MEDICAL NEEDS and AUTHORIZATION RELEASES

2019-2020 School Year
Statewide Educational Programs and Support Services
For Children who are Deaf or Hard of Hearing

Student Photo ID

STUDENT NAME: _____

DATE OF BIRTH: _____ AGE: _____ GRADE: _____

CURRENT WEIGHT: _____ ☐ 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

☐ Carries an inhaler ☐ Carries an EpiPen ☐ Individual health plan (please attach) ☐ Behavior plan (please attach)

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: (_____) _____

Student Name: _____ 19/20

HEALTH INFORMATION

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
- ☐ Cold/Flu Medicine
- ☐ Tylenol
- ☐ Bug Repellent
- ☐ Pepto-Bismol
- ☐ Antifungal Cream
- ☐ Benadryl Cream
- ☐ Cough Drops/Syrup
- ☐ Ibuprofen
- ☐ Midol
- ☐ Motion Sickness
- ☐ **None of these medications may be used to treat my child**

ALLERGIES: Please check "Yes" or "No" for each line below noting your child's allergies. If "Yes," please check further appropriate boxes.

Contact: Child experiences a reaction when directly introduced to allergen (i.e. eating a food or touching a horse).
Airborne: Child experiences a reaction when indirectly introduced to allergen (i.e. sitting next to someone who has eaten a food or ridden a horse).

ALLERGY	YES	NO	MILD	MOD.	SEVERE	Contact	Airborne
Food: Peanut	☐	☐	☐	☐	☐	☐	☐
Food: Tree Nut	☐	☐	☐	☐	☐	☐	☐
Lactose	☐	☐	☐	☐	☐	☐	☐
Gluten	☐	☐	☐	☐	☐	☐	☐
Hay Fever	☐	☐	☐	☐	☐	☐	☐
Insect Stings	☐	☐	☐	☐	☐	☐	☐
Penicillin	☐	☐	☐	☐	☐	☐	☐

OTHER FOOD ALLERGIES OR INTOLERANCES: _____

OTHER DIETARY RESTRICTIONS: _____

OTHER DRUG ALLERGIES: _____

OTHER ALLERGIES: (Please also indicate any antidote medications your child needs if allergies develop):

PHYSICIAN AND INSURANCE INFORMATION:

PRIMARY DOCTOR: _____ PHONE NUMBER: _____

PRIMARY DENTIST: _____ PHONE NUMBER: _____

INSURANCE COMPANY: _____ MEMBER ID NUMBER: _____

Additional Insurance Information or Group Number: _____

Student Name: _____ 19/20

HEALTH HISTORY & AUTHORIZATIONS

Please check "Yes" or "No" for each question below and enter a date if applicable. Has/does/is your child:

		YES	NO	DATE
1.	Had any recent injury, illness, or infectious disease?	☐	☐	_____
2.	Have been knocked out unconscious, had a concussion, or head injury?	☐	☐	_____
3.	Have a chronic or recurring illness/condition?	☐	☐	_____
4.	Ever had surgery?	☐	☐	_____
5.	Ever had seizures?	☐	☐	_____
6.	Have any skin problems?	☐	☐	_____
7.	Have diabetes?	☐	☐	_____
8.	Have asthma?	☐	☐	_____
9.	Have migraines?	☐	☐	_____
10.	Have lung disease?	☐	☐	_____
11.	Have liver disease?	☐	☐	_____
12.	Have kidney disease?	☐	☐	_____
13.	Have unusual sleep habits or wet the bed?	☐	☐	_____
14.	Have behavioral or emotional difficulties?	☐	☐	_____
15.	Have any physical limitations?	☐	☐	_____
16.	Have a diagnosis/syndrome (i.e. Down Syndrome, Aspergers, ADHD)?	☐	☐	_____
17.	Have frequent ear infections?	☐	☐	_____
18.	Have a heart defect/disease?	☐	☐	_____
19.	Have a bleeding/clotting disorder?	☐	☐	_____
20.	Have hypertension?	☐	☐	_____
21.	Have mononucleosis (mono) either now or in the past?	☐	☐	_____
22.	Current on all immunizations required for school? List date of last Tetanus shot.	☐	☐	_____

Please explain any "yes" answers to questions 1-21, noting the number of the question (attach additional paper if needed):

Please provide any other concerns or additional information that will be important for our staff to know about your child:

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 the regional staff will make a conscientious effort to locate parents/guardians, and/or any emergency contact listed on this form, as soon as possible. Parent/ guardian will accept the expense of medical or surgical treatment.

☐ YES ☐ NO

Parent/Guardian 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 these forms at activities that he/she participates in.

☐ YES ☐ NO ☐ No prescribed medications

Parent/Guardian 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 these forms.

☐ YES ☐ NO

Parent/Guardian Signature_____ **Date** _____

GENERAL INFORMATION

Please describe your child's swimming ability: ☐ Non-swimmer/afraid of water ☐ Plays in water/limited skills ☐ Beginning swimmier ☐ 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 Language ☐ Total Communication

My child uses a sign language interpreter in school: ☐ YES ☐ NO

AUTHORIZATIONS

AUTHORIZATION TO TRANSPORT STUDENT: 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 the schedule(s) will be distributed prior to the activity. 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 TO OBTAIN INDIVIDUAL HEALTH/BEHAVIOR PLAN: I give permission for the Nebraska Regional Program staff to contact my child's school to obtain a record of my child's individual health plan and/or behavioral plan.

☐ YES ☐ NO ☐ My child does not have an individual health or behavioral plan.

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 used by outside agencies and local newspapers connected with 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/Guardian 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. The Nebraska Regional Programs are not responsible for damaged, lost, or stolen items or money.

Parent/Guardian 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.**

Student Name: _____ 19/20

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 TOBACCO PRODUCTS INCLUDING E-CIGS

NO ALCOHOL (BEER, WINE, ETC.)

NO DRUGS (apart from prescription medications)

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

NO BULLYING/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 all attendees to follow the Rules of Conduct and to 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.

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/Guardian **Date**

_____ _____

Student's Name **Date**

_____ _____

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

Please return completed forms to your child's regional coordinator listed below:

CWNP – Heather Witte/Sara Peterson 5807 Osborne Drive West Hastings, NE 68901 402-463-5611 (Fax) 402-463-9555 heather.witte@esu9.us SPeterson@esu13.org	**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

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