ACCEPT
Education Collaborative

220 North Main Street, Suite 201, Natick, MA 01760
508.653.6776 • 508.653.0878 Fax • accept.org

Checklist for Forms

Consent Forms:

- ❑ Student Information
- ❑ Consent Form for Student: Photograph, ACCEPT Vehicle, Sun Screen
- ❑ Behavior Management Consent Form
- ❑ Authorization for Release of Medical Information
- ❑ Release of Information and Records
- ❑ Parent/Guardian Authorization for Dispensing Non-Prescription Medication
- ❑ Physician Medication Authorization and Administration Plan
- ❑ Questionnaire for Parent/Guardian of a Child with Seizure Disorder
- ❑ Massachusetts School Health Record

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Student Information

2015 - 2016 School Year

Student's Legal Name _____ Date of Birth _____
Home Phone _____ Address _____
City _____ State _____ Zip Code _____
Custody or Restraining Order: ❑ Yes ❑ No (If Yes, attach copy)
Student resides with: ❑ Mother ❑ Father ❑ Both ❑ Other _____

Parent/Guardian Information (Enter names of legal parents, stepparents or guardians only)

Name: _____
Relationship: ❑ Mother ❑ Father ❑ Stepmother ❑ Stepfather ❑ Other _____
Mailing Address (if different from Student) _____
City _____ State _____ Zip Code _____
Home Phone _____ Cell Phone _____
Work Phone _____ Email _____

Name: _____
Relationship: ❑ Mother ❑ Father ❑ Stepmother ❑ Stepfather ❑ Other _____
Mailing Address (if different from Student) _____
City _____ State _____ Zip Code _____
Home Phone _____ Cell Phone _____
Work Phone _____ Email _____

If your child becomes sick at school, he/she must be picked up and taken home. Please list emergency contacts, OTHER THAN YOURSELF, should you be unavailable.

1) Name _____ Phone _____
Relationship _____

2) Name _____ Phone _____
Relationship _____

Physician Name _____ Phone _____
Medical Specialist(s)/Clinic(s) _____
Dentist Name _____ Phone _____
Diagnosis _____

Current Medications – please indicate if medications are to be taken at home or school

Medication	Dosage	Times Given		Reason For Medication
		Home	School	
1.				
2.				
3.				
4.				
5.				

Asthma: ❑ Yes ❑ No
Inhaler: ❑ Yes ❑ No
Nebulizer: ❑ Yes ❑ No

Please see next page

Student's Legal Name _____ Date of Birth _____

Has your physician prescribed an Epi-Pen for a severe life-threatening allergy? ❑ Yes ❑ No
If yes, ACCEPT requires a written Doctor's order and an Allergy Action Plan.
Has your child ever required the use of an Epi-Pen: ❑ Yes ❑ No (If yes, most recent date) _____

Life Threatening Allergic Conditions (Check all that apply)

❑ Bee Stings
❑ Peanuts/Tree Nuts (list nuts) _____
❑ Latex
❑ Other food products (list foods) _____
❑ Medications (list medications) _____

Allergies (non-life threatening, i.e. food, medication, seasonal): _____

_____

Does your child have any of the following? If YES, please explain.

❑ Yes ❑ No Assistive Mobility Aids (i.e. wheelchair, walker, braces) _____
❑ Yes ❑ No Behavioral Problems _____
❑ Yes ❑ No Developmental Problems _____
❑ Yes ❑ No Bladder/Bowel Problems _____
❑ Yes ❑ No Bleeding Problems _____
❑ Yes ❑ No Cerebral Palsy _____
❑ Yes ❑ No Diabetes _____ Insulin dependent ❑ Yes ❑ No
❑ Yes ❑ No Feeding Tube _____
❑ Yes ❑ No Head or Spinal Injury _____
❑ Yes ❑ No Hearing Loss _____ Hearing Aid ❑ Yes ❑ No
❑ Yes ❑ No Heart Problems _____
❑ Yes ❑ No Recurring Illness _____
❑ Yes ❑ No Seizure Disorder/Epilepsy Type _____ Date of last seizure _____
❑ Yes ❑ No Speech Problems _____
❑ Yes ❑ No Surgeries (what and year) _____
❑ Yes ❑ No Swallowing Difficulties _____
❑ Yes ❑ No Vision Problems _____ Glasses ❑ Yes ❑ No
Other _____

Insurance Provider _____ Policy ID# _____

I will notify the ACCEPT Education Collaborative if there are any changes to the above information.
I give my permission, in a medical emergency, for the school nurse to contact my child's doctor and/or transport my child by ambulance to a hospital for treatment. Hospital preference _____

I give my permission to all medical providers to release health information to the ACCEPT Nurse Leader. I give my permission for the ACCEPT nurse to leave a voice mail on my:
❑ Home Phone ❑ Cell Phone

Parent/Guardian Signature _____ Date _____

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Consent Form for Student

2015 - 2016 School Year

Student's Name _____

Consent to Photograph

I authorize ACCEPT Education Collaborative to utilize my child's image and voice in any video tape or photograph for training purposes and publication on ACCEPT's web site and printed materials. No identifying information, other than your child's image, will be published.

Parent/Guardian Name (please print) _____

Parent/Guardian Signature _____ Date _____

Permission for Student to Ride as a Passenger in an ACCEPT Vehicle

I hereby give permission for my child to ride as a passenger in an ACCEPT vehicle for the purpose of community outings.

Parent/Guardian Name (please print) _____

Parent/Guardian Signature _____ Date _____

Permission to Apply Sunscreen

I hereby give permission for ACCEPT staff to apply sunscreen to my child as needed.

Parent/Guardian Name (please print) _____

Parent/Guardian Signature _____ Date _____

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Behavior Management Consent Form

2015 - 2016 School Year

I hereby give consent to the ACCEPT staff to use behavior management techniques for my child, _____, as deemed necessary and appropriate. The range of appropriate behavior management techniques which may be utilized with my child have been reviewed with me during our most recent IEP Team meeting and have been shared with me in writing in the IEP and in a review of the ACCEPT Academy's Restraint Policy. I understand there is a procedure in place for me express my concerns regarding restraint practices and have been given the name and contact number of the person to whom I may speak regarding the issues.

I understand that the staff of the ACCEPT Academy are trained by certified instructors in non-violent crisis intervention, a formal training program designed by Safety Care. While Safety Care training and individually tailored behavioral intervention programs emphasize non-physical de-escalation techniques, ACCEPT Academy staff, when deemed necessary and appropriate, may employ physical interventions that include:

- Escort (i.e., physically moving my child from one space to another)
- Physical restraint (i.e., physically holding my child's hands, arms, legs, feet and/or heard to prevent my child form injuring themselves or others)

I understand that, at their discretion as deemed necessary, ACCEPT Academy staff may employ time out procedures for my child (i.e., excluding the student from a given activity for a period of time due to disruptive, dangerous, or other behavior that compromises the individual or group learning opportunity).

Time out procedures may take place within the classroom setting or in an alternate Safe Space, i.e. an unlocked, low-sensory space where an adult staff member will be physically present at all times. My child will always have access to ACCEPT Academy staff during the implementation of any time out procedure.

I understand that ACCEPT Academy does not employ any forms of chemical or mechanical restraint, and does not endorse the use of any aversive behavioral interventions.

Parent/Guardian Signature _____ Date _____

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Authorization for Release of Medical Information

2015 - 2016 School Year

I give permission for my child's Health Care Providers to communicate with the ACCEPT Education Collaborative nursing staff regarding his/her health information and medical care.

Student's Name _____ Date of Birth _____

Parent/Guardian Signature _____ Date _____

I understand that the ACCEPT Education Collaborative will treat records confidentially and fully comply with the Family Educational Rights and Privacy Act (FERPA) and HIPPA Privacy laws.

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Release of Information and Records

2015 - 2016 School Year

Name of Student _____ Date of Birth _____

By signing below, I hereby request and authorize the following persons or organizations to exchange all pertinent information and/or records regarding my child with ACCEPT Education Collaborative staff.

1. Name of person and position or agency _____
   Phone _____ Address _____
   City _____ State _____ Zip Code _____

2. Name of person and position or agency _____
   Phone _____ Address _____
   City _____ State _____ Zip Code _____

3. Name of person and position or agency _____
   Phone _____ Address _____
   City _____ State _____ Zip Code _____

4. Name of person and position or agency _____
   Phone _____ Address _____
   City _____ State _____ Zip Code _____

5. Name of person and position or agency _____
   Phone _____ Address _____
   City _____ State _____ Zip Code _____

Note: The confidentiality of Medical and Psychiatric records is required under Massachusetts General Statues. By law, no information may be transferred to another party without written consent or other authorization of the parent/guardian. The patient or parent/guardian has the right to revoke the above agreement at any time. This request expires one year from this date.

Parent/Guardian Signature _____ Date _____

Student Signature (required if over 18) _____

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Parent/Guardian Authorization for Dispensing Non-Prescription Medication

2015 - 2016 School Year

Student _____ Date of Birth _____ Allergies _____

The following over the counter medications, or the generic equivalent, are ordered by the school physician for student use: Tylenol, Motrin, Benadryl, Bacitracin, Hydrocortisone, Calamine Lotion, and Cough Drops with Menthol. My child may have any of the above listed medications as needed. ❑ Yes ❑ No

If no, please list any of the medications you **DO NOT** want your child to receive:

_____

_____

*** Parent/Guardian will be contacted before administering a dose to be sure a dose was not given at home ***

A student who needs to take **any other medication** during school hours must have this form signed by a parent/guardian and a signed **Medication Authorization and Administration Plan** from the prescribing physician. Medication must be in a pharmacy labeled container, and taken under the supervision of the school nurse. **Students are not allowed to transport any medication.**

I give permission for the school nurse to give the medication(s) listed below (please list medication and prescribing physician):

_____

_____

_____

I give permission for the school nurse to share pertinent medication information with appropriate school personnel and to communicate with prescribing physician when necessary.
❑ Yes ❑ No Restrictions _____

I give permission, when necessary, for the school nurse to delegate administration of an EpiPen to trained personnel. ❑ Yes ❑ No ❑ Not Applicable

I request that my child receive his/her medication at school prior to dismissal on early release days.
❑ Yes ❑ No ❑ Not Applicable

My child currently takes the following medications at home:

Medication:	**Prescribed by:**
_____	_____
_____	_____
_____	_____

Parent/Guardian Name _____ Home Phone Number _____

Parent/Guardian Signature _____ Cell Phone Number _____

Emergency Contact Name _____ Phone Number _____

Relationship to student _____

Please request and complete a new form if medication changes.

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Physician's Medication Authorization and Administration Plan

2015 - 2016 School Year

All students receiving medication at school require a **Medication Authorization and Administration Plan** from the prescribing physician. Prescription and non-prescription medications, not included in ACCEPT's standing orders, can only be administered when the **Physician's Medication Authorization and Administration Plan** and the **Parent/Guardian Authorization for Dispensing Medications** is completed and on file with the ACCEPT Nurse Leader. The ACCEPT Nurse Leader will provide the plan to the school nurse at your child's school.

Doctor's Medication Order

Valid for the school year 2015-2016 (includes 2016 Summer Program)

Student _____ Date of Birth _____

Diagnosis/Medical Condition _____ Food/Drug Allergies _____

	Medication	Dose	Route	Time (to be given)	Reason for Medication
1.					
2.					
3.					
4.					

Please attach additional sheet if needed.

Possible side effects, adverse reactions:

_____

Other medications (taken at home) – dosage and reason for medication:

Drug _____ Dose _____

Reason _____

Drug _____ Dose _____

Reason _____

Drug _____ Dose _____

Reason _____

Doctor's Name (please print) _____ Telephone _____

Fax _____

Doctor's Signature _____ Date Ordered _____

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Questionnaire for Parent/Guardian of a Child with Seizure Disorder

2015 - 2016 School Year

Student's Name _____ Date of Birth _____
School _____ Grade _____
Classroom _____ Teacher _____

Mother's Name _____ Phone (home) _____
Phone (work) _____ Phone (cell) _____

Father's Name _____ Phone (home) _____
Phone (work) _____ Phone (cell) _____

The following information will be helpful to the school nurse and school staff in determining your child's special needs. Please complete all questions.

1. When was your child's first seizure and does your child continue to have active seizures?

_____

2. Is there a difference between past and current seizure patterns? ❑ Yes ❑ No
If so, how have they changed? _____

_____

3. Describe
• Seizure type _____
• Describe what happens during the seizure _____
• What triggers the seizure? _____
• How long does seizure typically last? _____
• How long should the student wait after the seizure before returning to the regular school schedule?

_____

• Are there any warnings and/or behavior changes before the seizure (ex. agitation, headache, blurred vision)

_____

• Average frequency ❑ daily ❑ weekly ❑ monthly ❑ yearly _____
• Usual time of day seizure(s) occur _____
• Date of last seizure _____
• Student's reaction to seizure(s) (ex. lethargic, nausea, vomiting,) _____

_____

4. When your child is sick, does the frequency of seizure(s) increase? ❑ Yes ❑ No

5. What medication(s) does your child take for seizure control?

Medication	Dosage	Frequency and Time of Day Taken

6. Does your child require emergency medications to treat long lasting seizures? ❑ Yes ❑ No
If yes, what type? _____

7. Will your child need to have medications administered during school hours? ❑ Yes ❑ No
If yes, complete below:
• Should the medication be administered in a special way? ❑ Yes ❑ No
If yes, please describe _____

• Should any particular reaction be watched for? ❑ Yes ❑ No
If yes, please describe _____

8. Does taking other medication(s) affect your child's seizure control? ❑ Yes ❑ No
If yes, please describe _____

9. What happens when your child misses a dose? _____

10. What do you do when your child misses a dose? _____

11. Should the school have backup medication available to give your child for a missed dose?
❑ Yes ❑ No If yes, please describe _____

12. List any special considerations related to your child's epilepsy while at school and describe them briefly.

• Educational concerns _____
• Behavioral concerns _____
• Emotional concerns _____
• Physical Education/Sport precautions _____
• Special considerations for field trips/transportation _____
• Other _____

13. What is the best way for us to communicate about your child's seizure(s), medication(s), and/or other observations/concerns (e.g., calendars, daily written notes, email, phone)?

_____

14. How often does your child see the doctor regarding seizures? _____
• When was his/her last appointment? _____

15. The physician treating your child's seizures is
Name _____
Address _____
Phone Number _____

16. Does your child have other recurring or chronic health problems? ❑ Yes ❑ No
If yes, please describe _____

_____

_____

Parent/Guardian Signature _____ Date _____

MASSACHUSETTS SCHOOL HEALTH RECORD
Health Care Provider's Examination

Name _____ ☐ Male ☐ Female Date of Birth:_____
Medical History _____
_____

Pertinent Family History

Current Health Issues

Y	N	
☐	☐	Allergies: Please list: Medications _____ Food _____ Other _____
		History of Anaphylaxis to _____ Epi-Pen®: ☐ Yes ☐ No
☐	☐	Asthma: Asthma Action Plan ☐ Yes ☐ No (*Please attach*)
☐	☐	Diabetes: ☐ Type I ☐ Type II
☐	☐	Seizure disorder: _____
☐	☐	Other (*Please specify)* _____

Current Medications (if relevant to the student's health and safety) *Please circle those administered in school; a separate medication order form is needed for each medication administered in school.*

Physical Examination **Date of Examination:**_____

Hgt: _____(_____%) Wgt:_____(_____%) BMI: _____(_____%) BP: _____

(Check = Normal / If abnormal, please describe.)

☐ General _____	☐ Lungs _____	☐ Extremities _____
☐ Skin _____	☐ Heart _____	☐ Neurologic _____
☐ HEENT _____	☐ Abdomen _____	☐ Other _____
☐ Dental/Oral _____	☐ Genitalia _____	

Screening:

	(Pass)	(Fail)
Vision: Right Eye	☐	☐
Left Eye	☐	☐
Stereopsis	☐	☐
Hearing: Right Ear	☐	☐
Left Ear	☐	☐
Postural Screening: (Scoliosis/Kyphosis/Lordosis)	☐	☐

Laboratory Results: ☐ Lead _____ Date _____ ☐ Other_____

The entire examination was normal: ☐

Targeted TB Skin Testing: ☐ Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):
Date of PPD: ____; Results: ____mm.
Referred for evaluation to: _____ ☐ Low risk (no PPD done)

This student has the following problems that may impact his/her educational experience:
☐ Vision ☐ Hearing ☐ Speech/Language ☐ Fine/Gross Motor Deficit
☐ Emotional/Social ☐ Behavior ☐ Other

Comments/Recommendations:_____

☐Y ☐ N **This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions:**_____

☐ Y ☐ N **Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record**.

_____ _____
Signature of Examiner *Circle:* MD, DO, NP, PA Date *Please print name of Examiner.*

_____
Group Practice Telephone

_____
Address City State Zip Code

Please attach additional information as needed for the health and safety of the student. *MDPH 12/14/04*