STATE OF WASHINGTON

WASHINGTON STATE SCHOOL FOR THE BLIND

2214 E. 13th St. · Vancouver, Washington 98661-4120 · (360) 696-6321 · FAX # (360) 737-2120

Enrollment Check List

Students name: _____

*Please mark the box of each form you are returning with your packet.

- ☐ Health Center Parent Consent Form
- ☐ Licensed Care Provider Medical Face Sheet
  (Completed by a licensed provider)
- ☐ Medicaid Consent
- ☐ Permissions
- ☐ School Counseling Consent

Please complete packet and return to:

Cindy.varley@wssb.wa.gov

Or

WSSB – Education Department
2214 E. 13th Street
Vancouver, WA 98661

STATE OF WASHINGTON

WASHINGTON STATE SCHOOL FOR THE BLIND

2214 E. 13th St. · Vancouver, Washington 98661-4120 · (360) 696-6321 · FAX # (360) 737-2120

Health Center Parent Consent

This form must be completed at the beginning of each school year to let us know what your preferences are in providing health care for your child at WSSB. Please read each section thoroughly, and mark all appropriate boxes. Please do not leave a section blank. PLEASE NOTE-WSSB Nurses are not able to administer medications to students without the Licensed Care Provider face Sheet properly completed and signed.

STUDENT NAME: _____ M/F DOB:_____

PARENT NAME:_____ PHONE:_____

EMAIL:_____

1. Medical Treatment & Communication

	Yes	No	Restrictions
Local physicians and physician contracted by WSSB may provide urgent medical care as needed. *(Non-urgent care should continue at home.)*			
WSSB staff may act on my behalf when making emergency medical decisions should I be unavailable in an emergency.			
Nurses may convey student's health and medical information that will be kept confidential, as they perceive beneficial, to staff working with my child.			

*Please note, per WAC 246-840-700, nurses may contact students health care provider as needed to obtain and relay necessary health information needed to provide health care services to your student.

PARENT/GUARDIAN signature_____ Date: _____

2. Over-the-Counter Medication Administration

Parent/Guardian please note: WSSB Health Center Nurses have a comprehensive list of physician's standing orders to administer students various over-the-counter remedies for minor non-recurring health ailments like headache, cough, cold, diarrhea, stomach upset, etc.

	Yes	No
WSSB nurses and delegated staff may administer over the counter medications and prescription medication prescribed by a licensed healthcare provider.		
Does your child have over-the-counter medication restrictions due to a health concern?		
Please note medication(s) your student CANNOT have:		

PARENT/GUARDIAN signature_____ Date: _____

3. Regularly Scheduled Prescription/Over-the-Counter Medications

	Yes	No
My child will take a regularly scheduled prescription medication while at WSSB.		
My child will take a prescription medication as needed for a specific condition while at WSSB. (Examples include migraine medications.)		
My child will take a regularly scheduled over-the-counter medication while at WSSB. (For example - vitamins, allergy medications, acne creams.)		

Please Note: Medication MUST be provided to WSSB nurses in original, properly labeled containers per RCW 28A.210.260(6) Medication will not be accepted in baggies, weekly pill containers, etc. and student may not be allowed to reside on campus until properly labeled medication is provided.

PARENT/GUARDIAN signature_____ Date: _____

4. Medication Refills
Mark all that apply below

☐	I would like my child's prescriptions transferred to Hi-School Pharmacy Medication On Time (MOT) for bubble packing. Phone: 360-639-8374 Fax: 360-693-7719, Monday through Friday 9am-5pm. *The Health Center will send home weekend and holiday medications monthly.* Please note—Kaiser and Group Health members will not be able to transfer prescriptions to MOT.
☐	I use a mail order pharmacy or choose to fill my student's prescriptions locally. I will send the prescription medication in the original bottle monthly for bubble packing at MOT. I understand I will pay the one-time account setup fee of $55.00 and a fee of $9.00 per prescription per month directly to MOT. *The Health Center will send home weekend and holiday medications monthly.*
☐	I will provide the WSSB Health Center with my student's prescription medication in bubble pack packaging from my pharmacy. *I will keep enough medication at home for weekends and holidays.*
☐	My child will take regularly schedule over-the-counter medication. I will provide these medications in their original packages. *I will keep enough medication at home for weekends and holidays.*

Please Note: It is the parent's responsibility to ensure WSSB receives sufficient medication in original and properly labeled containers. It is the parent's responsibility to provide monthly refills of medications not refilled with Hi-School Pharmacy Medicine On Time.

Name of Current Pharmacy: _____ Phone Number:_____
Address:
_____

PARENT/GUARDIAN signature_____ Date: _____

I am interested in having my student participate in the WSSB Nurse Supervised Self-Directed Medication Program, and request information about this great opportunity for my student. YES/NO

5. Medication Transportation

	Yes	No
I feel that my child is capable of safely transporting his/her medication should a monitor not be available to transport. (For example - students who fly home or take the train).		
I agree to call the health center to inform the nurses of medication sent, amount, and reason for the medication.		
I agree to sign and return the student transport form should medications need to be sent home with my student.		
I understand that medications may not be transported on local ESD buses		
I understand that medication transportation is based on nurse discretion.		

Comments:_____
_____
_____
_____
_____
_____

AUTHORIZATION FOR ADMINISTRATION OF MEDICATIONS AT WSSB

As the parent or legal guardian of _____ I request that medication be administered to my child by a member of the WSSB staff in accordance with my licensed care provider instructions. Medication will be administered at WSSB or on WSSB sanctioned field trips. I will notify the school immediately if I change licensed care providers or if the medication or dosages change.

I agree to provide WSSB nurses with prescription and over-the-counter medication that is properly labeled with the following information: date, name of student, name of medication, dosage, reason for needing medication, amount (count) of medication being provided, method of administration, time to be given, side effects to watch for, signature of parent/guardian and signature of licensed care provider.

I understand that medication not provided to the school in the above manner will not be given to the student, and the student may not be able to reside at WSSB until medications are properly labeled.

PARENT/GUARDIAN signature_____Date: _____

STATE OF WASHINGTON

WASHINGTON STATE SCHOOL FOR THE BLIND

2214 E. 13th St. · Vancouver, Washington 98661-4120 · (360) 696-6321 · FAX # (360) 737-2120

Licensed Care Provider Medical Face Sheet

It is required that this form be completed at the beginning of each school year. Please complete all sections, and sign where indicated. This form is to be completed and signed by the student's **licensed health care provider,** not the student's parent or guardian.

Student Name_____ **Date of Birth**_____

1. Please list diagnoses & significant medical conditions.	_____ _____ _____ _____
2. Does the student have seizures?	Yes(Please answer Questions 3 & 4) No (Go to Question 5)
3. If applicable, please describe the seizures.	List type of seizure disorder (grand mal, petite mal, etc.) _____ How often do seizures occur? _____ _____ _____ What are the symptoms of the seizures? _____ _____ List anything that triggers the seizures: _____
4. Interventions school staff should follow if the student has a seizure.	_____ _____
5. Does the student have a VP shunt?	Yes / No If yes, what kind, date of last shunt examination, left or right side shunt _____ _____
6. Has the student been diagnosed with an endocrine disorder?	Yes / No If yes, how is it being treated? _____ _____
7. Has the student been diagnosed with asthma?	Yes / No If yes, how it is it treated? _____ _____
8. Does the student have any known food, medication or environmental allergies?	Yes / No Please list all known allergies: _____ _____ _____ Are there emergency medications prescribed for this condition: _____ _____ _____
9. Does the student have any dietary restrictions, special diets, etc.	Yes / No Please describe: _____

10. Does the student have any activity restrictions?	Yes / No If yes, please describe: _____ How long will this activity restriction be necessary? _____
11. Has the student been diagnosed a mental health disorder?	Yes / No _____ _____ _____ _____

Name of Medication	Dosage	Time to be given and Method of administration	Reason for medication and Side Effects to Watch For

Please Note: Medication MUST be provided to WSSB nurses in original containers per RCW 28A.210.260(6)

Emergency Procedures in case of serious Medication side effects

_____
_____
_____

YES/ NO/NA Student may participate in the WSSB Nurse Supervised Self-Directed Medication Program.

YES/ NO/NA Student may carry an inhaler, Epi-pen or other emergency medication and self-administer.

AUTHORIZATION FOR ADMINISTRATION OF MEDICATION AT WSSB

I request/authorize WSSB staff to administer medication to the above named student in accordance with the licensed care providers instructions for the period of the 2014-2015 school year or (specify dates)_____.

Date of most recent medical recent exam_____

Height_____ Weight_____ Blood Pressure_____ Pulse_____ BMI_____

Comments:

_____
_____
_____
_____
_____

Provider's Name (Printed): _____ Clinic: _____
Address: _____ Phone: _____ Fax: _____

Provider's Signature: _____ Date: _____
Please Note: Provider signature required for administration of medication at WSSB, RN will be unable to administer medication without provider signature per RCW 28A.210.260 (4)

Please contact the nurses at the Washington State School for the Blind Health Center with any questions. We can be reached at 360-696-6321 ext. 123, fax 360-737-2120.

Thank you for your time filling out this form, we appreciate it!

Nurses Robin and Justine

STATE OF WASHINGTON

WASHINGTON STATE SCHOOL FOR THE BLIND

2214 E. 13th St. · Vancouver, Washington 98661-4120 · (360) 696-6321 · FAX # (360) 737-2120

Medicaid Consent

PURPOSE: This form asks for your consent to share necessary information to verify Medicaid eligibility and to bill for school-based Medicaid reimbursement with the Washington State Health Care Authority (HCA). When the district verifies Medicaid eligibility or bills HCA for school-based services based on you or your child's eligibility for public benefits, it does not affect either of your individual benefits under Medicaid.

Student's Name: Current School:
Student's SSID (if known): Date of Birth:

A school district is required to obtain your consent to verify eligibility for Medicaid and submit claims for reimbursable school-based services provided on behalf of your child. The types of services that can be reimbursed by Medicaid include physical therapy, occupation therapy, speech-language therapy, audiology, nursing, counseling, and psychological evaluations. These types of services which may be provided to your child through an individualized education program (IEP), may also be reimbursed by Medicaid if your child is eligible to receive Medicaid benefits. With your permission, Washington State School for the Blind) will submit your student's name and birth date to the Washington State Health Care Authority (HCA) to verify Medicaid eligibility. The submission of this information will not change the services provided in your child's IEP. With your consent, Washington State School for the Blind will also share necessary information from your child's education record to obtain reimbursement from the HCA if the services provided to your child can be reimbursed because of your child's eligibility for Medicaid benefits.

I authorize _____ to share any necessary identifying information from my child's educational record to verify Medicaid eligibility with the HCA, and to access my or my child's public benefits to obtain Medicaid reimbursement for school-based health services from the HCA. If my child is no longer served by this school district, I understand that this consent will not transfer to a new school district. This authorization will begin on the date that I sign and give consent below.

By giving consent, I acknowledge that: (1) I have been fully informed of all information relevant to accessing my or my child's Medicaid benefits and informed of the reasons I have been asked to provide consent to release relevant information from my child's education records to verify eligibility and to obtain reimbursement from HCA; (2) I also understand that the granting of consent is voluntary on my part and I may revoke consent at any time; and (3) if I revoke consent, the revocation is not retroactive; which means that it does not undo any verification or billing through HCA that has already taken place, but it will stop any future verification or billing.

☐ I give my consent to verify my child's Medicaid eligibility with HCA and to submit claims for allowable services.
☐ I do not give consent. I understand that my refusal to consent means that the district cannot verify eligibility or make a claim for reimbursement for services that might otherwise be covered by HCA. I also understand that my refusal does not affect my child's access to special education services under his or her IEP.

_____ _____
Parent/guardian signature *Date*

If you have questions about this consent please call or email your school district for an explanation as to why the request is being made at Washington State School for the Blind.

STATE OF WASHINGTON

WASHINGTON STATE SCHOOL FOR THE BLIND

2214 E. 13th St. · Vancouver, Washington 98661-4120 · (360) 696-6321 · FAX # (360) 737-2120

Permissions

WSSB academic and residential staff plans off-campus outings for students throughout the year. WSSB staff accompanies the students on these off-campus outings and the students are supervised according to their individual supervision needs. Students and staff will walk, use public transportation or use state vehicles. Activities or educational outings will be planned at a variety of local locations. These locations may include the following: Parks, Community Educational Resources, Restaurants, Banks, and/or various Recreation Activities. Most activities are free of charge; however there are few recreational activities that have a fee.

My student has permission to participate in off campus educational/recreation activities. ☐ Yes ☐No

WSSB serves as a statewide resource and provides training related to blind and visual impairment. For that purpose, WSSB would like permission to use photographs, video and audio recordings of your student for the following purposes:

- Sharing information throughout WSSB its partnership and educational community
- Training for parents and professionals
- Marketing of WSSB programs
- Educational purposes which increase public awareness such as blindness

My child be photographed, video and audio recorded by WSSB for purposes described above. ☐ Yes ☐No

My child may be photographed and/or interviewed by local news organizations, i.e. newspapers, television, etc. ☐ Yes ☐No

My child may have visitors at school ☐ Yes ☐No

If no or with restrictions please explain:

Blind and Visually Impaired students have access to instructional materials from a number of state and federals programs. WSSB has my permission to place the name of my child on student lists that qualify for such instructional programs. Examples include the American Printing House for the Blind, Washington Talking Book and Braille Library, and the Deaf Blind Registry among others.

☐ Yes ☐No

_____ _____

Student Name Signature of Parent/Guardian Date

STATE OF WASHINGTON

WASHINGTON STATE SCHOOL FOR THE BLIND

2214 E. 13th St. · Vancouver, Washington 98661-4120 · (360) 696-6321 · FAX # (360) 737-2120

School Counseling Consent

Washington State School for the Blind is pleased to have a clinical social worker on staff to be able to provide support and assistance to our students. Kimberly Curry, LICSW is available to provide brief therapy, assist with conflict resolution, conduct therapy groups, teach social skills, and generally be available should your student need to discuss an issue. Kim will also work with the student to meet any counseling goals that are identified on the student's IEP. The counselor works with the educational and residential staff to develop your student's behavioral and/or mental health goals, as identified by the student and staff. Mrs. Curry is also available to act as a liaison with the student's mental health provider should they have one.

Please be aware, in the state of Washington, clinicians may provide outpatient treatment to a minor 13 to 17 years of age without the consent of a parent. The minor is the client and has the right to confidentiality. The client's authorization is required to release information to third parties. If the minor has consented to treatment on their own (i.e. without their parent's involvement) the counselor will disclose information to the parent without the client's consent, only to the extent that it serves the best interest of the student or is required or permitted by law.

There are some limits and exceptions to patient confidentiality:

CHILD ABUSE

Generally, staff members are required by law to report any known or suspected cases of child abuse to the Children's Services Division or to any local law enforcement agency.

HARM TO SELF OR OTHERS

If the therapist learns that someone is about to kill or to do harm to someone else, she will do her best to warn the intended victim. If clinical staff learns that a student intends to harm his/her self, the counselor will breach confidentiality to the extent necessary for his/her protection.

CONSULTATION

Occasionally, it is in your best interest for the school counselor to consult with other school staff members who are working with your student regarding their treatment (e.g. medication issues, family issues, obtaining another's expert opinion, covering emergency phone calls, etc.). As employees of Washington State School for the Blind, these staff members will comply with the confidentiality policies of WSSB. In cases where consultation with another professional outside of WSSB is required, then your written consent will be obtained.

If you have any questions or concerns about your student, please call Kimberly Curry at 360-696-6321 ext. 152 or via email at kim.curry@wssb.wa.gov. Also, please keep this contact information as a resource, should you like me to talk to your student about an issue you are aware of at home or at school.

We would like your permission to provide the above services to your child,_____(Child Name).

My signature below signifies that I consent and authorize the above services for the school year 2015-2016.

_____ _____

Signature of Parent or Legal Guardian Date