Auglaize County Educational Service Center

Special Education Program 2022-23

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

Student Enrollment Packet

AUGLAIZE COUNTY ESC
EDUCATE SERVE CONNECT
1045 Dearbaugh Ave., Suite 2 Wapakoneta, OH 45895
419-738-3422 Fax: 419-738-1267
www.auglaizeesc.org

Special Education Program
2022-23 Registration Packet

Emergency Contact Form

Purpose: To enable parents/guardians to authorize the provision of emergency treatment for students who become ill or injured while under school authority; when parents cannot be reached. It is the **parent's responsibility to notify the school of any change in information.** The school does not provide accident/injury insurance. Financial obligations for medical expenses are a parent/student responsibility.

Student Name:_____ **Date of Birth:**_____ □ **Male** □ **Female**
Adress:_____ **City:**_____ **State:**_____ **Zip Code:**_____

Residential Parent/Guardian
Mother/Legal Guardian _____ Contact Number(s)_____
Father/Legal Guardian _____ Contact Number(s) _____

List (3) Emergency Contacts if parents cannot be reached:
1. Name/Relationship/Phone Number: _____
2. Name/Relationship/Phone Number: _____
3. Name/Relationship/Phone Number: _____

Part I *or* Part II must be completed

Part I – Consent of Medical Care

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

_____ _____
Doctor's Name **Address and Phone Number**

_____ _____
Dentist's Name **Address and Phone Number**

_____ _____
Local Hospital **Address and Phone Number**

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 designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the student to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. Facts concerning the student's medical history including allergies, medications being taken, and any physical impairments to which a physician alert:

_____

Signature of Parent/Guardian: _____ **Date:** _____

Part II – Refusal to Consent

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 actions:

_____

Signature of Parent/Guardian: _____ **Date:** _____

AUGLAIZE COUNTY ESC
EDUCATE SERVE CONNECT
1045 Dearbaugh Ave., Suite 2 Wapakoneta, OH 45895
419-738-3422 Fax: 419-738-1267
www.auglaizeesc.org

Special Education Program
2022-23 Registration Packet

Emergency Medical Form

Child's Name: _____ **Birthdate:** _____

Diagnosis/Physical Handicap/Disability _____

Medical Issues: (check issues which apply to your child)

□ Heart □ Diabetes □ Seizures □ Respiratory □ Hearing
□ Vision □ Speech □ Orthopedic □ Behavior □ Other

Please explain: _____

Medical Supports:
Does your child carry any medical supports with (epi-pen, inhaler, food medical reasons, etc.) **YES** or **NO**
If so, how/when does your child transport them?

_____

Medications: Please list all medications routinely given whether at home or school.

Medication _____ Medication _____ Medication _____

Medication _____ Medication _____ Medication _____

Allergies: Please List all allergies to medications, foods, pets, etc.

Allergies _____ Allergies _____ Allergies _____

Allergies _____ Allergies _____ Allergies _____

Special Transportation Needs (as listed on IEP): Harness, Music, Book(s) preferential seating

_____

Special Equipment: Glasses, Braces, Hearing Aids, etc… _____

Any Physical Limitations? (Explain) _____

Special Concerns: (Please explain any concerns)

Can your child get on and off a bus independently? _____

Does your child have difficulty sitting still? _____

Does your child understand what is said to him/her? _____

Can your child express his/her needs and wants? _____

Does your child have any fears or issues riding a bus? _____

Is there anything we need to know to transport your child safely? _____

AUGLAIZE COUNTY ESC
EDUCATE SERVE CONNECT
1045 Dearbaugh Ave., Suite 2 Wapakoneta, OH 45895
419-738-3422 Fax: 419-738-1267
www.auglaizeesc.org

Special Education Program
2022-23 Registration Packet

Emergency Medical Form

Emergency Contacts *(Required of ALL Students)*

Parents: This form is **extremely** important, as we will us this to make contact if your child becomes ill, has been injured, or if we need to contact you immediately. Please **notify** us if contact names/phone numbers change during school year.

A. Please complete the following:

Students Name: _____

Street Adress:	
City/State/Zip:	
City of Birth Place:	
Date of Birth:	

Mother/Legal Guardian Name:	Employer
Street Address:	Address
City/State/Zip:	City/State/Zip
Phone Number:	Phone Number
Cell Phone:	Department

Father/Legal Guardian Name:	Employer
Street Address:	Address
City/State/Zip:	City/State/Zip
Phone Number:	Phone Number
Cell Phone:	Department

B. List the names and relationships of person who have permission to pick your child up from school or meet the child at the bus stop. ***(No one else will be permitted to pick up your child without written permission from you.)***

Name	Relationship to Student	Telephone Number
1.		
2.		
3.		

C. The following people DO NOT have permission to pick up or meet my child:

Name	Relationship to Student	Telephone Number
1.		
2.		
3.		

*** **We must have a copy of a court order to prohibit a parent from interaction with their child.*****

AUGLAIZE COUNTY ESC
EDUCATE SERVE CONNECT
1045 Dearbaugh Ave., Suite 2 Wapakoneta, OH 45895
419-738-3422 Fax: 419-738-1267
www.auglaizeesc.org

Special Education Program
2022-23 Registration Packet

Preferred Contact/Permissions Form

Dear Parents: In order to maximize the school learning experience, it is important that the school and the parents/guardians communicate regularly. In case of an emergency, we will use your emergency contact information, but we also need a convenient method of communication for non-emergency situations and information sharing conversations. Email addresses will only be used for the purpose of communication with parents from the teacher and will be kept confidential. We hope to use email more often to share information with parents during the school year.

Student's Name:_____

Preferred method of contacting during school hours (no emergency)

Yes	No	
		Home Phone Number:
		Cell Phone Number:
		Work Phone Number:

PERMISSION FOR PHOTOGRAPHS/VIDEOTAPING

Photographs or videotapes may be taken of your child with his/her class to use for professional training or for public awareness. Please indicate if we have your permission to use your child's photograph or videotape.

Yes	No	
		I give my permission for photographs or videotapes to be used for professional training.
		I give my permission for photographs or videotapes to be used for community publication including sharing with other families.
		I give my permission for photographs or videotapes to be posted on ACESC website and ACESC Facebook, Twitter, Instagram, and Class DOJO.

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 _____