AUGLAIZE COUNTY EDUCATIONAL SERVICE CENTER

SPECIAL EDUCATION PROGRAM

2019-2020

Auglaize County ESC
1045 Dearbaugh Ave., Suite 2
Wapakoneta, OH 45895
(419) 738-3422

www.auglaizeesc.org

AUGLAIZE COUNTY ESC
EDUCATE SERVE CONNECT

Student Enrollment Packet

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REQUEST FOR THE ADMINISTRATION OF MEDICATION BY AUTHORIZED STAFF MEMBER

I request the medication described below be administered to my student named _____ by an authorized trained staff member. I understand I must submit a revised statement signed by physician if any changes occur during the school year.

1) All medication must be brought to school by parent/guardian.
2) All medication must be received in the original prescription bottle properly labeled by a registered pharmacist as prescribed by law. All medication must be labeled with the student's name, dosage, and medication name.
3) Nonprescription medication (over the counter) will not be administered within the school except with doctor's written orders.

_____ _____
Signature of Parent/Guardian Emergency Phone Number

_____ _____
PRINT Parent/Guardian Name Date

PHYSICIAN'S OR DENTIST'S ORDER FOR PRESCRIPTION MEDICATION

State Law requires the following information when student needs administration of prescription drugs during school. Please have doctor complete and turn into classroom teacher.

Name of Student: _____ is under my care and should receive

Name of Medication: _____

Dosage to be Administered: _____

Medication Administration Start Date: _____ End Date: _____

Times at which the medication is to be administered: _____

Specific instructions for administration: _____

_____

Significant side effects which should be reported: _____

_____

_____ _____ _____

Signature of Physician/Dentist Date Emergency Phone Number

_____

Physician/Dentist name printed

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EMERGENCY PROCEDURE FORM

Student Name: _____ Date of Birth: _____ Gender: M F Grade: _____

Address: _____ Email Address: _____

Mother:_____ Address:_____ Employer: _____

Primary Phone: _____ Secondary Phone: _____

Father: _____ Address: _____ Employer: _____

Primary Phone: _____ Secondary Phone: _____

Guardian: _____ Address: _____ Employer: _____

Primary Phone: _____ Secondary Phone: _____

Child Lives with: ___ Both Parents ___ Mother Only ___ Father Only ___Mother/Stepfather ___Father/Stepmother ___ Guardian Is there a court custody order for this student? _____ If so, who has custody? _____ (Custody papers must be on file in the ACESC main office) [Office Use Only: ___ Custody Papers on File]

Please list the names of all other children (Ages birth to 18) in the family:

Name:_____ Age: _____ Grade: _____ Date of Birth: _____

Name:_____ Age: _____ Grade: _____ Date of Birth: _____

Name:_____ Age: _____ Grade: _____ Date of Birth: _____

Name:_____ Age: _____ Grade: _____ Date of Birth: _____

Name:_____ Age: _____ Grade: _____ Date of Birth: _____

Including yourself, list the names of five adults who you would like us to contact in case of an illness or emergency. The listed people should be able to temporarily care for your child if you cannot be reached. Please list in the order you would like contact made:

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Name: _____ Relationship: _____ Phone Number: _____

Please list facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which the schools should be alerted:
Allergies (bee stings, foods, medications, etc).____

_____

Medications taken at home and at school_____

_____

Physical Impairments_____

Seizures_____
_

Check if your child has the following conditions:

____ Asthma ___Mild ___Moderate ___Severe

____Bleeding disorder (PLEASE EXPLAIN BELOW)

____Has a cast, brace or other supportive or assistive device

____Heart condition (PLEASE EXPLAIN BELOW)

____Central line (Hickman, Groshong, etc) (PLEASE EXPLAIN BELOW)

____Diabetes

____Shunt

____Wears a hearing aid

____Wears corrective lenses (glasses or corrective lenses)

_____Wears prosthesis

_____Other (PLEASE EXPLAIN BELOW)

_____

_____

The space below is provided for you to list any additional information concerning your child's health or medical conditions of which the school staff should be aware:____

_____

Consent for Medical Treatment

I give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment.

Signature of Parent/Guardian_____Date_____

Refusal to Consent for Medical Treatment

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 no action; or to:_____

_____

Signature of Parent/Guardian_____Date_____

Auglaize County Educational Service Center

Districts are required to identify students whose parents or legal guardians have been an active member of the Armed Forces or National Guard at any time throughout the current school year.

Students Name _____

_____ - Active Duty – Student is a dependent of a member of the Active Duty Forces (Army, Navy, Air Force, Marine Corp or Coast Guard

_____ - National Guard – Student is a dependent of a member of the National Guard (Army or Air Force)

_____ - Student is not a dependent of an active member of the Armed Forces or National Guard

Parent/Guardian Printed Name _____

Parent/Guardian Signature _____

Date _____

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RELEASE FORM FOR IEP DIRECTED TRIP FOR COMMUNITY AND RECREATION/LEISURE EXPERIENCE

We give the Special Education classrooms of Auglaize County Educational Service Center permission to transport our child to and from IEP directed community/recreation/leisure experience trips. The list may include, but is not limited to:

Activities relating to their educational plan
- swimming
- bowling
- shopping
- other schools outside the district of attendance
- other schools within the district
- sporting events
- plays, dramas
- errands
- community based work experience

Transportation could include:
- bus
- van

I give my permission for my child to participate in the above mentioned experiences.

Parent signature _____ Phone _____

Date _____ Location of Child's Classroom _____

✸ Note: Designated forms will be sent home for signature prior to date of experience.

Auglaize County Educational Service Center

Photo Release

I give my consent for photographs, video, audio, or electronic images of my student and / or work created by my child; to be used by the Auglaize County Educational Service Center for media publications such as the district website, Facebook and / or community news media

Name of minor (please print) _____

Parent/guardian signature _____ Date _____

I DO NOT give my consent for photographs, video, audio, or electronic images of my student and / or work created by my child; to be used by the Auglaize County Educational Service Center for media publications such as the district website, Facebook and / or community news media

Name of minor (please print) _____

Parent/guardian signature _____ Date _____