Do not click "submit form" button above - instead save form and email it to your coordinator as an attachment

17/18

MEDICAL NEEDS and AUTHORIZATION RELEASES

2017-2018 School Year

Statewide Educational Programs and Support Services for Children Who are Deaf or Hard of Hearing

STUDENT NAME: _____ DATE OF BIRTH: _____

AGE: _____ GRADE: _____ GENDER: ☐ MALE ☐ FEMALE

Does your child have a valid driver's license: ☐ YES ☐ NO SCHOOL DISTRICT: _____

NAME OF SCHOOL: _____ DEAF EDUCATOR: _____

STUDENT CELL PHONE: **(_____)** _____ TEXT MESSAGE OKAY ☐ YES ☐ NO

STUDENT EMAIL: _____

PARENT (or Legal Guardian) 1: _____

PARENT (or Legal Guardian) 2: _____

HOME LANGUAGE: _____ HOME PHONE: **(_____)** _____

ADDRESS: _____
Street/ P.O. Box City State Zip

EMAIL (of Parent/Guardian 1): _____

EMAIL (of Parent/Guardian 2): _____

CELL PHONE (of Parent/Guardian 1): (_____) _____ TEXT MESSAGE OKAY ☐ YES ☐ NO

CELL PHONE (of Parent/Guardian 2): (_____) _____ TEXT MESSAGE OKAY ☐ YES ☐ NO

EMPLOYER (of Parent/Guardian 1): _____ WORK PHONE: (_____) _____

EMPLOYER (of Parent/Guardian 2): _____ WORK PHONE: (_____) _____

PLEASE CHECK IF YOUR CHILD HAS: ☐ Asthma ☐ Seizure Disorder ☐ Life-Threatening Allergy

☐ My child carries an inhaler ☐ My child carries an EpiPen ☐ I have attached my child's individual health plan

DOES YOUR CHILD HAVE ANY MEDICATIONS THAT NEED TO BE TAKEN?

☐ NO ☐ YES (*If yes, please list medication(s) on page 2.)*

EMERGENCY CONTACTS (Please list two)

If we **cannot** reach you, please indicate **family member(s) or friend(s)** (other than parents) whom we should contact in an emergency:

NAME (Contact 1): _____ RELATIONSHIP: _____

ADDRESS: _____
Street/P.O. Box City State Zip

Home Phone: **(_____)** _____ Cell Phone: **(_____)** _____ Work Phone: **(_____)** _____

NAME (Contact 2): _____ RELATIONSHIP: _____

ADDRESS: _____
Street/P.O. Box City State Zip

Home Phone: **(_____)** _____ Cell Phone: **(_____)** _____ Work Phone: **(_____)** _____

CWNP - Sue Czaplewski
1117 E South St.
Hastings, NE 68901
402-463-5611
(Fax) 402-463-9555
sue.czaplewski@esu9.us

NERP - Jill Hoffart
P.O. Box 139
Norfolk, NE 68702
402-644-2500 ext. 1154
(Fax) 402-644-2506
jillhoffart@npsne.org

MRP - Mike Brummer
6949 South 110th St.
LaVista, NE 68128
402-819-4755
(Fax) 402-597-4811
MBrummer@esu3.org

SNRP - Lindsey Hinzmann
5200 South 75th St.
Lincoln, NE 68516
402-436-1896
(Fax) 402-436-1864
lhinzma@lps.org

Student Name: _____ 17/18

HEALTH INFORMATION & AUTHORIZATIONS

LIST ALL MEDICATIONS YOUR CHILD NEEDS TO TAKE (Attach an additional sheet of paper if needed)
Please send medication in its original prescription container and indicate the daily dose to be taken. Please send only amount needed and one extra dose.

Drug: _____ Dose: _____ Time of Dosage: _____
Drug: _____ Dose: _____ Time of Dosage: _____
Drug: _____ Dose: _____ Time of Dosage: _____
Drug: _____ Dose: _____ Time of Dosage: _____
Drug: _____ Dose: _____ Time of Dosage: _____

Special Instructions: _____
_____

OVER THE COUNTER MEDICATIONS: The following is a list of common medications that are often found in a first aid kit. Please indicate which medications may be used to treat your child, if necessary. Any medications which you do not indicate as being acceptable for your child will not be used in treating your child.

- ☐ Neosporin First Aid Ointment
- ☐ Hydrogen Peroxide
- ☐ Sunscreen
- ☐ Tylenol
- ☐ Bug Repellent
- ☐ Pepto-Bismol
- ☐ Antifungal Cream
- ☐ Benadryl Cream
- ☐ Cough Drops
- ☐ Ibuprofen
- ☐ Midol
- ☐ Motion Sickness

☐ **None of these medications may be used to treat my child**

DRUG ALLERGIES: _____

FOOD ALLERGIES or INTOLERANCE: _____

OTHER ALLERGIES: (Please also indicate any antidote medications that your child needs if allergies develop e.g. bees, peanuts)
_____

OTHER DIETARY RESTRICTIONS: _____

PHYSICIAN AND INSURANCE INFORMATION:

PRIMARY DOCTOR: _____ PHONE NUMBER: _____

INSURANCE COMPANY: _____ POLICY NUMBER: _____

AUTHORIZATION FOR EMERGENCY MEDICAL CARE: I hereby give my permission for the staff to call a doctor or emergency medical service and for the doctor, hospital or medical service to provide emergency medical or surgical care for _____, my child, should an emergency arise. It is understood that the regional staff will make a conscientious effort to locate parents, and/or any emergency contact listed on this form, before any action is taken. I/We will accept the expense of medical or surgical treatment.

☐ YES ☐ NO

Parent Signature _____ **Date** _____

AUTHORIZATION FOR DISPENSING PRESCRIBED MEDICATIONS: I give permission for a trained staff member to dispense my child's medications that are listed on the this page at activities that he/she participates in.

☐ YES ☐ NO ☐ No prescribed medications

Parent Signature _____ **Date** _____

AUTHORIZATION FOR DISPENSING OVER THE COUNTER MEDICATIONS: I give permission for a trained staff member to dispense over the counter medications, if needed, that are checked on this page.

☐ YES ☐ NO

Parent Signature _____ **Date** _____

GENERAL INFORMATION

Please describe your child's swimming ability: ☐ Non-swimmer/afraid of water ☐ Plays in water/limited skills ☐ Beginning swimmer ☐ Advanced/can be in deep end

Does your child wear glasses? ☐ YES ☐ NO

Does your child have a significant visual loss? ☐ YES ☐ NO

Does your child use amplification? ☐ YES ☐ NO

Type of amplification:

☐ Hearing Aid (right ear) ☐ Hearing Aid (left ear)
☐ Cochlear Implant (right ear) ☐ Cochlear Implant (left ear)
☐ BAHA (right ear) ☐ BAHA (left ear) ☐ Other _____

Severity of hearing loss: ☐ Mild ☐ Moderate ☐ Severe ☐ Profound

Preferred method of communication: ☐ Oral ☐ Sign ☐ Total Communication

Provide any other information that will be important for our staff to know about your child (i.e. ADHD, Aspergers, Down Syndrome, Bedwetter, etc.)

_____

_____

AUTHORIZATIONS

The Nebraska Regional Programs will attempt to provide transportation to activities sponsored by the Nebraska Regional Programs. Transportation to regional activities will be the decision of each regional coordinator and their administrator. The number of students and staff members attending will determine if a bus or van(s) is obtained. I understand that the schedule(s) will be distributed as soon as the coordinators have received registrations.

AUTHORIZATION TO TRANSPORT STUDENT: I give the Nebraska Regional Programs permission to transport my child to statewide and/or regional program activities. I will get my child to pick up and drop off points on time so the bus/van stays on schedule.

☐ YES ☐ NO

AUTHORIZATION FOR VIDEOS/PHOTOGRAPHS:

I give permission for videos/photographs of my child to be used by the Nebraska Regional Programs for promotion, presentations, calendars, and/or newsletters.

☐ YES ☐ NO

I give permission for videos/photographs of my child to be used on the Nebraska Regional Program websites.

☐ YES ☐ NO

I give permission for videos/photographs of my child to be used on social media sites (Facebook, Instagram, YouTube, Twitter, Snapchat, etc.) to promote the Nebraska Regional Programs.

☐ YES ☐ NO

I give permission for videos/photographs of my child to be shared with activity participants.

☐ YES ☐ NO

I give permission for my child's first name to be used in connection with videos/photographs of my child.

☐ YES ☐ NO

AUTHORIZATION FOR PARTICIPATION IN ACTIVITIES: I give permission for my child to participate in all activities ***EXCEPT FOR*** the following: _____

_____

Parent Signature _____ **Date** _____

TECHNOLOGY POLICY

The Regional Programs provide activities that are educational, enriching, and safe. These activities also provide social opportunities for children who are deaf or hard of hearing. The Regional Programs, like parents and schools, are learning how to deal with rapidly advancing technologies. Here are a few rules the Regional Programs expect students to follow during and after activities:

- No cell phone use during workshops, lessons, instructions, and/or directions.
- No inappropriate cell phone use during social times (i.e. sexting or bullying).
- To protect the privacy of all, public posting of personal photos from Regional Program activities on social networks is strongly discouraged. This includes Facebook, Instagram, YouTube, Twitter, Snapchat, etc.
- No posting inappropriate comments in connection with Regional Program activities on social networks including Facebook, Instagram, YouTube, Twitter, Snapchat, etc.

I have read the above rules and guidelines concerning technology at Regional Program activities.

Student Signature: _____Date: _____

I have reviewed the above rules and guidelines with my child and am aware my child is expected to follow these rules. Staff reserve the right to collect technology devices during activities at their discretion. I am aware many students have cameras and will take photos at Regional Program activities and that photos of my child could be posted on the Internet by other students.

Parent Signature: _____Date: _____

Here are also a few suggested guidelines for students using social networks:

- Don't post anything your parents, principal, teacher, or a predator shouldn't see.
- What you post online stays online - forever!!!! So **thinkb4uClick!**
- Don't do or say anything online you wouldn't do or say to a person's face.
- Protect your privacy and your friends' privacy too...**get their permission before posting something about them or their picture online.**
- Check what your friends are posting/saying about you. Even if you are careful, they may be putting you at risk.
- College representatives or employers may check your social networks. If you have something inappropriate, you may lose a scholarship or job opportunity.
- **When in doubt, DON'T.**

RULES OF CONDUCT

The following are basic guidelines of conduct that is expected of all students and staff members. Please read carefully.

NEBRASKA REGIONAL PROGRAMS REQUIRE that there be:

NO SMOKING

NO ALCOHOL (BEER, WINE, ETC.)

NO DRUGS (apart from prescription medications)

NO GUNS (FIREARMS), NO KNIVES, NO WEAPONS OF ANY KIND

NO BULLYING (INCLUDING CYBER BULLYING)/HARASSMENT OF OTHER STUDENTS OR STAFF

NO SEXUAL HARASSMENT

NO INAPPROPRIATE CONTACT

THIS IS A ZERO TOLERANCE POLICY. ANY PERSON WHO ENGAGES IN ACTIVITIES THAT MAY ENDANGER THEMSELVES OR OTHERS OR CAUSE DESTRUCTION TO PROPERTY WILL BE SENT HOME. (Parents will be required to pick up their child.)

We expect that students will respect and obey all staff members of any facility that we rent as well as the Nebraska Regional Program's staff and volunteers who are operating these activities or camps. We expect all members attending a state or regional activity to respect one another.

Because the Nebraska Regional Programs support school districts, we believe that any student who is under suspension or expulsion from their home school district should not attend regional or statewide activities. **Parents should contact their regional coordinator and let them know their child will not be attending the activity if the student is registered.**

If a student significantly misbehaves at a Nebraska Regional Program activity, it will be at the discretion of the coordinators to exclude the student from one or more following activities for up to one calendar year. Parents and students will be notified of that decision.

I have read the above information and explained it to my child. He/She agrees to be a responsible participant in the regional activities and/or camps.

_____ _____

Signature of Parent **Date**

_____ _____

Student's Name **Date**

_____ _____

Signature of Student (3rd grade and above if able) **Date**

Do not click "submit form" button above - instead save form and email it to your coordinator as an attachment