



DUN DUN…DUN DUN…DUN DUN…

JAWS and Braille Training Course

Weeks of July 17-21 and July 24-28, 2017

**This 2 week course will offer intensive instruction in braille and on the features of JAWS (Job Access With Speech) to increase student accessibility within their school environments. While working on a fun and creative joint project, students will learn tips and strategies to help them accomplish educational tasks equally with their peers and become more independent users of technology.**

This is a **FREE** program being offered to middle/high school students this summer. Students can participate daily (8:30-3:00) or residentially (Monday-Friday) to participate in evening activities with students in concurrent programs. Space is limited to 6 students.

Registration is due May 31, 2017

***PARTICIPANT INFORMATION***

Participant’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nickname \_\_\_\_\_\_\_\_\_\_\_\_\_

DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_ Sex\_\_\_ M \_\_\_F

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(PRINT CLEARLY)**

Parent/Guardian(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reading Level\_\_\_\_\_\_\_ Math Level \_\_\_\_\_\_\_ Vision Teacher:

***EMERGENCY CONTACTS (You must provide a minimum of 2 contacts with at least 2 phone numbers each)***

Emergency Contact #1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Day #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Night #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact #2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Day #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Night #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***VISUAL INFORMATION (Students are required to bring portable low vision or Braille devices and canes)***

Eye Condition:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Eye Dr.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Level of Vision: \_\_\_ Totally Blind \_\_\_ Partially Sighted \_\_\_ Legally Blind \_\_\_ Wears Glasses

Field Loss: \_\_\_ Yes \_\_\_ No

Child uses the following for learning: Regular Print:\_\_\_ Large Print:\_\_\_\_ Braille:\_\_ Auditory Skills:\_\_\_

Please list technology currently used: Low Vision Devices \_\_\_(Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

\_\_\_Tapes \_\_\_Digital Books/CD’s \_\_\_Kurzweil \_\_\_Braille Note taker \_\_\_Jaws \_\_\_Screen Enlarger \_\_\_Computer \_\_\_Other (Please list) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Travel Skills: \_\_\_Independent \_\_\_Needs Supervision \_\_\_Uses Cane \_\_\_Prefers Sighted Guide

***ADDITIONAL DISABILITIES/MEDICAL CONDITIONS (additional medical documentation may be required):***

Check any additional diagnoses that apply:

\_\_\_\_ Learning Disability \_\_\_\_ Multiple Sclerosis \_\_\_\_ ADD/ADHD

\_\_\_\_ Intellectual Impairment \_\_\_\_ Brain Injury \_\_\_\_ Autism

\_\_\_\_ Speech Impairment \_\_\_\_ Spina Bifida \_\_\_\_ Seizures

\_\_\_\_ Hearing Impairment \_\_\_\_ Down Syndrome \_\_\_\_ Diabetes

\_\_\_\_ Orthopedic Impairment (including Cerebral Palsy); please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emotional/Behavior Concerns:

\_\_\_\_ Anxiety \_\_\_\_ Depression

\_\_\_\_ Difficulty coping with frustration (please specify below):

\_\_\_\_ Displays aggression (i.e., hits others) \_\_\_\_ Tantrums \_\_\_\_ Uses loud or abusive language

\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Skills:

\_\_\_\_ Interacts easily with peers/sociable \_\_\_\_ Difficulty interacting with peers \_\_\_\_ Shy

Does your child take medication? \_\_\_\_ Yes \_\_\_\_No

If yes, please list medications or attach a printed list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have food allergies? \_\_\_\_ Yes \_\_\_\_ No

Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have environmental allergies or sensitivities? \_\_\_\_Yes \_\_\_\_ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have any dietary restrictions? \_\_\_\_ Yes \_\_\_\_ No

Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***ACTIVITIES OF DAILY LIVING SKILLS***

Indicate your child’s level of independence:

\_\_\_\_ Completely Independent \_\_\_\_\_ Needs minimal assistance/supervision in some areas

\_\_\_\_ Needs total assistance in one or more areas listed below

Specify type and degree of assistance required in each area, if any:

Eating \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dressing \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grooming \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bathing \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Toileting \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child attended an overnight camp or program before? \_\_\_\_ Yes \_\_\_\_ No

If yes, please list previous overnight programs attended and your child’s experience: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check any concerns that apply:

\_\_\_\_Bedwetting \_\_\_\_ Sleepwalking \_\_\_\_ Difficulty sleeping through the night

Please share any additional information you would like us to know about your child:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***PARENT AUTHORIZATION SHEET***

***(****Must be signed by parent/guardian)*

**Student Name: ­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Authorization to Release Information**

I give The Maryland School for the Blind permission to release written reports from the Summer Program on my child to our local school system.

**\_\_\_ Yes \_\_\_ No**

**Authorization to Transport**

During our Summer Program there may be some opportunities for off-campus activities. We believe these activities are important to a well-rounded program. Sometimes they may be of an educational nature, such as field trips to a museum or place of business. Other activities of a recreational nature, but equally important, might involve a baseball game, trip to a theater, etc. I grant permission for my child to participate in all off-campus activities of which the School approves.

**\_\_\_ Yes \_\_\_ No**

**Authorization to Utilize Image or Photograph**

Many pictures are taken during the summer program of various activities. These pictures are sometimes used, along with press releases, to provide public relations information to television stations, newspapers and other publications. I grant permission for my son/daughter to be photographed for the above purposes.

**\_\_\_ Yes \_\_\_ No**

**Authorization to Participate in Orientation and Mobility Experiences**

During the Program your child will receive exposure to mobility concepts which will facilitate the awareness or development of skills needed to become a safe, independent traveler in the community. Training may include basic overview and instruction in crossing city streets, using public transportation, and various other activities in an attempt to reach the above-mentioned purpose. Your child will be transported in the MSB vehicles by the mobility specialist(s) or MSB staff to the various travel sites. All safety precautions will be observed during this training period to safeguard your child who will be under the direct supervision of one of the Mobility Specialist(s) or MSB staff. I grant permission for my child to receive these services.

**\_\_\_ Yes \_\_\_ No**

**Permission to Apply Sunscreen and/or Insect Repellent**

I give permission for MSB staff to apply or assist with the application of sun screen and/or insect repellent which has been provided by me or MSB while my child is participating in summer program activities at MSB. Furthermore, I attest, to the best of my knowledge, my child is not allergic to sunscreen and/or insect repellent.

**\_\_\_\_ Yes \_\_\_\_ No**

**Legal Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DIET ORDER FORM**

**STUDENT NAME:**

\_\_\_\_ Regular Diet

\_\_\_\_ Special Considerations: (likes, dislikes, consistency)

\_\_\_\_ All Liquids (no restrictions on liquids)

\_\_\_\_ Other:

**Please indicate the recommended diet texture for the student listed above:**

\_\_\_\_ N.P.O. (no food by mouth)

\_\_\_\_ Pureed

\_\_\_\_ Ground

\_\_\_\_ Soft Foods (foods easily mashed with a fork)

\_\_\_\_ Regular Diet (food will be cut into small pieces if appropriate for age or

developmental level)

\_\_\_\_ Other:

If determined by the Speech/Language Pathologist that the student is ready to participate in a controlled munching program using crunchy/chewy foods, can the student participate?

\_\_\_\_ Yes \_\_\_\_ No

**Please indicate the recommendations for liquids:**

\_\_\_\_ No liquids by mouth

\_\_\_\_ Thickened Liquids Only (indicate consistency below)

\_\_\_\_ Nectar Consistency \_\_\_\_ Honey Consistency

\_\_\_\_ Products like “Thick-It” can be used to achieve consistency indicated above

\_\_\_\_ All Liquids (no restrictions on liquids)

\_\_\_\_ Other:

**Please indicate any other restrictions regarding oral feeding:**

\_\_\_\_ Food Allergies:

\_\_\_\_ Diet Restrictions:

\_\_\_\_ Other:

**Physician’s Signature Date**

**EMERGENCY (911) TRANSPORTATION CONSENT**

**and STUDENT INSURANCE INFORMATION**

STUDENT NAME:

PARENT/GUARDIAN:

ADDRESS:

PHONE:

The Maryland School for the Blind is hereby authorized to transport, or have my child transported, to the hospital in the event of an emergency.

The 911 dispatcher will determine which area hospital my child will be transported to under the existing circumstances.

By signing below, I grant permission for the above-named service to be provided for my child.

Signature of Parent/Guardian Date

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

**PLEASE PROVIDE A COPY OF THE FRONT AND BACK OF THE INSURANCE CARD**

**AND**

**COMPLETELY FILL IN THE STUDENT’S HEALTH INFORMATION BELOW**

Card holder’s name:

Card holder’s address:

Card holder’s phone number:

Card holder’s Employer:

Patient Relationship to card holder:

Insurance Carrier Name:

Insurance Carrier Address:

Policy Number: Group Number:

Group Name: Effective Date:

**MEDICAL ASSISTANCE/MCO INFORMATION**

MDMA Number:

Member/Policy Number:

**The Maryland School for the Blind**

**PERMISSION FOR OVER-THE-COUNTER MEDICATIONS**

Student Name Date of Birth

Date Weight Height Allergies

The Medical Director at MSB has written standard orders for common conditions students may experience while at school.

Please CHECK ALL medications that your child may receive at school.

A&D Ointment or Vaseline

Antibiotic Ointment with Pramoxine HCL

Artificial Tears

Benadryl (generic diphenhydramine) for allergic reactions

Cepacol throat lozenges for sore throat discomfort

Claritin – allergies (Provided by Parent)

Coke syrup for nausea

Cough drops for cough

Debrox – ear wax

Diaper Cream (Barrier Cream)

Dulcolax for constipation

Hydrocortisone 1% cream for rash

Ibuprofen (Motrin) for discomfort, fever, pain

Imodium for diarrhea

Midol (or generic equivalent) for menstrual cramps 12 yrs. and over 95 lbs.

Mucinex – congestion/non-productive cough

OraGel – mouth pain

Pepto Bismol – stomach upset

Robitussin (generic guaifenesin) (expectorant) dry non-productive cough

Robitussin DM (guaifenesin dextromethorphan) disruptive cough (antitussive expectorant)

Sudafed (generic pseudoephedrine) for nasal congestion

Sunscreen – sun protection

Topical anti-fungal cream - (such as Lotrimin) for athlete’s foot and other fungal areas)

(Provided by Parent)

Triple Antibiotic Ointment or Bacitracin

Tums (or generic equivalent) for heartburn

Tylenol (generic acetaminophen) for headaches, fever, pain

Any over-the-counter skin moisturizer (Provided by Parent)

Over-the-counter acne cream (Provided by Parent)

Over-the-counter acne wash (Provided by Parent)

Parent/Guardian Printed Name Parent/Guardian Signature

Date

**PART I – HEALTH ASSESSMENT**

**Health Center**

To be completed by parent or guardian

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Student’s Name (Last, First, Middle) | Birthdate (Mo. Day Yr.) | | | Sex (M/F) |
| Address (Number, Street, City, Zip) Phone No. | | | | |
| Parent/Guardian Names | | | | |
| Where do you usually take your child for routine medical care?  Name: Address: Phone No. | | | | |
| Where do you usually take your child for dental care?  Name: Address: Phone No. | | | | |
| What other source does your child receive health care?  Name: Address: Phone No. | | | | |
| ASSESSMENT OF STUDENT HEALTH  To the best of your knowledge has your child had any problem with the following? Please check “Yes” or “No” for each of the following. | | | | |
|  | Yes | No | Comments | |
| Allergies (Food, Insects, Drugs, Latex) |  |  |  | |
| Allergies (Seasonal) |  |  |  | |
| Asthma or Breathing Problems |  |  |  | |
| Behavior or Emotional Problems |  |  |  | |
| Birth Defects |  |  |  | |
| Bleeding Problems |  |  |  | |
| Cerebral Palsy |  |  |  | |
| Dental |  |  |  | |
| Diabetes |  |  |  | |
| Ear Problems or Deafness |  |  |  | |
| Head Injury |  |  |  | |
| Heart Problems |  |  |  | |
| Hospitalization (When, Where) |  |  |  | |
| Lead Poisoning/Exposure |  |  |  | |
| Learning Problems/Disabilities |  |  |  | |
| Limits on Physical Activity |  |  |  | |
| Meningitis |  |  |  | |
| Prematurity |  |  |  | |
| Problem with Bladder |  |  |  | |
| Problem with Bowels |  |  |  | |
| Problem with Coughing |  |  |  | |
| Seizures |  |  |  | |
| Serious Allergic Reactions |  |  |  | |
| Sickle Cell Disease |  |  |  | |
| Speech Problems |  |  |  | |
| Surgery |  |  |  | |
| Other |  |  |  | |
| If the answer to any of these questions is “Yes” then the physician needs to complete the order form.  Does your child take any medication?  No\_\_\_\_\_ Yes \_\_\_\_\_ Name of Medication  Is your child on any special treatments? (nebulizer, epi-pen, etc.)  No\_\_\_\_\_ Yes \_\_\_\_\_ Treatment  Does your child require any special procedures? (catheterization, etc.)  No \_\_\_\_\_ Yes \_\_\_\_\_ Please Describe  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Parent/Guardian Signature Date | | | | |

**PART II – INTERSCHOLASTIC ATHLETICS**

* To be completed by parent and sports candidate –

only if interested in participating in interscholastic sports at MSB.

**Student Name:**

**Last First Middle**

FOR STUDENTS PARTICIPATION IN INTERSCHOLASTIC ATHLETICS

Please check yes or no for each of the following questions. Explain all yes answers in the “Comments”

column. Include names and dates where appropriate.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Comments |
| Do you know of any reason why this individual should not participate in all sports? |  |  |  |
| Has the individual been advised by a physician during the past year to restrict activity? |  |  |  |
| Has the student ever had surgery? |  |  |  |
| Has the student ever: |  |  |  |
| been hospitalized? |  |  |  |
| been unconscious? |  |  |  |
| fainted? |  |  |  |
| had frequent headaches? |  |  |  |
| had convulsions? |  |  |  |
| had numbness or tingling of face, arms, hands, legs, or feet? |  |  |  |
| had chest pain? |  |  |  |
| had shortness of breath? |  |  |  |
| had enlarged liver or spleen? |  |  |  |
| become weak or ill when exposed to high temperatures? |  |  |  |
| Has the student ever had: |  |  |  |
| head injury? |  |  |  |
| neck injury? |  |  |  |
| back pain? |  |  |  |
| shoulder separation or dislocation? |  |  |  |
| ankle sprain? |  |  |  |
| knee trouble (including torn cartilage)? |  |  |  |
| knee cap dislocation? |  |  |  |
| broken bone or fracture? |  |  |  |
| pulled ligament or ruptured tendon? |  |  |  |
| swollen, dislocated, or painful joint? |  |  |  |
| serious muscle injury or rupture? |  |  |  |
| Does the student have loss or seriously impaired function of any paired organ? |  |  |  |
| eye |  |  |  |
| ear |  |  |  |
| lung |  |  |  |
| kidney |  |  |  |
| testicle/ovary |  |  |  |
| Does the student wear: |  |  |  |
| glasses? |  |  |  |
| contact lenses? |  |  |  |
| dental braces? |  |  |  |
| other? |  |  |  |

**Parent/Guardian Signature Date Sports Candidate Signature Date**

**PART III – SCHOOL HEALTH ASSESSMENT**

To be completed ONLY by Physician/Nurse Practitioner

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Student’s Name (Last, First, Middle) | | | | | | | | Birthdate (Mo. Day Yr.) | | Sex  M  F | |
| 1. Does the child have a diagnosed medication condition?  No  Yes | | | | | | | | | | | |
| 1. Does the child have a health condition which may require EMERGENCY ACTION while he/she is at school?   (e.g. seizure, insect sting allergy, asthma, bleeding problem, diabetes, heart problem, or other problem) if yes, please DESCRIBE. Additionally, please “work with your school nurse to develop an emergency plan.”    No  Yes | | | | | | | | | | | |
| 1. Evaluation Findings/CONCERNS | | | | | | | | | | | |
| Physical Exam | WNL | ABNL | COMMENTS | | | | Health Area of Concern | | | YES | NO |
| Head |  |  |  | | | | Attention Deficit/Hyperactivity | | |  |  |
| Eyes |  |  |  | | | | Behavior/Adjustment | | |  |  |
| ENT |  |  |  | | | | Development | | |  |  |
| Dental |  |  |  | | | | Hearing | | |  |  |
| Respiratory |  |  |  | | | | Immunodeficiency | | |  |  |
| Cardiac |  |  |  | | | | Lead Exposure/Elevated Lead | | |  |  |
| GI |  |  |  | | | | Learning Disabilities/Problems | | |  |  |
| GU |  |  |  | | | | Mobility | | |  |  |
| Musculoskeletal/Orthopedic |  |  |  | | | | Nutrition | | |  |  |
| Neurological |  |  |  | | | | Physical Illness/Impairment | | |  |  |
| Skin |  |  |  | | | | Psychosocial | | |  |  |
| Endocrine |  |  |  | | | | Speech/Language | | |  |  |
| Psychosocial |  |  |  | | | | Vision | | |  |  |
|  |  |  |  | | | | Other | | |  |  |
| REMARKS: (Please explain any abnormal findings.) | | | | | | | | | | | |
| 1. Screenings | Results | | | | | | | | Date Taken | | |
| Tuberculin Test |  | | | | | | | |  | | |
| Blood Pressure |  | | | | | | | |  | | |
| Height |  | | | | | | | |  | | |
| Weight |  | | | | | | | |  | | |
| BMI % tile |  | | | | | | | |  | | |
| Lead Test | Optional | | | | | | | |  | | |
|  |  | | | | | | | |  | | |
| 1. Medical evaluation of students for participation in interscholastic athletics. May this student participate in the supervised activities listed? | | | | | | | | | | | | |
|  | | | | Yes | No | Comments | | | | | | |
| Wrestling | | | |  |  |  | | | | | | |
| Swimming | | | |  |  |  | | | | | | |
| Goalball | | | |  |  |  | | | | | | |
| Cheerleading | | | |  |  |  | | | | | | |
| Track | | | |  |  |  | | | | | | |
| 1. Contact Sports | | | | | | | | | | | | |
|  | | | | Yes | No | Comments | | | | | | |
| Risk of Retinal Detachment | | | |  |  |  | | | | | | |
| Long Duration of Intense Cardiovascular Activity | | | |  |  |  | | | | | | |
| Any Weight Bearing Restrictions: i.e., Lifting Weights | | | |  |  |  | | | | | | |
| Special Requirements for Sun Exposure | | | |  |  |  | | | | | | |
| Tumbling Activities | | | |  |  |  | | | | | | |
| Must Wear Eye Protection During Physical Activity | | | |  |  |  | | | | | | |

Student has had a complete history and physical examination at our office and has no evident health problem except as noted above.

**Physician/Nurse Practitioner Signature Date**

**Physician/Nurse Practitioner (Print) Office Phone Number Office Fax Number**

**PHYSICAL ACTIVITY FORM**

**Student Name: Date of Birth:**

**Adapted Physical Education** - All students have Adapted Physical Education as part of their curriculum. Please indicate below if there are any medical reasons for exception.

Adapted Physical Education

(Example: Age appropriate skill development, fitness & activities) 🞏 No exception

Exception:

Adapted Aquatics 🞏 No exception

Exception:

Adapted Recreation (Example: Skiing, Bowling, Horseback Riding) 🞏 No exception

Exception:

**Extra-Curricular Activities**

MSB students compete against other visually impaired athletes in the Eastern Athletic Association for the Blind (EAAB) and occasionally other high schools from the surrounding area. Some of these activities are contact sports. A physical is required for all participation in these activities. The form for the physical exam is attached.

Cleared for participation in contact, competitive team sports (Example: Wrestling and Goalball)

Yes No

Cleared for all other non-contact, competitive team sports (Examples: Swimming, Cheerleading, Track/Field) Yes No

Physician’s Signature Date Physician Phone Number

Parent/Guardian Signature Date

**Swimming** –Cushioned bumpers at each end of the pool to let swimmers know when they have reached the wall. Goggles required for all swimmers.

**Wrestling** – Contact between both wrestlers maintained at all times.

**Cheerleading** - Sequential/rhythmic movements, counting steps, forward rolls, minimal tumbling skills if/when applicable.

**Track/Field** – Distant runners run with a “guide runner” (sighted runner attached to the visually impaired runner by means of a tether held by both runners.) Runners competing in the dash events use “guide wires” and handles to navigate the distance. Counting steps and raised markers also aide the athlete in performing other events.

**Goalball** – Goalball is a Paralympic team sport that is played exclusively by the visually impaired. All players are blindfolded during the game and use tactile markers on the floor to maintain their orientation. Goalball is a contact, fast pace game. Two teams of three players face each other on a court alternating rolling the ball and defending. The offensive team rolls the ball as hard as they can in an attempt to get the ball past the opposing players and across a goal line. The defensive team listens for the approach of the ball and attempts to block the ball with any part of their body from crossing the goal line. There are women’s and men’s teams, with no variations in equipment or rules.

CD/LB/MM/cic:4/30/15

For additional information contact: