MY PLACE TO BE
EMBRACING EVERY CHILD'S GIFT FOR POSITIVE LEARNING

STUDENT REGISTRATION FOR FY23 2022-2023 SCHOOL YEAR

STUDENT NAME	LAST:	FIRST:
ADDRESS:		
CITY:	ZIP:	COUNTY:
DATE OF BIRTH:		
AGE:	LAST GRADE COMPLETED:	
SCHOOL DISTRICT:		
DIAGNOSIS:		
PRIMARY PARENT/GUARDIAN NAME:		
ADDRESS IF DIFFERENT:		

PREFERRED CONTACT NUMBER:		CELL		LANDLINE
SECONDARY NUMBER:	EMAIL:			
SECOND PARENT/GUARDIAN NAME:				
ADDRESS IF DIFFERENT:				
PREFERRED CONTACT NUMBER:		CELL		LANDLINE
WORK PHONE:	EMAIL:			

FUNDING INFORMATION - WHO IS PAYING FOR?

	FAMILY - PRIVATE PAY		NEED HELP WITH FUNDING
	PLEASE UTILIZE MY LCBDD FFS FUNDS	SIGN:	
MY SERVICE COORDINATOR IS:			

(WE WILL BILL MONTHLY DIRECTLY TO LICKING COUNTY BOARD OF DEVELOPMENTAL DISABILITIES)

	JON PETERSON SPECIAL NEEDS SCHOLARSHIP		AUTISM SCHOLARSHIP

MEDICAL

MEDICATION FORMS MUST BE ON FILE PRIOR TO ADMINISTERING MEDICATION

LIST ANY ALLERGIES:(MEDICAL FORM FOR EPI-PEN MUST BE ON FILE)

SEIZURE DISORDER		**YES**		**NO**	**FREQUENCY:**	**LENGTH:**

INSTRUCTIONS IF SEIZURE OCCURS:(SEIZURE ACTION PLAN MUST BE ON FILE)

CURRENT MEDICATIONS:(MEDICATION FORM MUST BE ON FILE IF TAKEN AT SCHOOL)

HOSPITAL/CLINIC PREFERENCE:

PRIMARY PHYSICIAN:	**PHONE:**
DENTIST NAME:	**PHONE:**
INSURANCE COMPANY:	**POLICY #:**

EMERGENCY MEDICAL AUTHORIZATION

The purpose of this form is to enable the parent/guardian to authorize the provision of emergency medical treatment for a child who becomes ill or injured while under school authority when the parent/guardian cannot be reached.

PART 1: To Grant Consent

In the event reasonable attempts to contact me have been unsuccessful, I hereby give consent for:

1. Administration of any treatment deemed necessary by the above named doctor, or in the event the designated preferred practitioner is not available, by another licensed physician, and
2. transfer of my child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians concurring there is a necessity for such surgery to be obtained prior to the performance of the surgery. Facts concerning the child's medical history including allergies, medications being taken and any physical impairment to which a physician should be alerted are listed above.

Parent/Guardian Signature_____ Date_____

PART 2: Refusal to Grant Consent

DO NOT COMPLETE THIS SECTION IF PART 1 IS FILLED OUT

I DO NOT give permission for emergency medical treatment of my child, In the event of illness or injury requiring emergency treatment, I request that the school employees take the following action:

_____

_____

Parent/Guardian Signature_____ Date_____

SENSORY PROFILE

Please check all the apply

TACTILE STIMULATION

OTHER:

- [ ] Overreacts to unexpected touch or sound
- [ ] Dislikes light touch/any touch at all
- [ ] Unable to calm down after motor activity
- [ ] Needs to touch things
- [ ] Has decreased awareness to pain or temperature
- [ ] Avoids “getting messy”

AUDITORY SENSATIONS

OTHER:

- [ ] Overly sensitive to noise
- [ ] Seems oblivious within an active environment
- [ ] Has hearing loss
- [ ] Holds hands over ears
- [ ] Misses sounds
- [ ] Cannot work with background noise
- [ ] Likes to make loud sounds

ATTENTION / RESTLESSNESS

OTHER:

- [ ] Cannot sit still
- [ ] Lethargic at times
- [ ] Stares blankly on occasion
- [ ] Frequently misses directions
- [ ] Has wandering eyes; cannot focus
- [ ] Avoids eye contact
- [ ] Does not notice when people come into the room
- [ ] Jumps from one activity to another frequently

FINE MOTOR

OTHER:

- [ ] Difficulty manipulating small objects
- [ ] Difficulty using scissors, coloring, etc.
- [ ] Abnormal pencil grip
- [ ] Jerky or tremor-like motions in hands when drawing
- [ ] Difficulty tracing lines
- [ ] Eyes do not follow hands or seem to wander
- [ ] Difficulty using isolated finger movements

LEARNING BEHAVIORS

OTHER:

- [ ] Short attention span
- [ ] Difficulty with change in routine
- [ ] Slow worker
- [ ] Easily distracted
- [ ] Difficulty recognizing own errors

LEARNING BEHAVIORS (con't)

- [ ] Disorganized, messy
- [ ] Rushes through work
- [ ] Difficulty working independently
- [ ] Talks aloud, hums, etc.

SOCIAL / EMOTIONAL

- [ ] Verbally aggressive
- [ ] Behavior bothers others
- [ ] Physically aggressive
- [ ] Happiest playing alone
- [ ] Attention seeking
- [ ] Impulsive
- [ ] Lacks confidence
- [ ] Cries easily
- [ ] Fearful of new situations
- [ ] Easily-frustrated
- [ ] Falls asleep in class
- [ ] Cannot calm down
- [ ] Has difficulty making friends
- [ ] Does not express emotions
- [ ] Is overly serious

OTHER:

BEHAVIORS

Behaviors that we should know about:

Are there specific triggers to any of the above listed behaviors?

Are there ways that already work to help redirect or stop behavior?

What is your hope for your student to get out of this program?

Are there specific challenges you would like us to cover?

CONSENTS

Consent remains valid for the current school year

CONSENT TO PARTICIPATE

I/We give permission for our student_____, to attend My Place To Be. In doing so, I hereby release and waive any claim of cause of action which may occur against My Place To Be and any employees/volunteers working on their behalf, resulting in any injury to person or property of the above named individual during their time at My Place To Be and any activities they may be participating in while in the care of My Place To Be. I/We agree to assume all liability for any claims, which said person in his/her capacity, might have against any of My Place To Be's employees/volunteers for injury sustained as a result of the operation of My Plact To Be. ⬜ **DO NOT CONSENT**

Parent/Guardian Signature_____ Date_____

CONSENT FOR PHOTOGRAPHY AND/OR AUDIO/VIDEO RECORDING AND ITS USE

I/We understand that the photography and/or audio/video recording of our student, _____ _____, may be used in the future to promote My Place To Be. The photograph and/or audio/video recordings will be kept confidential and will be used only for the purpose of operational documentation and the promotion of My Place To Be. Therefore, I/We give consent for photographs and/or audio/video recordings to be made of the above-mentioned student. I/We also give consent for these photographs and/or recordings to be presented to the public in the form of documentations, publications, and posting on web pages for My Place To Be. ⬜ **DO NOT CONSENT**

Parent/Guardian Signature_____ Date_____

CONSENT AND WAIVER TO TRANSPORT CHILD

I/We authorize My Place To Be to transport my minor child, _____, driven by an individual authorized by My Place to Be. I/We understand my child is expected to follow the directions provided by the driver and/or staff or volunteer.

I/We have read, understand and discussed with my child:

1. My child will travel in a motor vehicle driven by an adult and my child is to wear their safety belt during travel;
2. My child is expected to listen to supervising staff/driver, respect staff and other children, in the vehicles they ride in, and the people they travel with during the trip.
3. Riding in a motor vehicle my result in personal injuries or death from accidents, collisions or acts by the riders, other drivers, or objects; and,
4. My child is to remain in their seat and not be disruptive to the driver of the vehicle.

I/We recognize participation in this activity, as with any activity involving motor vehicle transportation, my child may risk personal injury or permanent loss. I/We hereby attest and verify I/We have been advised of the potential risks, and I/We have full knowledge of the risks involved in this activity, and I/We assume any expenses incurred in the event of an accident, illness, or other incapacity, regardless of whether I/We have authorized such expense.

I/We release any claim on My Place To Be and their agents, officers, employees and volunteers from any claim that I could bring on my child's behalf with regard to any damages, demands or actions whatsoever, in any manner arising out of this transportation. I/We have read this entire waiver and authorization form, I/We fully understand its terms and conditions, and I agree to be legally bound by its terms. ⬜ **DO NOT CONSENT**

Parent/Guardian Signature_____ Date_____

CONSENTS

Consent remains valid for the current school year

STUDENT PICKUP/RELEASE

PLEASE KEEP LIST AND PHONE NUMBERS CURRENT

STUDENT NAME	

STUDENT RELEASE

Adults who are not listed as an emergency contact or authorized pickup will not be allowed to pick-up a student.

PICKUP LIST

Only adults listed by the parent or legal guardian on the “pickup list” will be permitted to take a child from school. To maintain student safety, a person being added to the pickup list must be provided to the office in writing, with parent/guardian signature. The school will not accept additions to the pickup list by phone.

STUDENT DISMISSAL ARRANGEMENTS

Changes to dismissal procedures must be in writing with parent/guardian signature. Changes may be sent to school with the child or sent via email to Christa Milner at cmilner@myplace2b.org.
It is the sole responsibility of the parent/legal guardian to ensure the school office has the correct emergency contact and pickup information.
Telephone notification of a change in dismissal should be reserved for emergencies. Any person listed on the dismissal form and those not on the list due to an emergency only, must be prepared to present an ID to a My Place To Be Education Center staff member. It is the responsibility of the parent/guardian to keep all contact information current.

Please notify the office at 740-899-4296 as soon as possible if a designated person other than the parent/guardian will be picking up your child.

NAME	PHONE NUMBER	RELATIONSHIP TO CHILD

_____ _____

Parent/Guardian Signature Date

☐ **By checking this box I acknowledge that I have read and understand the Parent/Student Handbook.**