Parental Consent to Access Public Insurance and to Release Personally Identifiable Information

Name: ID#: Date of Birth:

Age: Grade: Local Education Agency:

Primary Care Physician's Name (Optional):

Medicaid Number:

With parental consent, the school district can seek federal Medicaid reimbursement for the cost of the health services the school district provides to children who are eligible for Medicaid, and who receive those services that are Identified in their individualized education program (IEP). In order to seek the federal Medicaid funds for reimbursement, the school district must disclose information from your child's education records to Medicaid and Medicaid billing agencies.

Under the Family Educational Rights and Privacy Act (FERPA), parental consent is required in order to release student personally identifiable information to agencies not identified in the Act. This consent grants the school district the ability to release student information for the purpose of billing Medicaid.

By signing below, you are indicating the following:

- I understand and agree that I am giving the school district permission to access my or my child's public benefits or insurance.
- I understand that my child's education records and information about the services my child receives through an IEP may be released to the Department of Human Services, Division of Medical Services, Arkansas Medicaid, and the school district's Medicaid billing agent for the purpose of billing Medicaid.
- I understand that this may include sharing information with DHS, contracted billing agents, and or a physician to obtain necessary documentation to receive reimbursement for services provided through an IEP.
- I understand that information to be released may indude: student's name, date of birth, social security number, Medicaid ID, disability, IEP and evaluations, type of servlce(s), times and dates services were delivered, and progress notes.
- I understand that this consent will remain in effect at all times the district Is responsible for providing IEP services to my child, unless revoked by me.
- I understand that I may revoke consent at any time by notifying the school district in writing.
- I understand that revoking my consent does not change the school district's responsibility to provide all required IEP services to my child at no cost to me.
- Before giving my consent below, I was provided with a written notice further explaining my rights and protections under Part B of the Individuals with Disabilities Education Act (IDEA) regarding consent and the purpose of this fonn.

Parent or Guardian Signature: Date:

Is your child covered by private Insurance? ◯ Yes ◯ No

(If yes, please complete Third Party Liability Section)

Name:

Parental Consent to Release Personally Identifiable Information Third Party Liability Section*

*This section should only be completed if the student is covered by private insurance.

Information Related to Billing Third Party Insurance:

Title 42 Code of Federal Regulations (CFR), Part 433, Subpart D, Third Party Liability, requires that all third party sources must be utilized before reimbursement can be made by Medicaid. Part B of the Individuals with Disabilities Education Act (IDEA) prohibits a public agency from requiring parents, where they would incur a financial cost, to use insurance proceeds to pay for services that must be provided to a child with disabilities under the "free appropriate public education" requirements of these statutes. IDEA does not create exceptions to Title 42 CFR, Part 433, Subpart D. All Medicaid providers, including school districts, should attempt to exhaust third party liability prior to making claims to Medicaid.

Please check one of the following:

◯ I do NOT give permission to the school district to bill my private insurance for healthcare services delivered in the school.

◯ I give permission to the school to bill my private insurance for healthcare services delivered in the school.

Private Insurance Information:
Insurance Company:
Address:
Phone:
Name of Policy Holder:
Policy Holder Date of Birth:
Social Security Number:
Policy Number:
Group Number:

Parent or Guardian Signature: Date:

Residency Information – McKinney Vento

This questionnaire is in compliance with the McKinney-Vento Act, U.S.C. 42 11431 et seq. Your answers will help determine if the student meets eligibility requirements for services under the McKinney-Vento Act.

Please list siblings or other children in the home.

Sibling 1 name

Sibling 1 grade

Sibling 1 age

Sibling 1 school attended

Do you want to add a 2nd sibling?

- ◯ Yes
- ◯ No

Sibling 2 name

Sibling 2 grade

Sibling 2 age

Sibling 2 school attended

Do you want to add a 3rd sibling?

- ◯ Yes
- ◯ No

Sibling 3 name

Sibling 3 grade

Sibling 3 age

Sibling 3 school attended

Do you want to add a 4th sibling?

- ◯ Yes
- ◯ No

Sibling 4 name

Sibling 4 grade

Sibling 4 age

Sibling 4 school attended

Do you want to add a 5th sibling?

- ◯ Yes
- ◯ No

Sibling 5 name

Sibling 5 grade

Sibling 5 age

Sibling 5 school attended

Is the address listed in the Student Information Form Temporary or Permanent?

- ◯ Temporary
- ◯ Permanent

Please choose which of the following situations in which the student currently resides (you can choose more than one)

- ☐ House or apartment with parent or guardian
- ☐ Motel, Car, or campsite
- ☐ Shelter or other temporary housing
- ☐ With friends or family members (other than or in addition to parent/guardian)

If you are living in shared housing, please check all of the following reasons that apply:

- [ ] Loss of housing
- [ ] Economic Situation
- [ ] Temporarily waiting for house or apartment
- [ ] Providing care for a family member
- [ ] Living with boyfriend or girlfriend
- [ ] Loss of employment
- [ ] Parent / Guardian is deployed
- [ ] Other

Are you a student under the age of 18 and living apart from your parents or guardians?

- ◯ Yes
- ◯ No

Place a check for all services that are needed or desired:

- [ ] Free breakfast/lunch
- [ ] Transportation
- [ ] Clothing
- [ ] Teen Center
- [ ] Counseling
- [ ] Medical/Dental referral-medical coupons
- [ ] Vision Referral
- [ ] Medicaid/DSHS services -Food stamps
- [ ] Preschool Enrollment records
- [ ] Missing enrollment records
- [ ] Prior academic records
- [ ] Guardianship issues
- [ ] Tutoring
- [ ] After-school Programs
- [ ] School supplies
- [ ] Mentoring
- [ ] Special Education
- [ ] Gifted/Talented
- [ ] Vocational/Technical
- [ ] Community resources
- [ ] LEP/Bilingual Program
- [ ] Birth certificate
- [ ] Immunization/medical records

Residency and Educational Rights

Students without fixed, regular, and adequate living situations have the following rights:

1) Immediate enrollment in the school they last attended or in a school in the district in which they are currently staying even if they do not have all of the documents normally required at the time of enrollment, without fear of being separated or treated differently due to their housing situations;

2) Transportation to the school of origin for the regular school day;

3) Access to free meals, Title I and other educational programs, and transportation to extra-curricular activities to the same extent that it is offered to other students.

Any questions about these rights can be directed to the local McKinney-Vento Liaison, Melanie Brown, at 501-682-4823 or melanieb@asd.k12.ar.us.

E-signature of Parent/Guardian/Unattached Youth **By signing below I acknowledge that I have received and understand the above rights.

Date

☐ Parent acknowledgement

STUDENT MEDICAL HISTORY INFORMATION

Student Name: _____ Birthdate: _____ School Year _____Grade:_____

Street Address: _____City:_____County:_____

State & Zip Code _____Home Phone # _____Cell Phone #_____

V _____ Video Relay:_____ E-mail address_____

Please indicate which contact & # you prefer us to try 1st, 2nd, etc

Parent 1: Name:_____Work Place:_____Work Phone:_____

Pager or Cell #_____

Parent 2: Name_____Work Place:_____Work Phone:_____

Pager or Cell #_____

EMERGENCY REFERENCES (Please list three)

Name	Relationship to Student	Area Code & Phone # (TTY?)

HEALTH INSURANCE INFORMATION

Insurance Company Name:_____

Subscriber:_____

Policy# & Group:_____

Medicaid# _____

Parent Permission to Administer O.T.C. Medication at School

I, hereby give my permission for my child, _____, to receive any of the over the counter medications (O.T.C.) checked below by the health services staff or designee while attending the Arkansas School for the Deaf. I understand that these medications will be given per health services standing orders as prescribed by the school physician. I understand that the generic equivalent may be used. **Cross out the items the student should not be given.**

MEDICATION	**REASON TO GIVE**
Acetaminophen (Tylenol)	Fever, headaches, pain
Ibuprofen (Advil, Motrin)	Fever, headaches, pain
Antacid	Upset stomach
Antibiotic ointment	Minor cuts/abrasions
Cough drops	Minor sore throat
Cough syrup	Cough
Cortisone cream	Insect bites, skin irritations
Antihistamines	Stuffy nose, allergic reactions
Ear wax solutions (Debrox)	Ear wax removal
Antifungal cream	Body/foot fungal infections
Milk of Magnesia	Constipation
Eye drops/Eye wash	Eye irritations
Sunscreen	Outdoor Sun Exposure

Signature of Parent/Guardian _____Date _____

Health Questionnaire: check conditions that apply to your child – describe under Comments.

☐ ADD/ADHD
☐ Anxiety/Panic attack
☐ Asthma
☐ Bee Sting Allergy
☐ Behavior Problem
☐ Bowel Problem
☐ Cardiac Problem
☐ Cerebral Palsy
☐ Diabetes
☐ Epi-Pen
☐ Emotional Concerns
☐ Food Allergy
☐ Headaches
☐ Kidney/Urinary Problem
☐ Respiratory/lung condition
☐ Depression
☐ Stomach/liver/gallbladder
☐ Vision Problems
☐ Seizures
☐ Spina Bifida
☐ Muscle disorder
☐ Neurological Problems
☐ Orthopedic Problems
☐ Scoliosis

MENTAL, EMOTIONAL, AND SOCIAL HEALTH ISSUES

CHECK "YES" OR "NO" FOR EACH STATEMENT

HAS YOUR CHILD EXPERIENCED ANY OF THESE:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD) ☐ Yes ☐ No
2. Ever been treated for emotional or behavioral difficulties/problems? ☐ Yes ☐ No
3. Ever been treated for eating disorders or eating problems? ☐ Yes ☐ No
4. During the past 12 months been hospitalized for mental/emotional/mental health concerns? ☐ Yes ☐ No
5. During the past 12 months, has your child seen a professional who has addressed mental/emotional/mental health concerns? ☐ Yes ☐ No
6. Has there been a significant life event that continues to affect your child's life? ☐ Yes ☐ No
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster or anything else)

PLEASE EXPLAIN ANY OF "YES" ANSWERS IN THE SPACE BLEOW. NOTE THE NUMBER OF THE QUESTIONS.

********ALLERGIES (FOODS OR DRUG) *********LIST BELOW*************

List of Allergies to Foods or Drugs:

What is the cause of your child's loss of hearing?

_____

Does your child wear hearing aids? Yes ☐ No ☐

Does your child have cochlear implants? Yes ☐ No ☐ If yes, date of implant: _____

List any other operations, injuries, or hospitalizations your child has had: Give dates:

_____

_____

_____

_____

Is your child on any medication every day or as needed? Yes ☐ No ☐

List: _____

Does your child have any physical restrictions? Yes ☐ No ☐

List: _____

Does your child require mobility assistance? Yes ☐ No ☐

If so, what type _____

Does your child wear glasses? Yes ☐ No ☐ Contact lenses? Yes ☐ No ☐

PHYSICIAN INFORMATION	
Primary Care Physician:	Phone:
Dentist:	Phone:

PLEASE NOTE: Health information will be shared with all employees having a need to know, unless Health Services is notified otherwise. Parents/Guardians are responsible for notifying health services of any changes in the child's health.

Parent/Guardian Signature: _____Date: _____

Rev: 06/18

ASD DOES NOT PROVIDE 24 HOUR NURSING CARE. A NURSE IS AVAILABLE BY TEXT/PHONE AT ALL TIMES

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION BETWEEN MEDICAL PROVIDERS and SCHOOL DISTRICTS

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal laws (including FERPA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name: _____
Last First MI Date of Birth

I, the undersigned, do hereby authorize (name of agency and/or health care providers):
1)_____2)_____
to provide health information from the above-named child's medical record to and from:

Arkansas School for the Deaf 2400 West Markham, Little Rock, AR 72205
School District to which disclosure is made Address / City and State / Zip Code

Vicki Crump, MSN, RN, NCSN 501-658-09711
Contact Person at School District Area Code and Telephone Number

The disclosure of health information is required for the following purpose:
_____

Requested information shall be limited to the following:
☐ All minimum necessary health information; or
☐ Disease-specific information as described:
_____

DURATION:

This authorization shall become effective immediately and shall remain in effect until_____(enter date) or for one year from the date of signature, if no date entered.

RESTRICTIONS:

Law prohibits the Requestor from making further disclosure of my health information unless the Requestor obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:

I understand that I have the following rights with respect to this Authorization: *I may revoke this Authorization at anytime. My revocation must be in writing, signed by me or on my behalf, and delivered to the school district/health care agencies/persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization.*

RE-DISCLOSURE:

I understand that the Requestor will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA).

I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

APPROVAL:

_____ _____ _____
Printed Name Signature Date

_____ _____
Relationship to Patient/Student Area Code and Telephone Number

Arkansas Children's Hospital
Health Information Management
1 Children's Way Slot 109
Little Rock, Arkansas 72202
Release of Information
501-364-1268 Fax: 501-364-3968

For Official Use Only: MR#: _____ **Acct #:** _____

AUTHORIZATION TO RELEASE HEALTH INFORMATION TO SCHOOLS

ALL ELEMENTS ARE REQUIRED PRIOR TO INFORMATION BEING RELEASED

Patient Name: _____ **Date of Birth:** _____

1. Who is authorized to disclose the information? **Arkansas Children's Hospital AND Healthcare providers and those providing health services (school nurse, occupational therapist, speech therapist, physical therapist, etc.) within _____Arkansas School for the Deaf_____ School District**

2. Who is authorized to receive the information?

Arkansas Children's Hospital

Arkansas Children's Hospital
#1 Children's Way Slot 109
Little Rock, Arkansas 72202

AND

Healthcare providers and those providing health services within Arkansas School f/t Deaf **School District**
(please include patient's school address below)

Vicki Crump, MSN, RN, NCSN
2400 W Markham
Little Rock, AR 72205

3. The specific information to be requested or released is:

List the dates of service:

☐ All ☐ __/__/____ to ___/__/____ ☐ HOLD for pending appointment

☐ Discharge Summary ☐ ER Report ☐ Treatment Action Plans
☐ History & Physical ☐ Clinic Reports ☐ Other: _____
☐ Discharge Instructions

4. The information is needed for:
Continuity of Care and any necessary preparation or instruction needed in the school environment

5. I understand that if the person or entity that receives the information is not a covered entity under the federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

6. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used/disclosed under this authorization.

7. I understand that I may revoke this authorization in writing at any time by delivering a copy of my revocation to Arkansas Children's Hospital except to the extent that action has been taken in reliance on this authorization. This authorization expires: 1 year from date signed.

8. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and/or treatment for alcohol and drug abuse.

_____ _____
Signature of Patient or Representative Date

_____ _____
Phone Number Relationship to Patient

Witness:_____Phone Number:_____Date:_____

ARKANSAS SCHOOL FOR THE DEAF
SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

This order is valid only for school year (current) _2020-2021_____ including the summer session.

This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each school year, *for each medication*, and each time there is a change in dosage or time of administration of medication.

* Prescription medication must be in a container labeled by the pharmacist or prescriber.
* The school nurse will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

Prescriber's Authorization

Name of Student: _____ Date of Birth: _____ Grade: _____

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____ Route: _____

Time/frequency of administration: _____ If PRN, frequency: _____

If PRN, for what symptoms: _____

Relevant side effects: □ None expected □ Specify: _____

Medication shall be administered from _____ to _____
Month/Day/Year Month/Day/Year

Prescriber's Name/Title_____
(Type or Print)

Telephone: _____ Fax: _____

Address: _____

_____

Prescriber's Signature: _____Date: _____
(Original Signature or Signature Stamp ONLY)

(Use for Prescriber's Address Stamp)

PARENT/GUARDIAN AUTHORIZATION

I hereby give my permission for my child, named above, to have administered the above medication while attending the Arkansas School for the Deaf. I understand it is my responsibility to provide this medication in the original container labeled by the pharmacy or physician, including the name of my child, the name of the medication, the dosage, and time of administration. **I understand that medications arriving in baggies, envelopes, etc., labeled or not, will not be given.** I further understand that any school employee who administers any drug in accordance with written instructions from a physician or dentist shall not be liable for damages as a result of administering the drug as directed. I am responsible for updating this form if medication or dosages change.

Signature of Parent/Guardian: _____ Date: _____

Order reviewed by school nurse: _____
Signature Date

Rev: 06/16

Arkansas School for the Deaf

2400 W. Markham • Little Rock, Arkansas • 72205 • (501) 324-9506 • Fax (501) 324-9553

Johnny Key
Secretary

Dr. Janet Dickinson
Superintendent

School Immunization Clinic

I, _____, give
Parent/Guardian Name

permission for my child,_____ to
First and Last Name

participate in the School Immunization Clinic for the recommended and required immunizations.

In compliance with the Family Education Right to Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99)

I, _____,give permission to enter my
Parent/Guardian Name

child's_____ immunizations given at the Arkansas School for the
First and Last Name

Deaf in the Arkansas Department of Health WEBIZ.

Parent/Guardian Signature_____

Date Signed _____

Arkansas School for the Deaf

2400 W. Markham • Little Rock, Arkansas • 72205 • (501) 324-9506 • Fax (501) 324-9553

Johnny Key
Secretary

Dr. Janet Dickinson
Superintendent

Parent Authorization for Health Care at Arkansas School for the Deaf

I confirm that I am the parent of the child listed on this Health History form and as such I have current legal custody of said child. This health history is correct and accurately reflects the health status of the student to whom it pertains. I attest that all of my child's immunizations required for school are up to date and I will provide the immunization documentation to ASD Health Services. I give my permission to the physician selected by ASD staff to order x-rays, routine tests – including COVID-19 testing, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize and secure proper treatment for my child. I understand the information on this form will be shared on a "need to know" basis with the ASD staff. I give permission to photocopy this form. In addition Arkansas School for Deaf has my permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with ASD staff about my child's health status.

Student Name _____

_____ _____

Parent Signature Date

All Medication MUST be Given to ASD or Health Services Staff.

Prescription drugs which are medicines sold only to you if you possess a valid prescription from a healthcare professional. (I.E. Antibiotics, antidepressants, behavioral medication, etc).

All medication must be in the original container with a current pharmacy label and date. This includes inhalers and epi-pens. If your child takes a medication that is considered to be a "controlled substance", please ask the pharmacist to fill the amount of medication needed to be taken at school in a 'blister pack."

Arkansas School for the Deaf does not provide 24-hour nursing care, but a nurse is available by text or phone at all times.

ASD SOCIAL DEVELOPMENTAL HISTORY QUESTIONNAIRE

I. General Information

Person providing information / filling out form:

Relationship to child

Who does the child live with:

- [ ] Both Parents
- [ ] Mother
- [ ] Father
- [ ] Other

Father/Guardian's Name

Mother/Guardian's Name

Are there other adults who have a significant part in raising your child?

- ( ) Yes
- ( ) No

Have there been any significant changes in the home over the last few years? (Such as new marriages, deaths, births, address changes, family separations/divorce, parent dating, parent job change, money problems, etc.)?

Language(s) spoken at home

Primary Language spoken at home

What is your child's primary communication modality?

- ( ) ASL/Sign
- ( ) Voice
- ( ) Both Equally

Please describe your child's strengths:

Please describe your child's weaknesses:

Briefly describe your concerns for your child, if any:

Is your child:

- ◯ Biological Child
- ◯ Foster Child
- ◯ Adopted Child
- ◯ Other

If other, please explain

If adopted, please state the age of the child when adopted:

If the child was in foster care, please list: DHS Caseworker

DHS Caseworker Phone #

Please state length of time in foster care

II. Health and Development

Medication and medical problems will be noted on the Medical History forms

A. Pregnancy and Birth

How many weeks/months did the pregnancy last?

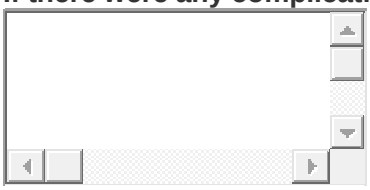
Child's birth weight: (pounds, ounces)

While the mother was pregnant with this child, were there any problems?

- ◯ Yes
- ◯ No

If yes, please explain

If there were any complications noted during or following delivery for the mother or baby, please explain:



Did the child go home from the hospital at the same time as the mother?

- ◯ Yes
- ◯ No

B. Hearing Information

Newborn Hearing Screening:

- ☐ Passed
- ☐ Failed
- ☐ Don't Recall

Approximate date of identification of deafness/hard of hearing:

Time of Onset:

- ◯ Birth
- ◯ First year of life
- ◯ 2nd or 3rd year of life
- ◯ 3 years or older

Please select:

- ☐ Unilateral Loss
- ☐ Bilateral Loss
- ☐ Sensorineural
- ☐ Conductive
- ☐ Mixed
- ☐ Mild
- ☐ Moderate
- ☐ Severe
- ☐ Profound

Is there a family history of deafness/hard of hearing?

- ◯ Yes
- ◯ No

Last audiogram date?

Last audiogram conducted where?

- ASD
- Other Clinic

Does your child use hearing aids?

- Yes
- No

Does your child have a cochlear implant?

- Yes
- No

Date/Age of child when amplification began?

Has your child used amplification in the past, but is currently a non-user?

- Yes
- No

C. Development

Please indicate the age or range when your child performed the following developmental milestones. If you are not certain of exact age, please provide an estimate:

Age child crawled

Age child walked alone

Age child spoke/signed first word

Age child spoke/signed words together

Age child became toilet trained

D. Health

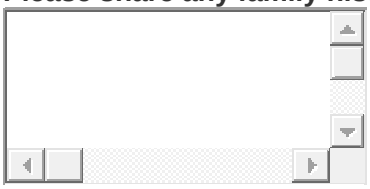
Describe the state of your child's current health:

- Excellent
- Good
- Fair
- Poor

Has your child ever been identified as having a disability?

- ◯ Yes
- ◯ No

Please share any family history of disability diagnoses or mental health diagnoses:



Has your child ever received psychological counseling?

- ◯ Yes
- ◯ No

Vision checked (date and results)

III. Behavior

Please check the positive characteristics that apply to your child:

- ☐ Puts forth good effort
- ☐ Attentive
- ☐ Persistent in efforts
- ☐ Seeks help when necessary
- ☐ Gets along well with siblings
- ☐ Gets along well with peers
- ☐ Makes friends easily
- ☐ Wishes to please
- ☐ Listens appropriately
- ☐ Follows household rules
- ☐ Cooperative
- ☐ Gets along well with parents
- ☐ Helpful
- ☐ Other

If Other, please explain

Please check any of the following characteristics that apply to your child:

- [ ] Easily distracted
- [ ] Overactive
- [ ] Poor concentration
- [ ] Difficulty completing tasks
- [ ] Has sleeping problems
- [ ] Seems unhappy
- [ ] Tires easily
- [ ] Low self esteem
- [ ] Has poor coordination and balance
- [ ] Rocking
- [ ] Bed wetting
- [ ] Inattentive
- [ ] Quick to anger/temper tantrums
- [ ] Loses things, is disorganized
- [ ] Difficulty following instructions
- [ ] Cries easily
- [ ] Lacks energy
- [ ] Withdrawn
- [ ] Easily frustrated
- [ ] Trouble adjusting to new situations or people
- [ ] Head bumping
- [ ] Sensory seeking (chews, spins)

Please briefly explain any checked items

Has your child ever been suspended or expelled from school?

- ( ) Yes
- ( ) No

IV. Educational History

How does your child feel about school?

- ( ) Likes
- ( ) Dislikes
- ( ) Is Indifferent

Can your child effectively express him/herself to you?

- ◯ Yes
- ◯ No

Has your child ever received speech therapy?

- ◯ Yes
- ◯ No

Has your child ever received occupational or physical therapy?

- ◯ Yes
- ◯ No

Has your child ever been retained?

- ◯ Yes
- ◯ No

Has your child been formally evaluated other than at ASD?

- ◯ Yes
- ◯ No

Attended an early intervention/preschool program?

- ◯ Yes
- ◯ No

Please list any other schools your child has attended since kindergarten

Parent/Guardian Name/E-signature

☐ Parent acknowledgement

Clear Form

Audiology 2020-2021

Please complete all fields.

Audiology Services - Arkansas School for the Deaf
Each year as part of district-wide services, ASD audiologists complete a hearing test and hearing aid/CI/Baha check on each student.

ASD can offer all students complete audiological services, including:

- Cochlear Implant, Baha, and hearing aid repairs
- New hearing aid orders
- Hearing aid programming
- Batteries for all amplification
- Ear mold orders and other supplies

I would like for ASD audiologists to manage my child's audiology needs.

- ◯ Yes
- ◯ No

I would like to continue my child's audiology services with current audiologist.*

- ◯ Yes
- ◯ No

***If you continue services with your personal audiologist, ASD will maintain current records, prescribed recommendations, and appropriate follow-up for your child.**

Parent E-Signature

Behavioral Health Services OF ARKANSAS

Name:_____ **Date of Birth:**_____

1. Consent to Evaluate/Treat: I voluntarily consent that *my* child will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by staff from Behavioral Health Services of Arkansas (BHSA), our collaborative community mental health agency. I understand that following the evaluation and/or treatment, complete and accurate information will be provided concerning each of the following areas:
    a. The benefits of the proposed treatment
    b. Alternative treatment modes and services
    c. The manner in which treatment will be administered
    d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
    e. Probable consequences of not receiving treatment

    The evaluation or treatment will be conducted by a psychiatrist, a licensed therapist, and a registered nurse. Additional supportive services may be provided when prescribed or indicated by a school counselor, educational guidance counselor, mental health paraprofessional, or licensed psychological examiner.

2. Benefits to Evaluation/Treatment: Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to *my* child, as well as the referring professional, to understand the nature and cause of any difficulties affecting *my* child's daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation, estimating prognosis, and education. Possible benefits to treatment include improved cognitive or academic performance, health status, quality of life, and awareness of strengths and limitations.

3. Confidentiality, Harm, and Inquiry: Information from *my* child's evaluation and/or treatment is contained in a confidential electronic medical record maintained by BHSA. Per Arkansas mental health law, information provided will be kept confidential with the following exceptions: 1) if *my* child is deemed to present a danger to himself/herself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

4. Right to Withdraw Consent: I have the right to withdraw *my* consent for evaluation and/or treatment of *my* child at any time by providing a written request to the treating clinician employed by BHSA.

5. Expiration of Consent: This consent to treat will expire 12 months from the date of signature, unless otherwise specified.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment of my child. I also attest that I am the legal guardian and have the right to consent for the treatment of this child. I understand that I have the right to ask questions of my child's service provider about the above information at any time.

_____ _____

Signature of legal guardian for minor under age 18 Date

_____ _____

Signature of witness Date

Photo and Video Release Form

At ASD, we think all of our students are BEAUTIFUL! We take a lot of photos and videos of our students during class time, on field trips, and during special activities. ASD uses photographs and videos of children for educational purposes and for publicity purposes. We love to brag on our students, so we promote our school through brochures, the ASD website, on Social Media, through ASD newsletters, and other types of promotional materials.

Please note that *all* students may occasionally appear in group photos taken at the school. Students who participate in sports, academic competitions, plays, performances, and other similar public activities may be photographed as part of the event. When photographs are used for publicity purposes, students are not identified by name unless it is a newsworthy event, such as being elected Homecoming Queen or winning a significant award.

We would like your permission to use your child's individual photos for publicity! Please sign the permission slip below to give your permission for ASD to use your child's individual photos for our publicity and promotional materials:

- ◯ **I give the Arkansas School for the Deaf permission to use individual photographs of my child for publicity purposes. I understand that my child will not be identified by name when photos are used for publicity purposes.**

OR

- ◯ I do not give permission for my child's photo to be used

ASD Parent Contact Form

We love to keep in touch with our families! Please let us know how to reach you so we can let you know about schedule changes, activities, and in case school closes for winter weather. You can enter multiple email addresses and phone numbers, if you like. Be sure you stay in the loop on things happening at ASD!

Parent Email Address

Parent Email Address 2

Parent Email Address 3

Please send me (check all that apply)

- ☐ Voice calls
- ☐ Text Messages
- ☐ Both

Please note: You may receive an introduction email from SchoolMessenger, ASD's Parent Message provider, if you elect to receive text messages. You will need to follow the instructions to OPT-IN to receive text messages.

Parent E-Signature

- ☐ Parent acknowledgement

Student Laptop Agreement 2020-2021

Arkansas School for the Deaf
Student Laptop Policy and Agreement
Laptop Agreement Terms and Conditions

Ownership
The laptop computer remains at all times the property of the Arkansas School for the Deaf. The student's possession and use of the laptop does not in any way change ownership of the laptop. The laptop is provided solely for the use of the student and solely for school purposes. The laptop may not be loaned to anyone else. The student's password and usernames are not to be shared with anyone.

Loss or Damage
Should the laptop be returned to the Arkansas School for the Deaf inoperable and/or damaged beyond normal use, the Student/Parent will need to pay $100 toward the insurance deductible to replace the laptop. If the laptop is lost or stolen, replacement expense of $100 will be the student/parent's responsibility. Report all incidents of theft, vandalism, and other criminal acts to the Principal's office and the police department within 48 hours. Incidents happening off campus must be reported to the police by the student/parent and a copy of the report brought to the school.

Financial Hardships
If the potential liability may create a financial hardship on the student or parent from obtaining a laptop, please contact the school principal. It is the desire of the District to provide all students with a laptop.

Terms of Agreement
It is understood that the laptop will be returned to the Arkansas School for the Deaf no later than the last day of the school year unless this agreement is terminated earlier by the District or upon the Student's withdrawal from the District. The agreement may be extended, if appropriate, into the summer months for use in the student's summer school studies.

Acceptable Use
The Arkansas School for the Deaf Handbook includes policies that govern the Students' Use of the laptop and the internet. Failure to comply with the School's Policies may result in the immediate repossession of the computer by the School and other consequences for violation of the School's policies. The Student's use is also subject to copyright laws. No software may be loaded on the computer without the express prior approval of the Arkansas School for the Deaf.

Compliance
Failure to comply with the terms and conditions set forth above may result in the termination of this Agreement by the Arkansas School for the Deaf and the immediate repossession of the computer by the School.

Repossession
Failure to return the computer to the Arkansas School for the Deaf at the end of this Agreement or when requested to do so, may result in the Arkansas School for the Deaf taking legal action for the return of its property. Should the Arkansas School for the Deaf have to initiate any such proceedings, you will be responsible for the fees incurred by the School in obtaining the return of its property.

General Laptop Policies and Procedures

Commitment

In your quest for academic success the Arkansas School for the Deaf is making a commitment to you by providing a laptop computer. The School needs you to make a commitment to care for the laptop and use it in accordance with School policies.

Inappropriate Content

Inappropriate content will not be allowed on laptops. Presence of weapons, pornographic materials, inappropriate language, alcohol, drug, and gang related symbols or pictures would result in disciplinary action. It is the student responsibility to report any web site accidentally loaded which contains obscene, pornographic material or otherwise offensive materials.

Privacy and Safety:

- Do not go into chat rooms without permission.
- Do not open, use, or change computer files that do not belong to you.
- Do not reveal your full name, phone number, home address, or social security number, or passwords.
- Files, email logs are not guaranteed to be private or confidential.
- Observe copyright laws, trademarks and license agreements.
- Plagiarism is stealing and in violation of board policy.
- Hacking is illegal and prohibited, Violators will be prosecuted.
- The student whose was assigned the laptop is responsible for the use of that laptop and account. DO NOT SHARE.
- You may connect to the Internet at home or at any “Hot Spot.”
- Student Laptops will be labeled by the Arkansas School for the Deaf, Serial Numbers, User Accounts and MAC addresses will be used for identification.

Student Responsibilities

- Monitor your laptop at all times or lock it up in a secure area.
- Nothing should be placed on top of the laptop.
- Do not store your laptop in a vehicle as extreme temperatures can damage them. It also increases the danger of theft.
- Bring the computer and charging unit to school every school day. Keep the computer in your locker when it is in school and not in use.
- Students should never carry their laptops while the screen is open.
- Laptops should be shut down before moving them to conserve battery life.
- Laptops must remain free of any writing, drawing, stickers or labels that are not the property of the District.
- Arrive at school each day with a fully charged battery.
- Do not let anyone use the computer other than your parents or guardians.
- Keep the equipment clean. For example: do not eat or drink while using the computer.
- Adhere to the Arkansas School for the Deaf policies included in the Student Handbook

Laptop Screen Care

- The laptop screen can be damaged if subjected to rough treatment.
- Do not lean on the top of the laptop or place object on top of it when it is closed.
- Do not poke the screen.
- Do not place anything on the keyboard before closing the lid (e.g. pens, pencils, papers, folders).
- The laptop screen should only be cleaned with a soft dry cloth. The screen can never be cleaned with glass cleaner.
- Computers that malfunction or are damaged must be reported to the Technology Department.

Technical Assistance Policies and Procedures

If Technical issues occur with your Laptop:

- The first step would be to review any technical assistance documentation provided on the Student Laptop Support Page.
- If you are unable to troubleshoot the problem please submit a Student Technology Support request to the Helpdesk. Once a support ticket has been submitted a technician will contact you to arrange repair details. If technical difficulties occur or illegal software is discovered the hard drive could be wiped clean. The school does not accept responsibility for the loss of data deleted. Files should be saved to the network, or to an external storage device.
- Loaner laptops may be issued to students when they leave their laptops for repair with the Technology Services Department. Students will be expected to return the loaner laptop when they receive their original laptop back.

Using your Laptop at School

Laptops are intended for use at school each day. Students are responsible for bringing their laptop to all classes, unless specifically advised not to do so by their teacher.

Charging your Laptop's Battery

- Laptops must be brought to school each day in a fully charged condition. Students need to charge their laptops each evening.
- Students should bring the charger each day. Use the charger during the day to charge the battery, when appropriate.

Screensavers and backgrounds

Individual selected screensavers and background may be used on the laptops. Presence of weapons, pornographic materials, inappropriate language, alcohol, drugs, gang-related symbols or pictures would result in disciplinary action.

Sound

- Sound must be muted at all times unless permission is obtained from the teacher for instructional purposes.
- Headphones may be used at the teacher discretion.

Printing

- Printing stations will be available at the school (configurations pending).
- Because of software installed to combat computer viruses, students will likely not be able to print at home. Students should save their work and print their work at school.

Laptop Software

Originally installed Software

- The software originally installed by the School must remain on the laptop in usable condition and be easily accessible at all times.
- It is the responsibility of the Technology Department to install additional software and files. Students are NOT ALLOWED to install programs on school laptops, unless given permission.

Virus Protection

- The laptop has Anti-Virus protection software installed.
- The Anti-virus software will be updated from the Internet. Students are to allow updates to download uninterrupted.

Internet Safety
There are many sites on the Internet that can be potentially dangerous to minors. These sites are blocked while students are logged on the School's network at school and at home. Students are in violation of school policy if they access these sites through proxies. Parents may want to restrict their home access.

Communication
Students will be given an email account through a School-maintained Gmail account.

Arkansas School for the Deaf: Rights and Responsibilities

The Arkansas School for the Deaf recognizes its obligation to protect the well-being of students in its charge. To this end, the School retains the following rights:

- To log electronic resource use and to monitor file server space utilization by users, and assume no responsibility or liability for files deleted due to violation of file server space allotments.
- To monitor the use of electronic resource activities. This may include real-time monitoring of network activity and/or maintaining a log of Internet activity for later review.
- To provide internal and external controls as appropriate including the right to determine who will have access to Arkansas School for the Deaf -owned equipment.
- To exclude those who do not abide by the Arkansas School for the Deaf policies governing the use of school facilities, equipment, and materials.
- To restrict electronic resource destinations through software or other means.
- To provide guidelines and make reasonable efforts to train staff and students in acceptable use and policies governing electronic resource communications.
- To use filtering software to block or filter access to visual depictions that are obscene and all child pornography in accordance with Children's Internet Protection Act (CIPA). Other objectionable material may be filtered. The determination of what constitutes "objectionable" material is a local decision determined by the School's educational goals.

Disclaimer
The Arkansas School for the Deaf cannot be held accountable for the information that is retrieved via electronic resources.

- Pursuant to the Electronic Communications Privacy Act of 1986 (18 USC 2510 et seq.), notice is hereby given that there are no facilities provided by this system for sending or receiving private or confidential electronic communications.
- Network administrators have access to all communication and will monitor messages.
- Messages relating to or in support of illegal activities will be reported to the appropriate authorities.
- The School reserves the right to monitor, inspect, copy, review, and store without prior notice any and all usage of: the network; user files and disk space utilization; user applications and bandwidth utilization; user document files, folders, and electronic communications; email; Internet access; and any and all information transmitted or received in connection with network and/or email use.

- All such information files shall be and remain the property of the Arkansas School for the Deaf, and no student or staff user shall have any expectation of privacy regarding such materials. The School reserves the right to disclose any electronic message to law enforcement officials or third parties as appropriate. All documents are subject to the public records disclosure laws of the State of Arkansas.

- While the district plans for disaster recovery, not all data is backed up. The responsibility is upon the user to use best practices for maintaining this data. Recovery is not guaranteed for accidental loss of deleted files.

- Filtering software is not 100% effective. While filters make it more difficult for objectionable material to be received or accessed, filters are not a solution in themselves. Every user must take responsibility for his or her use of the network and Internet and avoid objectionable sites.

- From time to time, the Arkansas School for the Deaf make determinations on whether specific uses of electronic resources are consistent with our School policies.

- The Arkansas School for the Deaf will not be responsible for any damages users may suffer, including loss of data resulting from delays, non-deliveries, or service interruptions caused by our own negligence or user errors or omissions. Use of any information obtained is at the user's own risk.

- The Arkansas School for the Deaf makes no warranties (expressed or implied) with respect to:
    - The content of any advice or information received by a user or any costs or charges incurred as a result of seeking or accepting any information;
    - Any costs, liability, or damages caused by the way the user chooses to use his or her access to the electronic resources.

The Arkansas School for the Deaf reserves the right to change its policies and rules at any time without notification.

Student Name

Parent/Guardian Name

Parent/Guardian Phone Number

Parent/Guardian Email

Asset Number

Model

Serial Number

The Laptop computer owned by the Arkansas School for the Deaf, described in the laptop description box above, is being provided for the use of the student under the following terms and conditions: The laptop computer remains at all times the property of the Arkansas School for the Deaf. Student's possession and use of the laptop does not in any way change ownership of the laptop. The laptop is provided solely for the use of the Student and solely for school purposes. The laptop may not be loaned to anyone else. The Student's password and usernames are not to be shared with anyone. The laptop is provided solely for the use of the Student and solely for school purposes. The laptop may not be loaned to anyone else. The Student's password and usernames are not to be shared with anyone. Should the laptop be returned to the District inoperable and/or damaged beyond normal use, the Parent may be responsible for the insurance deductible to repair or replace. If the laptop is lost or stolen, replacement expenses on the date of loss will be parental responsibility. Replacement cost is $100.00. It is understood that the laptop will be returned to the Arkansas School for the Deaf no later than the last day of the school year unless this Agreement is terminated earlier by the District or upon the Student's withdrawal from the District. The Arkansas School for the Deaf Student Internet and Network Safety Policy and Student Acceptable Use (AUP) Policy governs the Student's use of the laptop. Copies of the associated policies can be obtained online at the District website, www.arschoolforthedeaf.com. The School must have on file a copy of your child's signed AUP before the student will be allowed to take the laptop home. Failure to comply with these policies will result in the immediate repossession of the computer and other consequences for violation of the School's policies. The Student's use is also subject to copyright laws. No software may be loaded on the computer without the prior approval of the School. Failure to comply with the terms and conditions set forth above may result in the termination of this Agreement by the Arkansas School for the Deaf and the immediate repossession of the computer. Failure to return the computer to the Arkansas School for the Deaf at the end of this Agreement or when requested to do so may result in the School taking legal action for the return of its property. By agreeing below, I acknowledge that I have read the Arkansas School for the Deaf Laptop Guide and Agreement and I agree to abide by the conditions set forth. I agree to the above statement

--Select--

Parent E-Signature

Student E-Signature

☐ Parent acknowledgement

Arkansas School for the Deaf
Transportation Registration Details
2020-2021

Student No	Last Name	First Name	Grade	Sex	Birth Date	Age	Phone

Address

Guardianship	

Emergency Contacts					
Name	Relation	E-mail	Home	Mobile	Work

Forms	Completed
Authorization to Treat	☐
Residency Information – McKinney Vento E-signature of Parent/Guardian/Unattached Youth **By signing below I acknowledge that I have received and understand the above rights.	☐
Consent for Release b/t School and Hospital – General	☐
Medication Authorization	☐
Photo and Video Release Form	☐
FERPA Consent Form	☐

AUTHORIZATION FOR ADMINISTRATION OF MEDICAL AND/OR EMERGENCY TREATMENT

During the course of study at the Arkansas School for the Deaf, unforeseen circumstances may arise that necessitate the administration of medical and/or emergency treatment upon the child. I, therefore, authorize and request that should I be unavailable for purposes of granting permission for such treatment, officials of the Arkansas School for the Deaf shall provide for such medical and/or emergency procedures as are necessary and desirable in the best judgment of the medical profession.

☐ I agree with the above statement.

Parent/Guardian Information	
Parent/Guardian 1 Name:	
Phone number:	
Workplace:	Work phone:

Parent/Guardian 2 Name:	
Phone number:	
Workplace:	Work phone:

Student Information

Will this student be a dorm resident at ASD? ☐ Yes ☐ No

Emergency Medical Treatment

Permission is given to the Arkansas School for the Deaf and its Staff to take necessary steps, medical and otherwise, for my child. This permission includes the administering of prescription drugs as well as the use of emergency medical facilities in the area where the emergency occurs.

IMPORTANT: Please list all the student's allergies (e.g., food, drug). If none, please write "none."

Name of the student's physician:

Insurance provider:

Policy/Medicaid number:

Student's local school district:

Does your child have court restrictions regarding a parent/legal guardian contact? ☐ Yes ☐ No

Student Transportation

Student will travel to school by (check one): ◯ Local district ◯ Charter bus ◯ Parent/Guardian ◯ Drive self

Student will travel from school by (check one): ◯ Local district ◯ Charter bus ◯ Parent/Guardian ◯ Drive self

☐ I give permission for my child to be transported by ASD staff members in school vehicles to and from ASD for field trips and other sanctioned activities.

☐ I authorize ASD to drop off and leave my child at his/her charter bus stop without supervision (only for students age 14 or older).

☐ I agree to pick up my child when contacted by a school administrator due to illness, behavior concerns, or other circumstances.

Please list below names and contact information of person(s) other than parent/guardian, permitted to take your child off campus or pick up from the weekend charter bus stop; you must contact the dorm supervisor or school secretary via email, text, fax, telephone or personal note advising who will take the child and when to expect that person.

Name:	Name:
Relationship to student:	Relationship to student:
Phone number:	Phone number:
Name:	Name:
Relationship to student:	Relationship to student:
Phone number:	Phone number:

_____ _____

Parent/Guardian Signature Date

CLEAR FORM

Completed Forms Acknowledgement

I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, by updating my forms accordingly. (e.g., telephone numbers, work location, emergency contacts, child's physician, child's health status, child's food restrictions and immunization records, etc.)

I acknowledge that I have reviewed each form and now certify that the information contained therein is accurate and correct to the best of my ability.

By checking the box below, I agree with the statements above.

☐ Parent Acknowledgement

Parent/Guardian E-Signature: _____ Date: _____