CIBS FORM PACKET
SCH YR
2017-18
Student Information Forms Listing

1	Emergency Information Record Annual **– SIGNATURE REQUIRED & DATE**
2	Consent for SWCCCASE to publish student's name, photograph(s), art, written work, voice/verbal statement - **SIGNATURE REQUIRED**
3	Consent For **Release /Exchange** of Information
4	Medication Parent Guidelines
5	**AUTHORIZATION**
6	Health Care Procedure-Parent Guidelines
7	**Physician AUTHORIZATION**

OFFICE PHONE: (708) 687-4971
FAX: (708) 687-6495

EMERGENCY INFORMATION RECORD

Student

Name: _____ District of Residence: _____
(Last) (First)
Social Security Number: _____ Medicaid Number: _____
Home Address: _____ City: _____ Zip Code: _____
Home Phone: _____ Date of Birth_____ Male ☐ Female ☐

Parent/Guardian Information (add addresses if different from child)

Father: _____ Home/Cell Phone: _____/_____
Home Address: _____ Business Phone: _____
Email address: _____

Mother: _____ Home/Cell Phone: _____/_____
Home Address: _____ Business Phone: _____
Email address: _____

Legal Guardian/Surrogate: _____ Daytime Phone: _____

Child lives with: Mother ☐ Father ☐ Both ☐ Other ☐ Please specify: _____

I give permission for the following person(s) to pick up this student in case of emergency, if I cannot be reached.

Name: _____ /relationship_____ Home/Cell Phone: _____/_____
Address: _____ _____ City: _____
Name: _____ /relationship_____ Home/Cell Phone: _____/_____
Address: _____ City: _____

Medical

Student's Doctor: _____ Phone Number: _____

Address: _____ City_____ ST_____

Does your child take medication? Yes ☐ (if yes, please list medication/s below) No ☐
Medication: _____ Daily Dosage: _____
Medication: _____ Daily Dosage: _____
Medication: _____ Daily Dosage: _____

If given in school, what is the dosage? _____ What is medication for? _____
Is your child allergic to anything (e.g., food, medicine, animals)? Yes ☐ No ☐
If yes, please specify: _____

Signature: _____ Date: _____

CONSENT FOR RELEASE OF STUDENT INFORMATION ON SOUTHWEST COOK COUNTY COOPERATIVE ASSOCIATION FOR SPECIAL EDUCATION ("SWCCCASE") WEBSITE AND IN PUBLICITY/PUBLIC RELATIONS MATERIALS

We, _____, parent, and _____, student, give permission for Southwest Cook County Cooperative Association for Special Education ("SWCCCASE") to publish the student's name, photograph(s) (still or video), art and written work, and/or voice/verbal statements on the SWCCCASE website and in SWCCCASE's publicity and public relations materials. This publication is authorized by us pursuant to 20 U.S.C. § 1232g, 105 ILCS 10/1 et seq., and 740 ILCS 110/1 et seq., and we understand that it is for the purpose of providing general information to the public about SWCCCASE programs, activities, and services. We understand that our refusal to sign this consent form will result in the student's name, photograph(s), art and written work, and/or voice/verbal statements being excluded from the website or publicity and public relations materials. We also understand that no monetary consideration will be paid to the student in connection with such publications.

We understand that we may revoke this consent in writing at any time prior to publication. However, we further understand that once publication occurs we waive the right to revoke our consent to publish the student's name, photograph(s), art and written work, and/or voice/verbal statements on the current or future website and in publicity and public relations materials of SWCCCASE.

_____ _____

PARENT STUDENT

Date:_____ Date:_____

_____ Date:_____

WITNESS (age 18 or older only)

****This consent will expire one year from the date signed****

Southwest Cook County Special
Cooperative Association for Education

AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

I, _____, hereby authorize the exchange of communications and the
(name of parent or guardian)
release/exchange of the following records concerning _____ between
(name of student and date of birth)
Southwest Cooperative employees and _____.
(name of person/agency)

___Complete Eligibility Determination Reports
___Health Records (incl. immunizations)
___IEPs
___Medical Records
___Multidisciplinary Staff Reports
___Psychological Reports
___Report Cards/Progress Reports
___Social Worker Reports
___Therapy Reports
___Other_____

These disclosures are authorized pursuant to 20 U.S.C. Section 1232g, 105 ILCS 10/1 et seq., and 740 ILCS 110/1 et seq.,* and are to be made for the purpose of educational planning for above named student. I understand that I have the right to inspect and copy the information to be disclosed, challenge its contents, and limit my consent to designated records or portions of the information contained in those records. I also understand that my refusal to consent to the exchange of records and communications could result in incomplete and/or inappropriate educational planning for the above named student.

This consent expires one year from the date indicated below. However, I understand that I have the right to revoke this consent in writing at any time.

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

_____ _____
STUDENT SIGNATURE DATE
(for mental health/developmental disability records,
if student is age 12 or older)

_____ _____
WITNESS SIGNATURE DATE
(for mental health/developmental disability records)

* NOTE: Prior to the release of protected health information, health care providers may require the parent/guardian to execute an additional authorization form to comply with the Health Insurance Portability and Accountability Act (HIPAA).

4/29/11 jab (final)

SOUTHWEST COOK COUNTY COOPERATIVE ASSOCIATION FOR SPECIAL EDUCATION (SWCCCASE)

MEDICATION – PARENT GUIDELINES

The following procedural guidelines will state parental responsibilities and requirements for Cooperative students who require medication administration during the regular school day or school-related activity.

1. Medication Authorization form must be completed and signed by both parent and physician for any medications to be administered at school. This includes:

    a. Long-term prescribed medications
    b. Short-term prescribed medications
    c. Over-the-counter medications
    d. PRN (as necessary) medications.

An updated Medication Authorization form is required any time there is a change in medication, dosage, or time of administration. In the case of long-term medication administration, authorization must be renewed annually.

2. Medication should be brought to school by parent or pursuant to alternate arrangements made between the parent and school officials.

3. All prescriptions must be in proper pharmacist-labeled containers.

4. Over-the-counter medications must bear original label.

5. Without proper authorization, children will not be allowed to take their own medication(s) in their possession during school hours.

6. Children will not be allowed to take their own medication, unless specific written procedures for doing so have been authorized in writing by the parent and the student's physician on a SWCCCASE or District Medication Authorization Form, and the medication is taken pursuant to these procedures.

The above procedural guidelines have been established to ensure safe and effective medication administration practices.

SOUTHWEST COOK COUNTY COOPERATIVE ASSOCIATION FOR SPECIAL EDUCATION (SWCCCASE)

MEDICATION(S) – PARENT/PHYSICIAN AUTHORIZATION

Student Name: _____

Birth Date: _____ Program/Location: _____

MEDICATION	DOSAGE	ROUTE OF ADMINISTRATION	TIME OF ADMINISTRATION
1.			
2.			
3.			

Condition and purpose for which medication prescribed: _____

_____

Necessity for medication during school hours: _____

_____

Comments (Include special instructions, possible side effect, etc.):_____

_____

*When "PRN" is noted, please list specific conditions, which would warrant administration: _____

_____

_____ _____
Physician's Signature Date

_____ _____
Address Phone Number

PARENT AUTHORIZATION: Regarding the above listed medication(s), I hereby authorize the administration of medication to my child by individual as specified in SWCCCASE Medication Administration Policy.

☐ Yes ☐ No

_____ _____
Parent Signature/DCFS Representative (if student is in foster care) Date

Home Phone: _____ Cell Phone: _____ Work Phone: _____

SOUTHWEST COOK COUNTY COOPERATIVE ASSOCIATION FOR SPECIAL EDUCATION (SWCCCASE)

HEALTH CARE PROCEDURE – PARENT GUIDELINES

The following procedural guidelines will state responsibilities and requirements for Cooperative students who require specific medical/health care procedures during the regular school day or a school-related activity. Prior to the implementation of the procedure in the school setting by a trained staff member, it will be necessary that the following requirements be met.

1. Health Care Procedure Authorization form must be completed and signed by both parent and physician, and include the physician's written order for the procedure.

2. Physician's written order for specific procedure required during the regular school day or a school-related activity should include:

   a. Diagnosis
   b. Procedure
   c. Reason for procedure
   d. Frequency, including time schedule and/or indication for procedure
   e. Specific instructions (including precautions, possible adverse reactions and interventions)
   f. Duration of procedural implementation.

3. Authorization form including physician's order is to be renewed annually and/or at any time during the year if change from original order should occur.

4. The Cooperative nurse will act as a resource to designated trained staff member performing procedure.

5. Parent will be responsible for providing and replenishing the necessary supplies/ equipment for implementation of procedure.

6. Parent will be responsible for immediately notifying Cooperative nurse of any changes in procedure or child's physical condition affecting performance of procedure.

SOUTHWEST COOK COUNTY COOPERATIVE ASSOCIATION FOR SPECIAL EDUCATION (SWCCCASE)

HEALTH CARE PROCEDURE – ANNUAL PARENT/PHYSICIAN AUTHORIZATION

_____ _____ _____

Student Name **Date of Birth** **Program**

To be completed by Physician:

Diagnosis: _____

Procedure: _____

Duration: _____

Reason for Procedure: _____

Frequency: (Please include times and/or procedural indications): _____

_____

Specific instructions: (include precautions, possible adverse reactions and interventions; when "PRN" is noted, please specify indications for procedure to be performed):

_____

_____

_____ _____

Physician's Signature **Date**

_____ _____

Physician's Address **Phone Number**

****

Parent Authorization:

I authorize the release and exchange of information between SWCCCASE and the above named physician(s) or agency(ies) regarding the above listed procedure.

I hereby authorize and request the above procedure for my child during school hours by SWCCCASE employees.

_____ _____

Parent Signature (**do not sign until completed**) Date

Parent Phone Number: _____ **Work Phone Number:** _____