AUGLAIZE COUNTY EDUCATIONAL SERVICE CENTER

SPECIAL EDUCATION PROGRAM

2018-19

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

www.auglaizeesc.org

Student Enrollment Packet

AUGLAIZE COUNTY EDUCATIONAL SERVICE CENTER

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 or Dentist Date Emergency Phone Number

PRINT Physician/Dentist name _____

THERE MUST BE WRITTEN NOTIFICATION TO SCHOOL IF ANY INFORMATION CHANGES.

AUGLAIZE COUNTY EDUCATIONAL SERVICE CENTER

EMERGENCY PROCEDURE FORM

Student Name_____ Home Phone_____

Date of Birth_____ E-Mail Address_____

Home Address_____

Custodial Parents_____

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. **Please number in order of who should be called first, second and third.**

_____ _____ _____(Home Work or Cell)

Mother's Name Work Phone Daytime Phone

_____ _____ _____(Home Work or Cell)

Father's Name Work Phone Daytime Phone

To comply with Senate Bill 321, Missing child Legislation, 3313.96 Division B – Ohio Revised Code:

Please provide a comprehensive list of names and telephone numbers of individuals to whom your son or daughter may be released. Please number in order of pickup including Mother and Father above, then family members and other individuals who might be responsible for picking up or dropping off your child.

_____ _____ _____(Home Work or Cell)

Name Relationship Daytime Phone

_____ _____ _____(Home Work or Cell)

Name Relationship Daytime Phone

_____ _____ _____(Home Work or Cell)

Name Relationship Daytime Phone

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

_____ _____

Doctor Phone

_____ _____

Dentist Phone

_____ _____

Medical Specialist (if needed) Phone

_____ _____

Local Hospital Emergency Room Phone

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

Consent to Treatment

I do hereby 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 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_____

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:_____

_____

Auglaize County Educational Service Center

Parent Permission to Display Photographs, Video, or Electronic Images, Artwork and Stories

Student Name _____

_____ - I give consent for photographs, audio, video or electronic images of my students original written material, artwork, or other work created by my child during the course of instruction; to be used by the Auglaize County Educational Service Center for media publications such as the district website, Facebook and /or community news media

_____ - I DO NOT give consent for photographs, audio, video or electronic images of my students original written material, artwork, or other work created by my child during the course of instruction; to be used by the Auglaize County Educational Service Center for media publications such as the district website, Facebook and /or community news media

Parent/Guardian Name Printed _____

Parent/Guardian Signature _____

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 _____

Auglaize County Educational Service Center

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

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.