Elementary/Middle School Enrollment Packet

POTENTIAL DEVELOPMENT

Creating Brighter Futures for Students with Autism

2400 Market Street

Youngstown, OH 44507

330-746-7641

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Please use this check list to ensure that you are returning a completed enrollment packet. Missing or incomplete information may delay entry into the program.

- ☐ Potential Development Application
- ☐ Copy of Child's Birth Certificate
- ☐ Emergency Medical Authorization Form
- ☐ Phone Call System Contact Form
- ☐ Picture and Name Release – Class List Release
- ☐ Authorization to Obtain Information
- ☐ Authorization for Release of Information
- ☐ Parent/Guardian Agreement Form
- ☐ Income Chart for Therapy Services
- ☐ ODJFS Child Medical Statement
- ☐ Transportation/Emergency Contact Information
- ☐ YMCA Permission Slip
- ☐ Secondary YMCA Permission Slip
- ☐ Parental Consent to Share Information and Access Medicaid
- ☐ Potential Development Family Handbook

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Date_____

GENERAL INFORMATION

Student's Name_____ _____
(First) (Last)

Student's Address_____
(Street)

_____
(City, State, Zip)

Home Telephone Number_____

Student's Gender _____Female _____Male

Student's Date of Birth _____ _____ _____
(Month) (Date) (Year)

FIRST PARENT/GUARDIAN INFORMATION

Last Name_____ First Name_____

Relationship to Student_____

Address_____
(Street)

_____
(City, State, Zip)

Home Phone Number_____ Cell Phone Number _____

Place of Employment_____

Work Address_____
(Street)

_____
(City, State, Zip)

Work Hours_____ Title_____

Work Phone Number_____

SECOND PARENT/GUARDIAN INFORMATION

Last Name_____ First Name_____

Relationship to Student_____

Address_____
(Street)

_____
(City, State, Zip)

Home Phone Number_____ Cell Phone Number _____

Place of Employment_____

Work Address_____
(Street)

_____
(City, State, Zip)

Work Hours_____ Title_____

Work Phone_____

BIRTH/DEVELOPMENTAL HISTORY

Which doctor is most familiar with your child? _____

Doctor's phone number_____

Does your student take any medications on a regular basis? ☐ yes ☐ no

If yes, name of medication and dosage: _____

Has your student had any of the following illnesses (dates)?

_____ measles	_____ rheumatic fever	_____ mumps
_____ chicken pox	_____ whooping cough	_____ pneumonia
_____ middle ear infection	_____ hepatitis	_____ meningitis

Were there any complications with these illnesses, such as high fever, convulsions, muscle weaknesses, and so on?

☐ yes ☐ no Please describe: _____

_____

Has the student ever been hospitalized? ☐ yes ☐ no

Number of times_____ Total length of time_____

Reasons: _____

_____

Has the student had any other serious illness or injuries that did not involve hospitalization?

☐ yes ☐ no Please describe: _____

Does the student have:

Allergies? ☐ yes ☐ no (Please specify which allergies):

Foods_____

Animals_____

Medicine_____

Asthma? ☐ yes ☐ no

Hay Fever? ☐ yes ☐ no

Do you have any concerns about your child's speech or language development? ☐ yes ☐ no

If yes, describe: _____

_____

Does the student do some things that you find troublesome? ☐ yes ☐ no

Please describe: _____

Has your child had any problems with earaches or ear infections? ☐ yes ☐ no

If yes, how often in the past year? _____

Has your child's hearing been tested? ☐ yes ☐ no Date of test _____ _____
(month) (year)

Was there evidence of hearing loss? ☐ yes ☐ no
If yes, describe: _____

Does your child currently have tubes in his/her ears? ☐ yes ☐ no

Do you have any concerns about your child's speech or language development? ☐ yes ☐ no

If yes, describe: _____

_____

Has your child's vision been tested☐ yes ☐ no Date of test: _____ _____
(month) (year)

Was there any evidence of vision loss? ☐ yes ☐ no

Please describe: _____

Does your child do some things that you find troublesome? ☐ yes ☐ no
Please describe: _____

Has your child ever participated in out-of-the-home childcare services, for example, sitter, day care, preschool?

☐ yes ☐ no Please describe: _____

CHILD'S PLAY ACTIVITIES

Where does your child usually play, for example, backyard, kitchen, bedroom?

_____

Does your child usually play: _____alone _____with one to two other children? _____with brothers/sisters?

_____with older children? _____with younger children? _____with children of the same age?

Is your child usually _____cooperative? _____shy? _____aggressive?

What are some of your child's favorite toys and activities?_____

_____ _____

Are there any particular behaviors you would like us to watch?_____

_____

CHILD'S DAILY ROUTINE

Do you have any concerns about your child's:

_____eating habits?

_____sleeping habits?

_____toilet training?

If yes, please describe: _____

Is your child toilet trained? ☐ yes ☐ no

If yes, how often does your child have an accident? _____

What word(s) does your child use or understand for:

urination_____ bowel movement_____

How many hours does your child sleep?

At night? _____ Goes to bed at: _____P.M. Wakes up at: _____A.M.

Afternoon nap: _____

Describe any problems with sleep patterns_____

_____

When your child is upset, how do you comfort him or her? _____

_____

_____

The term family has many different meanings. Since the topic of families and family members is often included in classroom discussions, please list or describe whom your child considers to be "family" at home.

_____

_____

How many brothers and sisters does your child have?

Brothers (ages):_____ Sisters (ages):_____

_____ _____

_____ _____

What language(s) is/(are) most commonly spoken in your home?

English_____ Other_____

Is there any additional information that would help us understand or work more effectively with your child?

_____

_____

_____

_____

_____

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EMERGENCY MEDICAL AUTHORIZATION FORM

(Ohio Revised Code 3313.712)

Student Name _____
(Please Print) Last First

Date of Birth_____ Home Phone_____

School_____ Address_____

School Year_____ Grade_____ City_____ Zip_____

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached. This information will be shared, as necessary, with teachers, bus drivers, administrative staff, health personnel including student nurses, and other school personnel.

Residential Parent or Guardian

Mother's Name_____ Daytime Phone_____ Cell_____

Father's Name_____ Daytime Phone_____ Cell_____

Emergency Contacts

1._____Daytime Phone_____ Cell_____

2._____Daytime Phone_____ Cell_____

3._____Daytime Phone_____ Cell_____

It is extremely important that you provide **ANY** pertinent medical history or information about existing conditions that may affect your child at school.

Medical Information:_____

_____

_____

Medications:_____

_____

_____

Allergies:_____

_____

_____

PART I OR PART II MUST BE COMPLETED

PART I: TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor:_____Phone:_____

Dentist:_____ Phone:_____

Medical Specialist_____ Phone: _____

Local Hospital/Emergency Room_____ Phone: _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for: 1.) the administration of any treatment deemed necessary by above named doctors, or, in the event the designated practitioner is not available, by another licensed physician or dentist; and 2.) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical options of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

_____ _____

Signature of Parent/Guardian Date

PART II: REFUSAL TO CONSENT

I do **NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

_____

_____

_____

_____

_____ _____

Signature of Parent/Guardian Date

Dear Parent/Guardian

In an effort to ensure that families are kept up-to-date on school events, closings and other important information, we use the One Call Now automated calling system. The system can leave a message on the cell phone (s) or home phone(s) of your choice. Please list at least one phone number where a message can be left regarding school notifications.

Potential Development also uses an email system to keep the community posted on upcoming events at our schools. If you would like to receive these messages, please list a valid email address below.

Student Name: _____

Phone number #1: _____

Phone number #2: _____

Email address: _____

Do you prefer to be contacted by: ☐ Phone ☐ Cell Phone ☐ Email

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Parent/Guardian Consent to Share Information and Access Medicaid
The Ohio Medicaid School Program
Potential Development Program

Potential Development Schools has the opportunity to receive Federal Medicaid dollars through a program called the Medicaid School Program (MSP). Through this program, school districts can receive Medicaid dollars for services such as Speech, Audiology, Physical Therapy, occupational Therapy, Nursing, Psychology, Counseling and Social Work services. The district can received Medicaid funding when a student receives one or more of these services and the students has current Medicaid Insurance coverage. In the process of billing Medicaid for these services, certain billing information must be shared with the Ohio Department of Jobs and Families Services. Before the district can submit claim data for Medicaid billing purposes, we must first obtain a signed Parental Consent to Share Information and Access Medicaid.

Your consent is voluntary. You have the right under 34 CFR Part 99 and Part 300 to withdraw your consent at any time. You are not required to enroll in Medicaid. Billing Medicaid will not require you to incur any out-of-pocket expenses such as a deductible or co-pay, decreased lifetime coverage, increase premiums or lead to the discontinuation of benefits, or result in you paying for services that would otherwise be covered by Medicaid. No matter whether you grant consent, refuse consent or revoke consent your child will be provided with an evaluation and/or services listed in their IEP at no cost to you.

☐ I understand and agree to give permission to Potential Development Program to share my child's IEP records in order to bill Medicaid

☐ I do not give permission to Potential Development to share my child's IEP records in order to bill Medicaid.

_____ _____
Student's Full Name Date of Birth

_____
Parent/Guardian Name (Print)

_____ _____
Parent/Guardian Signature Date

For specific questions regarding the Medicaid Parental Consent, please contact Healthcare Billing Services, Inc. at 740-639-4218 or at TeamHBS@aol.com