Washington County Board of Developmental Disabilities
1701 Colegate Drive, Marietta, OH 45750
Susan E. Tilton, Superintendent
PHONE: (740) 373-3781
FAX: (740) 373-1373
WCBDD

Dear Parents/Guardians,

Please review the information included in this packet. Please fill out, complete and/or supply the front office with the following:

- ☐ Request for Enrollment Form
- ☐ Copy of child's birth certificate (the front office can make a copy if needed)
- ☐ Copy of child's Social Security Card or number (the front office can make a copy if needed)
- ☐ Child Updated Immunization Record **(*REQUIRED PRIOR TO STARTING)**
- ☐ 2017-2018 Student Information Form
- ☐ 2017-2018 Student Medical Information Form
- ☐ 2017-2018 Student Transportation Form (even if your child will not be riding the bus)
- ☐ 2017-2018 Release of Student Form
- ☐ 2017-2018 Student Consent Form
- ☐ Let's Get Acquainted Form
- ☐ Individual Data System (IDS) Form
- ☐ Notice of Privacy Practices
- ☐ Eye Examination Form
- ☐ Copy of Current IEP
- ☐ Copy of Current ETR

Please let us know if you have any questions regarding the forms or information.

2017-2018 Student Information

Typical ☐ Social Security Number _____ Birth Date _____

Last Name _____ First Name _____ Middle Name _____ Nick Name _____

Physical Address _____ Mailing Address _____ ☐ Lives in Group Home

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____

☐ White/Caucasian ☐ Black/African American ☐ Hispanic/Latino ☐ Other Other Race _____

Parent/Guardian Information:

☐ Married ☐ Divorced ☐ Single ☐ Living Together ☐ Guardian

Primary Household (This is the Parent/Guardian with which the student resides.)

First Name _____ Last Name _____ Relationship to Student _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____ I prefer to receive information via ☐ Email ☐ Mailings

First Name _____ Last Name _____ Relationship to Student _____

Cell Phone _____ Work Phone _____

Email _____ I prefer to receive information via ☐ Email ☐ Mailings

Secondary Household (This section should be completed if both parents don't live in the same household.)

First Name _____ Last Name _____ Relationship to Student _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email _____ I prefer to receive information via ☐ Email ☐ Mailings

First Name _____ Last Name _____ Relationship to Student _____

Cell Phone _____ Work Phone _____

Email _____ I prefer to receive information via ☐ Email ☐ Mailings

Emergency Contact (OTHER than Parent/Guardian) REQUIRED!!!!

1st Emergency Contact _____ Phone _____ Relationship _____

2nd Emergency Contact _____ Phone _____ Relationship _____

☐ SSA SSA Name _____

_____ _____

Parent/Guardian Signature Date

2017-2018 Student Medical Information

Medical Updated Date _____

Last Name _____ First Name _____ Birth Date _____

Required by the Ohio Department of Education:

Physician _____ Physician Phone _____ Last Physicial Exam _____

Dentist _____ Dentist Phone _____ Last Dentist Exam _____

Eye Dr _____ Eye Dr Phone _____ Last Eye Exam _____

☐ Permission to Transport to Hospital Refusal Actions _____

Diagnosis _____

Allergies/Treatment _____

Diets _____

Chronic Physical Problem _____

Hospitalizaiton History _____

Diseases _____

☐ Medications Medication Comments _____

Medication _____ Dosage _____ Time Given _____

Medication _____ Dosage _____ Time Given _____

Medication _____ Dosage _____ Time Given _____

Medication _____ Dosage _____ Time Given _____

Medication _____ Dosage _____ Time Given _____

Medication _____ Dosage _____ Time Given _____

Check any/all that apply:

☐ Has Seizures ☐ Knows Sign Language ☐ Wheelchair

☐ Non Verbal ☐ Is Hearing Impaired ☐ Harness

☐ Limited Verbal ☐ Is Visually Impaired/Blind

Other _____

I give my permission for medication to be given to the above individual while at school (if applicable) and agree to notify the WCBDD program nurse of any changes in physician's instructions of treatment or if medication or treatment is discontinued. In the event of a severe reaction, the WCBDD program nurse will be

_____ _____

Parent/Guardian Signature Date

2017-2018 Student Transportation Information

☐ YES Requesting Transportation ☐ NO Not Requesting Transportation

Last Name _____ First Name _____ Nick Name _____

Birth Date _____ ☐ Preschool: ☐ AM ☐ PM ☐ Schoolage

Physical Address _____ City _____ State _____

Home Phone _____ Cell Phone

State Rt # _____ County Rd # _____ Township Rd# _____

Landmarks: _____

☐ The bus driver has my permission to communicate verbal information with those I autorized on the release form.

Note: WCBDD Transportation is only available in the morning and afternoon. Mid-day transportation may be available by contacting the Transportation Department of your child's school district of residence.

Check day and times WCBDD will transport: (NOTE: NO Preschool on Mondays)

☐ **M-F BOTH AM/PM, If not Both Please check below:**

☐ Monday AM ☐ Tuesday AM ☐ Wednesday AM ☐ Thursday AM ☐ Friday AM

☐ Monday PM ☐ Tuesday PM ☐ Wednesday PM ☐ Thursday PM ☐ Friday PM

Comments _____

Physician _____ Physician Phone _____

Diagnosis _____

Allergies/Treatments _____

Traits and Characteristics _____

☐ Has Seizures ☐ Knows Sign Language ☐ Wheelchair

☐ Non Verbal ☐ Is Hearing Impaired

☐ Limited Verbal ☐ Is Visually Impaired/Blind

This form must be competed and returned to the Transportation Department at least ten (10) days prior to transportation of student/enrollee to our facilities.

If you have any questions, contact the Transportation Supervisor at: 740-374-4080

_____ _____

Signature of Parent/Guardian (REQUIRED) Date

To Be Completed By Agency Personnel:

☐ Harness ☐ Buckle Guard ☐ Car Seat ☐ Has Bus Aide ☐ Bus Bus No _____

☐ Behavior Support Plan Date of Behavior Support Committee Approval: _____

2017-2018 RELEASE OF STUDENT

Last Name _____ First Name _____

The following information is REQUIRED.

UNLESS YOU GIVE US PRIOR WRITTEN AUTHORIZATION, WE WILL NOT RELEASE YOUR CHILD TO ANY PERSON NOT LISTED ON THIS FORM. FOLLOW-UP PHONE CALLS AND REQUESTS FOR IDENTIFICATION MAY OCCUR.

*****IF INFORMATION CHANGES ON THIS FORM, A NEW FORM MUST BE FILLED OUT*****

Please list name and telephone numbers of person/s to whom your child can be released ***other than parent or guardian.***

	Name	Phone	Relationship
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

☐ The Ewing School staff and/or bus driver have my permission to communicate verbal information about my child with those autorized above.

_____ _____

Signature of Parent/Guardian Date

2017-2018 Student Consent Form

Last Name _____ First Name _____

I authorize Ewing School/WCBDD or the CABL bus to transport my child on field trips or community outings planned by the teacher. I will be notified in writing of planned trips or outing so that I know what trips my child will be attending. I understand that the Ewing School/WCBDD bus/van or CABL bus will be utilized for transportation with drivers approved by the Ohio Department of Education.

_____ _____

Signature of Parent/Guardian Date

Classroom roster permission:

We would like to include your child in a classroom roster for parties, meetings, etc. May we have your permission to include your child's name and telephone number on a roster so that we can furnish a list for each classroom?

☐ Classroom Roster Yes ☐ Classroom Roster No

☐ Yes ☐ No The Ewing School staff and/or bus driver have my permission to communicate verbal information about my child with those authorized on the release form.

I give my permission for my child to participate in:

☐ Aquatics/Swimming My child is a swimmer ☐ Swimmer Yes ☐ Swimmer No

☐ Gym Class/Physical Development

☐ Outdoor Play

☐ Community Outings/Walks/Field Trip

I give permission for my child to:

☐ Appear in Still Pictures

☐ Appear in Classroom Projects

☐ Appear in VCR/DVD Motion Pictures

☐ Appear in Power Point Presentation

☐ Appear in newspaper articles, etc

☐ Appear on the WCBDD web page

☐ Appear on TV* *approved by WCBDD for education, promotional, or other appropriate program purposes.

Note: No private use of pictures, such as personal cell phones/cameras, will be permitted without additional consent.

Consent Comments _____

_____ _____

Signature of Parent/Guardian Date

Let's Get Acquainted!

2017-2018 School Year

Last Name _____ First Name _____ Nick Name _____

Does your child have siblings? ☐ Yes ☐ No

List siblings names and ages:

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Name _____ Age _____

Is your child a swimmer? ☐ Yes ☐ No

What is the most important thing you would like your child to learn/accomplish this school year?

_____

What are your child's special talents? What make him/her unique?

_____

What area(s) seem to give your child the most difficulty?

_____

What is your child especially interested in?

_____

Are you interested in volunteering at school for special activities ☐ Yes ☐ No

Please list area(s) of interest _____

Please list any special talents or interests you would like to share with other students:

_____

What is the best time to contact you _____

What is the best phone number to call you during the day? _____

_____ _____

Signature of Parent/Guardian Date

INDIVIDUAL DATA SYSTEM (IDS) INFORMATION FORM

Full Name First _____ Middle _____ Last _____

Generation _____ Jr, Sr, I, II, III, IV Birth Date _____ Gender _____

Social Security Number _____ Medicaid Number _____

Current Living Arragement ☐ Parent/Relative Home ☐ Child Foster Care

Address _____

City _____ Zip _____

☐ YES Requesting Transportation ☐ NO Not Requesting Transportation

Race

☐ White/Caucasian ☐ American Indian or Alaskan Native

☐ Black/African American ☐ Asian

☐ Native Hawaiian or Ohter Pacific Islander ☐ Two or More Races

☐ Other

Ethnicity ☐ Hispanic/Latino ☐ Non-Hispanic or Latino

Enrollment Date _____

County Board Program ☐ Preschool ☑ Schoolage ☐ WAVE

☐ Asperger Syndrome

☐ Attention Deficit Disorder

☐ Autistic Disorder

☐ Bipolar Disorder

☐ Cerebral Palsy

☐ Down Syndrome

☐ Epliepsy/Siezure Disorder

☐ Fetal Alcohol Syndrome

☐ Fragile X Syndrome

☐ Hearling Impairment

☐ Intermittent Explosive Disorder

☐ Obsessive Compulsive Disorder

☐ Pica

☐ Post-Traumatic Stress Disorder

☐ Prader-Willi Syndrome

☐ Schizophrenia

☐ Spina Bifida

☐ Stereotyped Movement Disorder with SIB

☐ Substance-Related Disorder

☐ Tourette Syndrome

☐ Traumatic Brain Injury

☐ Visual Impairment

Other _____

_____

Parent/Guardian Signatuare

_____

Date

WCBDD
1701 COLEGATE DRIVE, MARIETTA, OH 45750
WASHINGTON COUNTY BOARD OF DEVELOPMENTAL DISABILITIES
Susan E. Tilton, Superintendent
PHONE: (740) 373-3781
FAX: (740) 373-1373

Notice of Privacy Practices

This notice describes how personal information about you may be used and disclosed and how you can get access to this information. Please review this information carefully.

The Washington County Board of Developmental Disabilities is required by law to:

- **Maintain the privacy of your personal information.**
- **Provide this notice that describes the ways we may use and share your personal information.**
- **Follow the terms of the notice currently in effect.**

We reserve the right to make changes to this notice at any time and make the new privacy practices effective for all information we maintain.

PRIVACY PROMISE

The Washington County Board of Developmental Disabilities understands that your personal information needs to be kept private. Protecting your personal information is important. We follow strict federal and state laws that require us to keep your personal information confidential.

HOW THE WCBDD USES YOUR PERSONAL INFORMATION

When you receive services from the WCBDD, we may use your personal information for such activities as providing you with services, billing for services, and conducting our normal board business known as health care operations.

If you have chosen a personal representative (guardian or someone else you have appointed) and have agreed to let that person obtain your personal information we will provide the information to them.

EXAMPLES OF HOW WE USE YOUR INFORMATION INCLUDE:

Services and/or Treatment – Records of the care and services provided to you within the WCBDD are kept for each service. For example, nurses, therapists and service coordinators keep notes on all contacts made in coordinating, arranging or providing a service. WCBDD staff may share your personal information while helping to develop your service plan.

Payment – The WCBDD keeps records that include payment information and documentation of the services provided to you. Your information may be used to obtain payment for your services from Medicaid, insurance and other sources. WCBDD also may disclose personal information about the services provided to you to confirm your eligibility for Medicaid, as well as determine the amount and type of Medicaid services you require.

Health Care Operations – The WCBDD uses personal information to make plans to better serve you and other enrolled individuals, improve its overall quality of care, train staff, manage costs and conduct required business duties. The agency may use your personal information to evaluate the quality of treatment and services provided by our agency staff.

If the WCBDD staff wants to share your personal information with anyone who is not employed by the WCBDD, you must give them written permission first.

WCBDD
1701 COLEGATE DRIVE, MARIETTA, OH 45750
WASHINGTON COUNTY BOARD OF DEVELOPMENTAL DISABILITIES
Susan E. Tilton, Superintendent
PHONE: (740) 373-3781
FAX: (740) 373-1373

OTHER SERVICES WE PROVIDE

We may also use your personal information to:

- Determine whether you are eligible for services from the Washington County Board of Developmental Disabilities
- Recommend to you service alternatives and other possible benefits
- Tell you about other service providers who may be able to help you
- Remind you of an appointment unless you tell the Washington County Board of Developmental Disabilities staff that you do not wish to be reminded.
- All the Washington County Board of Developmental Disabilities to review direct service contracts.
- All local, state, federal agencies to monitor your services.
- To investigate incidents affecting health and safety, to report these kinds of incidents and to take steps to protect your health and safety.
- To allow the Washington County Board of Developmental Disabilities to prepare reports required by the Ohio Department of Developmental Disabilities and the Ohio Department of Jobs and Family Services.
- Contact you for assistance in passing levies, unless you notify the Washington County Board of Developmental Disabilities that you do not wish to be contacted for these purposes.

USES AND DISCLOSURES OF HEALTH INFORMATION NOT REQUIRING CONSENT OR AUTHORIZATION

There are limited circumstances when the law provides that the Washington County Board of Developmental Disabilities may use/disclose your health information without consent or authorization in the following circumstances:

- For public health purposes, such as reports of communicable diseases, work-related illnesses or other diseases and injuries permitted by law, reports of births and deaths and reports of reaction to drugs and problems with medical devices;
- To protect victims of abuse, neglect or domestic violence;
- For health oversight activities such as investigations, audits and inspections;
- To reduce or prevent a serious threat to public health and safety
- When required by law;
- When requested by law enforcement as required by law or court order;
- Related to a death, (coroners, medical examiners, and funeral directors);
- For organ and tissue donation;
- For workers' compensation or other similar programs if you are injured at work and are covered by workers' compensation or other similar programs;
- For specialized government functions such as intelligence and national security.
- To prepare reports required by the Ohio Department of Developmental Disabilities and the Ohio Department of Jobs and Family Services

All other uses and disclosures not described in this notice require your signed authorization. You may revoke your authorization at any time with a written statement.

YOUR INDIVIDUAL RIGHTS

You have the right to:

- Request restrictions on how we use and share your personal information. We will consider all requests for restrictions carefully but are not required to agree to any restriction*
- Request that we use a specific telephone number or address to communicate with you.
- Inspect and copy your personal information, including service, medical and billing records. Fees may apply.*

WCBDD
1701 COLEGATE DRIVE, MARIETTA, OH 45750
WASHINGTON COUNTY BOARD OF DEVELOPMENTAL DISABILITIES
Susan E. Tilton, Superintendent
PHONE: (740) 373-3781
FAX: (740) 373-1373

- Request corrections or additions to your personal information. You must give the reasons for wanting the change.*Request an accounting of certain disclosures of your personal information made by us. Your request must state the period of time desired for the accounting, which must be within the six years prior to your request. The first accounting is free but a fee will apply if more than one request is made in a 12-month period.*
- Request a paper copy of this notice even if you agree to receive it electronically.

Requests marked with a star (*) must be made in writing. Contact the WCBDD Privacy Officer for the appropriate form for your request.

OUR ORGANIZATION

This notice describes the privacy practices of the Washington County Board of Developmental Disabilities (WCBDD). This notice also describes the privacy practices of persons or entities which have signed a contract with the Washington County Board of Developmental Disabilities and which are acting as business associates, and have promised to follow the same rules of confidentiality.

MORE INFORMATION

For more information about the practices and rights described in this notice, are concerned that your privacy rights have been violated or disagree with a decision that the Washington County Board of Developmental Disabilities has made about access to your personal information or would like to request a copy of this notice, please feel free to contact the Washington County Board of Developmental Disabilities:

Office of Service and Support Administration
2347 D St. Rt. 821
Marietta, Ohio 45750
(740) 373-5147

Current notices will be posted in Washington County Board of Developmental Disabilities Facilities and on our website at www.wcbdd.org.

We will investigate all complaints and will not retaliate against you for filing a complaint.

You also may file a written complaint with either

- The Secretary of U.S. Department of Health and Human Services at 1-877-696-6775
- The Office for Civil Rights, U.S. Department of Health and Human Services at 1-800-368-1019 or email at ocrmail@hhs.gov.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE _____

I acknowledge have received a copy of the privacy notice from the Washington County Board of Developmental Disabilities.

Printed Name of Individual Served:_____

_____ _____
Signature of Individual Receiving Notice (Parent/Guardian) Date

Washington County Board of Developmental Disabilities
1701 Colegate Drive, Marietta, OH 45750
Susan E. Tilton, Superintendent
PHONE: (740) 373-3781
FAX: (740) 373-1373
WCBDD

Dear Parents,

This is a note from the Ewing School program nurse to remind you that the Ohio Revised Code, Section 3323.19 requires every student who is identified with a disability for the first time and begins receiving services under an IEP must undergo a comprehensive eye exam performed either by a licensed optometrist or ophthalmologist. This exam needs to take place within three months of the effective date of your child's first IEP. Please note that the law specifies that the parent, not the school district, has full financial responsibility for this examination.

If you have already taken your child for an eye exam within the nine months before the initial eligibility determination, you have already satisfied this requirement.

For your convenience, we have attached a form for you to complete and return to the school once you child's eye examination has been completed so that we may keep an accurate record. Again, if you have already had your child examined within the 9 month grace period, your only obligation is to return the attached form to let us know.

Please understand that there is no "consequence" for not completing the eye exam. The special education services that your child is entitled to under your child's IEP will NOT be withheld, delayed, or denied pending completion of the eye examination.

If you have any questions about this, please call your child's school and ask to speak with the nurse, Carol Greening RN, 740-373-3781, ext 12.

Sincerely,

Carol Greening, RN

Carol Greening, RN

Washington County Board of Developmental Disabilities
1701 Colegate Drive, Marietta, OH 45750
Susan E. Tilton, Superintendent
PHONE: (740) 373-3781
FAX: (740) 373-1373
WCBDD

EYE EXAMINATION

Date_____

Child's Name_____

Name of Optometrist or Ophthalmologist_____

Address_____Phone_____

Date of examination_____

If you have **not** already taken your child to an eye exam, have you made an appointment?

Yes/No Date_____

Do you plan to make an appointment? Yes/No

If you are not planning to schedule an eye exam, please share your reason:

_____

_____

_____
Parent Signature

PLEASE RETURN THIS FORM FOR OUR SCHOOL RECORDS.