

Simon Kenton Consent Form

Child's Name: _____
School District of Residence: _____

Date of Birth: _____
Teacher's Name: _____

Please note: All information must be completed in its entirety before your child begins preschool.

Biographical Information

The Ohio Legislature has required all school districts to gather the following data as part of the statewide Education Management Information System (EMIS)

Citizen Status (Please circle one): 1. US Citizen 2. Exchange Student: _____ (country) 3. Other/Noncitizen

USDOE Race/Ethnicity Reporting: Race Detail: (if you mark *Multiracial*, please mark *ALL* that apply)

- White Asian/Pacific Islands Black/Non-Hispanic Hispanic/ Latino Multiracial
 Asian American Indian/Alaskan Native Native Hawaiian/other Pacific Island

NOTE: When the parent or guardian refuses to provide their child's racial group, the district shall use observer identification. This designation is required to be communicated to the parent or guardian by the district prior to designation.

Education History

Has your child attended a school or daycare previously? Yes No

If so, where? _____

Has your child received any of the following (please circle all that apply)?

- Speech Language Therapy Occupational Therapy Physical Therapy Vision Therapy
Early Intervention/Help Me Grow Services Play Therapy Other: _____

Videos and Pictures

We would like to take videos and pictures of various activities the children are doing in our classroom. **Please mark your decision below and then at the end of the packet you will sign and date. Thank You!**

- I give my permission for my child to be interviewed, identified, photographed or videotaped, while attending Simon Kenton school. I understand that these photos and videos may be used by the Hardin County Board of Developmental Disabilities or WestCON's publications, in the classroom, for newspaper publicity, documentation panels, social media (Facebook, etc.) and for parent and educator training sessions.
- I do not give my permission for my child to be interviewed, identified, photographed or videotaped, while attending Preschool.

Parent Roster

In accordance with ORC 3301-37-04, a parent roster is created annually for each group of children with parent/guardian contact information. If you would like to be included in this roster, please indicate what information you would like shared:

Child's Name: _____
Parent/Guardian Name: _____ Phone Number: _____

One Call Now

Simon Kenton School uses One Call Now to notify families of school delays, early dismissals, school closings, as well as reminders of events. This is an automated system that calls and/or text families at the same time.

- Please add my phone number to the One Call system. I agree to receive phone calls and text alerts.
- Please add the following individuals who give permission to receive phone calls and text alerts
- o Name: _____ Phone Number: _____
 - o Name: _____ Phone Number: _____

OVER



Transportation

Bus transportation is available to and from school for children with Individualized Education Plans (IEP). Transportation of peer models is based on availability. Additional transportation paperwork is required for children riding the bus.

To School

- I wish for my child to ride the bus to school
- I will provide transportation to school for my child

From School

- I wish for my child to ride the bus home from school
- I will provide transportation home from school for my child

Assessments & Evaluations

- I understand that my child will complete assessments and evaluations that will be given while attending school. I understand that these assessments and evaluations could be reported to the State of Ohio for data purposes. I also understand that only my child’s results will be reported.
- I understand that multiple school staff members, including related service members (Speech Language Pathologist, Occupational Therapist, Physical Therapist etc) will work with my child. These individuals may assist with developmental screenings as well as directly engaging in developmental activities with them.

Non-Prescription Medication Authorization

By completing the section below, you are requesting and giving permission for the school nurse or other certified and authorized personnel to administer the following non-prescription medication to your child.

Non-prescription, non-aspirin pain reliever

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

I agree to (please check all for full consents to be granted)

- Allow the medication to be administered at the discretion of the nurse as needed.
- Send the non-prescription medication in the original labeled container.
- Notify the nurse of any changes in medications.
- Notify the nurse of changes in physicians.
- I understand the nurse has the right and responsibility to check with the physician regarding the administration of any medication.

Medications are to be administered beginning _____ (date) and ending _____ (date). If dates are not provided, the range will be the current school year.

Parent/Guardian Signature

By signing and dating below you are acknowledging that the information you provided in each section of this registration packet to be valid. You also acknowledge permission or denial depending on your selection in certain sections. (Videos and Pictures, Parent Roster, One Call Now, Transportation, Assessments & Evaluations, Non-Prescription Medication Authorization)

Parent/Guardian Signature

Date

Child's Name: _____

List of Persons Not to Release Child To (if applicable):

Parent/Guardian Signature

Date

Child's Name: _____

PART I OR II MUST BE COMPLETED
(See Reverse Side)

PART I: TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

Physician _____ Phone (_____) _____

Dentist _____ Phone (_____) _____

Medical Specialist _____ Phone (_____) _____

Local Hospital _____ Phone (_____) _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for **(1)** the administration of any treatment deemed necessary by above-named doctors, **or**, in the event the designed preferred practitioner is not available, by another licensed physician or dentist; and **(2)** the transfer of the child to any hospital reasonable accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Medical Information

History of complications during pre-natal development or birth:

History of diseases/allergies/severe illness or medical diagnosis:

History of operations:

History of hospitalizations:

Allergies:

Medication currently being taken:

Dosage:

Reason Taken:

Physical conditions to which a medical caregiver should be alerted:

Date: _____

Signature of Parent/Guardian: _____

Child's Name: _____

PART II: REFUSAL TO CONSENT *(do not complete if completing Part I)*

I do **NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

Date _____

Signature of Parent/Guardian: _____

Student Medical Report for Hardin County Board of DD

As required by Rules 5101:2-12-37 and 5101-2-13-37, the child must be examined within twelve months prior to admission.

Student Information:

Name of student: _____ Date of Birth: _____
Gender: Male Female Height: _____ Weight: _____
BP: _____ RR: _____ HR: _____ Pulse Ox: _____ Temp: _____

Vision:

Within Normal Limits Wears Glasses Specific Concerns: _____

Hearing:

Within Normal Limits Wears Glasses Specific Concerns: _____

Dental:

No concerns noted Referred to Dentist (reasons): _____

General Medical Information:

Please indicate if areas noted are typical or abnormalities are present.

General Appearance: _____
Nutritional Status: _____
Head: _____
Neck: _____
Chest: _____
Heart: _____
Abdomen: _____
Lungs: _____
Genitalia: _____
Extremities: _____
Back: _____
Neurological: _____
Orthopedic: _____

Restrictions:

Physical: _____
Dietary: _____

Medical History

Chronic medial conditions/Diagnoses: _____
Allergies (Food/Medication): _____
Seizures (Type/Action Plan): _____
Surgeries: _____

Hemoglobin and Lead (REQUIRED)

Hematocrit Level: _____ Lead Level: _____

Immunizations

	Date	Date	Date	Date
DT/DTaP				
Polio				
MMR				
HIB				
Hepatitis B				
Varicella				
Hepatitis A				
Pneumococcal				
Rotavirus				
Influenza				
Meningococcal				
Chickenpox				

Are immunizations up-to-date? Yes No

If no, please provide reason:

Medically contraindicated Parent/Guardian declined for reason of conscience, including religious convictions

Current Medications:

Name of Medication	Dosage	Purpose

Certifications:

Based on the medical history and physical condition at the time of this examination, the child is free from apparent communicable disease and has received immunizations required under Section 3313.671 of the Ohio Revised Code and is in suitable condition for enrollment in a childcare facility.

Physician's Signature: _____ **Date of Exam:** _____

Physician's Name: _____ **Phone Number:** _____

Address: _____

OHIO DEPARTMENT OF EDUCATION
DIVISION OF **EARLY CHILDHOOD** EDUCATION

DENTAL FORM

Name of Child <input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of Birth	
Child's Current Age	
Parent(s)/Guardian(s) Name	

1. Is the child now receiving any of the following? If YES, include length of time receiving fluoride.

Topical fluoride application No Unknown Yes
 Fluoridated water No Unknown Yes
 Fluoride supplement diet No Unknown Yes
 Tablets Liquid

2. Does the child have any of the following? If YES, provide details.

Allergies Yes No
 Asthma Yes No
 Bleeding Yes No
 Diabetes Yes No
 Epilepsy Yes No
 Heart/vascular disease Yes No
 Liver disease Yes No
 Rheumatic fever Yes No
 Sickle cell disease Yes No
 Other (Please list.) _____

3. Does the child have any trouble with teeth, gums, or mouth? Yes No

If so, what kind? _____

4. Child has previously seen a dentist? Yes No

Dentist's Name _____ Date of last visit _____

5. Child is under a physician's care? Yes No

Physician's Name _____

6. Child is receiving medication? Yes No

7. PLEASE PROVIDE A **WRITTEN SUMMARY OF SERVICES REQUIRED** (on the back of this form):

- for the relief of pain or infection
- restoration and/or pulp therapy of decayed primary and permanent teeth
- extraction of non-restorable teeth
- dental prophylaxis and instruction in self-care oral hygiene procedures

Dentist's Name (Print)			
Dentist's Signature			
Complete Address			
Phone			Date of Current Visit:
License No.	Tax ID No.		

This is a **SAMPLE FORM** provided by the Ohio Department of Education that may be used to comply with the Head Start Performance Standards regarding dental examination and data (45 CFR 1304.3-3,4,5). The annual dental exam by a dentist is an oral diagnostic procedure which should include radiographs (x-rays) only if the dentist determines that they are absolutely necessary. This should be completed within 90 days of the child's entrance into the program. Developmental dental history should be part of health screening completed within 45 days of entrance.

Completed forms may be faxed to 419-675-3274 or emailed to dshepherd@hardindd.org

Eye Specialist Report

(* Return completed report to school health clinic or nurse)

Hardin County Board of Developmental Disabilities

Fax: 419-675-3274 **Email: DShepherd@hardindd.org

School Screening Information

Child's Name: _____	Date of Birth: _____
School: _____	Grade: _____
Reason for referral	
<input type="checkbox"/> School recommendation for all students	<input type="checkbox"/> Unable to screen
<input type="checkbox"/> Failed Distance Visual Acuity: <input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/> Failed Stereopsis
Circle screener used (Sloan Chart, LEA Symbols Chart 5 or 10 feet, JAEB Screener JVAS) (PASS 2 or Random Dot E)	

Eye Specialist Findings

Data of Exam: _____	without correction	with current prescription	with new prescription
<input type="checkbox"/> Normal	R _____ L _____	R _____ L _____	R _____ L _____
Summary of vision problem & diagnosis			
<input type="checkbox"/> Hyperopia: Indicate eye? _____	<input type="checkbox"/> Myopia: Indicate eye? _____		
<input type="checkbox"/> Amblyopia: Indicate eye? _____	<input type="checkbox"/> Strabismus: Indicate eye? _____		
<input type="checkbox"/> Esotropia: Indicate eye? _____	<input type="checkbox"/> Astigmatism: Indicate eye? _____		
<input type="checkbox"/> Exotropia: Indicate eye? _____			
<input type="checkbox"/> Other: Explain _____			
Recommendations & Treatment			
Glasses Prescribed: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Constant Wear <input type="checkbox"/> Near vision only <input type="checkbox"/> Far vision only <input type="checkbox"/> May remove for physical education			
<input type="checkbox"/> Medical /surgical treatment (e.g., patching, Atropine drops, etc.): _____			
<input type="checkbox"/> Contact Lenses _____			
Additional instructions for teachers			
Upon completion of any needed eye care treatment, I expect there will be:			
<input type="checkbox"/> No significant visual problem that may interfere with learning.			
<input type="checkbox"/> Visual problem that may interfere with learning. Explain (see blow): _____			
* <input type="checkbox"/> Preferential seating needed <input type="checkbox"/> Visual aids <input type="checkbox"/> Magnifiers <input type="checkbox"/> Assistive technology <input type="checkbox"/> Lighting conditions <input type="checkbox"/> Other: _____			
Is further treatment necessary? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, specify _____			
Do you wish to see this child again? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, specify _____			

Consent of Parent or Guardian

I agree to release the above information on my child or ward to appropriate school or health authorities.

Parent or Guardian Signature Date

Send completed report by medical professional to:
Dawn Shepherd, RN
Health Services Coordinator
DShepherd@hardindd.org** Fax: 419-675-3274

Eye Specialist Signature

Date

Address

City

State

Zip

Phone Number

This form is intended for the sole use of the intended recipient and may contain privileged, sensitive, or protected health information. If you are not the intended recipient, be advised that the unauthorized use, disclosure, copying, distribution or action taken reliance on the contents of this communication is prohibited.

Diet Prescription For Foods at Hardin County Board of DD

Student Information:

Name of student: _____

Date of Birth: _____

What disability or medical condition does the student have that requires a special diet?

Diet Prescription

Please check all diet needs

Diabetic

Modified texture

Increased calorie

Other (describe)

Reduced calorie

Foods Omitted and Substitutions

Please check all food groups to be omitted.

Meat and Meat Alternatives

Milk and Milk Products

Bread and Cereal Products

Fruits and Vegetables

Please list approved substitutions for those foods that are to be omitted.

Textures Allowed

Please indicate what textures are allowed for the above listed student.

Regular

Ground

Chopped

Pureed

Other Information Regarding Diet or Feeding

Please provide additional information related to any diet or feeding needs.

Certifications

I certify the above-named student needs special diet prepared as described above due to the student's disability or chronic medical condition.

Name of Physician: _____

Phone Number: _____

Physician Signature: _____

Date: _____

Prescription Authorization Form for Hardin County Board of DD

For prescribed medications to be administered to students enrolled in our program, this form is required to be on file. To avoid errors and confusion, all information requested below must be provided.

Student Information:

Name of student: _____ Date of Birth: _____

Address: _____

Prescription Information

Medication	Dose	Route	Time

Possible side effects: _____

Special instructions regarding administration or storage of medication: _____

Medications to be administered beginning _____ (date) and ending (date) _____. This form is valid for one program year.

Certifications

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: _____

Date: _____

Address: _____

Phone Number: _____

Signature of Physician: _____

Parent Guardian Authorization for Administration of Medication

I request and give my permission to the facility nurse or other certified and authorized personnel to administer ordered medications to my child as outlined above. 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 judgment it is prudent to do so

I agree to:

- Send 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.
- Notify the facility nurse of changes in physicians.
- Notify the facility nurse of changes in medication dose or administration.

Parent/Guardian Name: _____

Date: _____

Parent/Guardian Signature: _____

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**

Preschool Only

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

Name of Student: _____ Birthdate: _____
Date: _____

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.

I agree to:

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

I am aware that the 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 Transportation Form

Today's Date _____

Transportation Requested Start Date _____

Student Information

Student Name: _____

Date of Birth: _____

Address: _____

Does your child have an Individualized Education Plan (IEP/Special Education)? Yes No

Classroom Teacher: _____

Session Attending: Morning Afternoon All Day

Guardian Information

Mother/ Guardian Name _____ Phone Number: _____

Father/Guardian Name: _____ Phone Number: _____

Emergency Contact Information (additional emergency contacts listed in SK Emergency Medical Form)

Name: _____

Home/Cell Number: _____

Transportation Request

I would like my child transported by Simon Kenton School during the
 Summer School Year Both

I would like my child *(see note below*)*
 Transported to school by Simon Kenton Bus Home from school by Simon Kenton Bus

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 # _____

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:

****Please note: Transportation for peer models (children not on IEPs), is not guaranteed. If able, we will transport one way. Transportation for children with IEPs is provided both to and from school.**

Transportation Requirement Notes:

-  A photo identification is needed for anyone we release a child to.
-  We can only release to those individuals listed on the release list within the Emergency Medical Authorization.
-  We can only accommodate one address for pick up/drop off.
-  Transportation request and changes in request require at least 3 day written notice.
-  Times of pick up/drop off will be according to the route schedules. You will be notified of your pick up/drop off times.



2 Hour Delays

In the event that Simon Kenton School would be on a 2 hour delay, you will be notified by our One Call Now system, (if you have filled out the form), radio stations (WKTN and WKXA), TV Stations (Channel 6 and 10), and on Facebook (Hardin County Board of Developmental Disabilities and Simon Kenton Preschool closed group).

***Morning Preschool would begin at 10:15 am and end at 12:20 pm

***Afternoon Preschool would begin at 1:10 pm and end at 3:15 pm

If your child rides a bus, transportation will still be provided as usual: however, morning students will be picked up 2 hours later and dropped off 1 hour later, afternoon students would be picked up 1 hour later and dropped off at the normal time.

As always, feel free to contact us with any questions!

Simon Kenton School (419) 674-4158

Transportation (419) 679-8417