Wisconsin Center for the Blind and Visually Impaired

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

Registration Form – 2018 Summer Programs

Building Blocks to Knowledge

Check the event student will be attending:

☐	Beginning Literacy	July 31-August 3	Ages 4-7 [Day Program]
☐	Intermediate Literacy	July 29-August 3	Ages 8-13
☐	Transition	July 8-20	Ages 14-21

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 1, 2018
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.

Wisconsin Department of Public Instruction
MEDIA PERMISSION SLIP
PI-2431 (Rev. 07-09)

Date

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.

Address *Street, City, State ZIP*

Signature ➢	Telephone *Area/No.*

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:**
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Right ☐ Left ☐ Both Sides	If Yes, Type: Frequency: Date of last seizure:	If Yes: Hormones Currently Prescribed: ☐ Yes ☐ No
Functioning: ☐ Yes ☐ 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:			
☐ Yes ☐ 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?
☐ Seasonal ☐ Dogs/cats ☐ Milk/eggs/dairy ☐ Peanuts ☐ Tree nuts ☐ Wheat ☐ Fish/shellfish ☐Environmental (dust, smoke, etc.) ☐ Other:________		☐ Yes ☐ No	☐ Yes ☐ 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:

____

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____

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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: __________

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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:( ) _______________