

2023-2024 TEC Community Based Vocational Program (CBVI): Student Enrollment Form

IDENTIFICATION INFORMATION

Start Date _____

Name _____

SS# _____

Address _____

DOB _____

Male _____ **Female** _____

Home Phone _____

Cell Phone _____

Parent/Guardian Name _____

Address _____

Parent Email Address: _____

EDUCATIONAL INFORMATION

High School _____ **City, State** _____

Year Anticipated Graduation _____

High School Point of Contact _____

Address _____

Phone Number _____

E-Mail Address _____

Do you plan to further your education? Yes ___ No ___

Educational Interest _____

Disability Accommodations (check all that apply)

_____ Visual _____ Auditory _____ Seizures _____ Ambulatory
_____ Respiratory _____ Stamina _____ Addictions _____ Phobias (explain)

TEC may require, as part of the training program, students being involved in volunteer opportunities to learn necessary work skills. These opportunities may be at TEC or in other community sites. Specifically, neither TEC nor the contracting business will provide unemployment insurance, compensation or medical/vision benefits. _____ **Initials**

Student and/or Parent/Guardian Signature

Date

Staff Signature & Title

Date

Emergency Medical Information

Name _____ Start Date _____

Address _____

Phone _____

Emergency Contact

Name/Relationship _____

Address _____

Phone (Number while child is in care) _____

Current Medications

Medication	Dosage (AM/PM)	Side Effects
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies _____

Clinical Information

Primary Diagnosis _____ Secondary Diagnosis _____

Medical Insurance (Card & Number) _____

Primary Care Physician _____

I, _____, give my consent to TEC and any area hospital to receive emergency medical treatment as deemed necessary by the attending physician. I understand that signing this consent form releases TEC of any additional responsibility or liability provided the above steps are followed in an emergency.

Parent/Guardian Signature: _____ Date: _____

CONFIDENTIALITY POLICY

All records and or information received by TEC staff regarding any clients/students are to be considered confidential. By law, only those individuals and/or agencies that are named in a written release of information signed by the client and/or student/parent/guardian are permitted to have access to information about that client/student.

The following rules of confidentiality shall be adhered to regarding client/student information:

- ◆ All records shall be retained in accordance with any federal and state laws and regulations regarding the confidentiality of client/student identity and records.
- ◆ All records shall be kept in a locked file cabinet and shall not be left unattended when out of the cabinet.
- ◆ All disclosures of information require the written permission of the client and/or student/parent/guardian on a completed information release and the permission of the Executive Director.
- ◆ A copy of the consent shall be given to the client and/or student/parent/guardian a copy maintained in the service recipient's file.
- ◆ When consent is not required (e.g. Department of Public Welfare, Office of Vocational Rehabilitation, County Administrator, School District), the disclosure will be documented in the record and the client and/or student/parent/guardian informed of the disclosure.

Client/Student Signature

Date

Parent/Guardian Signature

Date



330 Central Avenue Washington, Pennsylvania 15301
724-225-3535 1-888-576-2365 Fax: 724-225-5085

Student Photo Release

I, _____ (parent/guardian), give my consent to TEC Education Center to photograph my child, _____.

(Print Student's name)

Parent/Guardian Name (printed)

Date

Parent/Guardian Signature

Date



330 Central Avenue Washington, Pennsylvania 15301
724-225-3535 1-888-576-2365 Fax: 724-225-5085

CONSENT TO EXCHANGE INFORMATION

Date of Birth: _____

Social Security #: _____

I, _____, hereby give my consent to allow Transitional Employment
(Client or person authorized to consent for client)

Consultants (TEC) /TEC Education Center to exchange information with _____
(Home School District)

regarding demographic, vocational and financial information.

The above information will be exchanged for the following purposes only, and any other use is forbidden:
vocational evaluation, obtaining and maintaining employment.

Information gathered and received by TEC regarding any client is strictly confidential. By law, only people
or entities that are named on this consent form and signed by the client are permitted to have access to
information about the client.

This consent is valid for the **2023-2024 School Year**, unless rescinded by my written request. I do
understand the nature of this consent and freely give my authorization.

Student Signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____

Witness: _____

Date: _____

TEC
Representative: _____

Date: _____

Expiration Date: _____

____ Client accepted/requested a copy of this Consent to Exchange Information

____ Client rejected a copy of this Consent to Exchange Information



330 Central Avenue
Washington, PA 15301
Phone: 724-225-3535
Fax: 724-225-5085

CONSENT TO EXCHANGE INFORMATION

Date of Birth: _____

Social Security #: _____

I, _____, hereby give my consent to allow TEC Education
(Client or person authorized to consent for client)
Center/Transitional Employment Consultants (TEC) to exchange information with _____
(Community Volunteer Site(s))
regarding demographic, and vocational information.

The above information will be exchanged for the following purposes only, and any other use is forbidden:
vocational evaluation, obtaining and maintaining employment.

Information gathered and received by TEC regarding any client is strictly confidential. By law, only people
or entities that are named on this consent form and signed by the client are permitted to have access to
information about the client.

This consent is valid for the **2023-2024 School Year**, unless rescinded by my written request. I do
understand the nature of this consent and freely give my authorization.

Student Signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____

Witness: _____

Date: _____

TEC
Representative: _____

Date: _____

Expiration Date: _____

____ Client accepted/requested a copy of this Consent to Exchange Information

____ Client rejected a copy of this Consent to Exchange Information



330 Central Avenue
Washington, PA 15301
Phone: 724-225-3535
Fax: 724-225-5085

CONSENT TO EXCHANGE INFORMATION

Date of Birth: _____

Social Security #: _____

I, _____, hereby give my consent to allow TEC Education Center/
(Client or person authorized to consent for client)

Transitional Employment Consultants (TEC) to exchange information with **Washington County OVR
Office Staff and/or Counselors** (OVR Office)

regarding demographic, educational, vocational and financial information.

The above information will be exchanged for the following purposes only, and any other use is forbidden:
vocational evaluation, obtaining and maintaining employment.

Information gathered and received by TEC regarding any client is strictly confidential. By law, only people
or entities that are named on this consent form and signed by the client are permitted to have access to
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