Simon Kenton Consent Form

Child's Name: _____ Date of Birth: _____
School District of Residence: _____ 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 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
- Name: _____ Phone Number: _____
- 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: _____

EMERGENCY MEDICAL AUTHORIZATION FORM

Purpose – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached. This form also services as signed consent for the student to be released into the care of anyone listed within this form.

Background Information:

Child's Name: _____ Called Name: _____
First Middle Last

Date of Birth: _____ Gender: _____ Mother's Maiden Name: _____

Birth City: _____ County of Residence: _____

Address: _____
Street City Zip

Parent or Guardian Information:

Please check the box beside the person we should contact first in the event of illness or emergency.

☐ Mother's Name: _____ Home/Cell Number: _____
Address: _____
Work Phone Number: _____ **Primary Email Address:** _____

☐ Father's Name: _____ Home/Cell Number: _____
Address: _____
Work Phone Number: _____ **Primary Email Address:** _____

☐ Guardian's Name: _____ Home/Cell Number: _____
Address: _____
Work Phone Number: _____ **Primary Email Address:** _____

Emergency Contact/Child Release Information

We need to record **at least three (3) ADDITIONAL names** of individuals with *working phone numbers* at *different addresses* to whom we would be able to release your child to or contact in case of an emergency. You may include more than three. Only those listed will be able to pick your child up from school or get them off the bus. Please note, a photo identification is needed as well at pick up.

I, _____, give my permission for my child to be released to the following persons:

1. Name: _____ Home/Cell Number: _____
   Address: _____
2. Name: _____ Home/Cell Number: _____
   Address: _____
3. Name: _____ Home/Cell Number: _____
   Address: _____
4. Name: _____ Home/Cell Number: _____
   Address: _____
5. Name: _____ Home/Cell Number: _____
   Address: _____

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 ____ Male ____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
   - Heat/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

[ ] School recommendation for all students [ ] Unable to screen

[ ] Failed Distance Visual Acuity: ☐ R ☐ L [ ] 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
[ ] Normal	R_____ L_____	R_____ L_____	R_____ L_____

Summary of vision problem & diagnosis

[ ] Hyperopia: Indicate eye? _____ [ ] Myopia: Indicate eye? _____

[ ] Amblyopia: Indicate eye? _____ [ ] Strabismus: Indicate eye? _____

[ ] Esotropia: Indicate eye? _____ [ ] Astigmatism: Indicate eye? _____

[ ] Exotropia: Indicate eye? _____

[ ] Other: Explain _____

Recommendations & Treatment

Glasses Prescribed: [ ] No [ ] Yes ➡ [ ] Constant Wear [ ] Near vision only [ ] Far vision only [ ] May remove for physical education

[ ] Medical /surgical treatment (e.g., patching, Atropine drops, etc.): _____

[ ] Contact Lenses _____

Additional instructions for teachers

Upon completion of any needed eye care treatment, I expect there will be:

[ ] No significant visual problem that may interfere with learning.

[ ] Visual problem that may interfere with learning. Explain (see blow): _____

* [ ] Preferential seating needed [ ] Visual aids [ ] Magnifiers [ ] Assistive technology [ ] Lighting conditions [ ] Other: _____

Is further treatment necessary? [ ] No [ ] Yes If yes, specify _____

Do you wish to see this child again? [ ] No [ ] 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

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
- ☐ Increased calorie
- ☐ Reduced calorie
- ☐ Modified texture
- ☐ Other (describe)

_____

_____

Foods Omitted and Substitutions

Please check all food groups to be omitted.

- ☐ Meat and Meat Alternatives
- ☐ Bread and Cereal Products
- ☐ Milk and Milk 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
- ☐ Chopped
- ☐ Ground
- ☐ 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

School Age 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.

over

NON-PRESCRIPTION SUNSCREEN

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

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.