Walden School
At The Learning Center for the Deaf

Date: _____

Parent's / Guardians:

Please be advised that The Walden School's Anti-Bullying and Intervention Plan is available for review on our website at: *www.tlcdeaf.org* If you would like a copy of this plan, please let us know by checking off the form below and returning it to us.

Sincerely,

Karen Bishop
Director of the Walden School

If you would like a copy of the Anti-Bullying and Intervention Plan, please mail the form below to The Walden School at The Learning Center for the Deaf, 848 Central Street, Framingham, MA. 01701

To Whom It May Concern:

☑ Please send a copy of The Walden School's Anti-Bullying and Intervention Plan to my home address.

☑ I will be contacting The Walden School to request a copy of the Anti-Bullying and Intervention Plan.

Parent / Guardian Signature: _____ Date: ___/___/___

Walden School
at The Learning Center for the Deaf
STUDENT EMERGENCY INFORMATION

Date: _____

Complete the following information and return to school immediately.

Student name_____ Date of Birth_____
Last, First, Middle name

Address_____

Home phone_____ Primary language at home_____ Grade_____ Sex_____

Does your child have health insurance? Yes ☑ No ☑

Health Insurance _____ Policy Number _____

Dental Insurance _____ Policy Number _____

Parent/guardian_____	Parent/guardian_____
Relationship to child_____	Relationship to child_____
Home address_____	Home address_____
_____	_____
Home phone_____	Home phone_____
Work phone_____	Work phone_____
Pager_____	Pager_____
Cell number_____	Cell number_____
Email address_____	Email address_____
Preferred contact number_____	Preferred contact number_____
Primary language_____	Primary language_____

List 2 Emergency contacts if parent/guardian is unavailable:
Required by Department of Elementary and Secondary Education

Name_____	Name_____
Relationship to child_____	Relationship to child_____
Day phone_____	Day phone_____
Pager _____	Pager_____
Email address_____	Email address_____
Work phone_____	Work phone_____
Cell phone_____	Cell phone_____

In case of emergency, the school will attempt to contact parent/guardian before calling student's primary care provider (physician). Your child will be transported by ambulance to an emergency care facility if necessary.

Parent/guardian signature_____ Date_____

Physician's name_____ Phone_____

Dentist's name_____ Phone_____

Walden School
at The Learning Center for the Deaf
STUDENT HEALTH INFORMATION

Date: _____

Student name _____ Height _____ Weight _____

Ethnicity _____ Hair color _____ Eye color _____ ID marks _____

Self care ability Feeding ☑ Independent ☐ Needs assistance

Toileting ☑ Independent ☐ Needs assistance

HEALTH HISTORY

Please list all medications that your child takes: _____

_____

What medications will be given at school: _____

_____

Please check all health issues that apply to your child:

☐ Heart condition ☐ Diabetes ☐ Asthma ☐ Seizure disorder ☐ Migraines

☐ Cochlear implant ☐ Left-date implanted _____ ☐ Right-date implanted _____

☐ Other medical issues (please specify) _____

_____

Please list mental health issues that apply to your child:

_____

_____

Please check allergies that apply to your child:

☐ food ☐ insects ☐ medication ☐ environment ☐ other ☐ NKA (no known allergies)

Specify your child's allergies: _____

_____

Epi-pen ☐ yes ☐ no Date of last dental exam _____

Recent surgical/serious illness or change in diagnosis _____

_____

TYLENOL/ADVIL PERMISSION

Please check ALL the following that you give your permission for your child to receive during school hours:

☐ Advil ☐ Tylenol ☐ Bacitracin ointment ☐ Sunblock

I give permission to the school nurse to share information relevant to my child's health condition with appropriate school and/or emergency medical personnel when needed to meet my child's health and safety needs. I give permission to exchange information with my child's primary care physician for the purpose of referral, diagnosis and treatment. I give permission for emergency medical treatment.

Parent/guardian signature _____ Date _____

Walden School
at The Learning Center for the Deaf
Authorization and Permission Form

Date: _____

I, parent/guardian of:_____ _____ _____
Last name First name Middle name

Yes ☐ No ☐ I authorize The Walden School to take my child on field trips utilizing school vehicles or other school approved means of transportation.

Yes ☐ No ☐ I authorize The Walden School to use a picture or videotape of my child for purposes of brochures, newsletters, TLC/WS web page and other media related to the promotion of the school and its activities. When possible I will be notified of the school's intentions to use this representation.

Comments:_____

_____

Parent/guardian permission to participate in the Physical Education and Athletics Program

Physical Education Program

Yes ☐ No ☐ My child may participate fully in The Walden School's Physical Education Program.

If **NOT** please specify restrictions:_____

_____

_____

Medical documentation of participant's restrictions is required

The Marie Philip School's Athletic Program

Yes ☐ No ☐ My child may participate fully in The Marie Philip School's Athletic Program.

If **NOT** please specify restrictions:_____

_____

_____

Medical documentation of participant's restrictions is required

In order to be accepted onto a team and participate in practice and sports events, a student is required to have a current physical exam, less than 1 year old, that states he/she may participate fully in sports and specifies any limitations.

Parent/guardian signature:_____Date:_____

Walden School
at The Learning Center for the Deaf
Physician's Orders

Date: _____

Student name:_____Date of Birth:_____
Last, First, Middle name

Allergies:_____

_____

Physician's name:_____Date:_____

Telephone #:_____Fax #:_____Email:_____

Date Ordered	Date of Renewal	Date to Discontinue	Orders

MD Signature:_____Date:_____

Walden School
at The Learning Center for the Deaf
Medication Permission

Date: _____

Student name:_____ _____ _____
Last name First name Middle name

The nurse or her designee gives all medications. Written permission from parent/guardian and a physician's order is needed for all medications and to allow for self-administration of medication.

Please list all medications presently being taken at school and at home. Include prescription and non-prescription medications.

Medication:	**Reason(s) child takes medication:**

I give permission to the school nurse or personnel designated by the school nurse to give prescribed medications listed above.

I give permission to the school nurse to share with appropriate school personnel information relative to the prescribed medicine as determined necessary for my child's health and safety.

Parent/guardian signature:_____Date:_____

Student signature (if 18 or older):_____Date:_____

In a medication emergency, the parent/guardian and licensed prescriber will be notified.

_____

_____

_____

Note: Parent/guardian may retrieve medication from the school at any time. Medications not picked up within 1 week following termination of the order or 1 week beyond the close of school will be destroyed unless alternative plans have been made

Walden School
at The Learning Center for the Deaf
Medication Self Administration

Date: _____

Walden School policy does not allow students to carry medication on their person or to self-administer medication.

Exceptions may be made for students with asthma who carry an inhaler, for students who carry an epi-pen or for students with other special needs.

The following documentation is required 2 weeks before the 1st day of school for self-administration:

- ✓ A written doctor's order for the medication.
- ✓ Written parent/guardian permission for the student to self-administer the specific medication.
- ✓ The student must demonstrate the ability to follow the procedure of self-administration.
- ✓ The student must be competent to keep a sufficient quantity of medication with them in school and on field trips and/or sports events.

Please feel free to contact the nursing department should you have any questions.

Please complete the following if your child currently uses an asthma inhaler, an epi-pen or has a special need:

I give my permission for my child to self administer:

☐ Asthma inhaler

☐ Epi-pen

☐ Other – special need:_____

Student:_____
Last name First name Middle name

Parent/guardian signature:_____Date:_____

Walden School
at The Learinng Center for the Deaf
Report of Dental Examination

Date: _____

This is to certify that on _____ I have examined the teeth of:
Date

_____ _____
Student name D.O.B.

☐ No dental treatment is necessary.
☐ Treatment has been recommended.
☐ Treatment is in progress.
☐ Treatment completed.

Recommendations/Comments:_____

_____

_____

Next scheduled visit:_____

A yearly report of a dental exam is required by The Department of Education.

_____ _____
Dentist Signature Date

PARENT/GUARDIAN PLEASE RETURN THIS FORM TO THE NURSES OFFICE.

Walden School
at The Learning Center for the Deaf
Medical Information Letter

Dear Parent/Guardian,

All students:

According to the Department of Education, Department of Public Health and the Department of Early Education and Care regulations, all students are required to have a yearly physical exam and an updated immunization report on file. A dental exam is strongly suggested.

Medication Requirements:

If your child takes medication during the school day, and/or during residential hours, the following documentation is **required** to permit medication administration.

- A new written doctor's order for the 2016 - 2017 academic year.
- Written parental permission to administer medication.
- An accurately labeled pharmacy container for medication(s).
- Medication supply of not greater than a 1 month quantity, to be kept in the nursing department.

Medications are to be delivered **directly to the nursing department** by a parent or adult, not the student. Medications will be administered by a nurse or her designee in the case of a field trip.

If your child has a special need regarding medication or medical treatment, delivery of a medication or a restriction, please call the nursing department on 508 879-5110 ext. 520 for Middle and High School students, call ext. 221 or 225 for Pre-K and lower/upper Elementary School students to develop a health plan to meet your child's needs.

Thank you.

Mary Rapa, RN
Director of Health Services

Walden School - Residential

Over-the-counter Medication Permission

Date: _____

Student name:_____Date of Birth:_____
Last, First, Middle name

The following over the counter medications will be given to your child if the need arises, with both parent/guardian permission and an MD's order.

I give permission for my child to receive the medications listed below during the school year. I have checked **NO** for any medications or creams that I do **NOT** give permission for my child to receive.

TYLENOL	Yes	☐	No	☐
ROBITUSSIN	Yes	☐	No	☐
BACITRACIN OINTMENT	Yes	☐	No	☐
TUMS	Yes	☐	No	☐
SUNBLOCK	Yes	☐	No	☐
ADVIL	Yes	☐	No	☐
COUGH DROPS	Yes	☐	No	☐
ORAJEL	Yes	☐	No	☐
MUSCLE RUB (i.e., Bengay)	Yes	☐	No	☐
HYDROCORTISONE CREAM	Yes	☐	No	☐

Please indicate any other over-the-counter medications your child may need:

_____
_____
_____

Parent/guardian signature:_____Date:_____

Student signature (if 18 or older):_____Date:_____

Walden School
at The Learning Center for the Deaf

July 22, 2016

Dear Parent,

In our efforts to ensure the health and safety of all of our students we have just completed a review of each student's medical files.

The following checked items are **required** in order to bring your child into compliance with the Department of Secondary and Elementary Education, the Department of Public Health regulations and The Walden School's policy.

- ☐ Annual physical exam report_____
- ☐ Dental exam report_____
- ☐ Vision exam report_____
- ☐ Other physician or specialist report_____
- ☐ Tdap_____
- ☐ Measles/Mumps/Rubella vaccine_____
  - ☐ 2nd measles vaccine_____
- ☐ Hepatitis B 1-2-3_____
- ☐ 1st Varicella vaccine (chicken pox)_____
  - ☐ 2nd Varicella vaccine _____
- ☐ Meningitis vaccine_____
- ☐ 1st Gardisil vaccine_____
  - ☐ 2nd Gardisil vaccine_____
  - ☐ 3rd Gardisil vaccine_____
- ☐ Allergy, Asthma, Epi-pen or Seizure Action Plan_____

_____

We need your cooperation to comply with Massachusetts law and to ensure a healthy environment for all of our students and staff.

Thank you.

Nursing Department

Walden School

at The Learning Center for the Deaf

Authorization and Permission for Pictures and Videotaping

Date: _____

I authorize Walden School to use a picture or videotape of my child for the purposes of brochures, newsletters, TLC Web page and other media related to the promotion of the school and its activities. When possible, I will be notified of the school's intentions to use this representation.

Yes ☐ No ☐

Name of Child: _____

Parent/Guardian Signature: _____