INDIVIDUAL INFORMATION SHEET

Child's Full Name _____

Residential Address: Street or Road _____

City, State, Zip Code _____

Mailing Address (if different) _____ School District: _____

Date of birth _____ Age _____ Sex _____ Phone _____

Physician _____ Dentist _____

Address _____ Address _____

Father's Name _____ **Mother's Name** _____

Address (if different) _____ Address (if different) _____

_____ _____

Email Address _____ Email Address _____

Phone _____ Married Status _____ Phone _____ Married Status _____

Place of work _____ Place of work _____

Work Phone _____ Work Phone _____

BUS TRANSPORTATION INFORMATION – **If identified in your child's IEP**

PICK UP POINT

Residents Name _____

Address _____

_____

Phone _____

DROP OFF POINT

Residents Name _____

Address _____

_____

Phone _____

EMERGENCY MEDICAL AUTHORIZATION

PART I **OR** PART II MUST BE COMPLETED for the purpose of enabling parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under program authority, when parents or guardians cannot be reached.

*** CHOOSE PART I OR PART II BELOW: ***

PART I TO GRANT CONSENT

In the event reasonable attempts to contact me at home or work or others (as stated above) have been unsuccessful, I hereby give my consent for, (1) the administration of any treatment deemed necessary by Dr. _____ (preferred physician), or Dr. _____ (preferred dentist) or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the enrollee to _____ (closest hospital) or any hospital reasonably accessible.
This authorization does not cover major surgery unless the medical opinions of other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

_____ _____ SIGN HERE

Date **Signature of Parent/Guardian**

PART II REFUSAL TO CONSENT

I **do not** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the program authorities to take no action or to: _____

_____

_____ _____

Date Signature of Parent/Guardian **Refusing Consent**

CONTINUED ON BACK

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted. Please include dentures, glasses, or any type of prosthesis, etc.

Check all that apply:

☐ Eyeglasses ☐ Visually Impaired/Blind ☐ Wheelchair ☐ Walker

☐ Hearing Aids ☐ Other _____

Health Information		Yes	No
Neurologic	Seizures		
	Stroke		
	Shunt		
Metabolic	Diabetes		
Respiratory	Reactive Airway Disease		
	Asthma		
Cardiac	Pacemaker Defibrillator		
	Heart Disease		
	Congenital		
Vision	Blindness		
Speech	Speech Disorder		
Hearing	Hearing Loss		
Muscular	Muscle Disorder		

Comments about any special health problem or behavioral concerns _____

_____

_____

Please list all medications/food supplements your child takes and indicate frequency:

Medication	Dosage	Times per day	Medication to be taken at school Yes	No

☐ **Allergies:** FOOD _____

_____

☐ **Allergies:** MEDICATIONS _____

_____

☐ **Special Diet:** _____

LIST TWO NAMES THAT CAN BE REACHED WHEN YOU (PARENT(S) / GUARDIAN) ARE UNAVAILABLE. BE SURE TO INCLUDE THEIR NAMES ON THE CHILD RELEASE FORM.

Name _____ Name _____

Address _____ Address _____

Phone _____ Phone _____

CHILD RELEASE FORM
School Year 2020-2021

Dear Parents:

We realize that there are times when your child needs to be picked up during school hours for doctor appointments or other reasons. When it is necessary to pick up your son/daughter, please send a note in that morning so we are aware that they are leaving early that day.

We want to make certain that we are releasing your child to someone authorized by you when a person other than the parents or the custodial parent is picking up your son/daughter.

Therefore we will only release your child to you unless the attached form is returned to us. We will only release your child to the **ADULT**(s) listed below when you return the form. If a situation comes where someone not listed below must pick up your child, we will only release your child when they present a note with your signature on it giving your permission.

This policy is necessary for your protection, the safety of your child, and for our regulations. Thank you for your cooperation.

Joy Badenhop

Educational Supervisor

Listed below are all **ADULTS** who may pick up your son/daughter from school or from the bus without further authorization. Anybody not listed below must have a note from me stating my permission.

LIST EVERYBODY WHO HAS PERMISSION TO PICK UP YOUR SON/DAUGHTER

NAME RELATIONSHIP TO CHILD PHONE

PLEASE LIST BELOW ANYONE SPECIFICALLY **NOT** ALLOWED TO PICK UP YOUR SON/DAUGHTER

_____ _____

(Student Name) **(Parent Signature - Mother)**

_____ _____

(Date) **(Parent Signature - Father)**

PICTURE / ROSTER RELEASE FORM
School Year 2020-2021

Dear Parents,

Throughout the year **photographs** and **videos** of the children learning and playing are used by the Discovery Center for Public Relations. Your child's name will not be used in this publication, however we do need your permission to use their photograph or video.

A **classroom roster** is also developed to share addresses and phone numbers with parents who may wish to contact families for such things as party invitations and car pooling. Your permission to include your child in this class roster is also needed.

Please complete the following section to reflect your wishes.

_____ Yes, my child may be included in photographs for publication and the class roster.

_____ No, I prefer my child not be included in public photographs or on the class roster.

_____ _____

Child's Name Parent Signature

_____

Date

It is important to us to know that you have received this information as required by the Health Insurance Portability and Accountability Act (HIPAA). Thank you for your cooperation.

PLEASE RETURN THIS PAGE TO:

LOGAN COUNTY BOARD OF DD
P. O. Box 710, Bellefontaine, OH 43311

☐ RTC Industries
☒ Discovery Center
☐ Board Office

Acknowledgment of Receipt of Privacy Notice

I, _____, have received a copy of the
(Print Name) privacy notice from the
LOGAN COUNTY BOARD OF DD.

_____ _____
Signature of Individual Receiving Notice Date

Please return ASAP. Thank You!

DISCOVERY CENTER for CHILDREN EARLY CHILDHOOD PROGRAMS

Student Registration

2020-2021 Data Collection Form

School District of Residence_____ Date of Birth____/____/____

Student's Name:_____
Last First Middle

Address:_____ City:_____ Zip Code:_____

Telephone:(____) _____ Student's Social Security #:_____

Student lives with:

Circle appropriate status Father Mother Grandparent Step-Parent Guardian Foster Parent

Student lives with:_____
Name(s)

STUDENT INFORMATION

(Circle One) Male Female

Is the student Hispanic/Latino heritage? Yes or No

(Circle at least one race, more if applicable)

A- Asian B- Black or African American, Non-Hispanic I- American Indian/Alaskan Native

W- White P- Native Hawaiian or Other Pacific Islands

City of Birth:_____

Mother's Maiden Name:_____

Copy of birth certificate is required at initial enrollment (Please complete both sides of form)

Dear Parents,

Due to enrollment guidelines from the Ohio Department of Education, we are asked to report approximate family income for all preschoolers in our agency. This form will be used for ODE reporting purposes and to identify potential scholarship students.

Please circle the size of your family unit and then, going across, circle the income level of your household in that line (see example below).

If you are paying tuition and your income falls in range A through E, you are encouraged to submit a copy of your 2019 income tax form for scholarship consideration. (the actual income tax form – not just W2's)

All information is strictly confidential.

Size of Family Unit	Range A 0-100%	Range B 101-125%	Range C 126-150%	Range D 151-175%	Range E 176-185%	Range F 186-200%	Range G 201%+
1	Below $12,760	$12,761-$15,950	$15,951-$19,140	$19,141-$22,330	$22,331-$23,606	$23,607-$25,520	$25,521
2	Below $17,240	$17,241-$21,550	$21,551-$25,860	$25,861-$30,170	$30,171-$31,894	$31,895-$34,480	$34,481
3	Below $21,720	$21,721-$27,150	$27,151-$32,580	$32,581-$38,010	$38,011-$40,182	$40,183 -$43,440	$43,441
4	Below $26,200	$26,201-$32,750	$32,751-$39,300	$39,301-$45,850	$45,851-$48,470	$48,471-$52,400	$52,401
5	Below $30,680	$30,681-$38,350	$38,351-$46,020	$46,021-$53,690	$53,691-$56,758	$56,759-$61,360	$61,361
6	Below $35,160	$35,161-$43,950	$43,951-$52,740	$52,741-$61,530	$61,531-65,046	$65,047-$70,320	$70,321
7	Below $39,640	$39,641-$49,550	$49,551-$59,460	$59,461-$69,370	$69,371-$73,334	$73,335-$79,280	$79,281
8	Below $44,120	$44,121-$55,150	$55,151-$66,180	$66,181-$77,210	$77,211-$81,622	$81,623-$88,240	$88,241

EXAMPLE

Size of Family Unit	Range A 0-100%	Range B 101-125%	Range C 126-150%	Range D 151-175%	Range E 176-185%	Range F 186-200%	Range G 201%+
1	Below $12,760	$12,761-$15,950	$15,951-$19,140	$19,141-$22,330	$22,331-$23,606	$23,607-$25,520	$25,521
(2)	Below $17,240	$17,241-$21,550	$21,551-$25,860	$25,861-$30,170	$30,171-$31,894	$31,895-$34,480	$34,481

Signature _____ Date _____

(Please complete both sides of form)

PR-10 PARENTAL CONSENT TO SHARE HEALTH INFORMATION FOR THE OHIO MEDICAID SCHOOL PROGRAM

CHILD'S INFORMATION

CHILD'S NAME _____

DATE OF BIRTH _____ DISTRICT NAME _____

Ohio school districts have the opportunity to receive federal Medicaid dollars through a program called the Ohio Medicaid School Program (MSP). Through this program, school districts can receive Medicaid dollars for services identified in the IEP, such as Speech, Audiology, Physical Therapy, Occupational Therapy, Nursing, Psychology, Counseling, and Social Work services. In the process of billing Medicaid for these services, billing information must be shared with the Ohio Department of Medicaid. For Medicaid billing purposes, schools must obtain a one-time signed Parental Consent to Share Health Information for the Ohio School Medicaid Program. After this one-time written consent, you will receive an annual notice of this consent.

Schools request this consent for all students who receive special education services, even students who may not be currently eligible for Medicaid. Some health information shared is specific to your student, while other information is related to all students within the entire school district. Schools can use this health information to help reduce special education costs that the district must deliver pursuant to the Individuals with Disabilities Education Act (IDEA). This student specific health information is protected and will be accessed only by people authorized to do so by the school's Medicaid contract.

Your consent is voluntary. You have the right to withdraw your consent at any time (34 CFR Part 99 and Part 300.) You are not required to enroll in Medicaid. If your school does bill Medicaid, you will not be required to incur any out-of-pocket expenses such as a deductible or co-pay, decreased lifetime coverage, increased premiums or the discontinuation of benefits, or result in you paying for services. If a bill or Explanation of Benefits (EOB) is received, you are not required to cover any cost for school-based services.

Regardless of whether you grant consent, refuse consent, or revoke your consent, your child will still be provided with an evaluation and/or the services as identified by the IEP team at no cost to you.

____ I understand and agree to give permission to share my child's *specific* health information in order for the school to access Medicaid. *

____ I do not give permission to share my child's *specific* health information in order for the school to access Medicaid.

Parent (printed) Name _____

Parent Signature _____ Date_____

* Signing this consent allows Healthcare Billing Services to submit all claims not older than 365 days from date signed.

Please contact **Healthcare Billing Services, Inc**. at **(740) 639-4218** with questions or if you feel you have incurred a personal cost for these services.

Notice of Parent/Guardian Rights
Parental Consent to Access Public Benefits (Medicaid)
The Ohio Medicaid School Program

Ohio School Districts have the opportunity to receive Federal Medicaid dollars through a program called the Ohio Medicaid School Program (MSP). Through this program, school districts can receive Medicaid dollars for services such as Speech, Audiology, Physical Therapy, Occupational Therapy, Nursing, Psychology, Counseling, and Social Work services. The district can receive funding when a student receives one or more of these services and the student has current Medicaid insurance coverage. In the process of billing Medicaid for these services, certain billing information must be shared with the Ohio Department of Jobs and Family Services. Before the district can submit claim data for Medicaid billing purposes, we must first obtain a signed Parental Consent to Share Information and Access Medicaid.

This annual notice is to inform you of all of your legal protections and rights under the Individuals with Disabilities Education Act (IDEA) and the Family Educational Rights and Privacy Act (FERPA).

Your consent is voluntary. You have the right under 34 CFR Part 99 and Part 300 to withdraw your consent at any time. You are not required to enroll in Medicaid. Billing Medicaid will not require you to incur any out-of-pocket expenses such as a deductible or co-pay, decrease lifetime coverage, increase premiums or lead to the discontinuation of benefits, or result in you paying for services that would otherwise be covered by Medicaid. No matter whether you grant consent, refuse consent, or revoke your consent, your child will still be provided with an evaluation and/or the services listed in their IEP at no cost to you.
For a more detailed explanation of Medicaid Parental Consent, please see the following Code of Federal Regulations (CFR).

34 CFR 300.154
34 CFR 300.503
34 CFR 300.622
34 CFR 99.30

For specific questions regarding the Medicaid School Program Parental Consent, please contact Healthcare Billing Services, Inc. at (740) 639-4218 or at TeamHBS@aol.com

Discovery Center

FAMILY INFORMATION FORM

2020-2021

Child's Name (Last)	*(First)*	*Nickname (If any)*

By providing complete information about your child, you will be assisting staff in creating a positive experience for him/her while in care. List any information about your child's habits, abilities or personality that you feel will be helpful to the staff while caring for your child.

Who is in the child's immediate family?

Who lives at home with your child?

What is the primary language spoken in your child's home?

Are there any special family arrangements, such as shared parenting, living in two homes, or custody specifications, etc.? Additional Details?

Are there any changes or transitions that your child has recently experienced or is experiencing? (moved from crib to bed, divorce, new home, death of family member, friend or pet) Additional Details?

Are there any cultural or religious practices of your family we should be aware of? (Dietary restrictions, clothing, head coverings, etc.)

Do you have any pets at home? If so, what are they and what are their names?

Has your child had a previous care arrangement? ☐ Yes or ☐ No Additional Details? (Center based, in home, with family, with parents, etc.)

My child drinks ☐ milk, ☐ formula, ☐ juice or ☐ water. (Check all that apply)

How much and how often?

Does your child have any favorite foods?

Does your child dislike any foods?

Are there any foods your child should not be fed? (Licensing requires documentation be completed for children with food allergies and/or dietary restrictions)

Please check all of the words that best describe your child's personality and behavior

☐ active ☐ adventurous ☐ affectionate ☐ anxious ☐ bossy ☐ bright ☐ busy ☐ calm ☐ cautious ☐ cheerful

☐ content ☐ creative ☐ curious ☐ easily-angered ☐ emotional ☐ energetic ☐ excitable ☐ friendly

☐ gives-in-easily ☐ happy ☐ hesitant ☐ insecure ☐ jealous ☐ likes structure/routines ☐ loud ☐ loving

☐ mellow ☐ outgoing ☐ prefers adult attention ☐ quiet ☐ sensitive ☐ serious ☐ shares-well

☐ social ☐ spontaneous ☐ stubborn tentative

☐ other:

Are there additional personality and behavior characteristics that would be useful to know about your child?

Are there things that frighten your child? If so, how does he/she react and what do you do to comfort him/her?

What routines/actions or items do you use to comfort your child?

What causes your child to feel angry or frustrated?

What methods do you use to respond to your child's negative behavior?

Does your child use any special comfort or support items that help him/her go to sleep? If so, what?

What is your child's mood upon waking? (happy, grouchy, clingy, slow to awaken)?

My child sits in a ☐ high chair, ☐ booster, ☐ child size chair or ☐ adult size chair. (Check the one that applies.)

Is your child toilet trained? If not, have you started the toilet training process? Please explain the process used.

Does your child need assistance when using the toilet? If so, how?
What words, gestures or signs does your child use if he/she needs to use the bathroom?
What time does your child normally go to bed at night and wake up in the morning?
What time(s), and for how long, does your child usually nap?
Does your child have trouble sleeping (Night terrors, trouble going to sleep, etc.)? Please explain.
What might you and/or your child be anxious about as he/she starts in this program?
What are you and/or your child excited about as he/she starts in this program?
What are your expectations of this program?
What are your developmental and / or educational goals for your child this year? (Please list 2.) 1. 2.
What other information would be helpful for the staff caring for your child to know?

Parent/Guardian's Signature	Date