# Hardin County Board of Developmental Disabilities

Simon Kenton School

705 N. Ida Street ·Kenton, Ohio 43326 · (419) 674-4158 · FAX: (419) 675- 3274


The following is a checklist to assist you with returning needed documentation for the nursing department and/or for required student records. If you have any questions, please feel free to call 419-674-4158.

- Birth Certificate
- Social Security Card
- Immunization Record or Waiver
- Physical (within 30 days of start of school; good for 12 months)
- including lead and hematocrit upon initial entrance into preschool
- Dental (within 30 days of the start of school)
- Vision/ Hearing (30 days from enrollment)
- Diet Modification Form (If applicable)
- Emergency Medical Form
- Non Prescription Form
- Prescription Form (if applicable)
- Transportation Form
- Child Release
- Roster Permission
- One Call Now

Included in your packet is the School Calendar, Step Up To Quality Family Information, and Parent's Guide to Rights of Children and Youth Experiencing Homelessness.

**Simon Kenton School**
705 N Ida Street
Kenton, Ohio 43326
Phone (419) 674-4158 Fax (419) 675-3274

# CHILD ENROLLEE MEDICAL REPORT

**Name:** _____ **Date of Exam:** _____
First Middle Last

**Date of Birth** ____/____/____ **Sex:** ❑ **Male** ❑ **Female**

**Height** [ ] **Weight** [ ]

**BP**_____ **RR**_____ **HR**_____ **Pulse OX**_____

**Temp**_____

**Wears Glasses** ❑**yes** ❑ **no**
**Vision Screening**
**(P=Pass F=Fail)** **Right eye** _____ **Left eye** _____ **Concerns**_____

**Wears Hearing Aids** ❑ **yes** ❑**no**
**Hearing Screening**
**(P=Pass F=Fail)** **Right ear** _____ **Left Ear**_____ **Concerns**_____

**Dental Screening**_____

## MEDICAL INFORMATION:

General Appearance _____

Nutritional Status _____

Head _____

Neck _____

Chest_____

Heart_____

Lungs_____

Abdomen_____

Genitalia_____

Extremities_____

Back_____

Neurological_____

Revised 6/2019

Orthopedic _____

Abnormalities as follows: _____

_____

_____

| * STATE MANDATED REQUIREMENT FOR PRE-SCHOOL | |
|---|---|
| * Hematocrit level: | * Lead level: |

## CURRENT IMMUNIZATIONS:

| | Date | Date | Date | Date |
|---|---|---|---|---|
| DT/ DTaP | | | | |
| POLIO | | | | |
| MMR | | | | |
| HIB | | | | |
| HEPATITIS B | | | | |
| VARICELLA | | | CHICKENPOX: | |
| HEPATITIS A | | | | |
| PNEUMOCOCCAL | | | | |
| ROTAVIRUS | | | | |
| INFLUENZA | | | | |
| MENINGOCOCCAL | | | | |

**Are Immunizations Up To Date?** ☐ **YES** **OR** ☐ **NO**

- **IF Immunizations Are Not Up To Date, WHY?**
  - ☐ **Medically Contraindicated**
  - ☐ **Not appropriate for the Age of the Child**
  - ☐ **Parent/Guardian declined for reason of conscience, including Religious convictions (Parents must sign waiver from school)**

## CAUSE OF DEVELOPMENTAL DISABILITY IF KNOWN:

How can the school assist with special programs, placement, or attention?

_____

_____

_____

## PAST HISTORY:

CHRONIC MEDICAL CONDITION: _____

(Diagnoses) _____

_____

ALLERGIES: _____

(Food/Medications) _____

_____

**SEIZURES: TYPE** _____

(SEIZURE ACTION PLAN)

**DESCRIPTION:** _____

_____

**SURGERIES:** _____

_____

**CURRENT LIST OF MEDICATIONS:**

| Name of Medication | Dosage | Purpose |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**PHYSICAL RESTRICTIONS, IF ANY:**

_____

_____

_____

**DIETARY RESTRICTIONS, IF ANY:**

_____

_____

_____

**G TUBE**

- ❑ YES
- ❑ NO

***I certify that this individual is free from apparent communicable disease and is in suitable condition to attend a preschool/school/adult program based on his/her medical history and physical condition at the time of this examination.***

_____
**Physician's Signature**

_____
Date

_____
Phone Number

_____
Physician's Name (Please Print or Type)

_____
Address

_____
City, State, Zip Code

Revised 6/2019

# *DENTAL/ORAL HEALTH REPORT*

*Student's Name* _____

*Date* _____

*Comments* _____

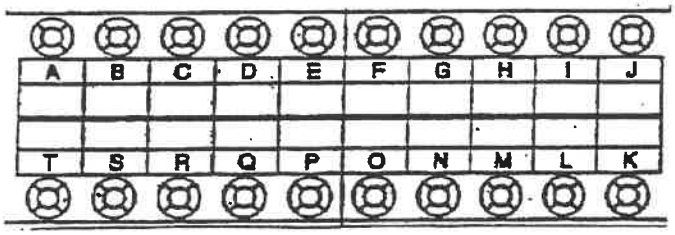
_____

_____

_____

_____

_____




*Dentist Signature* _____

*Dentist Printed Name* _____

*Office Name* _____

*Office Address* _____

*Office Phone Number* _____

*Return to:*
*Simon Kenton School*
*705 N. Ida Street*
*Kenton, OH 43326*
*Phone – 419-674-4158*
*Fax – 419-675-3274*

# Ohio Department of Health
# Eye Specialist Report

## School Screening Information

| Child's Name | Date of Referral |
|---|---|
| School | Grade |
| Reason for referral (test failed or type of symptom) | |
| School Screening visual acuity **without glasses** R_____ L_____ **with glasses** R_____ L_____ | |

## Eye Specialist

| Distance Visual Acuity **without correction** R_____ L_____ **with current prescription** R_____ L_____ **with new prescription** R_____ L_____ |
|---|
| Summary of vision problems and diagnosis |
| Recommendations |
| Additional instructions for teacher |

| Is further treatment necessary? ☐ Yes ☐ No<br>If yes, specify | I wish to see the child again. ☐ Yes ☐ No<br>If yes, when? |
|---|---|

## Please return form to

Dawn Shepherd RN
Simon Kenton School
705 N. Ida St.
Kenton, Ohio 43326
(fax) 419-675-3274

## From

| Eye Specialist | | |
|---|---|---|
| Address | | |
| City | State | ZIP |
| Date | | |

**SIMON KENTON SCHOOL**
**EMERGENCY MEDICAL AUTHORIZATION/INFORMATION**

Date _____ Student's Name _____

Date of Birth _____

Street Address, City, Zip Code _____

Name of Student's Parents/Guardians _____

Home Telephone Number _____

Email Address _____

Parents/Guardians Cell Numbers (Mom's)_____ (Dad's) _____
(Circle the phone number you prefer we contact first.) Accept Text _____Yes_____No

Parents/Guardians Place of Employment (Mom's) _____Work Number _____
(Can you be reached here? Yes ___ No ____) (Ext. # _____)

Parents/Guardians Place of Employment (Dad's) _____ Work Number _____
(Can you be reached here? Yes ___ No ____) (Ext. # _____)

May individual's name or photo appear in news releases or on our website? _____ Yes _____ No

May individual's picture (no name) appear on Facebook? _____ Yes _____ No

Facts concerning individual's medical history that the physician should be alerted to:

Any kind of allergies? _____

Specific Medical Problems: _____

Medications (include non-prescription medication and dosages):

_____

Does your child have tubes in his/her ears? _____ No left ear _____ right ear _____ both _____

There may be times when we need to contact you because of illness or some other reason. In the event that we cannot reach you, please provide us with the names and phone numbers of two (2) people we can contact.

Name _____ Phone _____

Name _____ Phone _____

OVER

Does the individual have a current "Do Not Resuscitate" order _____ Yes _____ No
(If so, please attach a copy to this form)

Medicaid Number: _____

Name of Local Physician: _____

Address: _____ Office Phone: _____

Name of Local Dentist: _____

Address: _____ Office Phone: _____

**PART I OR II MUST BE COMPLETED**

**PART I**

In the event that _____ (individual) experiences a life-threatening injury at Simon Kenton School, I acknowledge that he/she will be transported immediately to Hardin Memorial Hospital (or nearest hospital) and efforts will be made to contact me immediately.

Further, I acknowledge that should _____(individual) experience an injury that requires medical attention that is not life-threatening, all efforts will be made to notify me immediately. If I, or someone else, can not get to Simon Kenton School within 15 minutes of the accident, Simon Kenton School will ensure that the individual is transported to Hardin Memorial Hospital (or to nearest hospital).

In the event that reasonable attempts have been made to contact us (parents) at the above telephone numbers but are unsuccessful, I hereby give consent to:

Dr._____ (preferred doctor)

Dr._____ (preferred dentist)

Or in the event the designated preferred practitioner is not available, another licensed physician or dentist may administer the necessary treatment to the individual.

_____
Signature of Parent/Guardian/Individual

**PART II**

In the event of illness or injury requiring emergency treatment I authorize Simon Kenton School to take no action or to:

_____

_____
Signature of Parent/Guardian/Individual

Revised: April 23, 2013

**SIMON KENTON SCHOOL**
**705 N. IDA STREET KENTON, OH 43326**
**(419) 674-4158 FAX (419) 675-3274**

# PARENT/GUARDIAN AUTHORIZATION TO ADMINISTER NON-PRESCRIPTION MEDICATION

I request and give my permission to the facility nurse or other certified and authorized personnel to administer the following non-prescription medication to my child.

Name of Student: _____ Date: _____
Birthdate: _____

## NON-PRESCRIPTION, NON-ASPIRIN PAIN RELIEVER

1. Type of non-prescription, non-aspirin pain reliever: _____
2. Amount each dose: _____
3. Frequency each dose (ex. every four hours): _____
4. This medication may be administered four consecutive days at any one time.

## NON-PRESCRIPTION ANTACID

1. Type of non-prescription antacid: _____
2. Amount each dose: _____
3. Frequency each dose (ex. every four hours): _____
4. This medication may be administered fourteen consecutive days at any one time.

## NON-PRESCRIPTION DIAPER RASH OINTMENT

1. Type of non-prescription diaper rash ointment: _____
2. Amount of each dose: _____
3. To be administered after each diaper change.
4. This medication may be administered fourteen consecutive days at any one time.

## NON-PRESCRIPTION SUNSCREEN

1. Type of non-prescription sunscreen _____
2. Amount of each _____
3. To be administered before sun exposure _____

**Over**

I agree to:

1. Allow the medication to be administered at the discretion of the facility nurse as needed.
2. Send the non-prescription medication in the original labeled container.
3. Notify the facility nurse of changes in medications.
4. Notify the facility nurse of changes in physicians.

I am aware that the facility nurse has the right and responsibility to check with the physician regarding the administration of any medication when in the best judgement it is prudent to do so.

Medications are to be administered beginning _____ (date) and ending _____ (date).

_____ _____

Parent/Guardian Signature Date

**Simon Kenton School**
**705 N. Ida Street Kenton, OH 43326**
**(419) 674-4158 FAX (419) 675-3274**

## PRESCRIPTION AUTHORIZATION FORM

Dear Physician:

In order for prescribed medications to be administered to children enrolled in our program, it is necessary to have an authorization for such drugs on file. To avoid errors, we are requesting the following information for all drugs prescribed.

Sincerely yours,

Dawn Shepherd RN

Health Services Coordinator

**********

Name of Student _____ Date _____

Address of Student _____

Medication Dosage Route Administration Time

_____

Possible side effects: _____

Special instructions regarding handling, administration or storage of medication:

_____

Medication(s) to be administered beginning _____ (date) and ending _____ (date).

This form is valid for one program year.

The medications listed above have been prescribed by me for the above mentioned individual and are to be administered according to prescription directions when the individual is in attendance at programs operated by the Hardin County Board of Developmental Disabilities.

Name of Physician _____

Address/Office Phone Number _____

Signature of Physician _____

Revised 6/20/2018

Over →

## PARENTS/GUARDIANS REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SIMON KENTON PERSONNEL

I request and give my permission to the facility nurse or other certified and authorized personnel to administer ordered medication to my child.

I agree to:

1. Send in current medications in its original container with a label containing the child's name and written instructions for use from a licensed physician or nurse practitioner.

2. Notify the facility nurse of changes in physicians.

3. Notify the facility nurse of changes in medication, dose, or administration.

I am aware that the facility nurse has the right and responsibility to check with the physician regarding the administration of any medication when in the best judgement it is prudent to do so.

_____ _____

Parent/Guardian Signature Date

Revised 6/20/2018

**HARDIN COUNTY BOARD OF**
**DEVELOPMENTAL DISABILITIES**

Dear Parents,

Each year we put together a roster of each child enrolled in our program, their address, phone number and parent's names. This roster is made available upon request to other parents with children in the program and only to those parents.

We need your permission to include this information on the roster.

Please complete the form below and return it the first day your child attends school.

Sincerely,

Kara Brown
Superintendent

Student's Name: _____

Parent's/Guardian's Names: Mother _____

Father _____

Check all appropriate items:

_____ I give my permission for my name, my child's name, my address and phone number to be listed on the roster which is made available, upon request, to other parents in the program and only available to those parents. This permission will expire at the end of the current school year.

_____ I choose not to be included on this roster.

_____ Please send me a completed roster.

_____ _____

Parent's Signature Date

Revised 2/7/17

**SIMON KENTON SCHOOL**
**705 North Ida Street Kenton, OH 43326**
**(419) 674-4158 Fax (419) 675-3274**

## PROCEDURE AUTHORIZATION FORM

Dear Physician;

In order for prescribed procedures to be administered to children enrolled in our program, it is necessary to have an authorization for such on file.

To avoid errors, we are requesting the following information for all procedures prescribed.

Sincerely,

Dawn Shepherd, RN
Health Services Co-ordinator

Name of Student_____ Date_____

Address of Student_____

Procedure:_____
_____
_____

Possible side effects:_____
_____
_____

Special instructions regarding administration:_____
_____

Procedure to be administered beginning_____(date) and ending_____(date). This form is valid for one program year.

The procedure listed above has been described by me for the above mentioned individual and are to be administered according to prescription directions when the individual is in attendance at programs operated by the Hardin County Board of Developmental Disabilities.

Name of Physican_____
Address_____
Office Phone Number_____
Signature of Physican_____

**OVER PLEASE**

# PARENT/GUARDIAN AUTHORIZATION FOR SPECIALIZED HEALTH CARE

We (I) the undersigned, who are the parents/guardians of

Name_____ Birhtdate_____

Request that the following health care service(s)_____

_____

be administered to our child. We understand that the facility nurse or certified and authorized personnel will be performing the above-mentioned health care service. It is our understanding that in performing this service, the designated person(s) will be using standardized procedures which has been approved by our physician.

We will notify the school immediately if the health status of _____ changes, we change physicians, or there is a change or cancellation of the procedure.

Parent/Guardian_____

Date_____

# Diet Prescription For Foods at Hardin County Board of Developmental Disabilities

Name of student for whom special diet has been recommended:

_____

Disability or medical condition that requires the enrollee to have a special diet.

_____

Diet Prescription (Check all that apply.)

☐ Diabetic ☐ Reduced Calorie

☐ Increased Calorie ☐ Modified Texture

☐ Other (DESCRIBE) _____

FOODS OMITTED AND SUBSTITUTIONS (Please check food groups to be omitted. List specific foods to be omitted and suggest substitutions using the back of this form or attach information).

☐ Meat and Meat Alternates ☐ Milk and Milk Products

☐ Bread and Cereal Products ☐ Fruits and Vegetables

Textures Allowed (Check the allowed texture.)

☐ REGULAR ☐ CHOPPED ☐ GROUND ☐ PUREED

Other Information Regarding Diet or Feeding (Please provide additional information on the back of this form or attach to this form.)

I certify that the above named student needs special diet prepared as described above because of the students disability or chronic medical condition.

_____ _____ _____

Physician/Recognized Medical Authority Signature Office Phone Number Date

# Simon Kenton School Transportation Department

## Transportation Request

Date of Request _____ Start Date _____

Student Name _____ Birthdate _____

Parents/Guardians Names _____

Address _____

Home Phone # _____ Cell # _____

Emergency Contact Name and Phone #

_____

**IF THIS FORM IS FOR FIELD TRIPS ONLY CHECK HERE ____ AND STOP**

Classroom Teacher _____

For Preschool (please circle) AM or PM Class

Does your child require any special assistance on the bus? _____

If yes, please explain _____

Does your child have any medical, physical, or behavior concerns that will need to be addressed on the bus? _____

If yes, please explain _____

If your child will be picked up/dropped off **daily** at an address other than home, (Example- babysitter, grandparent, etc.) Please fill in below.

Name of person _____

Address _____

Phone # _____

**Please Note: We may ask for Photo Identification from anyone who gets your child off the bus, and they must be listed on the child release form.**

We can only accommodate one address for pick up/drop off.

Times of pick up/drop off will be according to the route schedules. You will be notified of your pick up/drop off times.

**If there is a change in address for pick up/drop off, transportation needs to be notified at least 3 days in advance to make accommodations.**

## *HARDIN COUNTY BOARD OF DEVELOPMENTAL DISABILITIES*

## *CHILD RELEASE PERMISSION*

In order to ensure the safety and well-being of your child, we are asking you provide us with the names of persons who are authorized to **pick up your child from the school or that can assist with your child off the bus.**

Everyone's name that appears on the list will be allowed to pick up your child at the end of the day or during the day when unique circumstances exist.

Other than the parents/guardians signing the bottom of this form, your child will not be released to anyone whose name is not on the list unless we receive a written note specifically authorizing someone else to pick up your child. There will be no exceptions to this policy. Identification may be required.

In the event that an unauthorized individual attempts to pick up your child, you will be contacted immediately.

| **Names of Authorized Persons** | **Relationship to Child** |
|---|---|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |
| 5. _____ | _____ |
| 6. _____ | _____ |

_____
Student's Name

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Parent/Guardian Date

Revised 4/17/19

HARDIN COUNTY BOARD OF DEVELOPMENTAL DISABILITIES
SIMON KENTON SCHOOL
2020-2021 CALENDAR

| | |
|---|---|
| July 1, 2020 | First Day of FY 2020 and Program Calendar for all Staff |
| July 3, 2020 | Recognition of Independence Day, Staff Holiday, Program Closed |
| August 17- 19, 2020 | Calamity Days Work in Classrooms |
| August 20-21, 2020 | Training/Work Days for all Staff |
| August 24, 2020 | First Day of School for School Age Students and Preschool Students on IEP's |
| August 31, 2020 | First Day of School for Typically Developing Preschool Students |
| September 7, 2020 | Labor Day Observed, Staff Holiday, Program Closed |
| September 18, 2020 | Professional Development for Staff, No School for Students |
| October 9, 2020 | Professional Development for Staff - No School for Students |
| October 12, 2020 | Columbus Day Observed, Staff Holiday, Program Closed |
| October 23, 2020 | Professional Development for Staff and Parent/Teacher Conference Day, No School for Students |
| November 11, 2020 | Veteran's Day Observed, Staff Holiday, Program Closed |
| November 20, 2020 | Professional Development for Staff, No School for Students |
| November 25-27, 2020 | Thanksgiving Observed, Staff Holiday, Program Closed |
| December 21-31, 2020 | Winter Break, Program Closed |

HARDIN COUNTY BOARD OF DEVELOPMENTAL DISABILITIES
SIMON KENTON SCHOOL
2020-2021 CALENDAR

| | |
|---|---|
| January 1, 2021 | New Year's Day Observed, Staff Holiday, Program Closed |
| January 4, 2021 | School Re-Opens for Students |
| January 18, 2021 | Martin Luther King, Jr. Day, Staff Holiday, Program Closed |
| February 5, 2021 | Professional Development for Staff, No School for Students |
| February 15, 2021 | President's Day, Staff Holiday, Program Closed |
| March 10 & 11, 2021 | No Preschool Classes, Closed for Typical Screening |
| April 1, 2021 | Parent/Teacher Conference Day- No School for Students<br>** Delegated Nursing Training for Certified Staff** |
| April 2 -5, 2021 | Spring Break, Program Closed |
| May 6, 2021 | No Preschool Classes, Closed for Parent Teacher Conferences |
| May 28, 2021 | Last Day of School |
| May 31, 2021 | Memorial Day, Staff Holiday, Program Closed |
| June 30, 2021 | Last Day of Fiscal Year |

# HARDIN COUNTY BOARD OF DEVELOPMENTAL DISABILITIES
# SIMON KENTON SCHOOL
# 2020-2021 CALENDAR

TOTALS

| | Hours in Session for School Age |
|---|---|
| Instructional Days/Hours | 1,124.5 hours |
| Parent/Teacher Conferences | 2 days |
| In-service Days | 2 days |
| Professional Development for Staff | 4 days |

| | Hours in Session for Preschool |
|---|---|
| Instructional Days/Hours | 446.16 hours |
| Parent/Teacher Conferences | 2 days |
| In-service Days | 2 days |

Make up days-
To be determined by the Superintendent

End of 1st Quarter: October 16, 2020
Progress Reports Due: October 26, 2020
End of 2nd Quarter: January 8, 2021
Progress Reports Due: January 18, 202
End of 3rd Quarter: March 12, 2021
Progress Reports Due: March 19, 2021
End of 4th Qtr./Progress Reports Due: May 21, 2021

Dear Parents/Staff Members,

Keeping you informed is a top priority at Simon Kenton School. That's why this year we again will offer the One Call Now notification service which will allow us to send a phone message to you providing important information about school events or emergencies. We anticipate using One Call Now to notify you of school delays, early dismissals, and cancellations due to inclement weather, as well as remind you about various events throughout the school year. In the event of an emergency at school, you can have peace of mind knowing you will be informed immediately by phone.

**What you need to know about receiving calls sent through One Call Now**

- Caller ID will display the school's main number (419-674-4158) when announcement is delivered.
- Cancellation and delay messages will be sent out immediately when a decision has been made. **This could be as early at 5:15am.**
- One Call Now will leave a message on any answering machine or voicemail.

The successful delivery of information is dependent upon accurate contact information for each student, so please make certain that we have your most current phone numbers. If this information changes during the year, please let us know immediately.

Please return the form below to the school office and allow up to two days before your number is added to the system. Note that all phone numbers will be dialed simultaneously. Thank you for your cooperation and if you have any questions, please don't hesitate to contact us.

## Please remember that you will not receive calls unless we have received this form.

Please get permission to provide another person's phone number on the list (such as grandparents or daycare providers). Please mark if these numbers will accept a text message. We are striving to be able to text to everyone.

**Student's Name(s)** _____

Phone Number _____ *accept text*_____

Phone Number _____ *accept text*_____

Phone Number _____ *accept text*_____

Phone Number _____ *accept text*_____

Phone Number _____ *accept text*_____

Phone Number _____ *accept text*_____

*Only authorized administrators of the company may activate the system. One Call Now keeps all of its clients' information confidential and secure. All data is password protected on secure servers.*

**HARDIN COUNTY BOARD OF**
**DEVELOPMENTAL DISABILITIES**

Dear Parents,

Each year we put together a roster of each child enrolled in our program, their address, phone number and parent's names. This roster is made available upon request to other parents with children in the program and only to those parents.

We need your permission to include this information on the roster.

Please complete the form below and return it the first day your child attends school.

Sincerely,

Kara Brown
Superintendent

---

Student's Name: _____

Parent's/Guardian's Names: Mother _____

Father _____

Check all appropriate items:

_____ I give my permission for my name, my child's name, my address and phone number to be listed on the roster which is made available, upon request, to other parents in the program and only available to those parents. This permission will expire at the end of the current school year.

_____ I choose not to be included on this roster.

_____ Please send me a completed roster.

_____ _____

Parent's Signature Date

Revised 2/7/17

Ohio Department of Job and Family Services

# FAMILY INFORMATION
# FOR STEP UP TO QUALITY PROGRAMS (SUTQ)

| Child's Name *(Last)* | *(First)* | Nickname *(If any)* |
|---|---|---|
| | | |

*By providing complete information about your child, you will be assisting staff in creating a positive experience for him/her while in care. List any information about your child's habits, abilities or personality that you feel will be helpful to the staff while caring for your child.*

Who is in the child's immediate family?

Who lives at home with your child?

What is the primary language spoken in your child's home?

Are there any special family arrangements, such as shared parenting, living in two homes, or custody specifications, etc.? Additional Details?

Are there any changes or transitions that your child has recently experienced or is experiencing? (moved from crib to bed, divorce, new home, death of family member, friend or pet) Additional Details?

Are there any cultural or religious practices of your family we should be aware of? (Dietary restrictions, clothing, head coverings, etc.)

Do you have any pets at home? If so, what are they and what are their names?

Has your child had a previous care arrangement? ☐ Yes or ☐ No Additional Details? (Center based, in home, with family, with parents, etc.)

My child drinks ☐ milk, ☐ formula, ☐ juice or ☐ water. *(Check all that apply)*
How much and how often?

Does your child have any favorite foods?

Does your child dislike any foods?

Are there any foods your child should not be fed? (Licensing requires documentation be completed for children with food allergies and/or dietary restrictions)

Please check all of the words that best describe your child's personality and behavior

☐ active ☐ adventurous ☐ affectionate ☐ anxious ☐ bossy ☐ bright ☐ busy ☐ calm ☐ cautious ☐ cheerful
☐ content ☐ creative ☐ curious ☐ easily-angered ☐ emotional ☐ energetic ☐ excitable ☐ friendly ☐ gives-in-easily
☐ happy ☐ hesitant ☐ insecure ☐ jealous ☐ likes structure/routines ☐ loud ☐ loving ☐ mellow ☐ outgoing
☐ prefers adult attention ☐ quiet ☐ sensitive ☐ serious ☐ shares-well ☐ social ☐ spontaneous ☐ stubborn ☐ tentative
☐ other:

Are there additional personality and behavior characteristics that would be useful to know about your child?

Are there things that frighten your child? If so, how does he/she react and what do you do to comfort him/her?

What routines/actions or items do you use to comfort your child?

What causes your child to feel angry or frustrated?

What methods do you use to respond to your child's negative behavior?

Does your child use any special comfort or support items that help him/her go to sleep? If so, what?

What is your child's mood upon waking? (happy, grouchy, clingy, slow to awaken)?

My child sits in a ☐ high chair, ☐ booster, ☐ child size chair or ☐ adult size chair. *(Check the one that applies.)*

Is your child toilet trained? If not, have you started the toilet training process? Please explain the process used.

Does your child need assistance when using the toilet? If so, how?

What words, gestures or signs does your child use if he/she needs to use the bathroom?

What time does your child normally go to bed at night and wake up in the morning?

What time(s), and for how long, does your child usually nap?

| |
|---|
| Does your child have trouble sleeping (Night terrors, trouble going to sleep, etc.)? Please explain. |
| What might you and/or your child be anxious about as he/she starts in this program? |
| What are you and/or your child excited about as he/she starts in this program? |
| What are your expectations of this program? |
| What other information would be helpful for the staff caring for your child to know? |

| | |
|---|---|
| Parent/Guardian's Signature | Date |

## Resources

**Ohio Department of Education Website**
education.ohio.gov/McKinneyVento

**LAU Resource Center for English Learners**
education.ohio.gov/LAU • (614) 466-4109 • lau@education.ohio.gov

**National Center for Homeless Education (NCHE) – Improving Learning through Research and Development**
nche.ed.gov/index.php

**School House Connection**
schoolhouseconnection.org/about-schoolhouse-connection

**National Law Center on Homelessness and Poverty**
nlchp.org

**Runaway and Homeless Youth**
acf.hhs.gov/fysb/programs/runaway-homeless-youth

**Coalition of Homelessness and Housing (COHHIO)**
cohhio.org • (614) 280-1984

**National Association for the Education of Homeless Children and Youth (NAEHCY)**
naehcy.org • (866) 862-2562

**National Law Center on Homelessness and Poverty**
nlchp.org • (202) 638-2535

**SERVE Improving Learning through Research and Development**
center.serve.org/nche • (800) 308-2145 (toll-free)

## State Homeless Liaison

**Susannah Wayland**
Ohio Department of Education
Center for Accountability and Continuous Improvement
Office of Federal Programs
25 S. Front St., Mail Stop 404,
Columbus, OH 43215-4183
Susannah.Wayland@education.ohio.gov

Phone: (614) 387-7725
Fax: (614) 752-1622
Toll-Free: (877) 644-6338

## District Homeless Liaison

Phone:
Email:



August 2017

# A Parent's Guide to the Rights of Children and Youth Experiencing Homelessness

Ohio | Department of Education

## The definition of homelessness

The McKinney-Vento law says that homelessness includes individuals who do not have a fixed, regular and adequate home because they have lost their own home. This means:

- Individuals who have lost their own home, suffering a financial hardship or similar reason;
- Individuals who are sharing the housing of others;
- Individuals who are living in hotels or motels or in campgrounds or trailer parks that are not viewed as year-round homes because they do not have accommodations, such as heat or running water;
- Individuals who are living in emergency shelters or who have been abandoned in hospitals;
- Individuals who are living in cars, parks or public spaces.

## The rights of homeless parents and their homeless students

- Your child may stay in the school he or she was in before becoming homeless or enroll in a school where the child is living for the time being;
- You may make this choice of schools with the best interests of your child in mind;
- Your child must receive the transportation he or she needs;
- You can expect to enroll your child in school without delay, even if you do not have paperwork, such as your child's birth certificate or medical records;
- Your child has the right to receive free meals;
- Your child must receive the same special programs and services that other children receive, including special education, migrant education and vocational education;
- Your child must receive the same public education other children receive, including preschool.
- Your child cannot be separated from other students in a different school or different program because he or she is homeless;
- Your child may attend the school you choose, even if there is a dispute while the dispute is in the appeal process;
- After being placed in permanent housing, your child may stay in his or her original school for the rest of the school year and receive transportation to that school. This will provide stability for your child.

## To help your student have stability, you can:

- Keep in touch with the school district's local contact person to update this person on changes that may occur with the child;
- Inform district contacts when you foresee a change in student's transportation needs;
- Make sure your student is going to school regularly;
- Ask the district contact person about help available in the community;
- Ask for more support for your child's education, if needed. This includes school supplies and support in learning, such as tutoring.

## Your district contact person can help you:

- Understand your rights;
- Make a choice between schools;
- Get school records sent to another school;
- Get birth certificates and vaccination records
- Get information about help in the community, such as health, dental and mental health care and other services;
- Make sure your student has the needed academic support;
- Refer your student for early education services, including Head Start and intervention services;
- Connect your student with after-school programs and activities;
- Represent your needs as an unaccompanied youth; and
- Manage disputes about whether you or your child qualify for these services.

Ohio | Department of Education

August 2017