

School Year 2011-12

Student Information Forms Listing

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EMERGENCY INFORMATION RECORD

Student

Name: _____ District of Residence: _____
(Last) (First)
Social Security Number: _____ Medicaid Number: _____
Home Address: _____ City: _____ Zip Code: _____
Home Phone: _____ Date of Birth: _____ Male Female

Parent/Guardian Information (add addresses if different from child)

Father: _____ Home/Cell Phone: _____ / _____
Home Address: _____ Business Phone: _____
email address: _____

Mother: _____ Home/Cell Phone: _____ / _____
Home Address: _____ Business Phone: _____
email address: _____

Legal Guardian/Surrogate: _____ Daytime Phone: _____
Child lives with: Mother Father Both Other Please specify: _____

I give permission for the following person(s) to pick up this student in case of emergency, if I cannot be reached.

Name: _____ Home/Cell Phone: _____ / _____
Address: _____ City: _____
Name: _____ Home/Cell Phone: _____ / _____
Address: _____ City: _____

Medical

Student's Doctor: _____ Address: _____
Phone Number: _____

Does your child take medication? Yes (if yes, please list medication/s below) No

_____ Daily Dosage: _____
Daily Dosage: _____
Daily Dosage: _____

If given in school, what is the dosage? _____ What is medication for? _____

Is your child allergic to anything (e.g., food, medicine, animals)? Yes No
If yes, please specify: _____

Signature: _____ **Date:** _____

AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

I, _____, hereby authorize the exchange of communications and the
(name of parent or guardian)
 release/exchange of the following records concerning _____ between
(name of student and date of birth)
 Southwest Cooperative employees and _____.
(name of person/agency)

- | | |
|---|--|
| <input type="checkbox"/> Complete Eligibility Determination Reports | <input type="checkbox"/> Psychological Reports |
| <input type="checkbox"/> Health Records (incl. immunizations) | <input type="checkbox"/> Report Cards/Progress Reports |
| <input type="checkbox"/> IEPs | <input type="checkbox"/> Social Worker Reports |
| <input type="checkbox"/> Medical Records | <input type="checkbox"/> Therapy Reports |
| <input type="checkbox"/> Multidisciplinary Staff Reports | <input type="checkbox"/> Other _____ |

These disclosures are authorized pursuant to 20 U.S.C. Section 1232g, 105 ILCS 10/1 et seq., and 740 ILCS 110/1 et seq.,* and are to be made for the purpose of educational planning for above named student. I understand that I have the right to inspect and copy the information to be disclosed, challenge its contents, and limit my consent to designated records or portions of the information contained in those records. I also understand that my refusal to consent to the exchange of records and communications could result in incomplete and/or inappropriate educational planning for the above named student.

This consent expires one year from the date indicated below. However, I understand that I have the right to revoke this consent in writing at any time.

_____ PARENT/GUARDIAN SIGNATURE	_____ DATE
_____ STUDENT SIGNATURE (for mental health/developmental disability records, if student is age 12 or older)	_____ DATE
_____ WITNESS SIGNATURE (for mental health/developmental disability records)	_____ DATE

* NOTE: Prior to the release of protected health information, health care providers may require the parent/guardian to execute an additional authorization form to comply with the Health Insurance Portability and Accountability Act (HIPAA).

4/29/11 jab (final)

"Opening the world through education to children and young adults with diverse abilities"



**SOUTHWEST COOK COUNTY COOPERATIVE ASSOCIATION FOR SPECIAL EDUCATION
(SWCCCASE)**

MEDICATION – PARENT GUIDELINES

The following procedural guidelines will state parental responsibilities and requirements for Cooperative students who require medication administration during the regular school day or school-related activity.

1. Medication Authorization form must be completed and signed by both parent and physician for any medications to be administered at school. This includes:
 - a. Long-term prescribed medications
 - b. Short-term prescribed medications
 - c. Over-the-counter medications
 - d. PRN (as necessary) medications.

An updated Medication Authorization form is required any time there is a change in medication, dosage, or time of administration. In the case of long-term medication administration, authorization must be renewed annually.

2. Medication should be brought to school by parent or pursuant to alternate arrangements made between the parent and school officials.
3. All prescriptions must be in proper pharmacist-labeled containers.
4. Over-the-counter medications must bear original label.
5. Without proper authorization, children will not be allowed to take their own medication(s) in their possession during school hours.
6. Children will not be allowed to take their own medication, unless specific written procedures for doing so have been authorized in writing by the parent and the student's physician on a SWCCCASE or District Medication Authorization Form, and the medication is taken pursuant to these procedures.

The above procedural guidelines have been established to ensure safe and effective medication administration practices.

Section 1.01

Section 1.02

Section 1.03

4/12/11 jab (final)



**SOUTHWEST COOK COUNTY COOPERATIVE ASSOCIATION FOR SPECIAL EDUCATION
(SWCCCASE)**

MEDICATION(S) – PARENT/PHYSICIAN AUTHORIZATION

Student Name: _____

Birth Date: _____ Program/Location: _____

<u>MEDICATION</u>	<u>DOSAGE</u>	<u>ROUTE OF ADMINISTRATION</u>	<u>TIME OF ADMINISTRATION</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____

Condition and purpose for which medication prescribed: _____

Necessity for medication during school hours: _____

Comments (Include special instructions, possible side effect, etc.): _____

*When "PRN" is noted, please list specific conditions, which would warrant administration: _____

Physician's Signature

Date

Address

Phone Number

.....
PARENT AUTHORIZATION: Regarding the above listed medication(s), I hereby authorize the administration of medication to my child by individual as specified in SWCCCASE Medication Administration Policy. Yes No

Parent Signature/DCFS Representative (if student is in foster care)

Date

Home Phone: _____

Cell Phone: _____

Work Phone: _____



**SOUTHWEST COOK COUNTY COOPERATIVE ASSOCIATION FOR SPECIAL EDUCATION
(SWCCCASE)**

HEALTH CARE PROCEDURE – PARENT GUIDELINES

The following procedural guidelines will state responsibilities and requirements for Cooperative students who require specific medical/health care procedures during the regular school day or a school-related activity. Prior to the implementation of the procedure in the school setting by a trained staff member, it will be necessary that the following requirements be met.

1. Health Care Procedure Authorization form must be completed and signed by both parent and physician, and include the physician's written order for the procedure.
2. Physician's written order for specific procedure required during the regular school day or a school-related activity should include:
 - a. Diagnosis
 - b. Procedure
 - c. Reason for procedure
 - d. Frequency, including time schedule and/or indication for procedure
 - e. Specific instructions (including precautions, possible adverse reactions and interventions)
 - f. Duration of procedural implementation.
3. Authorization form including physician's order is to be renewed annually and/or at any time during the year if change from original order should occur.
4. The Cooperative nurse will act as a resource to designated trained staff member performing procedure.
5. Parent will be responsible for providing and replenishing the necessary supplies/equipment for implementation of procedure.
6. Parent will be responsible for immediately notifying Cooperative nurse of any changes in procedure or child's physical condition affecting performance of procedure.



**SOUTHWEST COOK COUNTY COOPERATIVE ASSOCIATION FOR SPECIAL EDUCATION
(SWCCCASE)**

HEALTH CARE PROCEDURE – ANNUAL PARENT/PHYSICIAN AUTHORIZATION

Student Name

Date of Birth

Program

To be completed by Physician:

Diagnosis: _____

Procedure: _____

Duration: _____

Reason for Procedure: _____

Frequency: (Please include times and/or procedural indications): _____

Specific instructions: (include precautions, possible adverse reactions and interventions; when “PRN” is noted, please specify indications for procedure to be performed):

Physician’s Signature/Date

Physician’s Address

Phone Number

Parent Authorization:

I authorize the release and exchange of information between SWCCCASE and the above named physician(s) or agency(ies) regarding the above listed procedure.

I hereby authorize and request the above procedure for my child during school hours by SWCCCASE employees.

Parent Signature (do not sign until completed)

Date

Parent Home Phone Number: _____

Work Phone Number: _____



Authorization to Access Electronic Networks

We have the ability to enhance your child's education through the use of electronic networks, including the Internet. The Internet offers vast, diverse, and unique resources. The Southwest Cook County Cooperative Association for Special Education's (SWCCCASE) goal in providing this service is to promote educational excellence by facilitating resource sharing, innovation, and communication. Your authorization is needed before your child may use this resource.

The Internet electronically connects thousands of computers throughout the world and millions of individual subscribers. Students and teachers may have access to:

- Limited electronic mail communications with people all over the world,
- Information from government sources, research institutions, and other sources,
- Discussion groups, and
- Many libraries, including the catalog to the Library of Congress, and the Educational Resources Information Clearinghouses (ERIC).

With this educational opportunity also comes responsibility. You and your child should read the enclosed *Authorization for Electronic Network Access* and discuss it together. The use of inappropriate material or language, or violation of copyright laws, may result in the loss of the privilege to use this resource. Remember that you are legally responsible for your child's actions.

The Cooperative takes precautions to prevent access to materials that may be defamatory, inaccurate, offensive, or otherwise inappropriate in the school setting. On an unregulated network, however, it is impossible to control all material and a user may discover inappropriate material. Ultimately, parents/guardians are responsible for setting and conveying the standards that their child or ward should follow. To that end, the Cooperative supports and respects each family's right to decide whether or not to authorize Internet access.

Please read and discuss the *Authorization for Electronic Network Access* with your child. If you agree to allow your child to have an Internet account, sign the *Authorization* form and return it to your school.

Please retain the attached policy and procedures for future reference.



Authorization to Access Electronic Networks

Please sign and return this form.

Student Name: _____ Program: _____

I read, understand and consent to the SWCCCASE policy and procedures regarding permissible use of electronic networks. I understand that failure to follow SWCCCASE policy and procedures may result in the loss of privileges, disciplinary action, and/or appropriate legal action.

Student Signature

Date

Parent Signature

Date

Attachments: SWCCCASE Policy 6:235
Administrative Procedures 6:235-AP1