easterseals Florida **Easterseals Academy**

*Start Date*_____

School Application

STUDENT INFORMATION: (Please print clearly)

Child's Name_____ DOB_____ Age_____

Diagnosis: _____ Age Diagnosed_____

Parent:_____	**Parent:**_____
☐ Child's Primary Address	☐ Child's Primary Address ☐ Same
Address:_____	Address:_____
_____	_____
Cell:_____	Cell:_____
Home:_____	Home:_____
Work:_____	Work:_____
Email:_____	Email:_____
Employer:_____	Employer:_____
Occupation:_____	Occupation:_____
Marital Status: _____	Marital Status: _____

Diagnosing Dr. _____

FAMILY INFORMATION: PARENT/S and GUARDIAN/

Emergency Contact_____ Relation_____ Phone_____

Emergency Contact_____ Relation_____ Phone_____

In the case of shared custody, a signature from both parents is required on all documents.

PLEASE LIST ALL INDIVIDUALS EASTERSEALS MAY COMMUNICATE WITH REGARDING YOUR CHILD
(Grandparent, nanny, babysitter, cousin, aunt, etc)

Name	Relation	Phone

_____ _____ _____
Parent/Guardian's Signature ***Print*** ***Date***

_____ _____ _____
Parent/Guardian's Signature ***Print*** ***Date***

Easter Seals Florida, Inc.
Easterseals Academy Naples
8793 Tamiami Trail East #111, Naples, Florida 34113
239.403.0366

easterseals Florida **Easterseals Academy**

In the case of shared custody, a signature from both parents is required on all documents.

HIPAA – PRIVACY POLICY

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your family member's privacy. HIPAA outlines the strict **Federal** rules and regulations regarding the ways in which an individual's Protected Health Information (PHI) must be protected. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

Easter Seals strictly adheres to the following policies:

1. **Release of Information:** A signed Release of Information Form must be on file prior to communicating with any outside service provider or non-authorized family member about a student. Student information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to our student's care are handled appropriately. It is understood and agreed that this is a normal protocol and procedure utilized within the office for the handling of charts, student records, PHI and other documents or information.

2. **Staff:** All Easter Seals staff complete HIPAA training and are strictly prohibited from discussing student information with anyone other than a parent or guardian of the student they are working with and appropriate School staff. They may not share any school information nor can they acknowledge the presence of another individual/family enrolled in School services.

3. **Email:** Emailed student information to Easter Seals is not protected. We can communicate with families through secured email and will not send any protected information about the student via unsecured email.

4. **Fax:** Student information is only protected when it is faxed to and from a private landline from and to a dedicated fax machine.

5. **It is understood and agreed** that inspections of the office and review of documents including government agencies or insurance payers may occur.

6. **Confidential information** will not be used for the purposes of marketing or advertising.

7. **It is understood and agreed** to bring any concerns or complaints regarding privacy to the attention of the Privacy Officer, Rikesha Blake, at 407-306-9766 ext. 11108.

8. We agree to provide clients with access to their records in accordance with state and federal laws.

9. You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations. However, we do not have to agree to these restrictions.

Student's Name_____

➡ ***Signature***_____ ***Print***_____ ***Date***_____

➡ ***Signature***_____ ***Print***_____ ***Date***_____

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Emergency Release for Treatment

I authorize all medical and surgical treatment, X-Ray, laboratory, anesthesia and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. This waiver applies only in the event that neither parent/guardian can be reached in the case of an emergency.

***Parent/Guardian's Signature*_____ *Print*_____ *Date*_____**

***Parent/Guardian's Signature*_____ *Print*_____ *Date*_____**

Hospital/Clinic Preference:
Diagnoses (Medical &Psychiatric):
Allergies/Dietary Restrictions:
Current Medications/Dosage/Frequency:
Current over-the-counter medication and/or vitamins:
Primary Care Physician's Name/Number:
Specialist Physician's Name/Number:
Dentist's Name/Number:

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ENVIRONMENT

Who does your child live with_____

If shared custody, please list schedule_____

Name and Age of Brothers/Sisters_____

_____

Are there any family members or friends that are often in the home or caring for your child _____

_____

Pets in the home _____

How would you describe the activity level in your home _____

_____

MEDICAL HISTORY

List any significant information regarding your child's gestation or delivery

_____

Was your child adopted? ☐Yes ☐ No Foster Care Placement? ☐ Yes ☐ No

If yes, at what age? _____ Agency: _____

What behaviors prompted you to seek out a diagnosis?

_____

Family or Medical History that would be important for Easter Seals to know?

_____

_____

_____

Does your child have an Immunization form for a following exemption? ☐ Religious ☐ Medical

List any allergic reactions that your child has a past or current history of		Past	Current	Please Explain
Medications				
Environmental				
Dietary Restrictions				

PREVIOUS TESTING AND EVALUATIONS

Type	Copy Provided	Date	Provider	Results
Neurological Evaluation				
Psychological Evaluation				
Sleep Study				
Hearing Test				

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Allergy Test				
Speech Evaluation				
Occupational Evaluation				
Physical Therapy Evaluation				
Nutritional Panel				
Genetic Testing				
Gastro Evaluation				

Is your child receiving (or has received) any of the following therapeutic intervention/s privately:

Speech/ Language	Agency:	_____	From:	_____	To:	_____
Occupational Therapy	Agency:	_____	From:	_____	To:	_____
Applied Behavior Analysis	Agency:	_____	From:	_____	To:	_____
Physical Therapy	Agency:	_____	From:	_____	To:	_____

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Education

Name of Previous School: _____

District/County/State: _____

Copy of IEP Provided ☐ Yes ☐ No Copy of Behavior Support Plan Provided ☐ Yes ☐ No

McKay Scholarship Parental Consent form Submitted: ☐ Yes ☐ No Intended Enrollment Date: _____

PRESENT/PAST HEALTH

Please indicate if your child has had health issues related to the following areas:

	Current	Past	Brief Description and Treatment
Psychiatric			
Neurological			
Seizures			
Sleep			
Sensory			
Constipation			
Digestive Issues			
Hyperactivity			
Hives			
Asthma			
Eyes/Nose/Mouth			
Ears/Hearing			
Height/Weight			
Cardiovascular			
Musculoskeletal			
Surgeries			
Chicken Pox			
Broken Bones			
Scoliosis			
Skin/Blood Disorder			

Are there any additional medical information and/or history that you want us to be aware of? _____

_____

_____

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What behaviors do you wish us to assess and plan for? _____

_____

What behaviors would you like to decrease? _____

_____

Does your child tend to run away or leave without telling you? _____

_____

What, if any, aggressive or self-injuring behaviors does your child exhibit? _____

_____

Additional information regarding child's behavior: _____

_____

If limited, list the words and phrases your child currently uses to communicate: _____

_____

What would you like to see your child start doing? _____

_____

_____

What are your dreams for your child? _____

_____

_____

Knowing your child's abilities, what does success at Easterseals Academy mean to you? _____

_____

_____

Please check areas to work on:

- ☐ Communication
- ☐ Social Skills
- ☐ Cognitive Skills
- ☐ Academics
- ☐ Life-Skills
- ☐ Recreation Skills
- ☐ Job Skills
- ☐ Other: _____

Easter Seals Florida, Inc.
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Date: _____

Easterseals Academy

Emergency Contact Information

Student's Legal Name _____
First Middle Last

Date of Birth _____/_____/_____ **SS#** _____

Mother/Guardian name: _____

Father/Guardian name: _____

Student's Address: _____
Street City State ZIP

Students Home Phone _____

Father's Work # _____ **Cell #** _____

Mother's Work #_____ **Cell #** _____

Father's Email: _____ **Mother's email:** _____

In the event that neither parent/guardian can be reached, please contact:

Name _____ **Phone** _____

Relation _____

Name _____ **Phone** _____

Relation _____

Student Health and Medical Information

List all current medications taken, along with the time and dosage:

_____

_____

Family Physician _____ **Phone** _____

Is your child covered by: _____ **Private health insurance** _____ **Medicaid**

____ **Healthy Kids/Kids Care** _____ **No insurance**

***Attach copies of ALL insurance cards (Medical/Dental)**

*Does your child have any health conditions that staff members should be aware of? □ **No** □ **Yes –**

If yes, please briefly describe the condition and any assistance needed:

*Does your child have any activity restrictions? □ **No** □ **Yes – If yes, please explain:**

*Does your child have any allergies? □ **No** □ **Yes –**

If yes, what allergy? _____

If yes, does the allergy require life saving medication? □ No □ Yes – What are the medications?

_____

Briefly describe symptoms and treatment(s):

_____

Date: _____

Parent/Guardian Consent:

By my signature below I accept responsibility to notify my child's school of any changes of my home or business addresses and phone numbers in case of emergency. I understand that EMS (911) will be called when there is an emergency requiring evaluation and/or transport of my child for medical treatment and I will assume responsibility for payment for EMS services. In case of an accident or illness for which immediate emergency treatment is not needed, but my child in unable to remain in school, I request that the school contact the parent(s)/guardian(s) name above. If unable to reach a parent or guardian, I request that one of the emergency contact person(s) listed on this form be contacted to pick up and/or care for my child until I can be reached. I also authorize Eden Florida and its designated employees to provide health services and when necessary emergency care for my child and to exchange medical information as necessary to support the continuity of care for my child.

By, signing this document, I certify that all the above emergency, health and medical information is true and accurate to the best of my knowledge. I also understand and agree that if I have identified that my child has a health or medical condition that may require some kind of assistance or management while he/she is in school, it is my responsibility to contact the school to make them aware of the health or medical condition(s); and discuss a possible plan of care at school.

Printed name of Parent/Guardian	Signature	Relationship	Date

Easterseals Academy

Authorization for Medication Administered while at Easterseals Academy

Student's Name: _____ **Date of Birth:** _____

Primary/Administering Provider: _____

Address: _____

Telephone: _____ **Fax:** _____

Email: _____ **Secured** _____ **Unsecured** _____

I am a physician, physician's assistant, or Advanced Registered Nurse Practitioner licensed to practice in the State of Florida, and a provider of health care services for the above named individual attending Easter Seals Lily Academy. It is my professional opinion, based on my knowledge of the student's health status and physical condition, that he/she:

Requires medication administered by a validated medication administration provider.

Please provide the specifications, including, name of medication, dosage, and any additional special instructions:

_____

_____

_____ _____

Health Care Provider's Signature **Date Of Authorization***

**Authorization will be valid for one year from this date.*

OR

My child does not need to take medication while at school

_____ _____

Parent's Signature Date

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In the case of shared custody, a signature from both parents is required on all documents.

The information submitted in this release will allow Easter Seals to establish bi-directional communication regarding your child with the professional or individual you have provided contact information for. This will also enable us to request evaluations, reports, assessments, notes and any other pertinent information that will assist in the treatment process. This release is required by HIPAA.

Enter all information for BOTH boxes.
Complete a separate form for each provider we will be communicating with.

Child

Name of Child _____ Date of Birth _____

Parent/Guardian _____ Telephone _____

Address _____

Provider or Individual

Name of individual we are contacting _____

Company/School Name _____

Fax _____ Phone _____

Address _____

Please Indicate Type:

☐ Psychologist ☐ Neurologist ☐ Psychiatrist ☐ Speech Pathologist ☐ Physical Therapist

☐ Occupational Therapist ☐ Behavior Therapist ☐ Teacher ☐ Day Care ☐ Advocate

☐ Medicaid Support Coordinator ☐ APD Support Coordinator

☐ Family Member-Relation _____ ☐ Other _____

Provider: Please fax all records including, but not limited to:
Reports, Evaluations, Recent Notes, Laboratory Results, Diagnostic Tests upon receipt of this release.

I HEREBY AUTHORIZE THE RELEASE OF RECORDS AS PROVIDED ABOVE

➡ _____ _____ _____
Parent/Guardian Signature ***Print*** ***Date***

➡ _____ _____ _____
Parent/Guardian Signature ***Print*** ***Date***

Easter Seals Florida, Inc.
Easterseals Academy Naples
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Easterseals Academy

Informed Consent

I, _____, as the below-named student's legal
(Printed name of student's legal guardian/parent)

representative, contingent upon the authorization of his/her health care provider, provide my consent to Easterseals Academy to:

Administer medications prescribed for my child by his/her professional health care provider.

_____ _____
(Signature of student's legal guardian/parent) (Date)

_____
(Printed name of person signing)

_____ _____ _____
(Signature of Witness) (Printed name of witness) (Date)

This document remains effective until _____, unless I elect to
(Twelve months from signature date)
withdraw my consent.

Easterseals Academy

STUDENT NAME_____

Please complete for all medications taken at home and to be administered at school (if applicable).

MEDICATION	DOSAGE	TIMES ADMINISTERED	SIDE EFFECTS EXPERIENCED

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Authorization – Use of Disclose Protected Health Information Media and Testimonial Release for Child

Date: _____

Name: _____

Birth Date: _____ Last 4 Numbers Social Security # [ ][ ][ ][ ]

_____
Street Address Apt #

_____
City State ZIP

We appreciate the fact that you would like to provide information, a testimonial or comment about your child's experience or care received from us. With your permission and authorization we may use your child's information in printed materials, on our web site, on social media we create (e.g. Twitter, Facebook, Instagram), and we may release it to the media. We may send text messages e.g. photos internally to other Easterseals Florida staff to obtain approval prior to use. Please understand this may involve the use or disclosure of information protected by federal health privacy law that requires your authorization first. We will use or disclose only information you authorize. We may respond to a comment you post on social media we maintain or thank you for your testimonial. If we respond or thank you we will not use or disclose any information you have not previously authorized. Any narratives, depictions, pictures, film, photographs, audio-visual or sound recordings or testimonials of your child made by Easterseals Florida or its respective employees and agents may be used by Easterseals Florida, and those acting with its permission, for the purpose of illustration, broadcast, or testimonial in connection with the work of Easterseals Florida and these materials may be released to the general public. You assign to Easter Seals Florida all of your child's rights to these materials. This form explains your authorization. Please use it to authorize Easterseals Florida to use or disclose your child's information. We will give you a copy.

Authorization

I authorize Easterseals Florida to use and disclose information described in Section 1 of this form to publish information, a testimonial or comment about my child's experience or care received. This includes posting my comment on social media maintained by or for Easterseals Florida. My authorization to use my child's information extends to any persons working on behalf of Easterseals Florida to create or maintain materials in any format that may include my child's information, testimonial or comment including but not limited to printed materials, web sites and social media. I authorize Easterseals Florida to respond to any comment or testimonial I provide to the extent that its response does not use or disclose any protected health information other than the information described in this authorization.

1. Description of information to be used or disclosed
   For your convenience you may check one or more boxes describing information to be used or disclosed in your comment or testimonial.

   [ ] Client's photograph
   [ ] Client's name
   [ ] Client's initials only
   [ ] a comment I write
   [ ] recording (video or audio) of client
   [ ] client story
   [ ] any other information described in the box below

   [ ]

2. Identification of persons to whom use or disclosure of the information described in Section 1 may be made
   The information described above may be used or disclosed to the general public who may view or read the information on materials created by or for Easterseals Florida including but not limited to photographs, videos, printed materials, web sites and social media.
3. Purpose
   The purpose of this Authorization is to permit Easterseals Florida to use or disclose the information described in Section 1 for public relations and marketing purposes by publication in any medium it creates or is created on its behalf including but not limited to its web site, social media, social media web site, newsletters, printed materials and press releases. Easterseals Florida will not receive any payment or financial remuneration from anyone for use or disclosure of this information. The materials created by Easterseals Florida, its employees and agents are owned by Easterseals Florida. The materials do not need to be submitted to me for further approval.
4. Expiration Date of this Authorization
   This authorization shall be valid - unless I revoke it earlier in writing - for ten (10) years following the date of the authorization.

I understand

1. I may revoke this authorization at any time by giving Easterseals Florida notice of my revocation in writing to Rikesha Blake, Corporate Compliance Officer, 520. N. Semoran Blvd., Orlando, FL 32746
2. My revocation of this authorization will not apply to information used or disclosed as permitted by this authorization before I give Easterseals Florida written notice of my revocation.
3. Easterseals Florida may not condition my treatment or payment, enrollment or eligibility for benefits on whether I sign this authorization.
4. Information disclosed as permitted by this authorization may be re-disclosed by persons who receive it and is no longer protected by federal health information privacy law.
5. I have a right to request and receive a copy of this authorization.
6. I will not receive any payment or financial remuneration for the information I am authorizing Easterseals Florida to use and disclose by this authorization.

I understand this Authorization to Use or Disclose Protected Health Information for Testimonials and Social Media, signed it voluntarily and received a copy.

Signature, Individual/ Personal Representative _____

Name, Personal Representative (if any) _____

Personal Representative's Authority to Act _____

☐ Identity of the Individual verified

or

☐ Identity, Authority to Act of Personal Representative verified

Received and confirmed for Easterseals Florida
by:

_____

Signature Printed Name and Title

easterseals Florida

Authorization to Receive Protected Health Information via Text Message

Client: _____

Last First DOB

Parent/Legal Guardian: _____

Last First Relationship to client

I give permission for Easterseals Florida to send/receive information via text message to my electronic device that may contain protected health information. Protected health information can include the client's name, date of birth, address, diagnosis, treatment plan, medications, photos and any other medical related information. By signing this authorization, I understand that the information will not be encrypted and will not be secure. I also understand that there may be some level of risk that information in an unencrypted text message could be read by someone other than myself. Any information disclosed in accordance with this authorization may be re-disclosed by a recipient and is no longer protected by federal or state health privacy laws.

I understand that this authorization is voluntary and that Easterseals Florida will not condition any treatment or funding to the client on the completion of this authorization. I understand I have the right to revoke this authorization at any time. Revocation will be provided in writing to Easterseals Florida. Revocation will not apply to any information that has been released following receipt of this authorization and prior to revocation. This authorization is valid until the client is no longer receiving services with Easterseals Florida.

The telephone number(s) that I am authorizing to receive the text messages described above is:

Please initial below:

_____ I will inform Easterseals Florida of changes to my telephone number immediately. I understand that Easterseals Florida is not responsible for any communications sent to my former number, listed above, during the lapse in time from previous number to my new number.

Parent / Legal Guardian: Signature _____ Date: _____

Easterseals Academy

easterseals Florida

Community-Based Instruction

PERMISSION FORM

Student's Name_____ **Date:** _____

Community-based instruction (CBI) is an important component of our curriculum used to teach various skills in community settings.

By signing below, I give permission for my child to be transported by Easter Seals for community-based instructional outings and/or work-based training opportunities.

_____ _____

Signature of Parent or Guardian **Date**

_____

Name of Parent or Guardian

easterseals Florida

Easter Seals Florida

Financial Assistance Application

Easter Seals Florida's (ESF) work is driven by its purpose to make profound, positive differences in the lives of people with disabilities every day.

ESF makes financial assistance available, as finances permit, for its services to individuals with disabilities, for whom outside funding is unavailable and the services are beyond the scope of the individual/families financial means.

ESF believes that a strong sense of ownership, commitment and pride is developed if the financial assistance recipient has contributed to the cost of services, therefore, all financial assistance recipients will pay a portion of the cost of services. Volunteer hours may also be required by the program.

Assistance is granted strictly within the current fiscal year of ESF. Recipients may reapply within 30 days of the expiration of the current award.

How to Apply:

Applicants must complete all sections of the Financial Assistance Application. Please do not leave any spaces blank. Documentation from all sources of income must be provided.

Required documentation:

- A copy of your most recent IRS income tax return (if status is married filing separately, both forms are required)
- If you do not file a tax return, documentation of your income - for example: a copy of your SSI letter

You will receive determination within 10 business days of receipt of your complete application.

All information contained in the Financial Assistance Application will remain confidential.

FINANCIAL ASSISTANCE APPLICATION INFORMATION:

Program _____ Date: _____

Client: _____

Parent/Caregiver/Guardian: _____

Address: _____

_____

Email: _____

Phone: _____ County of Residency: _____

New Client: ❒ Existing Client: ❒

Client IRS Tax Status: ❒ Files own return ❒ Claimed as dependent by: _____

Total # of Exemptions from last IRS 1040/1040EZ: _____

Total Adjusted Gross Income from last IRS 1040/1040EZ: $_____

Current monthly gross income: $_____ Here's why it changed:

_____

_____

_____

Special Circumstances:

_____

_____

_____

Total number of household members: _____
Are there any other sources of household income? _____

VERIFICATION AND AUTHORIZATION

I declare that all of the information I have provided on this request for financial assistance is complete and accurate to the best of my knowledge. I understand incomplete applications (including those missing required documentation) will not be processed. In addition, I attest that I have sought all available third party funding available and agree to comply with the requirements of funders to obtain all third party funding, if qualified.

Signature of Client/Representative: _____ Date: _____

Office Use Only

Financial Assistance funding source: _____

Service:_____ Frequency: _____

Total amount approved: $_____ Start Date: _____ End Dates: _____

Approved by (Director): _____ Date: _____

Approved by VP (Over 25%) _____ Date: _____

Copy: Accounting Original: Program File Scan: Pro Care Documents Note: Pro Care Journal
Copy: Staff member recording Charges/Pmts to ProCare

FLORIDA DEPARTMENT OF EDUCATION
OFFICE OF INDEPENDENT EDUCATION AND PARENTAL CHOICE

IEPC – AFF1
Pursuant to Rule 6A-6.0970
Effective November 2009

AFFIDAVIT

STATE OF FLORIDA
COUNTY OF _____

Before me this day personally appeared _____ (Name of Parent), who being duly sworn, attests that he or she is the parent or legal guardian of _____ (Name of Student), and that the signature below is his or her true and correct signature and is the signature that will be used to endorse warrants issued on behalf of the above-named student under the McKay Scholarship Program.

_____
(SIGNATURE OF PARENT)

Sworn to (or affirmed) and subscribed before me this _____ day of _____, 20__, by _____ (Name of Parent).

Personally Known ☐ Or Produced Identification ☐

Type of Identification Produced _____

NOTARY SEAL

_____
(SIGNATURE OF NOTARY)

_____
(PRINTED NAME OF NOTARY)

Parent's Address _____

Parent's Home Telephone _____-_____-_____ Parent's Work Telephone _____-_____-_____

Please review the statutory parent and student responsibilities pursuant to Section 1002.39, Florida Statutes, which include, but are not limited to:

Any student participating in the program must remain in attendance at a McKay approved school a minimum of 170 actual school days at the school's physical location, unless excused by the school for illness or other good cause.

Each parent and each student has an obligation to comply with the private school's published policies.

The parent to whom the scholarship warrant is made must endorse the warrant to the private school for deposit into the account of the private school. The parent may not designate any entity or individual associated with the participating private school as the parent's attorney in fact to endorse a scholarship warrant.

Adam Miller
Executive Director
Office of Independent Education and Parental Choice

325 W. GAINES STREET • SUITE 1044 • TALLAHASSEE, FL 32399-0400 • (850) 245-0502 • Fax (850) 245-0875