Louisiana School for the Visually Impaired
Academic and Mobility Program
"AMP"

To: Interested Parents and Students
Re: AMP Registration Forms

Thank you for your interest in LSVI's summer camp programs. Enclosed is a copy of the registration forms needed for participation. Please fill out all forms and mail or fax back to us as soon as possible.

****AMP is open to Louisiana residents only****

It is important that the following information be included on the registration forms as indicated:

1. **Health insurance numbers**
2. **Medical information (including medications, up to date shot record)**
3. **Social security number**
4. **Date of birth**
5. **Physician signatures**

Please fax or mail the registration forms to:

Fax#: 225-757-3486

Address: Louisiana School for the Visually Impaired
Attn: Outreach Department/AMP
P.O. Box 4328
Baton Rouge, Louisiana 70821

For more information please call LSVI at 225-757-3489.

Registration Deadlines:
October 20, 2017 and January 12, 2018
Registration is limited … AMP slots are awarded on a first come/first served basis

Louisiana School for the Visually Impaired
Academic and Mobility Program
****Registration Deadlines: Oct. 20, 2017 & Jan. 12, 2018****

AMP Dates/**Please Check One**:

___ **November 13-17, 2017** (deadline Oct. 20, 2017) ___ **February 5-9, 2018** (deadline Jan. 12, 2018)

Student Name: _____ Parish: _____

Date of Birth: _____ Age:_____ Social Security Number: _____

Current School Grade Level: _____ Sex: Male ___ Female ___ Race_____(for food services)

Parent's Name: _____

Full Address: _____

_____

Home Number: _____ Work Number: _____

Cell Number: _____ Email: _____

Additional Emergency Numbers: _____ _____

Will your child be staying in the dorm? _____Yes _____No

What is your child's diagnosed visual impairment? _____

Please list below any food allergies (required for food services):

_____

_____

_____

PLEASE NOTE the following:

If your child takes medication, the medication form must be filled out and signed by a doctor and all prescriptions must be sent in their original bottles.

Medication shall be provided to the school by the parent or guardian in the container that meets acceptable pharmaceutical standards and shall include the following information:

1. Name of pharmacy
2. Address and telephone number of pharmacy
3. Prescription number
4. Date dispensed
5. Name of student
6. Clear directions for use, including the route, frequency, and other as indicated **MUST** MATCH the written prescription
7. Drug name and strength
8. Last name and initial of pharmacist
9. Cautionary auxiliary labels, if applicable
10. Physician or dentist's name

Please be sure to include social security number and insurance information.

PARENTAL CONSENT/RESPONSIBILITES

2888 Brightside Lane Baton Rouge, Louisiana 70820 (225)757-3247 Tel (225)757-3430 Fax

Student:_____ DOB: _____ School: LSD LSVI

1. If your child needs medications for serious health issues while at school, you must supply the medication and doctor's orders to the SHC (Student Health Center) before the student can attend LSDVI or reside on campus. You request the SHC to administer medications and treatments as ordered. Only medication with a prescriber's order on file will be administered, including over-the-counter medication. Prescribing health care providers must be licensed in Louisiana or adjacent states.
2. SHC is able to keep a 35 day supply of medication at school at a time. Quantities over this amount will be sent home. New orders are needed every school year and are required for changes in medications and/or dosages.
3. You are responsible for your child's medical expenses. This may include, but not be limited to: ambulance services, physician's billing, prescription medication, co-payments, and lab/x-ray services.
4. **You must send a copy of your child's insurance cards (front and back) to the SHC. You will inform the SHC of any changes in the student's medical status, insurance information, or contact information.**
5. By law, you are responsible for keeping your child's immunizations current. Without proper documentation, your child may be sent home. The SHC must be provided a copy of updated immunization records.
6. You give permission for your child to be tested for HIV and Hepatitis in the event staff or another student is exposed to your child's blood or bodily fluids.
7. You give permission for the SHC staff to communicate with your child's healthcare provider in order to provide continuity of care and to assist the provider in monitoring the effects of prescribed treatments.
8. When a student is ill/injured, he/she will be assessed and receive minor medical care from the SHC staff and medication as directed by the LSDVI pediatrician. If indicated the student will be scheduled for follow-up with the school pediatrician, or may be referred to their primary provider or another healthcare provider (ex: ER, Urgent Care Clinic, specialist) if necessary. Physician recommendations for medication will be initiated as prescribed for residential students. The school pediatrician DOES NOT manage chronic conditions such as behavior issues, asthma, diabetes, hypertension, allergies, etc.
9. You understand that LSDVI health care providers will communicate any health conditions and medical treatments to instructional and direct care staff on a need-to-know basis.
10. Medication orders must match medication labels on the bottle. Pharmacy labels WILL NOT substitute for a written doctor's order. You will provide the SHC with the most current pharmacy-labeled container for medications, including prescribed over-the-counter medications. Keep enough medication at home for weekends and holidays. Your pharmacy can provide an additional labeled bottle for your medication at home.
11. The first dose of any new medication ordered during home-goings should be administered at home and you should observe your child overnight for reactions.
12. SHC will schedule prescribed treatments per provider's orders and monitor compliance. You will be notified of noncompliance.
13. Medications that have been discontinued by the healthcare provider may be destroyed.
14. In the event medications need to be ordered from a pharmacy, the SHC may provide medical, billing, and insurance information.
15. SHC will pack needed medications for LSDVI events and your child's medications will be administered by trained school employees.
16. Parents are ultimately responsible for transporting medication to/from school. Medications should only be transported by responsible adults. If you choose to send your child's medication on the bus, it should be given to the adult/s accompanying students on the bus to be brought directly to the SHC. Adults on local routes are not employed by LSDVI. Students should NEVER transport medications nor should medications be packed in suitcases or book sacks.
17. You will arrange for medications/medical information to be provided to the caregiver for your child for any unscheduled home-goings.
18. Should a student require emergency medical or psychiatric treatments, LSDVI is authorized to consent to treatment on your behalf and communicate health information to the emergency provider.

My signature indicates I have read and understand my responsibilities and the health care role of LSDVI toward my child. I agree to all the above with the following exceptions: (Please list number.)

_____ _____

Signature Parent/Legal Guardian Date Signature of Student (18 or older) Date

LSDVI Visiting Student Health information

I. To be completed by PARENT

Program Name: **Program Dates:**

Name:	**Date of Birth:**	**Sex:** ☐ **Male** ☐ **Female**		
Emergency Contact #1	Name: Relationship:	Home #	Cell #:	Work #
Emergency Contact #1	Name: Relationship:	Home #	Cell #:	Work #

Check box if your child has had any of the following medical conditions:

☐ Meningitis (spinal)	☐ Diabetes	☐ Usher Syndrome	☐ Cerebral Palsy
☐ Artificial Limb	☐ Hearing Problems	☐ Tubes in Ears(PE Tubes)	☐ ADD / ADHD
☐ Tuberculosis (TB)	☐ Vision Problems	☐ Heart Condition	☐ Mood Disorder
☐ Asthma	☐ Tracheostomy	☐ Pacemaker	☐ Braces/Dental Appliance
☐ Seizures / Epilepsy	☐ Feeding Tube	☐ VP Shunt (or other type of shunt)	☐ Other (please specify):

Does your child need assistance with activities of daily living (i.e. toileting/diapering, feeding)? ☐ Yes ☐ No If yes, please explain:

Has your child ever had any surgeries or been hospitalized for medical reasons? ☐ Yes ☐ No **Has your child ever had treatment or been hospitalized in a psychiatric or behavioral health facility?** ☐ Yes ☐ No	**If yes please list:** (include hospital, date, reason hospitalized)

Visual Impairment – Complete below	**Hearing Impairment – Complete Below**
Wear glasses (circle) Sometimes/Always/Lost/Broken	Cause of hearing impairment:
Cause of visual impairment:	Age of onset:
Diagnosed by age:	Diagnosed by age:
Age of onset:	Aided by age:
Prosthetic Eye ☐ Right ☐ Left	Wear hearing aid (please circle) **1 aid** ☐ Left ☐ **Right** **2 aids**
Have a private eye doctor: YES NO	Have a cochlear implant (circle) ☐ Left ☐ Right
If yes, name and location of eye doctor:	Cochlear Implant Date: Last mapped:

I declare the information provided on this form is correct and true to the best of my knowledge and belief.

_____ _____ _____

Parent/Guardian Signature **Print Name** **Date**

II. To be completed by PHYSICIAN

Please attach an updated copy of immunizations.

Does student have any activity restrictions? ☐ Yes ☐ No **Please specify:** _____

Does student take any medication? ☐ **Yes - MD orders are attached** ☐ **No - Student takes NO medication**

*__Note to provider:__ We are a partial **RESIDENTIAL** school. This student may stay on campus in Baton Rouge, LA. If **ANY** medication is prescribed (scheduled or PRN, RX or OTC including vitamins & dietary supplements), medication orders must be provided on the attached Medication Order Form in accordance with R.S. 17:436.1 (2001).

Allergies(drugs/food/latex/insect/environmental) etc.	**Type of reaction:**
1	1
2	2
3	3
Is Epi Pen required ☐ Yes ☐ No If yes, can the student self-administer? ☐ Yes ☐ No (attach order if needed)	

PHYSICIANS AUTHORIZATION: The above named student is under my care and he/she may participate in all activities, except as noted. He/she is cleared to reside on the LSDVI campus for the duration of the program.

Physician signature_____**Date:**_____**Phone# (_____)**_____**Fax# (_____)**_____

LSDVI Student Health Center

Medication Order

TO BE COMPLETED BY LA, TX, AR, OR MS LICENSED PRESCRIBER

(In some instances, medications will be administered by unlicensed trained school personnel.)

PART 1: PARENT OR LEGAL GUARDIAN TO COMPLETE

Student's Name:	Birthdate:
School:	Grade:

PART 2: LICENSED PRESCRIBER TO COMPLETE

1. Relevant Diagnosis(es):
2. Student's General Health Status:
3. Medication:

Strength of medication: Dosage (amount to be given):

Check Route: ☐ By mouth ☐ Inhaled ☐ Topical ☐ Subcutaneous ☐ Intramuscular ☐ Other:

Frequency: Time of each dose:

School medication orders shall be limited to medication that cannot be administered before or after school hours. Special circumstances must be approved by school nurse.

4. Duration of medication order: ☐ Until the end of school term ☐ Other:
5. Desired Effect:
6. Possible side effects of medication:
7. Any contraindications for administering medication:
8. Other medications being taken by student when not at school:
9. Next visit with prescribing provider:
10. Is this medication necessary on school field trips: ☐ **yes** ☐ **no**

(which may include overnight field trips for consecutive days and weekends)

Prescriber's Name (printed) Address Phone and Fax numbers

Prescriber's Signature Credentials (i.e., MD, NP, DDS) Date

Each medication order must be written on a separate order form. Any future changes in directions for medication ordered require new medication orders. Orders sent by fax are acceptable. Legibility may require mailing original to the school. Orders to discontinue also must be written.

*****PLEASE NOTE: A copy of an emergency action plan is needed for any prescribed emergency medications.*****

PART 3: LICENSED PRESCRIBER TO COMPLETE AS APPROPRIATE

Inhalants / Emergency Drugs

Release Form for Students to be Allowed to Carry Medication on His/Her Person

Use this space only for students who will self-administer medication such as asthma inhaler.

1. Is the student a candidate for self-administration training? ☐ **yes** ☐ **no**
2. Has this student been adequately instructed by you or your staff and demonstrated competence in self-administration of medication to the degree that he/she may self-administer his/her medication at school, provided that the school nurse has determined it is safe and appropriate for this student in his/her particular school setting? ☐ **yes** ☐ **no**
3. If training has not occurred, may the school nurse conduct a training program? ☐ **yes** ☐ **no**

Licensed Provider's Signature Date

LOUISIANA SCHOOL FOR THE VISUALLY IMPAIRED

MINOR RELEASE

Student's Name_____

Please check one of the following boxes stating your agreement or refusal, then sign and date the form.

___ **I hereby agree** to allow my child to participate in any media involvement for educational purposes. I agree that I am to receive no compensation, financial or otherwise.

I further agree that my child's participation confers upon me no rights of use, ownership, or copyright whatsoever.

I release the Louisiana School for the Visually Impaired, its employees, agents, and assigns from all liability for any claims by me or any third party in connection with his/her participation.

I also agree to the use of my child's likeness, portrait, pictures, voice, and/or biographical material about him/her for program publicity and educational promotional purposes.

___ **I do not agree** to allow my child to participate in any media events; nor do I allow my child's name, likeness, portrait, pictures, voice and/or biographical information to be used for program publicity or educational promotional purposes.

Parent/Guardian's Signature **Date**

_____ _____

Office of Risk Management
State of Louisiana
Division of Administration

JOHN BEL EDWARDS
Governor

JAY DARDENNE
Commissioner of Administration

STUDENT'S NAME:_____ ☐ LSD ☐ LSVI

This form is to be used in lieu of the previously issued hold harmless agreement.
*It is to be completed by non-state employees who will be drivers of **or** passengers in state vehicles.*
Agency will retain the completed form, making it available in the event of an accident or claim.

ACKNOWLEDGMENT

By signing this document, I acknowledge that I will be operating, or will be a passenger in, a state-owned vehicle or a vehicle rented to the State of Louisiana (or to a Department, Agency, Board, Commission, other entity or official thereof). I acknowledge that operating, or being transported in, a vehicle is a potentially dangerous activity. I fully realize the physical risks involved, and further acknowledge that this risk, and the danger associated with this activity, is obvious to all persons. I nevertheless willingly and voluntarily elect to operate, or be transported in, said vehicle and expressly accept the risks inherent therein.

For purposes of operating said vehicle, I declare and certify that I have received training regarding the operation of motor vehicles, and that I currently possess a valid driver's license. Moreover, I certify that I am physically and mentally capable of operating, or being transported in, said vehicle, and suffer from no physical or mental condition that would prevent my safe and responsible operation of said vehicle. I affirmatively declare that the vehicle may be safely entrusted to me. Further, I certify that the State of Louisiana may rely on the representations made herein, which are true and correct to the best of my knowledge.

I hereby agree to indemnify and hold the State of Louisiana harmless from any injury or damage to myself that is sustained as a result of the fault of any third person or entity.

Print Parent Name _____

Signature _____

Date _____

Initial Notice and Consent
Regarding Medicaid Reimbursement

NOTICE

The Louisiana Department of Health and Hospitals (DHH) Medicaid program allows school districts to request reimbursement for costs associated with provision of certain IEP related services. These services include occupational and physical therapy, speech pathology, behavioral health services, nursing services, and special transportation. Schools are required to provide notice and to obtain consent from a parent before accessing a child's Medicaid benefits.

Louisiana Schools for the Deaf and Visually Impaired seeks your consent to disclose personally identifiable information about your child to Louisiana Medicaid to access reimbursement for the IEP/Medicaid covered health services that are provided at school. In order to submit claims for IEP/Medicaid covered services, the following types of records may be required: child's full name, address, date of birth, Medicaid ID, disabilities, types of services and dates of services delivered. This disclosure of information to Louisiana Medicaid and its affiliates and access to Medicaid reimbursement for the school district shall not result in any decrease in available lifetime Medicaid coverage, result in any cost to you or your family, increase any premiums or lead to the discontinuation of your child's benefits or insurance or create any risk of loss of your child's eligibility for home and community-based waivers based on total health- related expenditures.

You may withdraw this consent in writing at any time. If you refuse consent or withdraw consent to allow access to the Medicaid benefits, it will not relieve the school system of its responsibility to ensure that all required IEP services are provided at no cost to your child.

CONSENT

I hereby authorize LSDVI to disclose necessary information to Louisiana Medicaid in order to seek reimbursement for the IEP/Medicaid-covered health services provided to my child.

_____ _____

Name of Student Date

_____ _____

Parent(s)/Guardian(s) Signature Relationship to the Student

PROGRAM ACTIVITIES CHECKLIST PERMISSION FORM

Parents/Guardians: The following list of activities may be scheduled to take place during the Accelerated Academic Program that your son or daughter is attending. Please review the list of possible activities and indicate your willingness to allow your son or daughter to participate in these activities.

NOTE: Field trips are planned for the purpose of providing educational enrichment and enjoyment. These trips are carefully planned and are usually culminating activities to units of study.

All scheduled activities will abide by the following guidelines:

1. Adherence to safety regulations and recommendations will be strictly enforced.
2. Only certified personnel will monitor specific activities such as lifeguards for all water based activities and certified SCUBA Divers for "Introduction to SCUBA Diving Equipment".
3. Use of required/recommended safety equipment such as helmets and life vests.
4. Each activity will be provided at no charge to the students or their families.
5. Extended activities will generally take place within a 2 to 3 hour drive of Baton Rouge.

Indicate your approval by marking "YES" next to each activity; mark "NO" next to the activity for which you do not approve:

___YES ___NO LSVI Swimming Pool
___YES ___NO Blue Bayou/Dixie Landing Waterpark
___YES ___NO Introduction to SCUBA Diving Equipment
___YES ___NO Horseback Riding
___YES ___NO Day Trips to New Orleans
___YES ___NO It's My Party – Inflatable Bouncing Fun
___YES ___NO Local Movie Theater
___YES ___NO Canoeing
___YES ___NO Tandem Bicycling
___YES ___NO AMTRAK Passenger Train Trips
___YES ___NO Rock Climbing Walls
___YES ___NO Roller Skating
___YES ___NO Bowling
___YES ___NO Celebration Station
___YES ___NO Other School Sponsored Activities within a 2 to 3 hour drive of LSVI

Student Name: _____

Parent/Guardian Signature: _____ Date: _____

Additional Information

Registration Deadline:
Oct. 20, 2017 or Jan. 12, 2018
Registration is limited … AMP slots awarded on a first come/first served basis

What is your child's reading medium: ____Reg. Print ____Lrg. Print ____Braille

Additional Information

Does your child need transportation to attend this program? ____Yes ____No
If yes, there is a possibility LSVI can provide transportation and … we will be sending you information about transportation at a later date.

DID YOU REMEMBER TO WRITE DOWN THE SOCIAL SECURITY NUMBER ON PAGE 1?

ARE ALL ITEMS ON PAGES 2-8 COMPLETED?

IF YOUR CHILD TAKES MEDICATION HAS THE Dr. SIGNED THE MEDICATION FORM?

Thank you for filling out this packet in its entirety!