



Wisconsin Center for the Blind and Visually Impaired

Tony Evers, PhD, State Superintendent
Wisconsin Department of Public Instruction



Registration Form – 2017 Summer Programs

Oh, The Places You'll Go... Scavenger Hunt

Check the event student will be attending:

- | | | | |
|--------------------------|-----------------------|------------|------------------------|
| <input type="checkbox"/> | Intermediate Literacy | June 25-30 | Ages 8-13 |
| <input type="checkbox"/> | Transition | July 9-21 | Ages 14-21 |
| <input type="checkbox"/> | Beginning Literacy | August 1-4 | Ages 4-7 [Day Program] |

Student Name: _____ Age: _____ Grade: _____ M F

Home Address: _____

City: _____ State: _____ Zip Code: _____

Parent/Guardian Name: _____

Address (if different): _____

City: _____ State: _____ Zip Code: _____

Home phone: _____ Cell phone: _____

Email: _____ Work phone: _____

How can we best reach you? _____

Emergency Contact Information:

Who can we contact if we can't reach you in an emergency?

Name: _____ Relationship: _____

Home phone: _____ Cell phone: _____

Work phone: _____

Vision Teacher: _____

Email: _____ Phone: _____

Reading/Learning Media: Braille Large Print Standard Print Audio

Print w/Magnification (magnifier type and power): _____

Other (please explain): _____

O&M and Travel Aids: Cane Dog Guide Wheelchair Sighted Guide

Monocular (power): _____ Hat/Visor Other: _____

Please indicate Braille reading level:

Uncontracted **OR** Contracted

Please indicate your student's shirt size: (shirts are free)

Child Sizes: small medium large

Adult Sizes: small medium large extra-large 2X 3X

Students should bring their usual clothing and personal items. All who are staying in the dormitories could bring a sleeping bag, pillows, and towels if they wish.

**Completed Registration Form must be received by
May 15, 2017 to secure your child's place in this program!**

Completed Registration Form must be received by
May 15, 2017
to secure your place in this program!

Send registration to:
WCBVI – Summer Program
1700 W State Street
Janesville, WI 53546



Authorization to participate in the Wisconsin Center for the Blind and Visually Impaired

Activities: I hereby give permission for my child to go on WCBVI-sponsored field trips away from the program premises, whether on foot or by vehicle. I give permission for my child to participate in all program activities. I understand s/he is expected to follow the Center's rules and regulations for conduct while on any WCBVI-sponsored program activities.

Custodial Parent/Guardian Signature _____ Date _____

Parental Release of Information:

For photos/names, to be used in local news stories and our school newsletter.

 <p>Wisconsin Department of Public Instruction MEDIA PERMISSION SLIP PI-2431 (Rev. 07-09)</p>	Date
<p>I, _____ give permission to the WISCONSIN DEPARTMENT OF PUBLIC INSTRUCTION to make or use pictures, slides, digital images, or other reproductions of me, of my minor child _____, or of materials owned by me or my child, and to put the finished pictures, slides, or images to use without compensation in broadcast productions, publications, on the Web, or other printed or electronic materials related to the role and function of the Wisconsin Department of Public Instruction.</p>	
Address <i>Street, City, State ZIP</i>	
Signature 	Telephone <i>Area/No.</i>

Health Form 1

Insurance Coverage:

- We are covered by an insurance plan (see below)
- We are covered by Medical Assistance (see below)
- We do not have medical insurance

Insurance Plan Coverage (please PROVIDE a copy of insurance card):

Insured's (Employee) Name: _____

Employer: _____ Location: _____

Name of Insurance Company: _____

Insurance Company Address: _____

ID #: _____ Group #: _____

Contract #: _____ Effective Date of Coverage: _____

Medical Assistance Coverage (MA) (please provide a copy of MA card):

Forward #: _____ ID #: _____

Parental Medical/Emergency Authorization:

I understand that I am responsible for full payment of medical services and medication prescribed for my child while at WCBVI (Wisconsin Center for the Blind and Visually Impaired).

As the parent/guardian of the above named student, I give consent/permission for WCBVI Health Center staff/WCBVI staff, plane/bus chaperones, or medical/emergency personnel, in the event of sudden illness or injury, to obtain/provide necessary medical or emergency care.

Parent(s)/Guardian Signature: _____ **Date:** _____

Name of Student's Physician: _____

Telephone number: _____

Clinic or Hospital Name (if applicable): _____

Address: _____ City/State/Zip: _____

Student Health History:

Visual Acuity: OU: _____ (OD: _____ OS: _____)

Vision Diagnosis: _____

Date of last visit to physician/or health exam: _____

Recent history of hospitalization, injuries, or illnesses:

Any activities student is not able to participate in due to health reasons, please explain:

Special dietary requirements or food allergies: _____

Health Form 2

Illness History:

Has your child had any of the following?

- Anemia
- Asthma
- Bed-wetting
- Chicken Pox
- Constipation
- Diarrhea
- Ear Infections
- Eczema
- Heart Problems
- Hypoglycemia
- Lead Poisoning
- Measles
- Menstrual Problems
- Mumps
- Rheumatic Fever
- Rubeila
- Scarlet Fever
- Seizures
- Sickle Cell
- Skin Disorders
- Sleep Disorders
- Tonsillitis
- Whooping Cough
- Other: _____

Are there current for recent) concerns for your child?

- _____
- _____
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Health Information:

Shunt:	Seizure Disorder:	Growth Hormone Deficiency:
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both Sides	If Yes, Type: Frequency: Date of last seizure:	If Yes: Hormones Currently Prescribed: <input type="checkbox"/> Yes <input type="checkbox"/> No
Functioning: <input type="checkbox"/> Yes <input type="checkbox"/> No	Typical behavior post-seizure:	Child's tolerance to injections:
Neurosurgeon:	Neurologist:	Endocrinologist:
Telephone:	Telephone:	Telephone:
Address/City/St/Zip:	Address/City/St/Zip:	Address/City/St/Zip:

Health Form 3

Allergies:			
<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes:	What type of bodily response / physical reaction does your child have when exposed?	Is an Epi-Pen prescribed?	Does your child take allergy shots?
<input type="checkbox"/> Seasonal <input type="checkbox"/> Dogs/cats <input type="checkbox"/> Milk/eggs/dairy <input type="checkbox"/> Peanuts <input type="checkbox"/> Tree nuts <input type="checkbox"/> Wheat <input type="checkbox"/> Fish/shellfish <input type="checkbox"/> Environmental (dust, smoke, etc.) <input type="checkbox"/> Other: _____		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergist:	Address:	City/State/Zip:	Telephone:

Please list all special considerations, medications, etc. that pertains to your child while on a WCBVI-sponsored field trip/program activity:

Any information that will help us in working with your child:

Questions? Call us:

Diane Karrow, Office Operations Associate
 WSBVI
 1700 W State Street
 Janesville WI 53546
 608-758-6110 or 800-832-9784 Ext. (3, then 1)
 Fax 608-758-6116
diane.karrow@wcbvi.k12.wi.us

HEALTH 4

Parent(s)/Guardian Medication Authorization Form

Student's Name: _____ **Date of birth:** _____

Address: _____ **Grade:** _____

As the parent and guardian of the above mentioned student, I give the Wisconsin School for the Blind and Visually Impaired permission to administer the following prescription medication(s) to my child. I will keep the school district aware of any changes in medication(s) or health concerns of my child.

As a part of the Wisconsin Statute Chapter 118.29, Administration of Drug to Pupils and Emergency Care, school districts are required to have permission from a medical provider and parent to administrator medications at school. As part of this authorization form, school district employees may contact the medical provider with questions regarding the medication administration including clarification regarding dosage, side effects or indication of the medication(s) listed above with parent permission.

Parent(s) Guardian Signature: _____ **Date:** _____

Non-Prescription Medication:

I hereby give permission to the WCBVI staff including nurses, teachers, child care counselors, education assistants, coaches and other appropriate WCBVI personnel to administer non-prescription medication to my child as directed by the WCBVI nursing staff. I agree to notify the WCBVI in writing if I wish to terminate, withdraw, or modify this consent.

Parent(s)/Guardian Signature: _____ **Date:** _____

Feel free to take this form with you to your next appointment

Dear Parent or Guardian,

Any and All nursing care provided to students who attend the WSBVI can be provided only under the written direction of a physician or health care provider who has authority to write medical orders. If your child requires any of the following, (or other health care needs not listed), your child's doctor needs to provide a written order addressing each individual item.

1. Emergency medications and/or instructions for:
 - a. Seizures
 - b. Adrenal Insufficiency (Cortef dependency)
 - c. Asthma
 - d. Anaphylaxis (Epi Pen)
 - e. VP Shunt
2. Scheduled and/or as-needed prescription medication
3. Dietary needs or allergies:
 - a. Special diet
 - b. G-tube feeding schedule/amount/type
 - c. Thickened liquids
 - d. Fluid restrictions/guidelines
4. CPAP
5. Catheters
6. G-tube:
 - a. Care
 - b. Replacement
7. AFO guidelines

School forms or clinic-generated forms are acceptable IF signed and dated. Signed orders are good for a maximum of one year from the date they are signed. New orders are required every school year, and are required every time a new procedure or medication is ordered or and existing procedure or medication is changed. We are required by law to follow the most current written order on file. If we do not have a current signed order, we **CANNOT** provide the nursing care that your child needs. We can best prepare for child's needs if we receive your child's information before you arrive on registration day. Complete paperwork can be mailed or faxed directly to the health center at 608-758-6158.

Sincerely,
Rhonda Mulligan, Nursing Supervisor

Medications:

OTC (medications, vitamins, supplements, etc. available without prescription) medications which are administered according to the package instructions require only a parental signature for administration by school staff. If the dosage your child exceeds the recommended dose, a physician's authorization is also needed.

ALL MEDICATIONS MUST BE SENT IN THEIR ORIGINAL PACKAGE OR PHARMACY DISPENSED BOTTLE.

HEALTH 5

PHYSICIAN AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

In order for school personnel to proceed with the medication regime you have prescribed for the following student, please complete this form.

Student Name: _____ DOB: _____

Order Inclusive Dates: From: _____ To: _____

Student Street Address: _____ Phone: () _____

City: _____ WI Zip: _____ County: _____

Diagnosis: _____

Name of Prescription	Dose	Route	Frequency	Duration

Direct contact should be made with the prescribing physician in the event the student receiving the prescribed medication develops any of the following conditions or reactions to the medication:

PRN Medication (if needed)	Dose	Route	Frequency	Duration

Conditions under which PRN medications should be given:

Direct contact should be made with the prescribing physician in the event the student receiving the medication develops any of the following conditions or reactions to the medication:

Physician's Signature: _____ Date: _____

Physician's Name: _____ Phone: () _____

Physician's Address: _____ Fax: () _____