

School Year 2011-12

CIBS STUDENT PACKET **Information Forms Listing**

1	Emergency Information Record Annual – <u>SIGNATURE REQUIRED & DATE</u>
2	Consent for use of student's name, work and/or picture - <u>SIGNATURE REQUIRED</u>
3	Consent For Release /Exchange of Information
4	Medication Parent Guidelines
5	AUTHORIZATION
6	Health Care Procedure-Parent Guidelines
7	Physician AUTHORIZATION



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: _____ Phone Number: _____
Address: _____ City _____ ST _____

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

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



SOUTHWEST COOK COUNTY COOPERATIVE
ASSOCIATION FOR SPECIAL EDUCATION
6020 West 151st Street
Oak Forest, IL 60452
708-687-0900

CONSENT FOR USE OF STUDENT'S NAME, WORK, AND/OR PICTURE

We, _____, parent, and _____, student, give permission for Southwest Cook County Cooperative Association for Special Education ("SWCCCASE") to publish the student's name, work and/or picture in SWCCCASE public relations articles, videotapes, television education programs, and/or the SWCCCASE Internet educational web page ("publications"). These publications are authorized by us pursuant to 20 U.S.C. § 1232g, 105 ILCS 10/1 et seq., and 740 ILCS 110/1 et seq., and are for the purpose of providing general information to the public about SWCCCASE special education programs and services. We have seen and received a copy of the photograph or photographs of the student to be used in the publications before signing this consent form. We understand that student work made available on the website may be viewed by others on the internet. We understand that our refusal to sign this consent form will result in the photograph(s) of the student being excluded from the publications. We also understand that, once the publications are sent to the printer, we waive the right to revoke our consent to use the student's name and/or photograph(s) in such publications.

PARENT

STUDENT (if age 12
or older)

Date: _____
(not to exceed one calendar year)

Date: _____
(not to exceed one calendar year)

WITNESS (age 18 or older only)

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"

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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.



**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>
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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.

