CAOS Student Personal Information Sheet

Child's Name:_____ Birth Date:_____

Grown Up 1:_____ **Grown Up 2:**_____

In the event that the school needs to communicate with you during the day, please rank your preferred method of communication in the spaces provided below:

Please put an asterisk beside the address and phone number you would like your child to practice (beginning in Pre-K).

Name:_____	Name:_____
Address:_____	Address:_____
City/Zip:_____	City/Zip:_____
_____Home Phone:_____	_____Home Phone:_____
_____Cell Phone:_____	_____Cell Phone:_____
_____Text OK? Y/N List Carrier:_____	_____Text OK? Y/N List Carrier:_____
_____Work Phone:_____	_____Work Phone:_____
Employer:_____	Employer:_____
_____E-mail:_____	_____E-mail:_____

Family: Please list all persons living in the household(s) with the student. Please provide ages of other children in the home:

Name	Nickname	Relationship	Gender	Age

EMERGENCY INFORMATION

Pediatrician's Name:_____ Pediatrician's Phone Number:_____

Preferred Hospital:_____

In-area emergency contacts when parents cannot be reached:

Name:_____ Relationship to Child:_____ Can pick up child? __Y __N

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

Name:_____ Relationship to Child:_____ Can pick up child? __Y __N

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

Name:_____ Relationship to Child:_____ Can pick up child? __Y __N

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

It is your responsibility to inform us in writing if you need to add or remove authorized persons to pick up your child. Please indicate below other persons authorized to pick up your child.

Name:_____ Relationship to Child:_____ Contact #:_____

Name:_____ Relationship to Child:_____ Contact #:_____

CAOS | CARLE AUDITORY ORAL SCHOOL Carle

Known Allergies (Food Allergies will be reported separately):_____

_____

Medical/physical factors that may impact participation in school activities:_____

_____

Please sign below if you are interested in participating in the CAOS PTO organization:

_____ _____

Sponsor 1 Signature Sponsor 2 Signature

The CAOS PTO publishes a family directory that is useful for planning events and activities with other CAOS families and is not distributed for any other purpose. If you would like to be included in this directory, please provide consent to provide the following information to the CAOS PTO:

Patent name(s), e-mail addresses, cell phone numbers, home phone number, CAOS student's name, birth date, grade level, teacher and any siblings not at CAOS. Please mark through any items you do not wish to publish.

_____ _____

Sponsor 1 Signature **(consent for PTO directory)** Sponsor 2 Signature **(consent for PTO directory)**

Please confirm receipt of the tuition policy. I/We plan to:

_____Use Tuition Express (debit or credit cards) _____Carle payroll deduction _____Apply for exeption

I/We have read and understand the following information.

_____Illness policy
_____Attendance policy
_____Tuition policy
_____Weather closure process
_____Understanding of HIPAA regulations regarding communications
_____Parent handbook
_____University student placements
_____Offsite walks

Please confirm you have read and understand the above:

_____ _____

Grown Up 1 Signature Grown Up 2 Signature

CAOS Child Fact Sheet

805 W. Park St., Urbana, IL 61801

Child's Full Name (including middle)_____/_____
Nickname

Form Completed By:_____

Family interests and hobbies:_____

Facts about your child:

What are some of your child's likes?_____

What are some of your child's dislikes?_____

Are there some things that can generally make your child mad or sad?_____

What helps calm your child when he/she is upset?_____

Are there any situations that may be difficult for your child?_____

Please list any additional concerns/behaviors specific to your child that the teacher/therapist should know about:_____

Please list any special goals or areas of focus for your child this year:_____

Food Information Form (FIF)

Child's Name:_____ Date Completed:_____

Person Completing the Form/Relationship:_____/_____

Please complete the sections below to provide guidance on your child's interactions with food while enrolled at our school. Please mark in each box to indicate your child's dietary restrictions in each category. Please mark 'none', rather than leaving a box blank, if you do not have dietary restrictions to report in any of the listed areas.

Children may be exposed to a variety of foods during learning activities at the school. Under the family preferences section, please let us know how you would like us to support your child in trying new foods.

Potentially Life-Threatening Food Allergy: ingestion and/ or contact with the food trigger causes an immune system reaction resulting in respiratory distress that is treated using epinephrine. A Food Allergy Emergency Action Plan must be completed by a physician for each life-threatening food allergy. Family will complete the Food Allergy History. Additionally, the staff and family will work together to develop an Individual Health Care Plan.	**Food Sensitivity/ Intolerance:** ingestion of the food triggers undesirable gastrointestinal, skin or behavioural symptoms. A Physician Statement for Food Substitution form is required for each food sensitivity/ intolerance. Family will complete the Food Sensitivity History as well.
Religious Belief: the family's faith dictates avoidance of certain foods or food combinations; examples include avoiding meat on Fridays during Lent for a Catholic family or avoiding pork for a Jewish family. A Family Statement for Food Restriction/ Substitution form is required.	**Family Preference:** any dietary restriction determined by the family; examples include a family's choice to follow a vegetarian diet, avoid food dyes, or choking hazards or limit sugar intake. A Family Statement for Food Restriction/ Substitution form is required. How would you like us to support your child in trying new foods? Please indicate your choice below: ☐ Encourage child to taste food before saying 'no thank you'. ☐ Child can say 'no thank you' without first tasting.

CAOS | CARLE AUDITORY ORAL SCHOOL

Carle

Carle Auditory Oral School/Carle Foundation Hospital
Physician Authorization And Permission For Medication Administration

Student's Name:_____ _____ Today's Date:_____
(Last) (First) Birth Date

Student attends the following days/times:_____

Medication is administered following these guidelines:

- Physician/Prescriber signed, dated authorization to administer the medication
- Parent signed, dated authorization to administer the medication
- Medication is in the original labeled contained as dispensed (or the manufacturer's labeled container)

PHYSICIAN AUTHORIZATION:

Medication:	Dosage:
Time to be administered:	Intended effect of this medication:
Expected side effects, if any:	Administration instructions:
Other medications student is taking:	Discontinue/Re-Evaluate/Follow-up Date (circle one):
Physicians Signature:	Date Signed:
Physicians Name:	Physician's Emergency Phone #:

PARENT AUTHORIZATION AND PERMISSION FOR MEDICATION ADMINISTRATION

I herewith acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorization Carle Auditory Oral School and its employees and agents, on my behalf, to administer or attempt to administer to my child lawfully prescribed medication or over-the-counter medications that I have provided. These medications must be labeled appropriately as follows:

- Prescription medication is administered in accordance with the pharmacy label directions as prescribed by the child's health care provider. Instructions from the child's parent/guardian shall not conflict with the label directions as prescribed by the child's health care provider.
- Over the Counter medications may be administered in accordance with the product label directions on the container with physician authorization. The instructions from the child's parent/guardian shall not conflict with the product label directions on the container.

I further acknowledge and agree that, when the lawfully prescribed medication is so administered, I waive any claims I might have against Carle Auditory Oral School or Carle Foundation Hospital or its agents and employees arising out of the administration of said medication.

Child's Name:	Date Signed:
Parent/Guardian Signature:	Contact Phone #:

CAOS | CARLE AUDITORY ORAL SCHOOL

Carle

CAOS Nap/Quiet Time Information

Child's Name:_____

CAOS staff knows that getting adequate rest is an important part of being ready to learn and play each day. Because of this, nap will be provided to **three year olds/PS students** enrolled in Carle Auditory Oral School. We will continually monitor the napping procedures and napping behaviors of the children. If requested, families can receive daily notification about sleeping behaviors.

Napping behaviors include whether or not the child fell asleep during the allotted naptime as well as a description of their behavior during the time they are awake in the nap room.

Some children fall asleep quickly, and others more slowly. Some children sleep every day; others only sleep one or two times per week. These normal variances are okay as long as behaviors and noise levels do not detract from other students' ability to fall asleep. As with all processes and procedures at CAOS, nap time management is continually adapted to ensure maximal benefit. Staff will track napping behaviors and if concerns arise, the napper's family will be consulted to develop a plan moving forward. This plan may include development of a behavior plan for individual children, requests for support from home, or exclusion from nap at CAOS, if warranted.

Our four year-old Pre-K classroom schedule does not include a break for a nap. However some 4 year-olds have not yet transitioned out of a nap.

Please indicate below if your **four** year-old requires a nap during the school day. Please indicate your preferred nap duration:

Circle one: ☐ 30 min ☐ 60 min ☐ 90 min

I/We understand the napping procedures.

I/We understand that we may request a summary of my/our child's napping behavior.

I/We understand that CAOS staff will provide this summary if they have a concern about my/our child's napping behaviors.

_____ _____
Parent Signature Date

_____ _____
Parent Signature Date

CAOS | CARLE AUDITORY ORAL SCHOOL

Carle

CAOS Family Involvement Expectations

Child's Name:_____

Many private schools require parents to commit to a certain number of volunteer hours each year, helping in the classrooms, lunch room, school library or at after school events as part of their tuition agreement. Families who are unable to meet this requirement are often charged an additional fee. CAOS families are spared this requirement, largely due to the tremendous volunteer support that we receive from Carle's Volunteer Office and University of Illinois students. In lieu of this, we ask that families commit to each of the listed activities by initiating each expectation and signing below. Please see the handbook for additional information about each commitment statement.

ALL PARENTS:

_____Read with your children 5 – 7 days per week. Check and respond to information in your child's folder each night.
_____Review your child's journal each night, making entries as requested by your child's teacher.
_____Send morning snack for the school, approximately once every two months, for each enrolled student.
_____Share 3 traditions/ experiences with your child's class per school year.
_____Communicate with your child's teacher, school office or the program director if you have questions, suggestions or concerns about your child's educational program.
_____Participate in Parent Teacher Conferences two to three times per school year.

PARENTS OF CHILDREN WITH HEARING LOSS:

_____Ensure that your child arrives with functioning hearing device(s) on each day of attendance.
_____Ensure that you send extra batteries for your child's hearing device.
_____Ensure that you send troubleshooting equipment, such as earmold cleaning brushes, cochlear implant cables and headpieces, if applicable.
_____Observe or participate in 2 therapy session and 2 classroom lessons per year.
_____Participate in monthly Parent Professional Collaboration Meetings.

We greatly appreciate your support in these areas and realize that our school could not function successfully without you!

_____ _____

Signature Date Signature Date

FAMILY ENGAGEMENT

Please list three traditions you will share with your child's class this school year, the time of year most meaningful for sharing and whether you will be coming into class or providing materials to be shared at school. Please contact your child's teacher or the school office if you have any questions.

Tradition	When?	Provide materials only/provide materials & able to lead the activity

CAOS | CARLE AUDITORY ORAL SCHOOL

Carle

Tuition Policy

- Participation in automatic payment plan is **required** for all enrolled students. Electronic Funds Transfers (Tuition Express) will be made according to the attached schedule.

  With this method of tuition billing, all accounts should remain current. In the event that tuition is not paid in full (due to change in banking institution or other unforeseen circumstance), families have one week to reconcile accounts and return to a zero balance. Failure to keep the tuition bill current will result in a temporary suspension for the student.

  Students can be re-enrolled when tuition balance is paid in full within one week. The student's spot may be given to another family if tuition balance is not pain in full within two weeks.

  We apologize for any inconvenience this policy may cause. It is essential that revenue from tuition be kept current in order to maintain our program and educational offerings. Please contact the director with any questions or concerns.

- It may be possible to obtain an exception by completing the Exception Request Form.
  Any approved exception will come with an expectation to pre-pay tuition, one month at a time. That is, August school tuition would be paid by August 1st, September Tuition in addition to unforeseen childcare fees from August, would be paid by September 1st, etc. Failure to comply with this pre-payment plan would result in your child's suspension from school/child care.

- Please indicate on the Student Personal Information form which method of payment you will be utilizing - Tuition Express or Tuition Exception.

CAOS Tuition Policy Exception Request Form

Child's Name:_____ Child's Date of Birth:_____

Projected Classroom Placement:_____

Reason for Tuition Policy Exception Request:_____

_____

Details of Exception Request (I.E. Alternate Date Of EFT Withdrawal, Date/Method of Prepayment, Etc):_____

_____

Course of Action if Exception is Not Granted:_____

_____

_____

I/We understnd that if this exception is granted, that:

_____ Failure to comply with this payment plan will result in my/our child's suspension from the school and child-care programs until tuition is paid in full.

_____ If back tuition is not caught up within one week of suspension, my/our child's spot may be taken by another family.

Parent Signature:_____ Date:_____

Parent Signature:_____ Date:_____

OFFICE USE

Tuition Policy Exception Request:

☐ Approved ☐ Approved with Modifications ☐ Approved

Modifications, if Applicable:_____

_____

OUTLINE OF APPROVED EXCEPTION PAYMENT PLAN

Due Date:_____

Invoice to be Sent?	☐ Yes	☐ No	
Receipt Provided?	☐ Yes	☐ No	
Receipt Provided?	☐ Check	☐ Money Order	☐ Cash

I/We Agree to the Terms Outlined Above:

Parent Signature:_____ Date:_____

Parent Signature:_____ Date:_____

Staff Signature:_____ Date:_____

CAOS | CARLE AUDITORY ORAL SCHOOL

Carle

TUITION Express
ProCare Software

Hop aboard the Tuition Express and never write a check again!

As your childcare provider, we are excited to offer you the convenience of automatic tuition payments through Tuition Express. You'll no longer need to write a check or remember your checkbook when you're picking up your child at the end of a hectic day. Your payment will be safely and securely processed by Tuition Express, giving you peace of mind that your tuition has been paid on time! It's easy to enroll and even easier to participate. You'll be joining tens of thousands of parents nationwide who enjoy the ease and convenience of Tuition Express.

To learn more about Tuition Express, automatic payment notifications or reviewing your payment history, please visit www.tuitionexpress.com.

For Bank Account Authorization, complete and return to center management.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION

I (we) authorize _____, (called "CENTER" in this Authorization) to initiate debit entries to my (our) Checking or Savings Account indicated below at the depository financial institution indicated below (called "DEPOSITORY" in this Authorization). I (we) authorize CENTER to withdraw sufficient funds to pay my (our) regular childcare tuition and/or other childcare related fees that are due and payable. I (we) authorize CENTER to use the third party sender, Tuition Express* to process all payments. I (we) acknowledge that the origination of Automated Clearing House (ACH) transactions to my (our) account must comply with the provisions of United States Law.

Credit Union Members: Please contact your Credit Union to verify account and routing numbers for automatic payments.

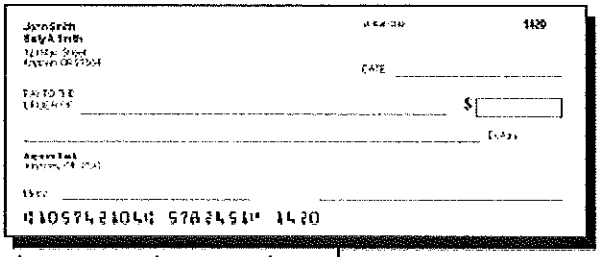
Your Name	Phone #	DEPOSITORY - Bank or Credit Union Name
Address		Bank or Credit Union Address
City	State Zip	City State Zip
		Type: ☐ Checking ☐ Savings
Routing Transit Number (see sample below)		**Account Number** (see sample below)

This authorization will remain in full force and effect until I (we) notify the CENTER in writing of its termination in such time and in such manner as to afford Tuition Express and DEPOSITORY a reasonable opportunity to act upon it. Notices must be received at a minimum of 5 business days in advance of the termination date.

Signature _____ Date _____

Record Retention Notice: The child care provider shall retain all parent (client) authorization forms in a secure location for a period of two years from the date of client withdrawal from the Tuition Express™ program.

*Tuition Express is an assumed business name of Blum Investment Group, Inc.



Please attach a copy of a voided check here. Deposit slips not accepted.

TUITION Express
ProCare Software

Hop aboard the Tuition Express and never write a check again!

As your childcare provider, we are excited to offer you the convenience of automatic tuition payments through Tuition Express. You'll no longer need to write a check, or remember your checkbook, as you're picking up your child at the end of a hectic day. Your account will be safely and securely debited by Tuition Express, giving you peace of mind, knowing your tuition is being paid when it's due. It's easy to enroll and even easier to participate. You'll join millions who already pay mortgages, car payments, and childcare tuition automatically. Tuition Express is convenient and safe for you, and it helps us do a better job caring for your child.

Frequently Asked Questions

When I pay my tuition automatically, how secure is my account information?

Very secure – more secure than when you write checks. The checks you write every day have your name, address, phone number, and sometimes your driver's license number on them. With this information, criminals have all they need to access your account or worse, *steal your identity*. Automatic payments greatly reduce this potential problem by limiting the amount of information available and who has access to it. Tuition Express also incorporates additional security procedures, utilizing 128 bit encryption.

What if the childcare center makes a mistake and takes out too much money?

Report the error to your childcare center immediately – it was most likely an honest mistake. The childcare center will then adjust your account accordingly.

What if my childcare center and I disagree about a payment?

If you feel that the payment should not have been made, you have the right to dispute the charge. Contact your bank or credit card company. Tuition Express and your childcare provider will work closely to resolve the issue in a timely manner.

Does this form of payment give the childcare center access to my account?

Nobody at the childcare center has access to your account. When you sign up for Tuition Express, you only authorize *your* bank or credit card company to release the exact amount owed to your provider when it is due and payable.

How will I know when a payment was taken out of my account?

Your childcare expenses will be taken out of your account on a schedule that you and the childcare center agree upon. Your childcare center has the ability to print statements for your records prior to the withdrawal of any money. Additionally, the charges will show up on your monthly statement as "Tuition Express".

When I sign up for Tuition Express, how will this help my childcare provider?

Your childcare provider has chosen to offer Automatic Payments for several reasons. First, it will give you the convenience of not having to write a check every time tuition and fees are due. Second, it allows regular scheduling of your payments. Most importantly, Automatic Payments reduce the amount of time your childcare center spends on management activities, giving staff more time to spend with the children.

How do I get started?

Simply complete the "Payment Authorization" form and return it to your childcare provider. They will do the rest! For more information on automatic payments, visit www.directpayment.org. This is an excellent resource explaining the system and its benefits.

Where can I learn more?

For more information on the benefits of Tuition Express, please visit us at www.tuitionexpress.com.

TuitionExpress.com

Your provider will issue you a unique Tuition Express account number: → **6288-6773-032**

What is Tuition Express?

Tuition Express™ is the premier payment processing service in the childcare industry. As one of the many benefits offered by Tuition Express, parents have the ability to receive their payment receipts via email. TuitionExpress.com keeps parents in-touch with their childcare center and their personal finances. Here are some of the features of TuitionExpress.com:

- Receive all your Payment Receipts via email.
- Email notification of all Non Sufficient Fund (NSF) items or Declined Credit Card transactions.
- View and print Transaction History reports.
- Re-generate past email payment notifications.
- All receipts are Flexible Spending Account qualified (provided center has submitted required data).
- Easy access to change email addresses notifications are sent to.

How to Register at TuitionExpress.com

- Your childcare provider will issue you a unique Tuition Express ID number.
- Go to http://www.tuitionexpress.com and click on "My Account".
- Click the "Click here to Register" link to begin the account set up.
- Enter the Tuition Express ID number and the Last 4 digits of your bank or credit card account number.
- Create a User Name and Password
- Type in your email address and check the box "Receive Notification"
- Click "Submit". When you receive an email from Tuition Express click on the link to confirm your email address.

Facts about Automatic Payments

- Automatic Payments have been around for more than 30 years and uses the same network as Automatic Deposits. More than 2 billion transactions a year are made via Automatic Payment.
- Each Automatic Payment is deducted from your account on the due date of each payment cycle so it is easy to track..
- Automatic Payments are confidential transactions. Just one or two people see them. In contrast, checks pass through three to nine hands as they are processed. PLUS, they have all the information available for a criminal to steal your identity.
- Automatic Payments help you maintain a good credit rating because bills are paid on time, every time.
- Record keeping is easy. Each bill paid automatically from your checking account or credit card is listed on your monthly statement.
- Consumers who use Automatic Payment are protected by the Electronic Funds Transfer Act of 1978, known as Federal Regulation E. www.bankersonline.com/regs/205/205.html
- Automatic Payment saves you money. It costs consumers close to $100 a year in time and Automatic costs, such as postage, to pay bills by check instead of using Automatic Payment.
- Automatic Payments is great for travelers — since bills are paid automatically, you do not have to worry about them when you are out of town.

Childcare Needs – August 2022

Childcare needs for:

		MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
		1	2	3	4	5
Before Care		School Closed/ Daycare Closed	School Closed/ Daycare Closed	School Closed/ Daycare Closed		
After Care						
Choose Your Own Hours Care	Drop-off Time:	School Closed/ Daycare Closed	School Closed/ Daycare Closed	School Closed/ Daycare Closed		
	Pick-up Time:					
		8	9	10	11	12
Before Care						
After Care						
Choose Your Own Hours Care	Drop-off Time:					
	Pick-up Time:					
		15	16	17	18	19
Before Care						
After Care						
Choose Your Own Hours Care	Drop-off Time:					
	Pick-up Time:					
		22	23	24	25	26
Before Care						
After Care						
Choose Your Own Hours Care	Drop-off Time:					
	Pick-up Time:					
		29	30	31		
Before Care						
After Care						
Choose Your Own Hours Care	Drop-off Time:					
	Pick-up Time:					

Please return no later than July 15, 2022 to ensure the early bird rate.

Drop off begins at 7:00 AM. Parents are encouraged to arrive by 5:25* PM. Late pickup charges of $1.00/minute will apply for every minute past 5:30 PM.
**5:25 pick-up allows our staff to gather their belongings, close up the building, and clock out on schedule.*

CAOS | CARLE AUDITORY ORAL SCHOOL

Carle

X5443-0322

CAOS PTO Information Form

Every Student Receives a CAOS PTO Family Directory
☐ Yes, please **include all my family information** in the PTO Directory.
☐ Please **include selected information** in the Directory. I have checked information to be included.
☐ **Do not include my family** in the Directory. You may use our information to inform us of PTO activities.

CAOS PTO has a Facebook page to promote the school and help families stay connected.
☐ Yes, please include images of my child and family on the CAOS PTO Facebook page.
☐ No, please do not include images of my child and family on the CAOS PTO Facebook page.

☐	Parent/Guardian Name:
☐	Email Address:
☐	Cell Phone:
☐	Parent/Guardian Name:
☐	Email Address:
☐	Cell Phone:
☐	Home Phone:
☐	Address:
☐	CAOS Student Name:
☐	Birthday: _____ /_____ /_____
☐	Teacher:
☐	Grade Level:
☐	CAOS Student Name:
☐	Birthday: _____ /_____ /_____
☐	Teacher:
☐	Grade Level:
☐	Siblings at CAOS:

Family Information will be used by the PTO to provide you information about events and activities. We will not distribute it to anyone else or use it for any other purpose.

CAOS | CARLE AUDITORY ORAL SCHOOL

Carle

Media Authorization Consent to Release Information

Name:_____ MRN/Badge#:_____ Date of Birth:_____/_____/_____

Phone:_____ E-mail Address:_____

Street Address:_____ City:_____ State:_____ Zip:_____

Throughout this document the reference to "Carle" collectively refers to Carle Health including Carle Foundation Hospital, Carle Physician Group, Carle Hoopeston Regional Health Center, Carle Richland Memorial Hospital, Carle BroMenn Medical Center and Carle Eureka. I authorize **Carle** to **release information** about me as follows:

1. **Carle** may use and/or disclose the information described below to the general public, through media, Carle publications or in other public venues including, but not limited to, print materials, social media, radio, television, and the internet.

2. I understand that the **purpose** of the disclosure(s) is for Carle's own marketing activities and/or general public information, awareness, education, and/or fundraising.

3. **Specific Records and/or Information** to be disclosed verbally, in writing or electronically, as the case may be:_____
   _____
   _____

4. **Revocation, Re-disclosure, & Expiration.** I understand that I may revoke this authorization at any time by submitting a written request to the Marketing & Communications department at 611 W. Park Street, Urbana, IL 61801, unless Carle has already acted upon my authorization. I understand that my revocation only applies to uses and disclosures of my personal information by Carle. I further understand that any information already disclosed pursuant to this authorization is no longer protected by the laws and regulations applicable to Carle, and may be subject to re-disclosure. Unless specified otherwise by me, this Authorization will have no expiration date.
   (Optional expiration date/event:_____).

5. I understand that my authorization to disclose the above information is **voluntary**, and Carle will not condition the provision of treatment or payment on this authorization.

6. **I waive any right to inspect or approve** the material prior to its use. All reproductions of my medical or personal information shall remain the property of Carle and may be edited prior to use. Furthermore, I release Carle, their licenses, agents, successors and assigns from any and all claims for damages for libel, slander, invasion of privacy or any other claim based upon the use and/or disclosure of my information.

COPY OF THIS AUTHORIZATION: I have been offered a copy of this authorization for my records.

_____ _____
Signature (Parent/Guardian/Authorized Signature where applicable) Date

_____ _____
Authority to Sign, if not the Patient/Employee Date

Facebook Permission Form

Dear CAOS Parents,

As you know, CAOS has a public Facebook page and a private Facebook group.

The **public page** is designed to communicate externally. First, it allows us to maintain our connection with former CAOS families by sharing events and experiences that current students are having at school. Only group photos will be shared on the public page. It also shares the mission and important elements of our program with prospective parents, professionals and donors who together ensure the future of our school.

The **private group** is intended for internal communication with families of current students. Both individual and group photos will be shared in the private group. This allows us to share more photos from different events and provide you with specific information and reminders, such as time and location of events like field trips and performances.

Based on some discussion with members of the PTO, we wanted to give families the opportunity to opt in or out of including their children's photos in Facebook posts. Please fill out the form to communicate your preference.

CAOS Staff

Child's Name:

I understand that Carle Auditory Oral School staff members take photographs during class, therapy, field trips and special events. I understand that these pictures may be posted on the public and/or private CAOS Facebook page following special events. I understand that child/ family member names are never included in the Facebook posts. Please initial to indicate your agreement with these statements. _____

Please carefully read the statements below and initial to indicate your agreement with each statement.

Yes, I grant permission for my child/family member's photos to be posted in:
_____ Group photos on the **public** CAOS Facebook page.
_____ Individual and group photos on the **private** CAOS Facebook group.

No, please do **not** post my child/family member's photos on the **public** CAOS Facebook page and the **private** CAOS Facebook group.
_____ No, I do not authorize

Parent/Guardian Signature:	Date Signed:
Relationship to Child/Authorization to Sign:	

CAOS | CARLE AUDITORY ORAL SCHOOL

Carle

Notice of Non-Secure Text Messaging

If you requested that CAOS staff contact you via text message on the Student Information Sheet, please complete the authorization below. If you do not want CAOS staff to contact you via text, please disregard this form.

Even though you should be aware that text messages are not encrypted and therefore unsecure, you have requested that CAOS communicate with you regarding your child/ children via text messaging. Please keep in mind that text messages containing information about your child can be read by anyone, forwarded to anyone, remain unencrypted on computer network servers, and permanently remain on both the sender's and receiver's phones. CAOS will honor your request to receive information via text messaging regarding your child/ children, but please be aware of the following:

- Text messages are not encrypted and therefore the information is not secured when sent via text.
- Unauthorized access to, or interception of, your medical information by others is possible.
- If you share your phone with family members, others may access your confidential information.
- If you use your employer's phone, you should determine the security/ ownership/privacy policy at your workplace. Your employer may have a legal right to your text messages.
- Do not use text messages for discussion of sensitive or highly confidential issues; for example, mental health issues, etc.
- Do not use text messages for emergencies.
- Please notify CAOS in writing if you wish to discontinue text messaging of your child's information.
- We highly recommend that you delete your messages after you have read them and no later than the end of each day.
- We prefer not to text/reply with any protected health information; therefore, our text messages will not identify your child by name.

Please confirm that you have read and understand the above information.

Child's Name _____ Date _____

Sponsor 1 Signature _____ Date _____ Sponsor 2 Signature _____ Date _____

CAOS | CARLE AUDITORY ORAL SCHOOL

Carle

CAOS Child Illness Policy

Should your child develop one or more of the following symptoms or conditions while at Carle Auditory Oral School, we will contact the parent/guardian to arrange for your child to be picked up. Your child must be picked up as soon as possible. If we are not able to reach a parent/guardian within 15 minutes, we will begin contacting emergency pick-up persons. Please be sure to inform us who will be picking up your child, even if you have listed them as authorized to pick up your child.

COVID-19 ILLNESS POLICY

The following symptoms are associated with COVID-19 infection.

List of Symptoms currently associated with COVID-19 (subject to change)

- Fever 100.4 or greater
- Chills
- Cough
- Shortness of breath
- Difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste
- New loss of smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

Due to the ongoing pandemic, children presenting with symptoms from the list above will not be admitted to school. Children will be excluded from school until one of the following conditions are met:

- Child has NEGATIVE PCR OR ANTIGEN COVID test result from a COVID testing center; child is free of fever/diarrhea/vomiting for 24 hours, and COVID related symptoms have improved/resolved per return to school criteria for diagnosed condition OR
- 10 days have passed since the onset of COVID related symptoms, child is free of fever/diarrhea/vomiting for 24 hours, COVID related symptoms have been improved/resolved per return to school criteria for diagnosed condition OR
- Letter from medical provider indicating that symptoms are related to another (named) diagnosis and that the child is cleared to return to school.

STANDARD ILLNESS POLICY (for symptoms not related to COVID-19)

Conjunctivitis (pink eye):	Unusual tearing, redness of eyelid lining, irritation followed by swelling and/or discharge
May return when:	Note from physician stating the child does not have conjunctivitis or 24 hours after antibiotic treatment has been initiated.
Skin rashes:	Yellowish, unusual or persistent rash, severe itching of body or scalp, potentially infectious skin patches that are crusty, dry, scabbed, weepy or gummy.
May return when:	Note from physician that child is not contagious or condition has been resolved.
Impetigo:	Blistery rash that when blisters are open, produce a thick, golden yellow discharge that dries, crusts and adheres to the skin.
May return when:	24 hours after treatment has begun and there is no longer discharge.
Head lice:	Tiny insects that live primarily on the head and scalp that appear as tiny white or dark ovals and are especially noticeable on the back of the neck and around the ears.
May return when:	Lice and nit free. Student must report to school office for head check before returning to class.
Chicken Pox:	Low grade fever, vesicular rash (blister-like rash or bumps).
May return when:	Child's blisters must be completely scabbed.

Sometimes children are not experiencing the symptoms described above, but are clearly not themselves/ are not able to engage in learning and play at school. If the staff notices that your child is not themselves/ is unable to engage in learning and play at school, staff will call to let you know. Then you can help to determine the best treatment for your child.

Exhibits unusual behavior such as cranky, less active, cries more, loss of appetite, generally uncomfortable, or stomach ache, watery eyes, trouble swallowing, etc.

Date: _____ Time: _____

_____ is being sent home for symptoms marked above. Child may return when conditions marked above are met.

Parent Signature: _____ Staff Signature: _____

CAOS | CARLE AUDITORY ORAL SCHOOL

Carle

CAOS Weather-Related School Closure Information*

Weather related school closure information will be reported to WCIA-TV by 6:30 a.m. The website is http://www.illinoishomepage.net/closings

If you have chosen to receive communications from us via e-mail, an e-mail communication will also be sent before 6:30 a.m. by Danielle.

If you have chosen to be updated about school closures via text messages, a text will be sent before 6:30 a.m. by Danielle.

*If you are a student volunteer and the school has been closed, please do NOT report for volunteer duty. A school closure due to weather will be considered an excused absence.

Carle Auditory Oral School

2018-2019 SCHOOL SUPPLY LIST

Early Start Preschool (Do not label)**	Preschool (Do not label)**	Pre-K (Label)**	Primary (Label)	
1 package of 8 count BOLD washable classic Markers^	1 package of 10 count BOLD washable classic markers^	1 package of 10 count BOLD washable classic markers^	1 package of 8 count BOLD washable classic Markers^	
Nap mat & blanket	Nap mat & blanket	Nap mat & blanket (optional)	1 package of 8-count washable classic color markers (skinny)^	
Fat Crayola® crayons	Fat Crayola® crayons	1 box of 24-count Crayola® crayons	1 box of 24-count Crayola® crayons	
Backpack (large enough to hold a folder and journal and still zip)	Backpack (large enough to hold a folder and journal and still zip)	Backpack (large enough to hold a folder and journal and still zip)	Backpack (large enough to hold a folder and journal and still zip)	
Lunch box with ice pack included (labeled w/child's name)	Lunch box with ice pack included (labeled w/child's name)	Lunch box with ice pack included (labeled w/child's name)	Lunch box with ice pack included (labeled w/child's name)	
2 composition journals (with stitched binding) **4 for children with hearing loss (2 are used for therapy)**	2 composition journals (with stitched binding) **4 for children with hearing loss (2 are used for therapy)**	2 composition journals (with stitched binding) **4 for children with hearing loss (2 are used for therapy)**	2 composition journals (with stitched binding, a picture box, and writing lines underneath) *** In addition to the above listed, children with hearing loss send 2 standard composition notebooks for therapy.**	
10 glue sticks	10 glue sticks	10 glue sticks	10 glue sticks	
2 bottles white school glue	2 bottles white school glue	2 bottles white school glue	2 bottles white school glue	
1 pair of child's rounded scissors	1 pair of child's rounded scissors	1 pair of child's scissors	1 pair of child's scissors	
1 bottle sunscreen (suggested Coppertone® Kids Continuous Spray ^^due to skin allergies)	1 bottle sunscreen (suggested Coppertone® Kids Continuous Spray ^^due to skin allergies)	2 bottles sunscreen (suggested Coppertone® Kids Continuous Spray ^^due to skin allergies)	2 bottles sunscreen (suggested Coppertone® Kids Continuous Spray ^^due to skin allergies)	
1 tray of watercolor paints^	1 tray of watercolor paints^	1 tray of watercolor paints^	1 pink eraser	
1 oversized t-shirt for art smock	1 oversized t-shirt for art smock	1 oversized t-shirt for art smock	1 oversized t-shirt for art smock	
Play-Doh® - a pack of 3 large (4 oz) or more	Play-Doh® - a pack of 3 large (4 oz) or more	Play-Doh® - a pack of 3 large (4 oz) or more	Play-Doh® - a pack of 3 large (4 oz) or more	
Barbasol® Shaving cream (for classroom use)	Barbasol® Shaving cream (for classroom use)	Barbasol® Shaving cream (for classroom use)	Plastic pencil box	1 package colored pencils
4 boxes of Kleenex®	4 boxes of Kleenex®	4 boxes of Kleenex®	1 package notecards	1 notecard holder
4 packages unscented baby wipes (classroom use)	4 packages unscented baby wipes (classroom use)	4 packages unscented baby wipes (classroom use)	4 boxes of Kleenex®	
If potty training, send diapers and additional wipes	**If potty training, send diapers and additional wipes**	**If potty training, send diapers and additional wipes**	4 packages unscented baby wipes	
1 container Clorox® wipes	1 container Clorox® wipes	1 container Clorox® wipes	1 container Clorox® wipes	
1 package small thin white paper plates	1 package small thin white paper plates	1 package small thin white paper plates	1 package small thin white paper plates	
1 package large thin white paper plates	1 package large thin white paper plates	1 package large thin white paper plates	1 package large thin white paper plates	
1 box snack size baggies	1 box Ziploc baggies quart size	1 box Ziploc baggies gallon size	1 box baggies sandwich size	

^Suggest Crayola® brand

^^Due to skin allergies

SUGGESTED SCHOOL DONATIONS

White paper lunch bags	Baking Soda	Brown paper lunch bags
Hand Sanitizer	Food Coloring	Vegetable Oil
Napkins	Lysol® Dual wipes	Cream of Tartar
Yarn	Cornstarch	Salt
Flour	Sugar	Cinnamon

Please see CAOS Parent Handbook for additional materials that your child will need while at school.

State of Illinois
Certificate of Child Health Examination

Student's Name Last First Middle	Birth Date Month/Day/Year	Sex	Race/Ethnicity	School /Grade Level/ID#
Address Street City Zip Code	Parent/Guardian	Telephone # Home		Work

IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for *every* dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.

REQUIRED Vaccine / Dose	DOSE 1 MO DA YR	DOSE 2 MO DA YR	DOSE 3 MO DA YR	DOSE 4 MO DA YR	DOSE 5 MO DA YR	DOSE 6 MO DA YR
DTP or **DTaP**						
Tdap; **Td** or Pediatric **DT (**Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles Mumps. Rubella				**Comments:** * indicates invalid dose		
Varicella (Chickenpox)						
Meningococcal conjugate (MCV4)						
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.
If adding dates to the above immunization history section, put your initials by date(s) and sign here.

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.
***MEASLES (Rubeola) MO DA YR** ****MUMPS MO DA YR** **HEPATITIS B MO DA YR** **VARICELLA MO DA YR**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.
Date of Disease **Signature** **Title**

3. Laboratory Evidence of Immunity (check one) ☐Measles* ☐Mumps ☐Rubella ☐Varicella Attach copy of lab result.**
*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.
**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____
Physician Statements of Immunity MUST be submitted to IDPH for review.

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and *Maintained* by the School Authority.

Last	First	Middle	Birth Date (Month/Day/ Year)	Sex	School	Grade Level/ ID

HEALTH HISTORY **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

ALLERGIES (Food, drug, insect, other)	Yes No	List:		**MEDICATION** (Prescribed or taken on a regular basis.)	Yes No	**List:**	
Diagnosis of asthma? Child wakes during night coughing?	Yes No Yes No			Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No		
Birth defects?	Yes No			Hospitalizations? When? What for?	Yes No		
Developmental delay?	Yes No						
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No			Surgery? (List all.) When? What for?	Yes No		
Diabetes?	Yes No			Serious injury or illness?	Yes No		
Head injury/Concussion/Passed out?	Yes No			TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.	
Seizures? What are they like?	Yes No			TB disease (past or present)?	Yes* No		
Heart problem/Shortness of breath?	Yes No			Tobacco use (type, frequency)?	Yes No		
Heart murmur/High blood pressure?	Yes No			Alcohol/Drug use?	Yes No		
Dizziness or chest pain with exercise?	Yes No			Family history of sudden death before age 50? (Cause?)	Yes No		
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Dental ☐ Braces ☐ Bridge ☐ Plate Other			
Ear/Hearing problems?	Yes No			Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature**		**Date**	
Bone/Joint problem/injury/scoliosis?	Yes No						

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE if < 2-3 years old **HEIGHT** **WEIGHT** **BMI** **BMI PERCENTILE** **B/P**

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐
Ethnic Minority Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE: Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** **Result**

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

No test needed ☐ **Test performed** ☐ **Skin Test: Date Read** **Result: Positive** ☐ **Negative** ☐ **mm**_____
Blood Test: Date Reported **Result: Positive** ☐ **Negative** ☐ **Value**

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	**Normal**	**Comments/Follow-up/Needs**		**Normal**	**Comments/Follow-up/Needs**
Skin			**Endocrine**		
Ears		Screening Result:	**Gastrointestinal**		
Eyes		Screening Result:	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ☐ **No** ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)
PHYSICAL EDUCATION **Yes** ☐ **No** ☐ **Modified** ☐ **INTERSCHOLASTIC SPORTS** **Yes** ☐ **No** ☐ **Modified** ☐

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

State of Illinois
Illinois Department of Public Health

PROOF OF SCHOOL DENTAL EXAMINATION FORM

Illinois law (Child Health Examination Code, 77 Ill. Adm. Code 665) states all children in kindergarten, second, sixth, and ninth grades of any public, private, or parochial school shall have a dental examination. The examination must have taken place within 18 months prior to May 15 of the school year. A licensed dentist must complete the examination, sign, and date this Proof of School Dental Examination Form. If you are unable to get this required examination for your child, fill out a separate Dental Examination Waiver Form.

This important examination will let you know if there are any dental problems that require attention by a dentist. Children need good oral health to speak with confidence, express themselves, be healthy, and ready to learn. Poor oral health has been related to lower school performance, poor social relationships, and less success later in life. For this reason, we thank you for making this contribution to the health and well-being of your child.

To be completed by the parent or guardian (please print)

Student's Name: Last	First	Middle	Birth Date: (Month/Day/Year)

Address: Street	City	ZIP Code

Name of School:	ZIP Code	Grade Level:

Parent or Guardian: Last Name First Name

Select from the below general racial category which most clearly reflects the student's recognition of his or her community or with which the student most identifies.

☐ White ☐ Black or African American ☐ Hispanic or Latino ☐ Asian
☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander ☐ Two or More Races

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To be completed by dentist

Date of Most Recent Examination:_____ (Check all services provided at this examination date)
☐ Dental Cleaning ☐ Sealant ☐ Fluoride treatment ☐ Restoration of teeth due to caries

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present on Permanent Molars**

☐ Yes ☐ No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

☐ Yes ☐ No **Untreated Caries —** At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

☐ Yes ☐ No **Urgent Treatment —** abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling.

Treatment Needs (check all that apply). Please list appointment date or date of most recent treatment completion date.

☐ **Restorative Care** — amalgams, composites, crowns, etc. Appointment Date:_____
☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis Appointment Date:_____
☐ **Pediatric Dentist Referral Recommended** Treatment Completion Date:_____

Dental Office Address: _____ Office phone number: _____

Signature of Dentist _____ Date _____

State of Illinois
Illinois Department of Public Health

State of Illinois
Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides eye examinations be submitted to the school no later than October 15 of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

Student Name _____
(Last) (First) (Middle Initial)

Birth Date _____ Gender _____ Grade _____
(Month/Day/Year)

Parent or Guardian _____
(Last) (First)

Phone _____
(Area Code)

Address _____
(Number) (Street) (City) (ZIP Code)

County _____

To Be Completed By Examining Doctor

Case History

Date of exam _____

Ocular history: ❑ Normal or Positive for _____

Medical history: ❑ Normal or Positive for _____

Drug allergies: ❑ NKDA or Allergic to _____

Other information _____

Examination

	Distance			Near
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation? ❑ Yes ❑ No

	Normal	Abnormal	Not Able to Assess	Comments
External exam (lids, lashes, cornea, etc.)	❑	❑	❑	_____
Internal exam (vitreous, lens, fundus, etc.)	❑	❑	❑	_____
Pupillary reflex (pupils)	❑	❑	❑	_____
Binocular function (stereopsis)	❑	❑	❑	_____
Accommodation and vergence	❑	❑	❑	_____
Color vision	❑	❑	❑	_____
Glaucoma evaluation	❑	❑	❑	_____
Oculomotor assessment	❑	❑	❑	_____
Other _____	❑	❑	❑	_____

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

Diagnosis

❑ Normal ❑ Myopia ❑ Hyperopia ❑ Astigmatism ❑ Strabismus ❑ Amblyopia

Other _____

Continued on back

State of Illinois
Eye Examination Report

Recommendations

1. Corrective lenses: ❑ No ❑ Yes, glasses or contacts should be worn for:
   ❑ Constant wear ❑ Near vision ❑ Far vision
   ❑ May be removed for physical education

2. Preferential seating recommended: ❑ No ❑ Yes
   Comments _____
   _____

3. Recommend re-examination: ❑ 3 months ❑ 6 months ❑ 12 months
   ❑ Other _____

4. _____

5. _____

Print name _____ License Number _____

Optometrist or physician (such as an ophthalmologist) who provided the eye examination ❑ MD ❑ OD ❑ DO

Address _____
_____

Phone _____

Consent of Parent or Guardian

I agree to release the above information on my child or ward to appropriate school or health authorities.

_____
(Parent or Guardian's Signature)

_____
(Date)

Signature _____ Date _____

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Printed by Authority of the State of Illinois

IOCI 15-391

CAOS Permission for Emergency Treatment (Must be Notarized)

You have my permission to proceed with any treatment necessary to care for my child in case of illness or injury while attending Carle Auditory Oral School.

Signature of Parent/Guardian:_____ Date:_____

In the state of _____, and the county of _____, on this_____day of _____, 20____, before me personally appeared,_____known to be the person described in and who executed the foregoing instrument, and acknowledged that he/she executed that same as his/her free deed and act.

In testimony whereof, I hereunto subscribe my name and affix my official seal at my office in_____ _____, the day and year first above written.

My commission expires: _____
Signature of Notary Public:_____

The information contained on this sheet is correct to the best of my/our knowledge and I/we agree to update the information on a regular basis.

Sponsor 1 Signature:_____ Date Signed:_____

Sponsor 2 Signature:_____ Date Signed:_____

Thank you for your interest in Carle Auditory Oral School's Outreach Program!

Attached you will find the documents required to complete our intake process. Please print, complete, and return the documents. If you do not have access to a printer, please share your mailing address and we will send a packet to you in the mail. Forms can be returned by scanning and emailing the forms to me at Danielle.Chalfant@carle.com or by mailing them to us at Carle Auditory Oral School, 611 W. Park St., Urbana, IL 61801 ATTN: Outreach Intake Forms.

- Outreach Information Form
- Consent for Tele-Intervention
- Consent to Use Google Drive
- Tuition Express Information Forms

The Outreach Information Form allows us to collect contact information and communication preferences for our outreach families to help us to stay connected with you moving forward. There is a section for you to share information about members of your child's household as well. We have included this section because children often share stories about parents, siblings and other members of their household during therapy and having the names and ages up front helps us to be better communication partners. The third section of the form asks for contact information for other members of the child's team so that we can collaborate with them to ensure that your child's learning is as effective, relevant and efficient as possible. We offer a variety of Outreach Support services. Some are billed to insurance, others are billed through therapy tuition. Please complete the bottom section of the form if you are planning to access our therapy tuition sliding scale.

The Consent for Tele-Intervention documents your consent for your child's outreach services to be provided using Zoom.

The Consent to Use Google Drive documents your consent for the creation of a folder on the google drive which contains your child's outreach goals, documents progress toward those goals, and allows for consistent collaboration between individuals who have access to the drive.

Families that access the therapy tuition sliding scale have the option of making monthly payments by check, or to use our Electronic Funds Transfer payment option. After your intake packet is reviewed, I will be in touch to discuss your cost per session and approximate billing dates. If you choose to use Tuition Express, the Tuition Express Information Forms attached to this email provide information about how Tuition Express works and includes a form where families can enter their routing and account information to allow for deductions to occur. **Families will be billed for all scheduled sessions.** Please let us know if you have any questions about these payment options by contacting Myra Fawbush (Myra.Fawbush@carle.com) and Danielle Chalfant (Danielle.Chalfant@carle.com). We look forward to hearing back from you!

Sincerely,

Danielle M. Chalfant, Director
Carle Auditory Oral School

CAOS | CARLE AUDITORY ORAL SCHOOL

Carle

INFORMED CONSENT FOR TELEHEALTH CONSULTATION

Carle

☐ Carle Foundation Hospital_____
☐ Carle Physician Group_____
☐ Carle SurgiCenter_____
☐ Hoopeston Regional Health Center_____

CONSENT

imprint

A telehealth consultation has been recommended as a way to facilitate my care. Telehealth allows my condition to be assessed by a specialist who is not in my community. In order to perform the telehealth consultation, the specialist will review information about my condition. My healthcare provider will decide what information will be provided. The information will be transmitted electronically. Electronic transmission of information is like an e-mail but takes place using protected and dedicated communication lines. Information to be transmitted may include patient reports, laboratory results, radiograph reports, and photographs. In some situations, my healthcare provider will receive the specialist's report and will be able to review the recommendations with me.

By signing this agreement, I authorize the electronic transmission of my medical information and/or a telehealth session to _____ (name of healthcare provider completing telehealth consultation) **and other persons involved in my medical treatment and care.** I understand the specialist providing the telehealth consultation and other persons involved in this telehealth consultation will have access to this information if applicable. I have been advised that the likelihood of this transmission being intercepted by persons other than those at the consulting site is extremely small. I understand that this agreement is not intended to describe actual treatment limitations and risks. This agreement is intended only to describe limitations and risks specific to the electronic transmission of information.

I understand that I can withdraw my permission to participate in a telehealth consultation at any time. Although I may choose not to answer any questions that I consider to be inappropriate or am unwilling to have heard by other persons, doing so may impair the specialist's ability to understand and address fully my healthcare issue(s). I understand that if I choose not to participate in the telehealth consultation, no action will be taken against me. I am always at liberty to pursue a face-to-face consultation.

I understand telehealth does have limitations. For example, the specialist is not able to palpate (directly examine with one's hands) but may use small special cameras to view close up details during a physical exam. My healthcare provider will address any other questions that I may have about the limitations of telehealth applicable to my specific condition.

I understand that if applicable, medical records of telehealth services will be kept at both the referring site and the consulting site. If I want to obtain copies of my records, I understand that I must contact the appropriate site's medical record office.

I understand that some or all of my medical information may be used for teaching or educational purposes at Carle.

I also agree to have my telehealth medical records reviewed for the purposes of evaluation (data collection, analysis, quality assurance and presentation in verbal or written format at scientific meetings). I understand that any presentation will not identify me by name or other identifiable markers. DECLINE _____ (initials of patient only if declining)

My healthcare provider has discussed with me the information provided above. I have had an opportunity to ask questions about this information, and all of my questions have been answered. I have read and agree to a telehealth consultation.

_____ _____/_____
Signature of Patient or Authorized Person Date Time

_____ _____/_____
Signature of Witness Date Time

INTERPRETER SERVICES:

I have provided interpretation in _____ of any verbal and/or written information.
(type of language)
including this consent form, that have been provided to the patient/authorized person to consent.

Interpreter: _____ _____/_____
(print full name/badge #) Date Time

Signature (or if remote source, indicate company used): _____

Outreach/Therapy Information Sheet

Child's Name:_____ Birth Date:_____

In the event that we need to communicate with you during the day, please rank your preferred method of communication in the spaces provided below, with "1" being the primary mode of communication:

ADULT 1:		ADULT 2:	
Name:		Name:	
Address:		Address:	
City/Zip:		City/Zip:	
Cell Phone:		Cell Phone:	
Text OK? ☐ Yes ☐ No	List Carrier:	Text OK? ☐ Yes ☐ No	List Carrier:
Work Phone:		Work Phone:	
Email:		Email:	

Family: Please list all persons living in the household(s) with the child. Please provide ages of other children in the home:

Name	Nickname	Relationship	Gender	Age

COLLABORATION INFORMATION:

Pediatrician's Name:	Pediatrician's Phone #:
School Name and Address:	
Teacher Name:	Teacher Email:
Speech Language Pathologist Name:	Speech Language Pathologist Email:
Hearing Itinerant Name:	Hearing Itinerant Email:
Audiologist Name:	Audiologist Email:
Name/Role of Other Members of the Team:	Other Members Email:

*If accessing the sliding scale, please attach most recent tax return to this intake packet so that we can determine your rate. Sign below to acknowledge receipt and agreement with the therapy tuition billing policy.

Signature:	Signature:

I/we plan to: ☐ Enroll in Tuition Express ☐ Make monthly payments by check

Office Use Only: Assigned Rate per Session_____

CAOS | CARLE AUDITORY ORAL SCHOOL

Carle

Google Drive Permission Form

Dear CAOS Parents,

During the COVID school closure, CAOS staff created the CAOS Google Drive to be an online location where parents and staff could collaborate, share materials and updates with one another. Each parent was asked to give permission for the creation of a folder for their child. Once permission was granted, access to that folder was shared with the child's team (i.e., parents, deaf educator, and therapists). Each member of the team could read information, add their own updates and provide input into goal selection. In the past, we have used a folder on Carle's shared drive which can be accessed by all staff members while logged into their Carle computer. The Google drive allows us to extend access to families as well.

We found that this worked really well and we are interested in continuing it during the coming school year. Please read and sign below to grant permission for us to create a Google folder for your child. If you choose to opt out of the CAOS Google drive, you will still receive monthly newsletter updates and can provide input via email or phone calls. If you have questions, please contact Danielle.

Thank you for your time and collaboration!

CAOS Staff

Child's Name:

I understand that a folder for my child will be created and added to the CAOS Google drive, that the CAOS Google drive will contain information about my child's test scores, monthly targets and progress toward achieving those targets, and that my child's team will be invited to read and edit the documents in my child's folder. Further, I understand that the Google drive is outside Carle's encrypted network, but is protected by Google's security measures and each user needs to be invited to collaborate by CAOS staff.

Please carefully read the statements below, mark that statement that represents your decision about the CAOS Google drive for the coming school year.

Yes, I grant permission for CAOS staff to create a folder for my child on the CAOS Google drive.	
Signature:	Date Signed:
Relationship to Child/Authorization to Sign:	

No, I do **not** grant permission for CAOS staff to create a folder for my child on the CAOS Google drive.	
Signature:	Date Signed:
Relationship to Child/Authorization to Sign:	

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

ROI

Patient Name:_____ Date of Birth:_____

Other Names:_____ Last 4 digits of SSN:_____ MRN:_____

I authorize: The Carle Foundation* -Health Information Management
3310 Fields South Drive, Champaign, IL 61822
**Includes Carle Physician Group and Carle Hoopeston Regional Health Center*

☐ To Send to:
OR
☐ To Request from:

_____
(Name of Health Care Facility, Physician, Individual, or Agency, etc.)

_____
(Address)

_____ _____ _____
(City, State, Zip) (Phone) (Fax)

Method of Release: ☐ Mail ☐ Pick up at HIM Department (217) 902-6500 ☐ MyCarle Account (Available for 30 days)

SPECIFIC RECORDS TO BE RELEASED: *If no dates are indicated, only records created prior to or on the date of signature will be released.*

HOSPITALIZATION Dates:_____ to _____		CLINIC/OTHER	Dates:_____ to _____
☐ Inpatient Hospitalization ☐ Abstract ☐ Complete Stay ☐ History and Physical ☐ Consult(s) ☐ Progress Note(s) ☐ Operative Report(s) ☐ Discharge Summary ☐ Cardiology ☐ Reports ☐ Images	☐ Immunization Record ☐ Laboratory Report(s) ☐ Pathology ☐ Report(s) ☐ Slides ☐ Radiology (X-ray) ☐ Reports ☐ Images ☐ Therapy Services ☐ Other_____ ☐ Billing Records	☐ Cardiology ☐ Reports ☐ Images ☐ Immunization Record ☐ Laboratory Report(s) ☐ Pathology ☐ Report(s) ☐ Slides ☐ Radiology (X-ray) ☐ Reports ☐ Images	☐ Office Visits (Specify Provider) _____ _____ ☐ Emergency Department Visit(s) ☐ Home Care/Hospice ☐ One-Day Surgery ☐ Therapy Services ☐ Other _____ ☐ Billing Records

- The purpose of this disclosure of information is_____.
  (i.e., continuing care, insurance claim, legal counsel, etc.)
- I understand that my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), treatment for alcohol and/or substance abuse, and genetic testing results. A separate special authorization must be completed to release mental health records.
- I have the right to inspect and obtain a copy of the records that are to be disclosed (CFR 164.524). I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
- I understand that I am not required to sign this authorization in order to seek medical treatment at the above named facility, unless the sole purpose of my visit is to create health information for someone else's use. (Ex: Pre-employment physical)
- I understand that I may revoke this authorization at any time. I understand that if I want to revoke this authorization, I must provide a written revocation to the Health Information Management department of the above named facility. I understand that the revocation will not apply to information that was released previously.
- This authorization will expire on the following date or event_____. If I do not specify an expiration date or event, this authorization will expire on the date of the signature below and records will only be released for services up to and including that date.
- I understand that I am entitled to a copy of this authorization.
- I understand there may be a charge to obtain a copy of these records.

ATTENTION: This is a legal document. Please read carefully. By signing, you agree that you understand and accept the terms on this form.

If the patient is 18 years of age or older, the patient must sign and date the form.

If the patient is 18 years of age or older and is incapable of signing, a legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship:

☐ Legal Guardian or Conservator ☐ Health Care Agent (Health Care Power of Attorney)

If the patient is 17 years of age or younger, the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law. Please indicate your relationship: ☐ Parent ☐ Legal Guardian

Signature:_____ Date Signed:_____

Printed Name of Person Signing (if not patient):_____ Phone#:_____

Mailing Address of Patient:_____ City:_____ State:_____ Zip:_____

STAFF USE ONLY *- Released by: Staff Initials_____ Type of ID Verified_____ Date:_____*

CAOS Funding Source Identification and Request Form

Updated February 2021

Child's Name: _____ Date of Birth:_____

SECTION 1: FAMILY FINANCIAL INFORMATION

A. **Please attach a copy of your most recent income tax forms (unless fully funded by school district). If you do not have a tax form from last year, you must submit proof of income. Please see director for acceptable forms.**

B. **Adjusted Gross Income:**_____

C. **Explanation of Special Considerations:** Please share additional information about your financial responsibilities that you would like us to consider in determining your financial need. Examples include: transportation costs, vehicles and food as well as other payments (e.g., school tuitions, child support…) that impact your family's ability to fund your child's education. Please include the amount you feel your family could pay to access the support provided at CAOS. Attach an additional sheet if necessary.

_____

_____

_____

How much money would your family be able to commit to your child's communication skill development each month?_____

SECTION 2: NARRATIVE

The purpose of this section is to ensure that the family's commitment to developing listening and spoken language skills warrants financial support from Carle Center for Philanthropy. Producing successful listening and spoken language communicators is the goal of CAOS and the Carle Center for Philanthropy. That goal cannot be achieved without support and commitment from home. Ensuring that there is family support and commitment is essential before awarding financial support.

Why do you want your child to attend Carle Auditory Oral School?_____

_____

_____

Why do you want your child to develop listening and speaking skills? _____

_____

_____

Why are you requesting financial aid / scholarship? _____

_____

_____

SECTION 3: EXPECTATIONS:

What will your child be doing at each of these time slots with the listening and spoken language communication skills they develop in this program? Possible examples include: saying "mama", "talking in sentences", "working on the phone as a telemarketer", "going to school with hearing peers", "attending a university of their choosing"… There are many possibilities. What are your goals for your child?

In 6months:_____

At Age 6:_____

At Age 10:_____

At Age 18:_____

At Age 25:_____

Research shows that children with involved families progress farther and more rapidly. Please initial below to indicate your willingness to do each of the following to help maximize your child's progress at Carle Auditory Oral School.

_____ Provide transportation to and from Carle Auditory Oral School

_____ Ensure a timely arrival for school and therapy sessions

_____ Secure funding for / Make family sacrifices to pay my child's tuition

_____ Participate in fundraising activities for the school

_____ Participate in education opportunities

_____ Complete daily journal entries for class and therapy, as needed

_____ Check folder regularly / respond to communication from CAOS

_____ Read to my child nightly

_____ Participate in Parent-Professional collaboration meetings

_____ Share information with school about your child's use of targets when not at school.

_____ Enforce amplification during all waking hours

_____ Continue to "up the ante" regarding my child's use and understanding of acceptable communication and spoken language.

_____ Participate in up to three Parent Teacher conferences during the school year.

I/ We certify that the above information is true to the best of my/our knowledge.

_____ Date: _____

_____ Date: _____

Thank you for taking the time to complete this application. The information included in this application will provide the funding committee with the information necessary to ensure that families receive needed financial assistance and that the funds being accessed are being used responsibly.

CAOS Family Notification Announcement

What is OPTION, Inc.?
OPTION is an international, non-profit organization of programs and schools for children who are deaf or hard of hearing learning to listen and talk. The organization advances the excellence in listening and spoken language education by providing information, engagement, and support to its member's programs. OPTION members educate the public, professionals, and policymakers as to what is possible for children who are deaf and hard of hearing in the 21st century.

What is LSL-DR?
OPTION developed the Listening and Spoken Language Data Repository (LSL-DR) in 2010. LSL-DR is an international database that contains non-identifying information on a child and their family's journey in developing spoken communication skills. Your child's program, **Carle Auditory Oral School**, is a member of OPTION. As part of the OPTION membership benefits, your child's program uses LSL-DR to store select data about your child's progress in developing listening and spoken language skills. LSL-DR does not store any protected health information.

What type of information is entered into the LSL-DR?
The type of information stored in LSL-DR is your child's annual speech-language-hearing information, type of technology used, services received, and non-identifying demographic information. The OPTION database does not contain any names, dates, or identification numbers that could be traced back to your child or family. Only your child's program can access your child's specific data. Since LSL-DR is a de-identifiable database, **no personal identifying information is entered into the database**. OPTION views the combined data from all the programs and does not know which data belongs to which child or family.

How does my child's intervention program and OPTION use the data entered into LSL-DR?
Your child's program reviews the data entered into LSL-DR to monitor the child's progress over time, assist with curriculum development, identify potential treatment goals, determine continuing education opportunities for their teachers and staff, and apply for grants that require outcome reporting. OPTION uses the data stored in LSL-DR to summarize data across all the programs to describe the population and overall outcomes and to learn about what factors contribute to a child's success.

Where is the data stored?
The computer software program that OPTION uses to store the de-identified data is REDCap (Research Electronic Data Capture). REDCap is a secure, web-based application designed to support data capture for research studies and is used all around the world. This system meets all security guidelines for web-based systems and is stored on the University of Miami server. This database has been reviewed by the University of Miami's Institutional Review Board.

Who do I talk with if I want more information about LSL-DR and my child's involvement?
If you have any questions about this project, please feel free to contact **Danielle Chalfant at (217) 326-2824** or the Principal Investigator of LSL-DR, Ivette Cejas, Ph.D., at icejas@med.miami.edu, or lsldr@optionschools.org.

Please note that unencrypted emails are not a secure or private means of communication. Email messages can be intercepted and read by others with access to your email account. Because of these risks, we recommend you avoid sending any health information or sensitive information via email unless encryption is used. However, the best means of communication is up to you.

This letter serves as a notification to you about **Carle Auditory Oral School's** participation in this project. You may notify Danielle Chalfant if you wish for your child's information not be stored in this database, LSL-DR. Choosing not to participate will have no effect on your child's placement or services at the school.

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One goal of the LSL-DR project is to combine our children's outcomes with those of children enrolled in Listening and Spoken Language programs across the country to demonstrate that listening and spoken language is a viable communication option for children who are deaf and hard of hearing. We know that the services children receive through ECHO/ CAOS have changed lives and enabled children and families to return to their neighborhood schools to participate fully in their communities. But many people do not know about these outcomes. So many parents and professionals make the assumption that sign language is the only option for communication and education access once a hearing loss is diagnosed, and that children who are deaf and hard of hearing will lag behind their typically hearing peers in communication, social and academic skills. Your children's outcomes prove that it doesn't have to be that way.

The LSL-DR data base now contains outcome data on over 9,000 children who are deaf and hard of hearing who are enrolled in LSL programs across the country and are progressing in communication, social and academic areas because of those services. This large data set shows that children who are deaf and hard of hearing can advance in their communication, social interactions and academics, and can, on average, develop age appropriate skills in these areas.

Current research shows that individual child factors, such as the age they were first identified with hearing loss, family income level, and primary language spoken in the home impacts outcomes. But we also know that there are programs that are able to help children advance in their communication skills regardless of where children fall within these demographics. We want to be able to look at those programs that are successful with special populations and learn how they are supporting different groups of children so that our field as a whole can attain high outcomes for all of our students.

Toward that end, the next step of the project is to document demographic variables for each of the students in the data base and attempt to identify the impact of different variables. We hope to analyze the data and identify adaptations to our program to better engage and support children and families from a wider range of demographics and achieve even better outcomes for our students.

In order to do that, we are asking families to provide additional demographic data to help us in analyzing the factors impacting outcomes for our students. We are hopeful that each family will help us with this important project! The following information will be kept confidential and will be used only for the purposes of the LSL-DR project.

Please complete and turn in with the registration forms. Thank you for your time!

Child's Name: _____ Date: _____

Demographics

Child's Race: _____

Primary language spoken in the home: _____

Highest level of education completed - Mother: _____

Highest level of education completed - Father: _____

Hearing status since childhood - Mother: _____

Hearing status since childhood - Father: _____

Total number of children in the home: _____

Birth History

Pregnancy full term? _____

If not full term, how many weeks at delivery? _____

Hearing History

Child's age at diagnosis: _____

Child's age when fit with hearing aids: _____

Child's age when they first started services (speech, hearing or developmental therapy): _____

_____

Child's age at first appointment with ECHO/CAOS: _____

Does your child have a known medical diagnosis related to the hearing loss? _____

If yes, what is the medical diagnosis? _____

Does your child have a known syndrome associated with the hearing loss? _____

If yes, what is the name of the syndrome? _____

Does your child have another disability, in addition to the hearing loss? _____

If yes, what is the name of the additional disability? _____

Services

Does your child receive services outside of ECHO/CAOS? _____

If yes, please describe services, frequency and duration of services: _____

_____

Family Income Level (please check one)

- ☐ Less than $24,999
- ☐ $25,000 - $49,999
- ☐ $50,000 - $74,999
- ☐ $75,000 - $99,999
- ☐ Greater than $100,000