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NCC SCHOOL PROGRAMS: ANNUAL ENROLLMENT PACKET 14-15 SCHOOL YEAR

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Dear Parent/Guardian:

As your son/daughter enrolls or re-enrolls at NCC, we are asking for your assistance in completing/updating the following paperwork to ensure that your child's needs are met. The following paperwork must be submitted as close to your child's start date or the upcoming school year as possible.

The following paperwork is required in our main office:

- **Emergency Contact Form**
- **Authorization for Pick-up Release**
- **Approved Contact Form**
- **Authorization for Administration of Medication (if applicable)**
- **Authorization for Specific Medical Procedure/Treatment**
- **Photo Release Form**
- **Annual Authorization to Release/Obtain Information**
- **Statement of Student and Guardian Rights**
- **Authorization to Disclose Images and Health Information Consent and Release**
- **Parental Permission for Community-Based Vocational Training**
- **Parent Permission for Yoga**
- **Application for Participation in Special Olympics District of Columbia**
- **NCC Meals Benefit Form (SE School ONLY)**
- **DC Health Certificate and Oral Health Forms**

All documentation is due in our office as soon as possible. The paperwork can be mailed to or dropped off at your student's school location. The NW School's address is:

National Children's Center – NW Campus
201 Rittenhouse Street, NW
Washington, DC 20011

These forms for a student attending the NW Campus can also be faxed or scanned and emailed to Marquita Pickett's attention at the NW Campus at 202-722-2503 or scanned and emailed to marquitapickett@nccinc.org. If you have any questions, or if you require assistance in completing these forms please do not hesitate to give us a call at 202-722-2319.

All documentation is due in our office as soon as possible. The paperwork can be mailed to or dropped off at your student's school location. The SE School's address is:

National Children's Center – SE Campus
3400 Martin Luther King Jr. Avenue, SE
Washington, DC 20032

These forms for a student attending the SE Campus with the exception of the NCC Meals Benefit Form can be faxed or scanned and emailed to Antoinette Junious' attention at the SE Campus at 202-561-7284 or scanned and emailed to ajunious@nccinc.org. If you have any questions, or if you require assistance in completing these forms please do not hesitate to give us a call at 202-561-7280.

Sincerely,
NCC's Administrative Team

National Children's Center
Educational Program
Emergency Contact Information
SY 2014 - 2015

Student's Full Name (INCLUDE MIDDLE NAME): _____

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

Address: _____

_____

City **County** **State** **Zip Code**

Parent/Guardian's Name: _____

Home Numbers: _____

Mother and/or Father (Guardians) ***Please Indicate**

Mother's/Guardian #1 Work: _____ Cell: _____

Email Address: _____

Father's/Guardian #1 Work: _____ Cell: _____

Email Address: _____

Emergency Contact Person #1 or Social Worker:

Name: _____

Relationship to Student: _____

Phone #: _____

Emergency Contact Person #2:

Name: _____

Relationship to Student: _____

Phone #: _____

Parent/Guardian (Print Name):_____

Signature:_____

Date:_____

CONTINUED ON THE BACK

QUICK REFERENCE MEDICAL INFORMATION

PLEASE LIST ALL KNOWN ALLERGIES

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

PLEASE LIST ALL MEDICATIONS AND DOSAGES (if applicable)

1. _____
2. _____
3. _____
4. _____
5. _____

For Office Use Only:
Date Received:_____

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AUTHORIZATION FOR PICK-UP RELEASE

As a non-public school, our main concern is for the health and safety of the students in our care. Therefore, the students will only be released to authorized persons who are currently named on this registration form. If you have made other arrangements regarding your child's pick-up from school, please inform the staff immediately and provide the name and physical description of the person(s) who will be transporting your child. The person picking up your child will be asked to show a picture photo identification in order for our staff to verify their identity prior to signing your child out.

If an unauthorized person arrives to pick up your child we will not release the child until we have the consent of the parent/guardian. If the parent/guardian cannot be contacted the child will remain at the school until an authorized person can pick them up. This procedure will take place in the event that the child appears to recognize the person picking them up.

It is our staff's responsibility not to release a child to any person who is unable to adequately care for the child. Therefore, at the beginning of each school year we will ask you to provide Community Companions with names of three (3) individuals who are authorized to pick up your child in the event that you are unable to do so.

STUDENT NAME: _____

Please list the names of the three people you authorize to pick up your child from school below:

	NAME	PHONE NUMBER	RELATIONSHIP
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

For the safety and protection of my child(ren) and the staff of the school program, I understand and accept this policy.

_____ _____

PARENT SIGNATURE DATE

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2013-2014 APPROVED CONTACT FORM

NAME OF STUDENT _____ DATE OF BIRTH _____

The following people are approved to access information and records on the above-named student:

	NAME	RELATIONSHIP/AGENCY	PHONE NUMBER
1.			
2.			
3.			
4.			
5.			

PARENT/GUARDIAN SIGNATURE _____ DATE OF APPROVAL _____

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NCC SCHOOL HEALTH PROGRAM
AUTHORIZATION FOR ADMINISTRATION OF MEDICATION

Dear Parent/Guardian and Physician:

We discourage the administration of medication in the school setting and request that whenever possible medications are scheduled during non-school hours. However, if medication is required while your child is in school, the following requirements must be met on the first day that the student is to receive medication:

1. No medication will be administered without the parent's/guardian(s) signed consent and the physician's written Medication Authorization Order. This will be kept on file in the student's Health Record. The parent/guardian is responsible for obtaining the required information from the physician.

2. A separate Parent/Guardian Consent Form and Physician's Medication Authorization Order must be on file for each medication a student is to receive at school.

3. The medication must be properly labeled by a pharmacist. The label must include a) the student's name, b) the name of the medication, c) the date the prescription was filled, d) the dosage and timing of administration, and e) directions for administration.

4. The first day's dosage of any new medication must be given at home.

5. All medications must be brought to school by the parent/guardian and delivered to authorized personnel.

6. The parent/guardian is responsible for submitting to the school, in writing from the physician, notification of any change in dosage or time of administration.

7. All medication kept in school will be stored in a secure area accessible onto to authorized administering personnel. Such storage will be at the risk of the parent/guardian. Neither the School Nurse nor NCC personnel will assume any responsibility for possible loss of a student's medication.

8. The unused portion of the medication must be collected by the parent/guardian within one week after expiration of the physician's order or the medication will be destroyed.

9. NCC personnel nor the School Nurse will assume any responsibility for non-medically prescribed medication or medication self-administered by the student.

10. Parents/Guardians must inform NCC and the School Nurse if a student is lactose intolerant or has any food allergies.

NCC SCHOOL HEALTH PROGRAM
AUTHORIZATION FOR MEDICATION ADMINISTRATION FORM

Student's Name: _____ **DOB:** _____

Address: _____

Phone Number: _____ **NCC School:** _____

PART ONE: PARENT/GUARDIAN CONSENT FORM

Parent/Guardian: Please complete and sign this section.

I hereby request and authorize the NCC School Nurse/Licensed Practical Nurse/trained, certified NCC personnel to administer prescribed medication as directed by the physician to my child, _____
(STUDENT'S NAME)

I have read the procedures on page 1 of this form and agree to assume responsibility as required.

This medication is a ☐ new or ☐ renewed prescription. If a new prescription, enter date and time the first dose was administered at home: DATE: _____ TIME: _____ A.M./P.M.

_____ _____
SIGNATURE OF PARENT/GUARDIAN RELATIONSHIP TO STUDENT

_____ _____
PRINT NAME DATE

(PLEASE TAKE THIS FORM TO THE STUDENT'S PHYSICIAN FOR COMPLETION!)
PART TWO: PHYSICIAN'S MEDICATION AUTHORIZATION ORDER

Physician: Please complete and sign this action. ☐ Original ☐ Renewal ☐ Change

Student's Name: _____ **DOB:** _____

Diagnosis: _____

Name of medication: _____ **Dose:** _____

Time and circumstances of administration at school: _____

Expected duration of administration: _____

Can a reaction be expected? ☐ Yes ☐ No **If yes, please describe:** _____

_____

If there are any changes, please advise us in writing immediately.

_____ _____
SIGNATURE OF PHYSICIAN PRINT NAME

_____ _____
ADDRESS PHONE

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AUTHORIZATION FOR SPECIFIC MEDICAL PROCEDURE/TREATMENT

Dear Parent/Guardian and Physician,

Students in need of specific medical procedures/treatments during school hours must meet the following requirements:

1. Parent/guardian must present to the Principal and School Nurse a signed Parent/Guardian Consent and Physician's Authorization for the procedure/treatment. The Physician Authorization and Parent/Guardian consent will be maintained in the Student Health Record.

2. The Parent/Guardian signed consent and Physician Authorization must be in place before the student can receive the specific medical procedure/treatment.

3. The Physician Authorization must include the student's name, date of birth, address, telephone number, and diagnosis, the name of the procedure/treatment, reason for and any precautions or possible adverse reactions to the procedure/treatment that authorized personnel may expect.

4. The parent/guardian must meet at the school with the Principal, School Nurse, and other authorized school personnel to initiate the specific medical procedure/treatment.

5. Supplies to provide a specific medical procedure/treatment must be provided by the parent/guardian. All equipment and/or supplies that are required should remain in the school if possible.

6. Physician authorization for specific medical procedures/treatments must be renewed at the beginning of each school year if the student continues to need the procedure/treatment.

7. If any adjustments (i.e., technique, frequency, medications) are made, a new physician authorization and parental consent form will be required.

8. All equipment and supplies stored in the school will be stored in a secure area accessible only to authorized administering personnel. Such storage will be at the risk of the parent/guardian. NCC personnel assume no responsibility for possible loss or damage to equipment and/or supplies.

9. All equipment and unused portions of supplies must be collected by the parent/guardian within one week of the expiration of the physician's order or they may be destroyed or discarded.

10. NCC personnel assume no responsibility for non-medically prescribed procedures/treatments or those self-administered by the student.

NCC AUTHORIZATION FOR MEDICAL PROCEDURE/TREATMENT

Student's Name: _____ **DOB:** _____

Address: _____

Phone Number: _____ **NCC School:** _____

PART ONE: PARENT/GUARDIAN CONSENT FORM

Parent/Guardian: Please complete and sign this section.

I hereby request and authorize the NCC School Nurse or a trained NCC employee to perform

_____

(SPECIFIC MEDICAL PROCEDURE/TREATMENT)

on my child, _____ as prescribed by the

(STUDENT'S NAME)

physician below. I have read the information on page 1 of this form and agree to assume responsibility as required.

_____ _____

SIGNATURE OF PARENT/GUARDIAN RELATIONSHIP TO STUDENT

_____ _____

PRINT NAME DATE

PART TWO: PHYSICIAN'S SPECIFIC MEDICAL PROCEDURE/TREATMENT AUTHORIZATION

Physician: Please complete and sign this section.

Student's Name: _____ **DOB:** _____

Diagnosis: _____

Specific procedure/treatment: _____

To begin on: _____ **and end on:** _____

Reason for procedure/treatment: _____

Instructions: _____

_____

Precautions: _____

Possible Adverse Reactions: _____

_____ _____

SIGNATURE OF PHYSICIAN PRINT NAME

_____ _____

ADDRESS PHONE

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Photo Release Form

I hereby grant the National Children's Center, Inc. (and other entities contained therein) permission to use images of my likeness (from photographs and/or videos) in any and all of its publications, marketing materials, including website entries and the like, without payment or additional consideration.

I understand and agree that these materials will become the property of the National Children's Center, Inc. and will not be returned.

I hereby irrevocably authorize the National Children's Center to edit, alter, copy, exhibit, publish or distribute these images/videos for purposes of publicizing the National Children's Center programs or for any other lawful purpose. In addition, I waive the right to inspect or approve the finished product, including written or electronic copy, wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of these images.

I hereby hold harmless and release and forever discharge the National Children's Center from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I am 18 years of age or older and am competent to contract in my own name. I have read this release before signing below and I fully understand the contents, meaning, and impact of this release.

_____ _____
(Signature) (Date)

_____
(Printed Name)

If the person signing is under age 18, or is not competent to contract in his/her own name, there must be consent by a parent or guardian, as follows: I hereby certify that I am the parent or guardian of _____, and do hereby give my consent without reservation to the foregoing on behalf of this person.

_____ _____
(Parent/Guardian's Signature) (Date)

_____
(Parent/Guardian's Printed Name)

ANNUAL AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

RE: _____

DATE OF BIRTH: _____ SSN: _____

I authorize National Children's Center, Inc. to release/exchange the following information:

- ☐ Summary of Treatment (including diagnosis, services, duration and outcome)
- ☐ Summary of Psychiatric Treatment (including medications)
- ☐ Psychiatric Evaluation
- ☐ Psychological Evaluation/Test Results
- ☐ Assessment (including diagnosis, recommended services, psychosocial history)
- ☐ Financial
- ☐ Employment
- ☐ Other _____
- ☐ Initiation of and Attendance in Mental Health Services only
- ☐ Medical Records (including testing, diagnostic information treatment and recommendations)
- ☐ Academic Records (including testing, recommendations for treatment)
- ☐ Including, but not limited to, information disclosed to this agency from others
- ☐ Individual Treatment Plan/ Service Reviews
- ☐ Progress Notes

TO: Name of Person/Agency: _____

Address: _____

City: _____ State: _____ Zip Code: _____

FOR THE PURPOSE OF:
- ☐ Continuity of care and treatment planning
- ☐ Third party reimbursement
- ☐ Other: _____

This consent is valid until _____/_____/_____

I understand that this information may be transmitted in written, verbal and/or electric form. I understand that I may revoke this consent at any time and that the above named person authorized to receive this information has the right to inspect and copy the information to be disclosed. I understand that the requested records may contain information regarding psychiatric treatment, drug/alcohol abuse treatment, and/or HIV testing.
I understand that I (or a guardian as provided by statute) have the right to inspect and copy information to be disclosed.

It has been explained to me that if I refuse to consent to this release of information, the following are consequences, if any: _____

Individual's Signature: _____ Date: _____/_____/_____

Guardian's Signature: _____ Date: _____/_____/_____

Witness' Signature: _____ Date: _____/_____/_____
(Name/Staff Position)

Copy given/mailed to individual/guardian on: _____ _____
Date Staff Signature

NOTICE TO RECEIVING AGENCY/PERSON: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to this re-release.

Under the Federal Regulations (CFR) Title 42, Confidentiality of Alcohol and Drug Abuse Records, July 1975, no such records, nor information from such records may be further disclosed without specific authorization for such re-disclosure.
Revised 8/14

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Statement of Student and Guardian Rights

Student's Name: _____

NCC School Program: _____

The National Children's Center policy regarding the right of students and their guardian(s) is in accordance IDEA. Students and guardian(s) need to be aware of the following:

Confidentiality of Information/Records
You have the right to:
*See the records.
*Make copies of the records, or request and receive a copy of the records.
*Get a list of all records on your child and be informed of where they are kept.
*Ask for an explanation of anything in the record.
*In writing object to information contained in your child's records and request changes or additions to the records.
*Request a hearing from the appropriate public school authority if the agency reuses to make the additions or changes you have requested.
*Give or withhold consent for other people to see your child's record, including people in other agencies the National Children's Center receives local and federal funding to help cover the cost of providing education and training for your child, therefor, the center must allow the following agencies to review student records: district schools officials, and agencies enforcing federal laws.
*Beware that when a student become 18 years of age, the right accorded to and consent required of the parent of the student shall after that only be accorded to consent required of the eligible student: unless otherwise prohibited.

Evaluation or Assessment
You have the right to:
*Give or withhold consent before your child can be tested by the public school authority.
*Know how your child will be evaluated or tested, specifically; know what test will be used
*Know how the results will be reported.
*Know that these tests should not discriminate against your Childs on the basis of race, language, or culture
*Know that theses test must take into account special problems your child may have, including sensory, manual or speaking skills problems that these tests will be given to your child in his/her native language, or in any other way in which he/she communicates.
*Know that these test will be given by a team of trained, licensed, or certified persons.
*Know that the referring agents, (i.e. public school districts) are required to discuss and/or re-evaluate your child at least every three years.
*Ask for an impartial due process hearing from the appropriate public school authority if you disagree with the evaluation of your child.
*Ask for an independent evaluation if you disagree with the schools e3valuation this evaluation must be requested through the appropriate public school authority and should be provided at no expense or low cost to you.

Individualized Education Program (IEP)
You have the right to:
*Participate in the development of the IEP within 30 days of the days of the date that he/she was determined eligible for special education(time frame varies from state to state):
*Participate in the devolvement of a new IEP each year.
*Receive copy of the IEP upon request.
***Have a statement of needed transition services in the IEP beginning at age 14 and annually thereafter. Transition services are a coordinated set of activities for each student which promotes movement from school to Post School activities.
*Have an impartial due process hearing if you disagree with any part of the IEP. Request for hearings must be directed to the appropriate public school authority.

Lease Restrictive Environment
Your child has the right to:
*Be educated according to his/her IEP.
*Be educated to the maximum extent possible with children who are not handicapped.
*Be educated in the regular classroom unless he/she cannot receive satisfactory education in the classroom by first using special aids and services.
*Have the school consider a variety of instructional options and education placements for him/her before the decision is made.
*Be educated as close to home as possible.
*Participate with students without disabilities in other school activities, such as, meals, recess, clubs, athletics and special interest groups, when appropriate.

The Right to Due Process
You have the right to:
*Request an impartial due process hearing to challenge what the special education division has done in identifying and/or placing your child, or providing a free appropriate education to your child.
*If at any time you feel that your child's educational placement is no longer meeting his/her needs, you may request a change in placement from the local public school authority. If the public school authority does not respond to the request within the proper time frame (the time frame varies from state to state), you may then request a due process hearing.
*You have the right to be told about any free or low cost legal services (such as evaluation and assessment) that are available to you.

I have read and understand the above statements:

Parent/Guardian Signature: _____

Date: _____

NCC Representative: _____

Date: _____

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AUTHORIZATION TO USE AND DISCLOSE IMAGES AND HEALTH INFORMATION CONSENT AND RELEASE

STUDENT NAME: _____ DOB: _____

NCC PROGRAM: _____

NOTE: National Children's Center, Inc. (NCC) will not use or disclose your health information without your permission except as provided in our Notice of Privacy Practices. This form means you are giving permission for us to use and disclose your information as described below.

I hereby give permission for NCC and its authorized agents to use and disclose my images and/or health information for promotional, public relations, fundraising, and marketing purposes, including but not limited to the NCC Annual Report, newsletters, website, brochures, presentations, and newspaper and other published articles.

I authorize the use and disclosure of the following information by and for NCC's purposes (please check all that apply):

_____ Images of me
_____ In any type of media _____ For specific purposes (specify) _____

_____ Success Story about me (including medical and demographic information)

_____ My name. The name you may use is:
_____ Full name _____ First name only _____ Preferred pseudonym _____

_____ Other (please specify): _____

By signing this authorization, I hereby waive any and all claims that I might otherwise have arising from any use of my images, health information, or this authorization, as well as any and all claims for payment or royalty in connection with any use of said images or health information. I agree that my authorization confers upon me no rights or ownership whatsoever and waive the right to inspect, restrict use of, or otherwise approve the use of my images and health information. I further indemnify and hold harmless NCC, its employees, directors, officers, agents, affiliates, successors, and assigns from any and all claims, liabilities, suits, costs, charges, expenses, damages, and fees arising from, or in connection with, the use of my images, health information, or this authorization.

I understand that my permission expires **one year** from the date below.

SIGNATURE: _____ PRINT NAME: _____
(*Signature of person with authority to consent)*

AUTHORITY: _____ TODAY'S DATE: _____
(e.g., Self, POA for Medical Care, Parent, Legal Guardian)

WITNESS SIGNATURE:_____ TODAY'S DATE: _____

You may revoke this authorization at any time. You may refuse to sign this authorization. You do not need to sign this authorization to receive services from NCC. The person or organization that receives your information because of this authorization may have the legal right to disclose this authorization to others and it may no longer be protected by federal privacy rules. SEE NATIONAL CHILDREN'S CENTER NOTICE OF PRIVACY PRACTICES for more information.

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2014-2015 PARENTAL PERMISSION FOR COMMUNITY-BASED VOCATIONAL TRAINING

During the school year your child will be participating in a variety of community-based activities. We refer to these as Community-Based Instruction, or CBI. We use the CBI activities to teach your child skills that s/he may not grasp in the classroom setting but are essential to independent living. Your child will participate in CBI once or twice a week depending on the weather and on his/her needs. You will receive a reminder note before each CBI describing where and when we are going as well as any needed items or money.

Please sign and date below.

I, _____, give permission for my
(Parent/Guardian name)
son/daughter _____, to participate in the
(Student name)
NCC CBI program.

Signature: _____

Date: _____

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STUDENT PARTICIPATION IN YOGA
ANNUAL PERMISSION FORM

National Children's Center contracts with a certified yoga instructor who will work with our students on a weekly basis teaching basic breathing, relaxation, and posture techniques. There will be a 30-45 minute class where the instructor will incorporate yoga techniques and other relaxation exercises designed to help our students learn to self-soothe and to increase their self-confidence and focus.

If you are interested in your child participating, please complete this form. Failure to complete this form will result in your child's inability to participate.

I give permission for my child, _____, to participate in a weekly yoga class at the National Children's Center. I understand that undertaking any physical activity has some inherent risks and I agree to hold NCC harmless for any injury my child might sustain related to performing yoga either before or after the sessions.

At any time a student or parent/guardian can revoke the permission to participate in Yoga. Decisions to terminate participation in Yoga must be submitted in writing to your child's school.

_____
Parent/Guardian's Name (Print)

_____ _____
Signature of Parent/Guardian Date