INSTRUCTIONS FOR COMPLETING SCHOOL ENTRANCE FORMS

"PLEASE READ CAREFULLY AND FILL OUT COMPLETELY."

STUDENT INFORMATION FORM:

1 page - Please fill in appropriate information as completely as possible.
Must list at least 2 different numbers of people who live close enough to come get your child if he/she becomes sick and you are not able to come and pick up your child.
Only those names listed will be allowed to take your child from school.

ADDITIONAL AUTHORIZATIONS:

Additional parental authorizations on the bottom section indicate your approval for:
Field trips to be taken
Preschool only- ODE Early Learning Assessment, Ages and Stages, Social-Emotional, Early Childhood Outcomes Summary Form.

EMERGENCY MEDICAL AUTHORIZATION FORM:

2 pages – State regulations require the NAME/PHONE NUMBER/ADDRESS **of both** a DOCTOR AND DENTIST.
Signature at top of page indicates your consent for listed medical care.
Fill in facts concerning your child's medical history as completely as possible, if doesn't pertain write none. Please do not leave any lines blank.
List any illnesses/hospitalizations your child has had up until now.

If you sign the second section on page 2, you **MUST** provide alternate arrangements, which in turn will need to be approved by the Superintendent.

PHYSICIAN AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

1 page - Medication Record Section **MUST** be filled in and **signed by your Doctor** each new school year.
This section must be filled out completely if you are requesting the school to give any medications including over-the-counter medications.
Any prescription medication to be given at school **MUST** be sent to the school in a container with an unexpired prescription label. Over-the-counter medications must be labeled with the same information that would be on a prescription label: name, doctor, how much given and how often.

Individuals with prescribed emergency medication will need one dosage left at school. A seizure action plan signed by the student's doctor is required each year when emergency seizure medication is ordered, in addition to the physician authorization form. All medication forms need to be received two weeks before the first day of school.

MEDICAL STATEMENT

1 page - All Preschool children (ages 3-5) **MUST** have a current Medical Statement on file no later than the first day of attendance! This form **MUST** be signed by your Doctor/Nurse Practioner. Current Immunization Record Section must accompany medical statement; **lead and hematocrit must also be included.**

STARLIGHT SCHOOL
518 CHURCH AVENUE SW, NEW PHILADELPHIA, OH 44663-2200

STUDENT INFORMATION FORM

NAME OF CHILD_____ DATE OF BIRTH_____

ADDRESS_____
Street City/Zip Code

SCHOOL DISTRICT OF RESIDENCE_____

RESIDENTIAL PARENT OR GUARDIAN

_____(___)_____(___)_____
Mother's name Home Phone Work phone/company name

_____(___)_____(___)_____
Father's name Home Phone Work phone/company name

Preferred Email Address:_____

*Emergency contacts: If a parent or guardian cannot be located please list names, (in order of preference) to be contacted in case of emergency/illness to release above child to.

_____(___)_____(___)_____
Name of persons to whom child may be released Home Phone Work phone/relationship to child/family

_____(___)_____(___)_____
Name of persons to whom child may be released Work phone/relationship to child/family

_____(___)_____(___)_____
Name of persons to whom child may be released Home Phone Work phone/relationship to child/family

ADDITIONAL PARENTAL AUTHORIZATIONS

I give permission for my son/daughter to participate in recreational activities and go on field trips, where supervised by Starlight Staff and transported by Starlight vehicles, for the current school year.

_____ _____
Signature of Parent or Guardian Date

I give permission for my son/daughter to participate in ODE assessments: Early Learning Assessment, Ages and Stages –Social –Emotional, Early Childhood Outcomes Summary Form etc. as deemed necessary and for scores to be reported to ODE as requested.

_____ _____
Signature of Parent or Guardian Date

TUSCARAWAS COUNTY BOARD OF DEVELOPMENTAL DISABILITIES
STARLIGHT SCHOOL
EMERGENCY MEDICAL AUTHORIZATION

The purpose of this form is to enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under Starlight School authority when parents or guardians cannot be reached.

Name of enrollee _____ Birthdate _____

Social Security Number _____ Insurance _____

Street Address _____ City _____ State _____ Zip Code _____

1. Mother's Name _____ Home Phone _____ Work Phone _____

2. Father's Name _____ Home Phone _____ Work Phone _____

3. Emergency Contact- Name _____ Phone _____ Address _____ Relationship _____

4. Emergency Contact- Name _____ Phone _____ Address _____ Relationship _____

Preferred Physician _____ Phone _____ Address _____

Other Physician _____ Phone _____ Address _____

Preferred Dentist _____ Phone _____ Address _____

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

1.Allergies_____

2. Special precautions and/or treatments for allergies_____

3. Food supplements, modified diet, fluoride supplement_____

4. Chronic physical problems_____

5. Dates of hospitalizations and reason_____

6. Any diseases the child has had to date_____

7. List ALL medications presently being taken (include type/dosage/time given)_____

PART I- CONSENT

In the event no responsible person can be contacted:

I hereby give my consent for medical treatment to be administered by the above mentioned physician or dentist or, if not available by another licensed physician/dentist. I understand that emergency transport will be made to Cleveland Clinic Union Hospital for stabilization until a responsible person arrives, (possible further transfer to preferred hospital ____). Consent for major surgery may not be authorized without the concurrence of two other licensed physicians/dentist before such surgery is performed.

Signature of consent:____

Responsible Person

____

Address Date

++

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

PART II- REFUSAL TO CONSENT

I do not give my consent for emergency medical treatment of enrollee. In the event of illness or injury requiring medical treatment I wish the facility's authorities to:

____

____

____

____

Signature of responsible person Date

Tuscarawas County Board of Developmental Disabilities and
Tuscarawas County Help Me Grow
610 Commercial Avenue SW, New Philadelphia, Ohio 44663

PUBLIC RELATIONS RELEASE

The Tuscarawas County Board of Developmental Disabilities (TuscBDD) utilizes many avenues to show our communities how we are helping individuals live their lives to the fullest. It is our goal to help promote and celebrate their successes.

In addition, it is imperative that people who need services know what is available. Additionally, it is vital that others in our community who come in contact with people living with disabilities have information that fosters acceptance and respect. The Community Relations Department is responsible for keeping members of the public informed on an ongoing basis.

From time to time, we would like to showcase persons served and our employees as well. Allowing our Community Relations Department to publish and distribute your quotes, pictures, letters, and other testimonials is priceless.

Please initial the lines in which you give permission for the Tuscarawas County Board of Developmental Disabilities to use your image and/or story for public awareness purposes.

_____ Newspaper articles - print & digital
_____ TuscBDD website
_____ Agency publications such as the annual report, brochures, postcards, calendars, etc. either printed or digital
_____ Presentations or videos
_____ Billboards
_____ Bulletin Boards
_____ Social Media platforms including but not limited to: Facebook, Twitter, Instagram, Google Plus, LinkedIn and YouTube
_____ TuscBDD blogs
_____ *I understand*, that by placing my initials on the lines, I am allowing TuscBDD to use my image or story for the purposes listed above.
_____ *I understand* I may revoke my permission, in writing, at any time.

Name of Person/Student_____

Signature_____/Date_____

Guardian signature (if applicable)_____/Date_____