



## SPECIAL NEEDS SCHOOL QUESTIONNAIRE

Name of organization: \_\_\_\_\_

Number of years in operation: \_\_\_\_\_

Website address (URL): www. \_\_\_\_\_

1. Number of students in each age group: \_\_\_age 0-5    \_\_\_age 6-12    \_\_\_age 13-18    \_\_\_age 19+

2. What are the dates of your current school term and next school term? \_\_\_\_\_

3. How many teachers? \_\_\_\_\_

4. Is school licensed? YES  NO

5. Is this a charter school? YES  NO

6. If school was built prior to 1980, has premises been inspected and certified lead free? YES  NO

7. Are any in-home services offered? YES  NO

8. Is the building handicap accessible? YES  NO

9. Is a security system in place to control and monitor entrances, and exits of students and visitors? YES  NO

10. Are there metal detectors at all school entrances? YES  NO

11. Do you use security officers? YES  NO

**If yes,** are security officers armed? YES  NO

12. Is restraint of students allowed? YES  NO

**If yes,** how many incidents of restraint have occurred in the past year? \_\_\_\_\_

13. Is corporal punishment coverage desired? YES  NO

14. Are all medications kept in a locked area? YES  NO

15. Does school have any stadiums, bleachers or grandstands? YES  NO

16. Do you have an outdoor play area? YES  NO

**If yes,**

a. Does the value of your outdoor equipment, including surfacing, exceed \$25,000? YES  NO

**If yes,** attach a schedule of locations with value at each.

b. Was all equipment manufactured by a commercial manufacturer? YES  NO

c. Was all equipment installed by an insured contractor? YES  NO

17. Indicate any of the following activities offered:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Archery   | <input type="checkbox"/> Downhill skiing | <input type="checkbox"/> Off Premises Water Activities |
| <input type="checkbox"/> Baseball/Basketball   | <input type="checkbox"/> Football-flag   | <input type="checkbox"/> Riflery                       |
| <input type="checkbox"/> Boxing/ Martial Arts -Contact   | <input type="checkbox"/> Football-tackle | <input type="checkbox"/> Soccer                        |
| <input type="checkbox"/> Boxing/Martial Arts- Non-Contact  | <input type="checkbox"/> Gymnastics      | <input type="checkbox"/> Track and Field               |
| <input type="checkbox"/> Climbing/Rappelling/Ropes Course  | <input type="checkbox"/> Lacrosse/Rugby  | <input type="checkbox"/> Wrestling                     |
| <input type="checkbox"/> Equine/Horseback Riding   |  |  |
| <input type="checkbox"/> Swimming or Diving- <b>complete Pool questionnaire</b> if there is a pool on school premises. |  |  |
| <input type="checkbox"/> Other: _____  |  |  |

# SHS Surplus Lines



18. Do you provide accident insurance for students? YES  NO

**If yes:**

a. Insurance company name: \_\_\_\_\_ Policy number : \_\_\_\_\_  
Policy period: \_\_\_\_\_ Limits: \_\_\_\_\_

b. Accident insurance:  
 applies to all students  applies to sports participants  is optional, at student's expense

19. Is your school's primary purpose or mission to serve any of the following student groups: YES  NO

**If yes**, indicate all applicable:

Developmental impaired  Learning impaired  Physical impaired  
 Emotionally impaired, including mentally ill, suicidal, violent and/or oppositionally defiant

20. Is auto coverage desired for owned and/or non-owned vehicles? YES  NO

**If yes**, complete the Auto Questionnaire and provide Acord Auto applications

21. **As respects to abuse coverage:**

a. Have any claims been filed or allegations been made, against your organization or anyone working on behalf of your organization alleging abuse? YES  NO

b. Are you aware of any occurrences that could lead to a claim? YES  NO

22. Does your facility have written policies that require known or suspected abuse incidents be reported to proper authorities? YES  NO

Abuse coverage currently in place:

- None  
 Occurrence  Sublimit: \_\_\_\_\_  
 Claims Made  Sublimit: \_\_\_\_\_

1. Total number of clients: \_\_\_\_\_

	Employees	Volunteers
a. Is unsupervised contact allowed with clients?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
b. Education verified?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
c. Personal references checked?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
d. Written application required?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
e. State <b>10-digit fingerprint</b> criminal record check	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
f. Federal <b>10-digit fingerprint</b> criminal record check if in state less than 5 years	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
g. Federal <b>10-digit fingerprint</b> criminal record check regardless of time in state	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
h. Are all controls indicated in e, f & g required before client contact?	YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
i. How long are records kept documenting all screening activities outlined above?	_____ years	_____ years

### Federal checks require a second set of 10-digit fingerprint cards

23. **As respects professional liability:** Is professional liability coverage desired? YES  NO

24. Is your organization aware of any circumstances which may result in any claim being made or any claims or suits which have been made during the past five years, against the entity or any of its past or present officers or employees? YES  NO

If yes, explain: \_\_\_\_\_

## SHS Surplus Lines



25. Has any similar insurance for the entity, present officers or employees ever been cancelled? **YES**  **NO**   
If yes, explain: \_\_\_\_\_

26. **Professional coverage currently in place:**

- None  
 Occurrence       Sublimit: \_\_\_\_\_  
 Claims Made       Sublimit: \_\_\_\_\_

27. Prior professional liability insurance carrier: \_\_\_\_\_

28. Indicate all services applicable:

- Any invasive procedure       Psychiatric Shock Therapy       Catheterization  
 Obstetrical/Gynecological       Feeding Tube Maintenance       X-rays  
 Any procedures not supported by the American Medical Association (procedures that are experimental, are not used as prescribed by the AMA or are unsupported by AMA accepted clinical research)  
 Alternative or Complementary Medical practices (e.g. Acupuncture, Chiropractic, Homeopathy, Massage, Mental Healing, Naturopathy, etc.)

Explain any services indicated: \_\_\_\_\_

29. Describe any other health care services provided by the organization:  
 \_\_\_\_\_

30. List the number of employed medical professionals:

Degree	Full-time	Part-time (less than 15 hrs/wk)
Medical Doctors		
Psychiatrist		
RN		
LPN / CAN / Nurse Aides		
Therapists (e.g., Speech, Occupational, Physical)		
<b>Professional Educators</b>		
Classroom Teachers		
Teacher Aids, Student Teachers, Daycare Workers		
Special Education Teachers		
Guidance Counselors, Vocational Counselors, Psychological Counselors		
School Nurse		
Other professionally trained educators (including administrators)		

31. Of the professionals listed, do any carry their own professional liability insurance and want to be excluded from coverage under this policy? **YES**  **NO**

If yes, list all individuals and position: \_\_\_\_\_

32. List the names of any Medical Doctor's or Psychiatrist's that require professional coverage while performing job duties for the named insured. Note these individual's must be scheduled in order for coverage to apply:  
 \_\_\_\_\_

Completed by: \_\_\_\_\_

Date completed: \_\_\_\_/\_\_\_\_/\_\_\_\_