with local programs. We are still working on this process but our plans are:

- Receive an electronic registration form
- Download the forms and add to the local program OneDrive
- Enter into GMS – updated exports will be available upon request
- Share a spreadsheet that will be updated weekly showing forms that have been received

Will we have more athletes registering now that the form is simplified?
That is very likely! We will all continue to work together on how to welcome new athletes and build the systems needed to provide programming to them including coach recruitment, fundraising, etc.

When does this start and what is the future timeline?

This change is effective immediately. See the chart below to understand how we will transition from the previous form/process. We will still accept and honor old forms as we make this change.

An athlete who has a form on file now	**An athlete who is in the process of completing an old form and physical before 12/31/24**	**A new athlete or a continuing athlete who has not yet received an old form to complete or not yet in the process of completing an old form**
Their old form is good until the original 3-year expiration date.	We will still accept the old form and it will be good for 3 years.	They should complete the new ARF (including the waiver) which will be good for this program year. The old form will still be accepted but it will only be good for that program year.
They will then need to complete the full new ARF i(ncluding the waiver) which will be good for that program year.	They will then need to complete the full new ARF (including the waiver) which will be good for that program year.	
The following year they will complete the renewal form.	The following year they will complete the renewal form.	The following year they will complete the renewal form.

Special Olympics
North Carolina

Welcome to Special Olympics North Carolina!

Special Olympics North Carolina (SONC) is a non-profit organization which provides sports training and competition for over 45,000 children and adults with intellectual disabilities. In North Carolina, 20 sports are offered on a year-round basis; sport offerings vary by local program (primarily county).

Special Olympics was created by the Joseph P. Kennedy, Jr. Foundation. Special Olympics North Carolina is authorized and accredited by Special Olympics Inc. and is licensed by the Secretary of State's office with the State of North Carolina and is a 501(c)3 organization as determined by the Internal Revenue Service.

Special Olympics athletes get continuing opportunities, to develop physical fitness, demonstrate courage, experience joy and participate in a sharing of gifts, skills and friendship with their families, other Special Olympics athletes and the community.

To become a Special Olympics athlete, contact the local program in your county. A full list of contact information is available on the Web site at www.sonc.net.

Athlete Eligibility

Special Olympics training and competition is open to every person with an intellectual disability who is at least eight years of age. There is no maximum age limit. Eligible individuals must be identified by a medical agency or professional as having an intellectual disability. Some Special Olympics athletes may also have a physical disability, but it is their **developmental** disability that qualifies them to participate in Special Olympics.

Children who are ages two through seven may participate in the Young Athletes Program (there is a different registration form for this program).

Registration Procedure

To become a new athlete:

- ☐ **Basic Info & Health History Form (2 pages):** This section captures health history in order to understand an athlete's health status. This section must be completed by a parent/guardian or an adult athlete who is his/her own guardian.

- ☐ **Release & Waiver Form (2 pages):** This form goes over some important details about Special Olympics participation and requires a signature. This will only need to be completed one time. The Release/Waiver Form instructs you to complete other forms in certain situations. Those will be sent out to be completed on a case by case basis.

- ☐ **Code of Conduct (1 page):** It is important that we all have clear expectations of how we act and treat each other. While a signature is not required here, a local coordinator or coach may ask everyone to sign to indicate agreement.

This form is good for one year. After the first time an athlete completes this full form, they will be prompted to complete a simple **renewal form** each year to continue participation.

Please submit registration forms to your local program coordinator – contact information can be found at www.sonc.net.

Athlete Registration Form

Special Olympics North Carolina

Required for all athletes participating in Special Olympics.

Local Special Olympics Program: _____ School/Agency: _____

Athlete Information - *To be completed by the athlete or parent/guardian/caregiver.*

First name: _____ Last name: _____ Middle name: _____

Date of birth (dd/mm/yyyy): ____/____/____ Gender: ◯ Female ◯ Male ◯ Other

Email: _____ Primary phone number: _____ ◯ Mobile ◯ Landline

Place of employment/school: _____

Home address: _____

Optional – *Check all that apply:*		
Race / Ethnicity	☐ American Indian / Alaskan Native ☐ Black / African American ☐ Middle Eastern / North African ☐ White / Caucasian ☐ Other: _____	☐ Asian American ☐ Hispanic / Latino ☐ Native Hawaiian / Other Pacific Islander ☐ Unknown ☐ Prefer not to answer
Language(s) Spoken by Athlete	☐ English ☐ French ☐ Spanish ☐ American Sign Language (ASL) ☐ Other (please list): _____	

Parent/Guardian Information - *Required if minor or otherwise has a legal guardian.*

First Name: _____ Last Name: _____ Relationship to athlete: _____

Email: _____ Phone number: _____ ◯ Mobile ◯ Landline

Home address: _____

Emergency Contact ☐ *Same as Parent/Guardian*

First name: _____ Last name: _____ Phone number: _____ ◯ Mobile ◯ Landline

Relationship to athlete: ◯ Parent/guardian ◯ Caregiver ◯ Family member ◯ Healthcare provider ◯ Coach ◯ Other

Associated Conditions - *Mandatory*

Associated Conditions *Check all that apply:*	☐ Autism ☐ Cerebral Palsy ☐ Down Syndrome ☐ Fetal Alcohol Syndrome ☐ Marfan Syndrome ☐ Spina Bifida ☐ Epilepsy ☐ Fragile X Syndrome ☐ Other ☐ Unknown
Please specify other known intellectual disability diagnoses:	

Assistive Devices and Accommodations - *Do you use any of the following? Check all that apply:*

Mobility	☐ Walker ☐ Braces or crutches ☐ Wheelchair ☐ Removable orthotics ☐ Prosthetics ☐ None
Lifestyle Aids	☐ CPAP ☐ Dentures ☐ Glasses, contact lenses, or protective eyewear ☐ None
Communications	☐ Hearing Aid ☐ Communication devices ☐ Sign Language ☐ None
Medical Devices	☐ Implantable cardioverter defibrillator (ICD) ☐ Implantable device for seizure management ☐ VP Shunt ☐ Pacemaker ☐ None

Do you have a specific dietary requirement? ◯ Yes ◯ No	If yes, please specify:	Do you use other assistive devices? ◯ Yes ◯ No If yes, please specify:

General Health Questions	Athlete Name _____	
Do you have a heart condition?	◯ Yes	◯ No
Do you have asthma?	◯ Yes	◯ No
Do you have diabetes that requires you to take insulin?	◯ Yes	◯ No
Do you have a vision impairment?	◯ Yes	◯ No
Do you have a hearing impairment?	◯ Yes	◯ No
Do you have a bleeding disorder?	◯ Yes	◯ No
Has a doctor ever limited your participation in sports?	◯ Yes	◯ No
Do you have epilepsy or any type of seizure disorder?	◯ Yes	◯ No
Do you have sickle cell disease?	◯ Yes	◯ No

Have you ever had a concussion?	◯ Yes	◯ No	If yes, please specify how many in your lifetime: _____ Date of last one (mm/yyyy): _____
Do you have behavioral, mental health, and/or sensory conditions?	◯ Yes	◯ No	If yes, please specify:
Do you have severe allergies that requires the use of an EpiPen?	◯ Yes	◯ No	If yes, please specify if it is to any of the following: ☐ Insect stings ☐ Medication/drugs ☐ Food ☐ Latex ☐ Other (please specify): _____

Medication and Treatment - *Please list:*

Are you taking any prescription or over-the-counter medications or treatments? (Including birth control pills, insulin, multivitamins allergy shots or p inflammatory medication, supplements of any kind. etc.)

◯ Yes ◯ No

If yes, please list:

Medication, Vitamin, or Supplement Name	Dosage	Times per day

Medication, Vitamin, or Supplement Name	Dosage	Times per day

Name of person completing the form: _____

Today's date (dd/mm/yyyy): _____/_____/_____

Is this form being completed by someone other than the athlete? ◯ Yes ◯ No

If yes, please select the relationship to athlete:

Relationship to athlete: ◯ Parent/guardian ◯ Caregiver ◯ Family member ◯ Healthcare provider ◯ Coach ◯ Other

Special Olympics encourages all participants to get a yearly physical examination.

WAIVERS, RELEASES, AND POLICIES **Athlete Name** _____

Please read the following information and check boxes fully before signing.

I agree to the following:

1. **Ability to Participate.** I am physically able to take part in Special Olympics activities, and will abide by all applicable rules, requirements and codes of conduct.

2. **Likeness Release.** I give permission to Special Olympics, Inc., Special Olympics games organizing committees, Special Olympics accredited Programs (collectively "Special Olympics"), as well as official Special Olympics supporters and partners that have authorization from Special Olympics, to use my likeness, photo, video, name, voice, words, biographical information and similar or related material (my "likeness") to promote Special Olympics and raise funds for Special Olympics. I understand that my likeness may be used in all forms of media in local or global campaigns – including those by supporters and partners of Special Olympics – but understand that my likeness will not be used to endorse commercial products or services. I understand that I will not be compensated for the use of my likeness.

3. **Emergency Care.** If I am unable, or my guardian is unavailable, to consent or make medical decisions in an emergency, I authorize Special Olympics to seek medical care on my behalf, unless I mark one of these boxes:

☐ I have a religious or other objection to receiving medical treatment.

☐ I do not consent to blood transfusions.

(If either box is marked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)

4. **Overnight Stay.** For some events, overnight accommodations may be required. If I have questions, I will contact my Special Olympics Program.

5. **Health Programs.** If I take part in a health program, I consent to health activities, screenings, and treatment. This should not replace regular health care. I have the right to decline Health programming treatment (which is different from sideline or emergency medical care) at any time."

6. **Personal Information.** I understand that Special Olympics will be collecting my personal information as part of my participation, including my name, image, address, telephone number, health information, and other personally identifying and health related information I provide to Special Olympics ("personal information").

I agree and consent to Special Olympics:

- using my personal information in order to: make sure I am eligible and can participate safely; run trainings and events; share competition results (including on the Web and in news media); provide health treatment if I participate in a health program; analyze data for the purposes of improving programming and identifying and responding to the needs of Special Olympics participants; perform computer operations, quality assurance, testing, and other related activities; and provide event-related services.

- using my contact information for communicating with me about Special Olympics.

- sharing my personal information confidentially with (i) researchers such as universities and public health agencies that are studying intellectual disabilities and the impact of Special Olympics activities, (ii) medical professionals in an emergency, and (iii) government authorities for the purpose of assisting me with any visas required for international travel to Special Olympics events and for any other purpose necessary to protect public safety, respond to government requests, and report information as required by law.

- I have the right to ask to see my personal information or to be informed about the personal information that is processed about me. I have the right to ask to correct and delete my personal information, and to restrict the processing of my personal information if it is inconsistent with this consent.

Privacy Policy. Personal information may be used and shared consistent with this form and as further explained in the Special Olympics privacy policy at www.SpecialOlympics.org/Privacy-Policy.

SYMPTOMS FOR SPINAL CORD COMPRESSION and ATLANTOAXIAL INSTABILITY
(For athlete with Down syndrome only)

If I (or the athlete) have been diagnosed with or experienced any of the following symptoms that have increased in severity over the past three years – difficulty controlling bowels or bladder; numbness or tingling in legs, arms, hands, or feet; weakness in arms, legs, hands or feet; burner/stinger/pinches nerve, pain in neck, back shoulders, arms, hands, buttocks, legs or feet; spasticity or paralysis – I must obtain a review and permission from a licensed medical practitioner to train and/or participate in Special Olympics activities.

WAIVER AND RELEASE OF LIABILITY / ASSUMPTION OF RISK / INDEMNIFICATION

In consideration of being allowed to participate in any way in Special Olympics activities, the undersigned acknowledges, appreciates, and agrees that:

1. While particular rules and personal discipline may reduce this risk, the risk of illness (including communicable diseases), injury (including concussion), disability, and death does exist;

2. If I observe any unusual or significant hazard during my presence or participation, I will remove myself from participation and bring such to the attention of the nearest Special Olympics representative immediately; and,

3. **I understand the risks involved with participation in Special Olympics activities. I fully accept and assume all risks and all responsibility for losses, costs, and damages I may incur as a result of my participation. To the fullest extent of the law, I release and agree not to sue any Special Olympics organization, its directors, agents, volunteers, and employees, other participants, sponsoring agencies, sponsors, advertisers, and, if applicable owners and lessors of premises on which any Special Olympics activity is occurring ("Releasees") related to any liabilities, claims, or losses on my account caused or alleged to be caused in whole or in part by the Releasees even if arising from the negligence of the Releasees. I have read this release of liability and assumption of risk provision, fully understand its terms, acknowledge that I have given up substantial rights by signing it, and sign it freely and voluntarily without any inducement. I further agree that if, despite this release, I, or anyone on my behalf, makes a claim against any of the Releasees, I will indemnify and hold harmless each of the Releasees from any such liabilities, claims, or losses as the result of such claim. I agree that if any part of this form is held to be invalid, the other parts shall continue in full force and effect.**

Athlete Name: _____

ATHLETE SIGNATURE
(required for adult athlete with capacity to sign legal documents)

I have read and understand this form. If I have questions, I will ask. By signing, I agree to this form.

Athlete Signature: _____ Date (dd/mm/yyyy): _____/_____/_____

PARENT/GUARDIAN SIGNATURE
(required for athlete who is a minor or lacks capacity to sign legal documents)

I am a parent or guardian of the athlete. I have read and understand this form and have explained the contents to the athlete as appropriate. By signing, I agree to this form on my own behalf and on behalf of the athlete.

Parent/Guardian Signature: _____ Date (dd/mm/yyyy): _____/_____/_____

Printed Name: _____ Relationship: _____

EVALUATION AND RESEARCH
(Optional)

Special Olympics wants to help our athletes and their families stay healthy and happy. We may take part in research studies and would share information for your potential participation. All studies will be checked by the Special Olympics Chief Health Officer.

Would you or your family be interested in learning about research studies?

◯ Yes ◯ No

Special Olympics
North Carolina

Athlete & Unified partner Code of Conduct

All Special Olympics athletes and Unified Sports partners agree to the following Code of Conduct:

SPORTSMANSHIP AND RESPECT FOR OTHERS

- I will practice good sportsmanship, toward my fellow local program participants, opposing program members, officials, volunteers, staff, family members and spectators at all times including during, before and after practice and competition.
- I will act in ways that bring respect to me, my coaches, my team and Special Olympics.
- I will not use inappropriate or offensive language, including swearing or insulting other individuals, in any form of communication.
- I will not fight with other athletes, coaches, officials, volunteers, staff, family members or spectators.
- I will respect the rights and dignity of all athletes, Unified partners, coaches, volunteers, staff, family members, and spectators in Special Olympics, and will not willfully engage in discriminatory behaviors.
- I will treat everyone equally and with respect regardless of gender, gender identity, sexual orientation, age, race, ethnicity, national origin, religion, ability, or any other characteristic.

TRAINING AND COMPETITION

- I will train regularly and I will learn and follow the rules of my sport.
- I will listen to my coaches and the officials and ask questions when I do not understand.
- I will always try my best during training, divisioning and competitions.
- I will not "hold back" in preliminaries just to get into an easier final heat/division.
- I will follow Special Olympics' concussion protocol.

RESPONSIBILITY FOR MY ACTIONS

- I understand all forms of communication between me and any other participants must always be appropriate and respectful.
- I will not engage in any form of verbal, physical, psychological, emotional, or sexual abuse, unwanted sexual advances, or harassing, bullying, or hazing behavior in person, via telecommunications, or via any other form of electronic communication, including, but not limited to email, texting, and social media. I will not share inappropriate language, derogatory comments, or slurs, and/or inappropriate images.
- I understand that any social media connections I make with other Special Olympics participants or delegation members on my personal social media accounts are my choice and I am completely responsible for all such communications and who I choose to friend/follow on social media.
- I know that I can tell Special Olympics North Carolina leadership immediately, at any point during my experience, if I feel I am experiencing bullying, or abusive or disrespectful behavior from any member of Special Olympics. I will also tell leadership if I become aware of such behavior occurring between other participants.
- I understand any form of sexual activity between any participants including volunteers and staff is strictly prohibited while participating in any Special Olympics activities.
- I will not drink or possess alcohol, smoke (tobacco products, e-cigarette devices), or possess or consume recreational cannabis or cannabis-based products or take illegal drugs while representing Special Olympics or participating in Special Olympics activities.
- I will not take drugs for the purpose of improving my performance.
- I will be honest and forthcoming about any behavioral or medical needs or considerations I may have, and potential needed supports, that should be known by Special Olympics to help ensure the safety, health, and experience of all involved.
- I will respect and not misuse any equipment or property belonging to Special Olympics or that is provided to Special Olympics for its use.
- I will obey all applicable laws where I am participating, as well as Special Olympics rules and operating policies.

I understand that if I violate this Code of Conduct, I will be subject to a range of consequences, up to and including being prohibited from participating in Special Olympics.

BRUNSWICK
COMMUNITY COLLEGE

BRUNSWICK INTERAGENCY PROGRAM

Other Helpful Resources

The ARC of North Carolina
www.arcnc.org
1.910.493.0003

Disability Rights of North Carolina
www.disabilityrightsnc.org
800.662.8706

Mental Health Association of NC, Inc
www.mamInc.org
888.881.0740

NC Care-Line
www.ncdhhs.gov/osc.careline.htm
800.662.7030

NC Division of Health Service Regulation
www.ncdhhd.gov/dhsr
800.624.3004

Trillium Health Resources
www.trilliumnc.org
1-877-685-2415 (Crisis Line)
1-866998-2597

Exceptional Children's Assistance Center
www.ecac-parentcenter.org
800.962.6817

National Alliance and Mental Illness (NAMI)
www.naminc.org
800.451.9682

NC Care Link
www.carellink.gov
800.662.7030

NC Mental health Consumers Organization
www.ncmhcosupports.org
800.662.3842

Substance Abuse and Mental Health Services Administration (SAMHSA)
www.sMHS.gov
800.662.4357

Veterans Services
www.nccarelink.org
800.662.7030. or 919.733.1011 ext.216

National Council on Alcoholism and Drug Dependence
800.NCA.CALL

Updated 7/18/2023