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SierraSpecialty

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:

☐Archery	☐Downhill skiing	☐Off Premises Water Activities
☐Baseball/Basketball	☐Football-flag	☐Riflery
☐Boxing/ Martial Arts -Contact	☐Football-tackle	☐Soccer
☐Boxing/Martial Arts- Non-Contact	☐Gymnastics	☐Track and Field
☐Climbing/Rappelling/Ropes Course	☐Lacrosse/Rugby	☐Wrestling
☐Equine/Horseback Riding		

☐Swimming or Diving-**complete Pool questionnaire** if there is a pool on school premises.
☐Other: _____

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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 or 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** ☐ **NO** ☐	**YES** ☐ **NO** ☐
b. Education verified?	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
c. Personal references checked?	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
d. Written application required?	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
e. State **10-digit fingerprint** criminal record check	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
f. Federal **10-digit fingerprint** criminal record check if in state less than 5 years	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
g. Federal **10-digit fingerprint** criminal record check regardless of time in state	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
h. Are all controls indicated in e, f & g required before client contact?	**YES** ☐ **NO** ☐	**YES** ☐ **NO** ☐
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: _____

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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)		
Professional Educators		
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:_____/_____/_____