

Annual Update Information for Students

Student's name _____ Date of Birth _____

Sex M/F Race _____ Religion (optional) _____

Place of Birth _____ Social Security # _____

School WISER ID# _____

Parent or Guardian name(s) _____

Address _____ Phone Number(s) _____

Parent/Guardian e-mail _____

Emergency Contacts name(s) _____ number(s) _____

Is the student covered by Title XIX? _____ If yes, # _____

Is the student covered by SSI? _____ if yes, # _____

Insurance Provider/Numbers _____

Medical Insurance Provider information _____

PLEASE ATTACH COPIES OF THE FOLLOWING DOCUMENTS and initial that you have attached them:

_____ Immunization Records

_____ Social Security Card

_____ Copy of Birth Certificate

_____ Title XIX Card

-----OFFICE USE ONLY-----

Date of Placement _____ Time: _____ Referral Source _____

Address: _____ Staff initials _____

Student Medical Information Form

BOCES encourages yearly physical exams for each student. Physicals are required for participation in Special Olympics (see attached form). Please have the student's physician sign the form if they will be participating.

We also require dental exams prior to entry for grades 3 & 7, but routine check-ups are highly encouraged. Attached you will find a dental report you may have your dentist fill out and return to our nursing office as verification of an exam.

Current Primary Medical Doctor _____ phone # _____

Date of last exam by primary MD _____ (yearly recommended)

Height? _____ Weight? _____ Age? _____

Any diagnosis student has been given _____

Surgeries or other medical history _____

Current Dentist _____ number _____

Date of last dental exam _____ (yearly recommended)

Any special instructions re: dental care of this student? _____

*Our school nurse will arrange for vision/hearing/scoliosis screening as recommended per WY Department of Education. You will be notified if concerns are found. If you do not want these screenings, initial here _____

PRIVATE DENTIST REPORT OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE

NAME OF SCHOOL _____ DATE _____ 20 ____

| | | | | |
|-------------------------------------------------------------|------------------|------------------------------------------------------------------|--------------------|---------------------------|
| NAME OF CHILD _____ | AGE _____ | SEX <input type="checkbox"/> M <input type="checkbox"/> F | GRADE _____ | SECTION/ROOM _____ |
| Last First Middle | | | | |

ADDRESS

| | | | | | |
|----------------|---------------------|---------------------|--------|-------|-----|
| No. and Street | City or Post Office | Borough or Township | County | State | Zip |
|----------------|---------------------|---------------------|--------|-------|-----|

REPORT OF EXAMINATION

| | TOOTH CHART | | | | | | | | | | | | | | | | |
|-------|-------------|----|----|----|----|----|----|----|------|----|----|----|----|----|----|----|-------|
| | RIGHT | | | | | | | | LEFT | | | | | | | | |
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | |
| UPPER | | | | A | B | C | D | E | F | G | H | I | J | | | | Upper |
| LOWER | 32 | 31 | 30 | 29 | 28 | 27 | 26 | 25 | 24 | 23 | 22 | 21 | 20 | 19 | 18 | 17 | Lower |
| UPPER | | | | | | | | | | | | | | | | | Upper |
| LOWER | | | | | | | | | | | | | | | | | Lower |

Is The Child Under Treatment Yes No

Treatment Completed Yes No

Date of Dental Examination

Signature of Dental Examiner

Print Name of Dental Examiner

Address



550 North Poplar, Suite 3
Casper, WY 82601
(307) 235-3062

APPLICATION FOR PARTICIPATION IN SPECIAL OLYMPICS WYOMING

(For individuals with mental disabilities)

This form must be updated every three years

DEMOGRAPHICS

ATHLETE INFORMATION

Local Program: _____ Social Security Number: ____ - ____ - ____ Gender: Male Female

Partner Name: _____ Date of Birth: ____ / ____ / ____ Home Phone: (____) _____

Address: _____
STREET CITY STATE ZIP CODE

PARENT/GUARDIAN INFORMATION

Name: _____ Please add us to the SOWY Newsletter mailing list

Address (if different): _____
STREET CITY STATE ZIP CODE

Work Phone: (____) _____ Home Phone: (____) _____ e-mail: (____) _____

Emergency Contact (if other than parent/guardian): _____ Phone: (____) _____

Health/Accident Insurance Company: _____ Policy Number: _____

HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER

| | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Disease/Heart Defect/High Blood Pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Chest Pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Seizures/Epilepsy/Fainting Spells</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> Concussion or Serious Head Injury</p> <p><input type="checkbox"/> <input type="checkbox"/> Major Surgery or Serious Illness</p> <p><input type="checkbox"/> <input type="checkbox"/> Heat Stroke/Exhaustion</p> <p><input type="checkbox"/> <input type="checkbox"/> Blindness/Impaired Vision</p> <p><input type="checkbox"/> <input type="checkbox"/> Contact Lenses/Glasses</p> <p><input type="checkbox"/> <input type="checkbox"/> Hearing Loss/Hearing Aid</p> <p><input type="checkbox"/> <input type="checkbox"/> Impaired Motor ability</p> <p><input type="checkbox"/> <input type="checkbox"/> Bone or Joint Problem</p> <p><input type="checkbox"/> <input type="checkbox"/> Parent/Sibling (under 40) died of Heart Disease</p> <p>Date of most recent tetanus immunization: ____ / ____ / ____</p> | <p>YES NO</p> <p><input type="checkbox"/> <input type="checkbox"/> Allergies:</p> <p>Medicines: _____</p> <p>Food: _____</p> <p>Insect Stings/Bites: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Special Diet</p> <p><input type="checkbox"/> <input type="checkbox"/> Asthma (exercise induced wheezing)</p> <p><input type="checkbox"/> <input type="checkbox"/> Tobacco Use</p> <p><input type="checkbox"/> <input type="checkbox"/> Tendency to bleed easily</p> <p><input type="checkbox"/> <input type="checkbox"/> Emotional/Psychiatric/Behavioral</p> <p><input type="checkbox"/> <input type="checkbox"/> Sickle Cell Trait or Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Uses a wheelchair</p> <p><input type="checkbox"/> <input type="checkbox"/> Dentures/False Teeth</p> <p><input type="checkbox"/> <input type="checkbox"/> Immunizations Up To Date</p> <p><input type="checkbox"/> <input type="checkbox"/> Other: _____</p> |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

(Medications): Use separate sheet for additional space.
Please print medication name, amount, date prescribed and number of times per day medication is given. Use separate sheet for additional space.

| Medication Name | Dosage | Date Prescribed | Times Per Day | Medication Name | Dosage | Date Prescribed | Times Per Day |
|-----------------|--------|-----------------|---------------|-----------------|--------|-----------------|---------------|
| | | | | | | | |
| | | | | | | | |

SIGNATURE OF PARENT/GUARDIAN/ADULT ATHLETE: _____ DATE: ____ / ____ / ____

ATLANTO-AXIAL INSTABILITY ASSESSMENT FOR ATHLETES WITH DOWN SYNDROME

PHYSICIAN'S NOTE: If the athlete has Down syndrome, Special Olympics requires a full radiological examination establishing the absence of Atlanto-axial Instability and the completion of the Special Examination Form before he/she may participate in sports or events which, by their nature, may result in hyper-extension, radical flexion or direct pressure on the neck or upper spine. The sports and events for which such a radiological examination is required are: Judo, Equestrian sports, Gymnastics, Diving, Pentathlon, Butterfly stroke and Diving Starts in Swimming, High Jump, Alpine Skiing, Snowboarding, Squat Lift, and Football Team Competition (Soccer).

YES NO

Has an x-ray evaluation for Atlanto-axial Instability been done?

If yes, was it positive for Atlanto-axial Instability? (Positive indicates that the atlanto-dens interval is 5mm or more)

PHYSICAL EXAMINATION

Blood Pressure: ____ / ____ Weight: ____ Height: ____

| | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Normal Abnormal</p> <p><input type="checkbox"/> <input type="checkbox"/> Vision</p> <p><input type="checkbox"/> <input type="checkbox"/> Hearing</p> <p><input type="checkbox"/> <input type="checkbox"/> Oral Cavity</p> <p><input type="checkbox"/> <input type="checkbox"/> Neck</p> | <p>Normal Abnormal</p> <p><input type="checkbox"/> <input type="checkbox"/> Extremities</p> <p><input type="checkbox"/> <input type="checkbox"/> Cardiovascular System</p> <p><input type="checkbox"/> <input type="checkbox"/> Respiratory System</p> | <p>Normal Abnormal</p> <p><input type="checkbox"/> <input type="checkbox"/> Gastrointestinal System</p> <p><input type="checkbox"/> <input type="checkbox"/> Genitourinary System</p> <p><input type="checkbox"/> <input type="checkbox"/> Skin</p> | <p>Normal Abnormal</p> <p><input type="checkbox"/> <input type="checkbox"/> Cranial Nerves</p> <p><input type="checkbox"/> <input type="checkbox"/> Coordination</p> <p><input type="checkbox"/> <input type="checkbox"/> Reflexes</p> |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Other: _____

I have reviewed the above health information and have performed the above examination on this athlete within the past 6 months and certify that the athlete can participate in Special Olympics.

RESTRICTIONS: _____

EXAMINERS SIGNATURE: _____ DATE: ____ / ____ / ____

Print Examiners Name & Title: _____

Address: _____

Phone: _____

Any significant family medical history? (Diabetes, asthma, epilepsy, etc).
Please list who/what diagnosis:

Student's Medical History: Please circle any that apply

| | | | |
|-----------|--------------|-----------------|-------------------|
| Diabetes | Tuberculosis | Rheumatic Fever | Mental illness |
| Seizures | Pneumonia | Kidney disease | Bleed/clot issues |
| Migraines | Hepatitis | HIV | Heart disease |
| Stroke | Arthritis | Dental problems | Bladder problems |

Please tell us about any treatments for the issues noted above! Be sure to list any prior hospitalizations, fractures, etc... and include dates of each incidence/treatment_____

If applicable, please give us a brief menstrual history regarding your student.

Age of Onset?_____Regular?_____

Last period?_____Lasting how long?_____

On Depo Provera?_____If yes, date/documentation of last injection?_____ Any other concerns with menstruation?_____

Who is your student's OBGYN doctor?_____

Student Behavioral/Mental Health Information

Please tell us what you'd like us to know about your child, for example:
likes/dislikes, nick names, favorites, etc...

Toileting Habits/Issues? _____

Is your child currently under the care of a psychiatric or neurologic
physician? Y/N Name of MD? _____ phone _____

How often does your child see his/her doctor(s)? _____

- Please be aware that Gillette does not have a local neurologist, and these visits will need to be maintained by you, the parent/guardian.

BOCES greatly appreciates the convenience allotted to our students/families by our visiting Psychiatrist, Dr. Wojciech Zolcik, and Pyschologist, Dr. Tim Blaney. They visit our school several times a month to review each student's medications/behavior and visit with student's caregivers/teachers. If you give permission for Dr. Zolcik and/or Dr. Blaney to evaluate/treat your child, please sign below. You will be notified of any recommendations or medications ordered prior to them being implemented or changed.

X _____ Date _____

Medication/Diet Information

Special Dietary Concerns/suggestions: Please be specific (chopped, pureed, likes/dislikes, avoidances/substitutes,

etc....

If a special diet is required, please attach the recommendation/orders received from the MD, dietician, speech pathologist, or other:

*All residential students who do not have a previously documented positive Mantoux skin test (TB test) shall be tested via public health/BOCES RN.

*If you authorize the annual influenza vaccination for your child, please complete the attached form so we can order the vaccine early this year!

*Any immunizations not up-to-date via the recommendations of WY public health will need to be given. If immunizations are not given due to medical/religious reasons, you will be required to complete an exemption form according to WY Dept. of Education law. BOCES reserves the right to refuse attendance for non-immunized students during pandemics or mandated immunization situations.

INFLUENZA VACCINATION CONSENT FORM – 2010

Please read the following information before completing this form and receiving the vaccine.

Adverse Reactions – The vaccine is usually well tolerated apart from occasional soreness at the injection site. A mild fever, tiredness or muscle aches may occur within 6-12 hours and lasting 1-2 days. **It cannot give you a dose of the 'Flu'.**

More severe adverse events such as hives and anaphylactic reactions are rare.

You should *NOT* have the vaccine if:

1. **You have a hypersensitivity (allergy) to eggs.** *This would include swelling of the lips or tongue or respiratory distress upon the ingestion of eggs, or sensitivity to chicken feathers.*
2. **You have a sensitivity to any of the product components.** *(Beta-propiolactone, formaldehyde, thiomersal).*
3. **You are allergic to the antibiotics neomycin or polymyxin.**
4. **You have an illness with a temperature (fever over 38.5°C).** *Minor illness with/without fever does not contraindicate vaccination.*
5. **You have a history of Guillain-Barre Syndrome with previous influenza vaccination related onset.**

I have read and understand the above information and consent to receiving /allowing the influenza vaccine.

Name _____ Signature _____
(please print)

Student's name: _____

Campus N.E.W. BOCES

*This year's influenza vaccine will protect against both the yearly influenza strain and the H1N1 strain. Only one shot will be necessary this season. Vaccine information sheets will be sent home to you as soon as they become available.

OFFICE USE ONLY

Date ___/___/___ Batch _____ Given by _____

Medications to be given while at BOCES

BOCES recognizes that many students have medication doses prescribed during hours of school and/or residence. For this reason, we employ a registered nurse, and ensure that all staff who deal with medication administration are trained to do so carefully. Please keep the following general guidelines in mind when authorizing BOCES to administer medications to your student:

Medications should be administered at home if at all possible.

"Over-the-Counter Medications" that may be given by designated BOCES staff need to be identified and authorized in writing by **BOTH the student's parent/guardian AND Physician**. Parents AND the student's medical practitioner shall provide written instructions including medication name, dose, frequency, and duration of use. **Refer to "Authorization to Administer Medication Form"**. ***If student meds are ordered/monitored by Dr. Zolcik, you will not be required to have physician areas signed below- he may authorize the medications on his regular visits to your student.**

Any medication administered cannot exceed the recommended dosage, time interval, or directions listed on the container unless specifically ordered, in writing, by a physician.

The medication(s) shall be kept in a locked place and records shall be kept on medications administered.

Medication(s) may only be administered by the school nurse, Executive Director, or a medication trained staff member chosen by the Executive Director.

All medication authorizations will expire one year from which they were written/signed. Medications not picked up by parent/guardian by the student's last day of school, or 30 days following notification that the medication has been discontinued, shall be discarded per policy.

If medications (prescription or non-prescription) will be brought to the school, they must be in their original, labeled container(s). We encourage parents/guardians not to send the medication with the student, but to hand-deliver the medication directly to the office or nursing staff.

*Also note that each new prescription or change to dose/time administered will need to be accompanied by a **doctor's order**. Please bring the nurse a copy of the script, or a note from the MD, to indicate what changes are being made.

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AND RELEASE OF LIABILITY

The undersigned, in accordance with Wyoming Statute 33-21-154, hereby recognize that the School Nurse and designated staff employed by N.E.W. BOCES, be known as designated "friends" of the student and hereby authorizes these "friends" to administer the following medication to:

(STUDENT'S NAME) _____

Medication(s) being furnished/authorized: _____

As prescribed by **(Name of Physician, if applicable)**

and filled by **(Name of Pharmacy)** _____
under RX#(s) _____

Said medicine shall be administered at the following times and dosages: _____

Known possible side effects are: _____

In consideration of the N.E.W. BOCES personnel administering such medicine, the undersigned hereby releases said School and its personnel from claims, demands, and liabilities, direct and indirect, which may result or accrue by reason of the administration of such medicine, the failure to administer it, or the improper administration thereof.

I have read and understand this authorization.

Dated this _____ day of _____, 20_____.

X _____
(Parent or Legal Guardian)

X _____
(Parent or Legal Guardian)

PHYSICIAN
SIGNATURE _____ **DATE** _____

Below is a list of common over-the-counter medications we have available to keep the students comfortable while staying/schooling here at BOCES. Please **circle each of the following medications you give BOCES (RN or trained staff members) permission to administer to your child as needed**, per label instructions, and sign/date here:

X _____ DATE _____

- Tylenol/Acetaminophen Benadryl Dimetapp/cough syrup/robitussin
Motrin/Ibuprofen Milk of Mag/Mylanta Cough drops
Pepto-Bismol Tums Emetrol (nausea) Mucinex
Benadryl cream/hydrocortisone cream/antifungal cream/acne creams/regular lotions
Gold bond medicated powders/antifungal powders children's vitamin chews/tablets
Stool softeners imodium probiotics (if taking antibiotics) others? _____

PLEASE HAVE STUDENT'S PHYSICIAN SIGN HERE OR CALL/FAX ORDER TO CO-AUTHORIZE ABOVE OTC MEDICATION USAGE (FAX # 307-686-7628, Nurse Phone 307-689-2012).

X _____ DATE _____

Anything else you think the nursing/cottage staff should know regarding use of as-needed meds or common complaints or home remedies for your child?

List your child's medication/environmental

ALLERGIES: _____

***Unless you otherwise inform our staff, we will assume consent has been given for any medication (e.g. Epi-Pen) or treatment (e.g. AED) deemed necessary to treat LIFE THREATENING symptoms.**

Please review the following pages and complete any of them that are applicable to your child.

Dear Parent/Guardian:

Students who take certain medications need periodic blood work done to ensure their safety and the drug's efficacy. Different medications require different lab work, examples are outlined below.

1. Some medications require periodic blood level monitoring to ensure the amount of medication in the bloodstream is not too high or low. The dose of the drug may need to be adjusted. Examples of these types of medications are: Lithium, Depakote, Tegretol, Clozaril, Dilantin, etc. At the beginning of treatment with these types of medications, more frequent monitoring may be required (often every 2-4 weeks) until a therapeutic level is reached. Once the proper dose is reached and blood levels remain steady, on-going testing will be necessary every 6-12 months or as determined by the physician.
2. Other medications need to be monitored for a variety of factors, such as liver/kidney function tests or blood cell counts, to ensure the body is metabolizing them properly. This type of lab work is often drawn once a year or as needed. Almost all medication falls into this category. The physician will determine when these tests shall be obtained.
3. **Please sign below if your student IS a patient of Dr. Zolcik's and you wish to give consent for routine lab work. If your student is seen by another physician, please alert the school nurse to any abnormal laboratory results you become aware of.**

If we draw your labs, you will be informed of the results by way of your choice, as indicated below (please select/complete one):

SIGNATURE _____ DATE _____

Please FAX results to: _____

Please MAIL results to: _____

Please CALL results to: _____

We also request your consent to obtain all necessary medical treatments for your child in the event that you cannot be reached (you will be contacted regarding the situation as soon as possible). Testing, if an exposure has occurred, may include HIV/Hepatitis status {initial here for **HIV/Hepatitis testing consent**_____}. Please sign below to authorize BOCES staff to obtain any necessary medical treatment for your child. By signing, you also authorize BOCES to release pertinent medical information about your child to medical personnel and agree to assume all financial responsibilities not covered by insurance/Medicaid for injuries/illnesses that occur as a result of your child's participation in activities at BOCES.

Signature of Parent/Guardian _____ Date _____

Pictures and Information:

I hereby give my permission for Northeast Wyoming BOCES/The Powder River Basin Children's Center to publish or release pictures of and appropriate information concerning my child to the media (newspaper, pamphlets, etc.) as pertaining to school related activities within the school year.

_____ YES _____ NO

Activities:

I hereby give my permission for my child to attend school sanctioned activities, whether in Gillette or elsewhere (another county or state), to go on any field trips planned by teacher(s) or cottage staff, and to be involved in any extracurricular activities, such as attending local concerts, ball games, parties, movies, etc., during the school year and ESY I and ESY II.

_____ YES _____ NO

Art Contests:

I hereby give my child permission to enter any art contest approved by the Northeast Wyoming BOCES/The Powder River Basin Children's Center.

_____ YES _____ NO

Long Distance Phone Calls:

I hereby give my child permission to make long distance phone calls and charge them to my home phone number. He/she may call the following numbers: _____

the call(s) to: _____ And may charge

_____ YES _____ NO

Visitation:

I hereby give permission for the following person(s) to visit my child in the school or cottage:

I hereby give permission for the following person(s) to take my son/daughter off of the Northeast Wyoming BOCES/The Powder River Basin Children's Center grounds:

| Adult Name | Phone Number | Days of the Week | Time Frame |
|------------|--------------|---------------------------|-------------|
| _____ | _____ | Mon, Tue, Wed, Thurs, Fri | _____ hours |
| _____ | _____ | Mon, Tue, Wed, Thurs, Fri | _____ hours |

Times available for off campus outings:

Monday – Friday: times available will fall between 3:00 p.m. to 9:00 p.m.
Saturday – Sunday: times available will fall between 9:00 a.m. to 9:00 p.m.

Outings and Activities:

I give permission for staff authorized by the Executive Director of Northeast Wyoming BOCES to take my child on outings, overnight visits, or special events approved by the Executive Director.

_____ YES _____ NO

Transportation:

I will call Northeast Wyoming BOCES/The Powder River Basin Children's Center's Office to inform school personnel if someone other than I or my spouse is going to transport my child from the school or cottage.

_____ YES _____ NO

Emergency Medical Treatment:

In the event that emergency treatment is deemed necessary by Northeast Wyoming BOCES/The Powder River Basin Children's Center staff, I hereby give my permission for the staff to seek and carry out appropriate actions. I understand that I will be notified of action(s) taken or that are to be taken. I understand that I and/or my medical insurance will be responsible for all medical bills. I understand that all precautions shall be taken at all times and that Northeast Wyoming BOCES/The Powder River Basin Children's Center, its agents, and employees shall not be liable in the event an accident should occur.

_____ YES _____ NO

Department of Family Services:

I hereby give my permission for the Department of Family Services to release to Northeast Wyoming BOCES/The Powder River Basin Children's Center pertinent information regarding my child.

_____ YES _____ NO

Signature of Legal Representative/Relationship

Date

Signature of Witness

Date

Student Transportation

Student Name: _____

Parent/Guardian Name(s): _____

Physical Address: _____

Easiest Route: _____

Alternate Route: _____

Emergency Contact/Drop Off: _____

Inclement Weather Instructions: _____

a Hazards: _____

b Road Maintenance: _____

Special Needs for Travel: _____

If bus is 15 or more minutes late, the driver will call and advise the parent/guardian of expected time of arrival

If no one is at drop off after 5 minutes, the driver will contact the emergency contact/drop off person. If contact cannot be reached your child will be returned to BOCES cottages. The parent/guardian will be billed at the current one/one rate - \$16.00 per hour.

I do hereby acknowledge that I have read, am familiar with, and fully understand the terms and conditions of this form.

Signature of Legal Representative/Relationship

Date

Behavior Consent Form – Seclusionary Time-out

Student's Name: _____

Dear Parent/Guardian:

Northeast Wyoming BOCES/The Powder River Basin Children's Center's behavior management policy requires written parental consent prior to implementation of specific behavior management techniques. Seclusionary time-out is one such technique proposed for use with your child.

The following is a brief description of the plan to implement this technique as an integral part of your child's behavior management program.

1. Verbally state problem or targeted behavior.
2. Non-verbally or verbally state to stop the behavior and remind him/her of the consequences. (If you don't stop you can take a chair in time-out)
3. Give him/her time to process and continue repeating the consequences. (Up to 3 times)
4. Tell him/her, "This is your first warning." Tell him/her to do what is expected of him/her again. Give him/her 10 seconds to respond, and then tell him/her if he/she won't take a chair then he/she will go to time-out.
5. Give second warning and repeat consequences allowing processing time.
6. If he/she does not do his/her chair time he/she needs to go to the time-out room
7. If he/she is willing, walk with him/her to time-out.
8. If he/she will not check him/her self into time-out get assistance from his/her one-on-one paraprofessional or another staff member. (It usually takes 2-3 staff members to transport.)

Please sign and date your approval or disapproval for the use of seclusionary time-out.

_____ Yes, I approve of seclusionary time-out.

_____ No, I do not approve of seclusionary time-out.

Signature of Parent/Guardian

Date

Behavior Consent Form – C.P.I. Techniques

Student Name: _____

Dear Parent/Guardian:

Northeast Wyoming BOCES/The Powder River Basin Children's Center's behavior management policy requires written parental consent prior to implementation of specific behavior management techniques. C.P.I. is one technique proposed for use with your child.

The following is a brief description of the plan to implement this technique as an integral part of your child's behavior management program.

- Step 1: A verbal warning will be given to the student identifying the problem.
- Step 2: A warning will be given to the student explaining the possible consequences or their action(s).
- Step 3: If the behavior continues to escalate to the point the student might injure themselves, other students, staff members, or use force for the destruction of property, Step 4 will be used. If the student interferes with the normal operations of Northeast Wyoming BOCES/The Powder River Basin Children's Center during the episode, Step 4 will also be enforced. Step 4 will be used immediately in a serious or potentially dangerous situation.
- Step 4: C.P.I. techniques (See Below)

***Anytime the student changes the behavior pattern and becomes compliant with the directions of the staff member, the procedure will be discontinued.

Please sign and date your approval or disapproval for the use of C.P.I. techniques.

_____ Yes, I approve the use of C.P.I. techniques

_____ No, I do not approve the use of C.P.I. techniques

Signature of Parent/Guardian

Date

Reasons for not approving the C.P.I. techniques: _____

C.P.I. Techniques
(Non-violent Physical Crisis Intervention)

1. Single Basket Technique:

The single basket technique is a single restraint that could be used if the physically acting out student is smaller and not as strong as the staff who is using the technique to provide control.

2. Team Control Position:

Staff member's face the same direction as the student. Inside leg is placed in front of the student. Staff's outside hand holds wrist. Staff's inside hand is placed on student's shoulder.

There are three control dynamics to this technique:

- 1 Reduce upper body strength;
- 2 Reduce lower torso strength; and
- 3 Close body on both sides.

3. Transport Technique:

Staff remove their hands from the student's shoulders and move them under the arms of the student to clasp their (staff's) own wrists. This forms a cross-grained grip to secure the student between staff. Staff should remain close to the student.

4. Interim Control Position:

The staff member with the acting out student should always maintain control of one of the arms and move their other hand under the acting out student's arm to possibly gain control of the acting out student's loose arm.

***Parents/Guardians are encouraged to attend the C.P.I. training session free of charge from Northeast Wyoming BOCES/The Powder River Basin Children's Center

Suggested Clothing and Personal Items for Residential Students

| <u>Boys</u> | <u>Girls</u> |
|-----------------------------------------------------------|-----------------------------------------------------------|
| 6 under-wear | 6 under-wear |
| 6 pants | 4 bras |
| 6 shirts | 6 pants |
| 7 pairs of socks | 6 tops |
| 2 pairs of shoes | 7 pairs of socks |
| 1 pair of snow boots | 2 pairs of shoes |
| 2 pairs of pajamas | 1 pair of snow boots |
| 1 swimsuit | 2 pairs of pajamas |
| 1 toothbrush | 1 swimsuit |
| 1 tube of toothpaste (if you prefer a certain brand) | 1 robe |
| 1 comb and/or brush | 1 pair of slippers |
| 1 electric razor (if needed) | 1 toothbrush |
| 1 shampoo and conditioner (if you prefer a certain brand) | 1 tube of toothpaste (if you prefer a certain brand) |
| 1 deodorant | 1 comb and brush |
| 1 jacket (light weight) | 1 shampoo and conditioner (if you prefer a certain brand) |
| 1 coat | 1 deodorant |
| 1 nice outfit for special occasions | 1 jacket (light weight) |
| | 1 coat |
| | 1 nice outfit for special occasions |

If there are any other personal items that you would like to bring (bedding, sheets, pillows, TV, stereo, I-pods, etc)

Please put student's initials on all items before bringing to school with a permanent marker, or sewn in

Powder River Basin Children's Center

DISCHARGE PLAN

To be completed by Parent/Guardian:

Anticipated date of departure if known: _____

Issued to be addressed during placement:

Placement goals and objectives will be as identified in the child's Individual Education Plan (IEP).

I, _____, understand and agree that the IEP will be the basis for services to be provided by Northeast Wyoming BOCES.

Signature Parent/Guardian

Date

To be completed by Northeast Wyoming BOCES.

Description of child's condition at the time of intake as observed by intake worker

Clothing/Appearance _____

Mood/Affect _____

Attitude: _____

How does the child feel about being placed with us?

Name (Printed)

Signature

Date

Permissions

Student Name: _____

Release of Information

I, _____, for _____, a minor child, do hereby consent to and authorize Northeast Wyoming Board of Cooperative Educational Services/The Powder River Basin Children's Center to exchange information concerning treatment with the agencies and/or organizations listed below. My initials, below, indicate which organization(s) may exchange information with:

- _____ Department of Family Services
- _____ Probation and Parole
- _____ (List) County Attorney's Office
- _____ Wyoming Regional Counseling Center
- _____ Life Strategy Center
- _____ (List) County School District
- _____ Youth Emergency Services
- _____
- _____
- _____
- _____

I authorize disclosure of the following information, as indicated by my initials, to the agencies and/or organizations designated above:

- _____ Discharge Summary
- _____ History and Physical Examination
- _____ Psycho-Social History
- _____ Psychiatric Evaluation/Consultation
- _____ Psychological Testing
- _____ Educational Testing
- _____
- _____

I understand that the agencies and/or organizations indicated by my initials, above, will also be sharing information with Northeast Wyoming Board of Cooperative Educational Services/The Powder River Basin Children's Center.

The purpose for the release of this data shall be:

- _____ Further mental health/psychological/psychiatric care
- _____ Coordination of Services
- _____ Treatment Planning
- _____
- _____