Student's Name _____ Phone_____

THE FOLLOWING MATERIALS MUST BE FURNISHED FOR REGISTRATION

Please bring with you:

____ 1. Driver's License with current FPS District Address. Must be provided within 7 days of enrollment.

____ 2. Three (3) of the following: tax bill, or closing papers, or lease with all occupants names printed on lease, and 2 utility bills (not water). Utility bills must be furnished within 30 days of occupancy and in occupant's name. If not received within 30 days of occupancy, student may be withdrawn from school.

____ 3. Birth Certificate – Certified Copy

____ 4. Record of Immunizations – Must list all dates with month/day/year – Waivers

____ 5. Guardianship papers

____ 6. Last IEP

Forms in this packet are for you to complete and bring back to us before your appointment:

____ 1. Release of Records Form.
____ 2. Enrollment Form filled out completely (3 pages)
____ 3. Health Information
____ 4. Residency Affidavit
____ 5. Consent to Release of Leasing Records (if applicable
____ 6. Medication Authorization Form (if applicable)
____ 7. Home Language and Race-Ethnicity Survey

Free & reduced lunch applications are available to complete on line or you can pick up a paper copy in the office.

Farmington PUBLIC SCHOOLS

ENROLLMENT FORM

PARENT

OFFICE

School & Year: | Grade/YOG:

Student ID#: | Entry Date:

Please print. Enter student's full name *exactly* as it appears on their birth certificate

Last Name	First Name	Middle Name	Suffix	Birth Date (mm/dd/yy)

Gender (M / F)

ETHNICITY: Is this of student Hispanic/Latino Ethnicity (Choose Only One):

O No, not Hispanic/Latino

O Yes, Hispanic/Latino (Cuban, Mexican, Puerto Rican, South or Central American, or other culture or origin, regardless of race.)

RACE: The previous question was regarding ethnicity, not race. No matter what you selected to the left, please answer the following by marking one or more boxes to indicate what you consider your student's (or your) race to be:

O American Indian O Asian O Black/African American

O Native Hawaiian/Other Pacific Islander O White

HOME LANGUAGE

Is the primary language in your home a language ***OTHER*** than English? **Circle one**

YES NO

If Yes, please note the language:

STUDENT PRIMARY LANGUAGE

Is your students' native tongue a language ***OTHER*** than English? **Circle one**

YES NO

If Yes, please note the language:

LEGAL BINDINGS: Please indicate any special circumstances regarding your child:

Home Phone w/Area Code

Type— Resident/Cell Etc.

☐ Unlisted ☐ Message Only

Entry Comment

Indicate District / School name & state of last school attended, and whether the student had an active IEP:

Has this child attended Farmington Schools? __ Yes ___ No

Does this child have an active IEP? __ Yes ___ No

Do you have any other children in your household enrolled at Farmington Public Schools? If so, please list their names below:

As the parent/legal guardian, my signature to the right, affirms all information provided within this form is true and accurate, and that my child and I reside at the listed address. I understand false information provided by me, may subject me to legal penalties for perjury.

Parent Signature **Date**

VERIFICATION CHECKLIST - FOR OFFICE USE ONLY

Birth Certificate: _____

- Other Proof & Affidavit: _____

Residency Verification: _____
(Determinative / Corroborative Type)

- Affidavit of Student Living w/Relative: _____
- Affidavit of Family Living w/ Friend/Relative: _____

Immunization Record: _____

Homeless: _____
(File paperwork w/Enrollment Office)

Custody Verification: _____
(If Applicable)

HmRm # / Teacher: or Counselor: _____

Verified / Entered By: _____

Verifier Title: _____

Farmington PUBLIC SCHOOLS

ENROLLMENT FORM

OFFICE | PARENT

Current Household Information / Student Residence

House # | Street Name | Apt - Box - Lot# Circle 1 | Zip Code | Geo Code

City

Preferred Mailing: To send mail to an address other than home address, provide mailing information

Membership | District of Residence (Not= 63030) & Residency Code | **Birthplace as appears on Birth Certificate:** List city of birth
***If city unknown—enter state. **If state unknown—enter country*

Citizenship (Not=USA) | Track & Year | Status (A/F/M/P) | Entry Date | Entry Code | Grade | Registration Date (Misc. Tab) | FTE if < 1

Restrictions/Publications: What data can be shared / used by the district?

☐ All Data / All Photos ☐ All Data / No Photos ☐ No Data / All Photos ☐ No Data / No Photos

Student Email Address

With Whom Does Your Child Reside?

☐ Both parents ☐ Mother Only ☐ Father Only
☐ Mother/Stepfather ☐ Guardian(s) ☐ Foster Parent(s)
☐ Father/Stepmother ☐ Other:_____

Contacts — Male / Guardian of Student (In Same Household Only)

Last Name | First Name | Middle Name & Suffix (Jr, III, etc.)

☐ Y / N Lives with Student? Yes, my address is the same as my child. If no, list address to the right.

Street Number & Name | Apt/Lot # etc. | City, State | Zip

Area Code | Primary / Home Phone | Area Code | Cell | Area Code | Work Phone

Male Parent / Guardian Email Address (General Tab)

Relationship to Student (Father, Stepfather, etc.)

Contacts — Female / Guardian of Student (In Same Household Only)

Last Name | First Name | Middle Name & Suffix (Jr, III, etc.)

☐ Y / N Lives with Student? Yes, my address is the same as my child. If no, list address to the right.

Street Number & Name | Apt/Lot # etc. | City, State | Zip

Area Code | Primary / Home Phone | Area Code | Cell | Area Code | Work Phone

Female Parent/Guardian Email Address (General Tab)

Relationship to Student (Mother, Stepmother, etc.)

Farmington PUBLIC SCHOOLS

ENROLLMENT FORM

PARENT | OFFICE

Parent Living Elsewhere

Complete the section below if the Shared or Non-custodial parent lives in a home other than the student.

Last Name | First Name | Middle Name & Suffix (Jr, III, etc.)

Street Number & Name | Apt/Lot # etc. | City, State | Zip

Area Code | Primary / Home Phone | Area Code | Cell | Area Code | Work Phone

Parent Elsewhere / Guardian Email Address (General Tab) | Relationship to Student (Mother, Father, etc.)

Other Adult Contacts

1

Last Name | First Name | Relationship to Student (Relative, Neighbor, etc.)

Street Number & Name | Apt/Lot # etc. | City, State | Zip

Area Code | Primary / Home Phone | Area Code | Cell | Area Code | Work Phone

2

Last Name | First Name | Relationship to Student (Relative, Neighbor, etc.)

Street Number & Name | Apt/Lot # etc. | City, State | Zip

Area Code | Primary / Home Phone | Area Code | Cell | Area Code | Work Phone

Emergency Information - Physician / Insurance information is optional and will only be used in cases of emergency.

List Health Alert Information (Health Module)

List medical conditions (allergies, health conditions etc.) or other information which you want teachers and office personnel to know. This information when entered, will be available for teachers to see in class on a secure desktop application.

☐ **This is a critical alert item**

By listing this information here, I agree to share this information with school officials. Parent/Guardian Initials _____

First and Last Name of Physician (Include phone number)

Preferred Hospital (include city where hospital is located)

Family Insurance Provider

Insurance Policy Number

Special Education
Release of Records

Farmington PUBLIC SCHOOLS

Serving Farmington, Farmington Hills, and West Bloomfield

Date of Request: _____

The purpose of this request is: *(please check one box)*

Complete name and address:

☐ **For Farmington Public Schools to release records or information to:** → **Name:** _____

Address: _____

– **OR –**

☐ **For Farmington Public Schools to receive records or information from:**

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

Address: _____

Specifically:

- ☐ **Educational Reports**
- ☐ **Medical Information**
- ☐ **Occupational Therapy Reports**
- ☐ **Physical Therapy Reports**
- ☐ **Psychological Evaluation**
- ☐ **Social History**
- ☐ **Speech Evaluation**
- ☐ **IEPT/MET**
- ☐ **OTHER:** _____
- ☐ _____

I hereby authorize you and/or your department to release information as indicated above concerning the named individual. Information received will be used solely for educational planning and will not be transferred to a third party without written permission from parents or legal guardian, licensed physician, registered nurse, social worker, school social agency, or other helping professionally qualified personnel whose training and/or information would be useful. The parental release of information and/or sending of school information is in compliance with Federal Public Law 93-380

Please send requested information to:

Farmington Public Schools
Visions Unlimited
33000 Freedom Rd
Farmington, MI 48336

Fax to: 248-489-3839
Attention: Dorene Forster/ Records

Printed Student Signature or Parent/Guardian if student is under 18: - _____ **Telephone No.:** _____

Signature of Student or Parent/Guardian if student is under 18: _____ **Date:** _____

School Personnel Signature: _____ **Building:** _____

The parental release of information and/or sending of school information is in compliance with Federal Public Law 93-380. Parents, Legal Guardians, or students of legal age may request a review and/or copy of the school records transferred. If this is desired, the school office should be notified. If you request a copy of the school records being transferred, the school is relieved of the responsibilities for confidentiality of those records.

Farmington Public Schools
Visions Unlimited

Form: Release 1f
Revised: 1/20/2021

Sent: ■**Yes** □**NO**

By: _____
staff

Phone: 248-489-3833
Fax: 248-489-3839
www.farmington.k12.mi.us

Farmington PUBLIC SCHOOLS

Department of Bilingual Education

HOME LANGUAGE AND RACE-ETHNICITY SURVEY

The Farmington Public School District is collecting information regarding the language background of its students. This information will be used by the District to determine the number of children who should be provided bilingual instruction pursuant to **Language Instruction for Limited English Proficient and Immigrant Students, Title III** of the No Child Left Behind Act. Please provide the following information:

Name of Student _____ Date of Birth _____

Last Name First Name

School Building _____ Grade _____

1. What is your child's Country of Birth? _____

   If other than U.S., date of arrival in the United States: _____

2. Is your child's native tongue a language *other than* English?

   ☐ Yes ☐ No What is the language? _____

3. Is the primary language* used in your child's home or environment a language *other than* English?

   ☐ Yes ☐ No What is the language? _____

**for this purpose, primary language is the dominant language used by a person for communication.*

Part A. **Is this student Hispanic/Latino?** (Choose only one)

No, not Hispanic/Latino

Yes, Hispanic/Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

The above part of the question is about ethnicity, not race. No matter what you selected above, **please continue to answer the following** by marking one or more boxes to indicate what you consider your student's race to be.

Part B. **What is the student's race?** (Choose one or more)

American Indian or Alaska Native (A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.)

Asian (a person having origins in any of the original peoples of the Far East, Southeast, Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam).

Black or African American (A person having origins in any of the black racial groups of Africa).

Native Hawaiian or Other Pacific Islander (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands).

White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa).

Signature of parent/guardian _____ Date _____

White Copy: Student CA-60 file
Yellow Copy: Bilingual Department

VISIONS UNLIMITED **2022-23 SCHOOL YEAR**

STUDENT EMERGENCY INFORMATION

Birthdate:_____

Student Name:_____ Home Phone:_____

Address:_____

(street) (city) (zip)

Please indicate the FIRST telephone number we should call in the event of an emergency:

_____ _____

Telephone Number Contact Name

Please list the student's parents, stepparents, guardians that child lives with. State relationship where applicable (i.e., father, stepmother, guardian*). *Guardianship papers must be on file in office.

Student Lives With:

1._____

Last Name First Relationship Place of Employment Day/Cell

2._____

Last Name First Relationship Place of Employment Day/Cell

Non-custodial parent information

Parent_____

Last Name First Number/Street City/Zip Day/Cell

Step-parent_____

Last Name First Number/Street City/Zip Day/Cell

Neighbors or relatives school may contact in case of emergency if parent/guardian cannot be reached:

_____

Name Relationship Day/Cell

_____

Name Relationship Day/Cell

HOSPITAL OF CHOICE (IN CASE OF EMERGENCY): _____

In case of serious illness or accident, if the school is unable to contact me, I hereby authorize the school authorities to use their best judgment on behalf of my child.

PLEASE FILL OUT BACK OF THIS FORM

Health Information

Particular health problems: e.g., Heart, Kidney, Orthopedic, etc. No_____ Yes_____ (Please specify) _____

Does student have seizures? No_____ Yes_____ (If yes, describe likely pattern) _____

Does student have allergies: If yes, please indicate below:

Medicine:_____
Foods:_____
Insects:_____
Pollen:_____
Others:_____

List all medications taken BOTH AT SCHOOL AND HOME

Name of Medicine:_____ Dosage:_____Time Administered:_____

Name of Medicine:_____ Dosage:_____Time Administered:_____

Name of Medicine:_____ Dosage:_____Time Administered:_____

Attach a list of additional medications, if necessary, including dosage and time administered.

Date of last physical examination:_____

Physician's Name:_____Phone:_____

Dentist's Name:_____Phone:_____

DATE OF ALL IMMUNIZATIONS *(If you submitted these records to Visions in the past, no need to send them in again.*

_____
_____
_____
_____
_____

Parent/Guardian Signature:_____Date:_____

Farmington Public Schools

BLANKET FIELD TRIP PERMISSION & MEDICAL CONSENT FORM
2022-23 SEASONAL ACTIVITIES

For students who are part of a school sponsored activity that takes place off home school property repeatedly (i.e. parks, museums, malls, farmer's market, Farmington Festival, walks to Farmington).

It will not be necessary for my son/daughter to have a permission form signed by me each time he/she leaves the home school to participate in the following activities.

_____has my permission to participate in the off-school site of
student's name

___Community Based Instruction_____ while at Visions Unlimited.
name of activity or class

PLEASE PROVIDE THE FOLLOWING HEALTH INFORMATION, IF APPLICABLE:

MEDICATION_____

ALLERGIES_____

SPECIAL HANDLING_____

PLEASE PROVIDE THE FOLLOWING MEDICAL INSURANCE INFORMATION:

INSURED'S NAME_____NAME OF INSURANCE _____

CONTRACT NUMBER_____GROUP NUMBER_____

In the event of an emergency and I cannot be reached, please contact the following person:

NAME_____RELATIONSHIP_____

PHONE(S)_____ _____

I recognize that while on a field trip, medical treatment on an emergency basis may be necessary, and I further recognize that school personnel may be unable to contact me for my consent for emergency medical care. Therefore, I do hereby consent in advance to such emergency care including hospital care as may be deemed necessary under the existing circumstances. In addition, I have discussed with my children the necessity of acting responsibly while on the trip.

In consideration of my child being able to participate in this event I relieve and hold harmless members of the Board of Education, its employees and agents for any claims, lawsuits and judgments arising out of the use and operation of a vehicle operated by my child or a vehicle operated by a fellow student, school employee or volunteer driver.

_____ _____ _____ _____ _____
Parent/Guardian Signature Home Phone Work Phone Cell Phone Date

(A COPY OF THIS COMPLETED FORM MUST BE IN THE POSSESSION OF TEACHER/SUPERVISOR WHILE ON EVENT)
Form ST07-4/06

Farmington PUBLIC SCHOOLS

VISIONS UNLIMITED

AUTHORIZATION FOR PHOTOGRAPHS
2022-23 SCHOOL YEAR

I AUTHORIZE VISIONS UNLIMITED TO TAKE AND USE PHOTOGRAPHS AND/OR VIDEORECORDINGS (INCLUDING NAMES) OF

MY STUDENT _____ FOR:
Student Name

PLEASE CHECK ALL APPROPRIATE BOXES TO GIVE PERMISSION

- ☐ VISIONS NEWSLETTERS, YEARBOOK
- ☐ PHOTOGRAPHS POSTED WITHIN THE BUILDING (BULLETIN BOARDS, etc.)
- ☐ VIDEORECORDING SCHOOL ACTIVITIES (i.e., TALENT SHOW)
- ☐ INSERVICE TRAINING RECORDINGS, SLIDES AND PHOTOGRAPHS
- ☐ SCHOOL WEBSITE
- ☐ LOCAL NEWSPAPER AND NEWSLETTERS

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

- ☐ I DO NOT AUTHORIZE ANY OF THE ABOVE OPTIONS FOR

MY STUDENT _____
STUDENT NAME

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

Farmington PUBLIC SCHOOLS

Visions Unlimited
33000 Freedom Rd
Farmington, Michigan 48336
248-489-3833

July 11, 2022

Dear Parents, Guardians, and/or Care Providers:

In order to be in compliance with the rules set forth by the State of Michigan and/or the Oakland County Intermediate School District, we must update our students' guardianship records. If you or someone else has full or partial guardianship of your student, we MUST have a copy of the court order on file. Please complete the form below:

Student: _____

Current Guardian Status:

_____ Full guardianship held by _____

(PLEASE ATTACH COURT ORDER)

_____ Partial guardianship held by _____

(PLEASE ATTACH COURT ORDER)

_____ Student is his/her own guardian

Again, if there is full or partial guardianship, PLEASE ATTACH A COPY OF THE COURT ORDER granting the guardianship so that we may include it in the student's file.

Thank you for your cooperation in this matter.

Sincerely,

Dorene M. Forster

Dorene Forster, MEd Principal

Farmington Public Schools

Consent for Disclosure of Immunization Information to Local and State Health Departments

Immunizations are an important part of keeping our children healthy. Schools and State and Local health departments must monitor immunization levels to ensure that all communities are protected from potentially life-threatening diseases and, if necessary, respond promptly to an emerging public health threat. It is important that disease threats be minimized through the monitoring of students being immunized.

Sharing immunization and personally identifiable information including the students name, Date of Birth, gender, and address with local and state health departments will help to keep your child safe from vaccine preventable diseases. The Family Educational Rights and Privacy Act (FERPA), 20 U.S.C. § 1232g, requires written parental consent before personally identifiable information from your child's education records is disclosed to the health department. If your child is 18 or over, he or she is an "eligible student" and must provide consent for disclosures of information from his or her education records.

You may withdraw your consent to share this information in writing at any time.

I authorize Visions Unlimited/Farmington Public School District to release my child's immunization record to the Michigan Department of Health and Human Services and Local Health Department. I understand this information will be used to improve the quality and timeliness of immunization services and to help schools comply with Michigan Law. This includes any immunization information and limited personally identifiable information from the school.

Student's Name:_____ Date of Birth: __/__/_

Signature of Parent/Guardian
or Eligible Student: _____Date:__/__/__

Printed Parent/Guardian
Name: _____

FARMINGTON PUBLIC SCHOOL

RESIDENCY AFFIDAVIT

I, _____, declare that I physically reside at _____, _____, Michigan, and I have no other residence other than that listed on this affidavit.

I also declare that I am in compliance with the State of Michigan General School Laws, which require that students attend school in the district which they live with their parents or legal guardians.

In order to affirm my residency in the Farmington Public School District, I have presented certain documents with my address to school officials. I declare that these documents are true and accurate and further, I am aware that the deliberate falsification of information for school attendance purposes is unlawful.

I am aware also of the policy of Farmington Public Schools, which is that if a student is found to have established residency in out district by using false or inaccurate information, the student will be immediately dismissed from school, and the parents or guardian of the student will be held liable for all costs incurred while the student was enrolled in the Farmington Public School District.

Student's Full name _____ Grade _____

Resides at _____,

Michigan 48 _____

Signed _____

Date _____

Complete next form only if:

- You are renting your place of residence

Farmington PUBLIC SCHOOLS

Consent to Release of Leasing Records Pursuant to All Residency and Residency Affidavits

I recognize that enrollment in Farmington Public Schools is limited to qualified residents of the Farmington Public School District. Therefore, I authorize my landlord, landlord's agent, employee, or my landlord's management company to release any and all leasing information requested by a representative of Farmington Public Schools to that representative including evidence that I reside on the premises, copies of lease agreements and termination thereof including eviction notices.

This release applies to all rental agreements including, but not limited to, apartments, condominiums, motel, hotel and Extended Stay.

Such information shall be used to establish residency in compliance with applicable Michigan Law and the Farmington Public Schools Policies and Procedures Manual.

Printed Name of Tenant or Lessee(s): _____

Signature of Tenant or Lessee: _____

Printed name of Landlord or Apartment Complex: _____

Phone #: _____, Address: _____

City: _____, Zip: _____

Other Occupants at Same Address	**Relationship to Lessee**
_____	_____
_____	_____
_____	_____
_____	_____

The above information is true to the best of my information, knowledge and belief and I consent to the release of the records set forth above.

_____, _____

Signature of Lessee(s) Signature of Lessee(s)

Witness: _____

Principal/Secretary

Complete next forms only if:

- Your student needs to take medication or may have medical needs during the school day

Farmington Public Schools

AUTHORIZATION FOR MEDICATION FORM

Dear Parent and physician:

PLEASE READ THE ATTACHED MEDICATION ADMINISTRATION GUIDELINES ON THE BACK OF THIS FORM.

PHYSICIAN PLEASE COMPLETE THE FOLLOWING:

Student Name_____

Name of Medication_____Dosage_____

Route Given_____Time_____

Start Date_____End Date_____

Student's diagnosis and reason for medication_____

_____

Adverse reactions or side effects_____

_____

Additional Comments_____

Students may self carry/administer (grades 6-12) only if authorized by the physician and parent/guardian.

-This student is both capable and responsible for self-administering this medication according to school policy

___No ___Yes-Supervised ___Yes-Unsupervised Physician Initials_____

-Student is authorized to self carry this medication:

___No ___Yes Parent/Guardian Initials_____

___Please indicate if you have provided additional information as an attachment.

I certify this student requires such medication be given during school hours and that no alternative schedule is medically advisable.

Physician Signature_____**Date**_____

Print Name_____Phone_____

Address_____

City/State_____Zip Code_____

Parent/Guardian Signature_____**Date**_____

**Return fax to: 248-489-3839 (Farmington Public Schools)

Farmington Public Schools
Medical Record Update

This form is required in order to certify the student for appropriate Special Education Services. It must me completed and signed by both the parent/guardian and physician.

Student Name:_____ **DOB:**_____

- Date of Last Physical Exam:_____
- Student Medical Diagnosis:_____

_____

_____

- Is this a lifelong diagnosis or will it be resolved with treatment/time:_____
- Medication (include prescription, over the counter, and herbal):_____

_____

_____

- Allergies (include all medication, food, seasonal, etc):_____

_____

- Up to Date Immunizations: Yes____ No____ (Please attach current immunization record)

- List of Medical Procedures (MRI, CT scan, swallow study, etc):_____

_____

_____

- Surgical History:_____

_____

_____

Please continue to other side to complete and sign this form

- Orthopedic Impairment: Yes____ No____

If yes, describe:_____

_____

- Neurological Impairment: Yes____ No_____

If yes, describe:_____

_____

- Hearing Impairment: Yes____ No____ Hear Aids: Yes____ No____

If yes, describe:_____

- Vision Impairment: Yes____ No____ Glasses: Yes____ No____

If yes, describe:_____

- Are there any other medical factors that the school should be aware of that might affect the student's

educational performance:_____

_____

_____

I certify that the information on the form is current and correct.

Physician Signature:_____Date:_____

Print Name:_____Phone:_____

Address:_____

City/State:_____Zip Code:_____

Parent/Guardian Signature:_____Date:_____

Please return this form to Farmington Public Schools, 33000 Freedom Road, Farmington, MI 48336
Phone: 248-489-3833 Fax: 248-489-3839

Farmington Public Schools

AUTHORIZATION FOR MEDICAL PROCEDURE

Parent/Physician:
Please read the **procedure guidelines on the back of this form** then complete, sign and return to school if you wish to authorize district staff to perform a specific medical procedure during school hours.

PHYSICIAN PLEASE COMPLETE:

Student's Name_____School_____

Medical Diagnosis and reason for procedure_____

_____

Type of Procedure:

- Oxygen Administration

Frequency_____ Rate of Delivery_____

- Oral Suction_____
- Tracheal Suction_____
- Tube Feeding: G-tube _____ J-Tube _____ Time (s) _____

Formula_____Amount_____

Bolus_____

_____

Gravity Drip_____ Bolus_____

- Urinary Catheterization: Catheter Size_____ Type_____

Frequency/Time_____

- Other Procedure_____

_____

Physicians Signature_____**Date**_____

Print Name_____**Phone**_____
Address_____
City/State_____**Zip**_____

Parent/Guardian Signature_____**Date**_____

Return fax to: 248-489-3839 (Farmington Public Schools)

School Year_____

ALLERGY ACTION PLAN (AAP)

Farmington Public Schools

Place Student Picture Here

(Face Only)

Student Name_____BD_____

School_____Grade_____Teacher_____

The back of this form must be signed and dated by both the parent and treating physician or licensed prescriber.

Parent Contact Information

Parent/Guardian_____Relationship_____

Home_____Cell_____Work_____ _____

Parent/Guardian_____Relationship_____

Home_____Cell_____Work_____ _____

Emergency Contact (If parent/guardian cannot be reached)

Name_____Relationship_____Phone_____

Allergic History

List all Foods student is allergic to: (If nuts, specify: Peanuts Tree Nuts Both)

_____ _____

List all Non-Food allergies (including: Insect stings, Latex, Medication, Exercise, etc.)

_____ _____

Does your child have Asthma? Yes___(higher risk of severe allergic reaction) No___

If yes, please complete a separate **Asthma Action Plan** and if needed an **Authorization for Medication Form**

Does your child have Eczema? Yes___ No___

History of Anaphylactic Reaction? Yes___ No___ Was an Epinephrine injection given? Yes___ No___

Comments_____ _____

MEDICATION/DOSES PRESCRIBED (Parent/Guradian is responsible for suppling all medication)

Antihistamine (Brand name and dose)_____

Location_____

Epinephrine (0.15mg Junior) (0.3mg Adult) (Brand:_____

Location_____

Please Note: Only Secondary (Grade 7-12) students may Self-Carry/Self-Administer Medication

This student is both capable and responsible to self-carry Epinephrine.

No___ Yes___ Physicians Initials_____

Note: If a student is to self-carry his/her epinephrine, help may still be needed to give the medication.

Student is authorized to carry this medication. Yes___ No___ Parent/Guardian Initials_____

If Student is to self-carry epinephrine, school will be supplied with a back up auto-injector. Yes___ No___

Extremely reactie to the following:_____

THEREFORE:

____If checked, give epinephrine immediately for ANY symptoms if the allergen was likely eaten.

____If checked, give epinephrine immediately if the allergen was definitely eaten, even if no symptoms are noted.

If ANY SEVERE SYPMTOMS after suspected or known ingestion (or contact, if allergen other than food)

One or more of the following:

LUNG: Short of breath, wheeze, repetitive cough

HEART: Pale, blue, faint, weak pulse, dizzy, confused

THROAT: Tight, hoarse, trouble breathing/swallowing

MOUTH: Obstructive swelling (tongue and/or lips)

SKIN: Many hives over body

Or combination of symtoms from different body areas:

SKIN: Hives, itchy rashes, swelling (eyes, lips, etc.)

GUT: Vomiting, diarrhea, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (See "monitoring" box below)
4. Give additional medication**
   If ordered such as: Antihistamine or Inhaler

*Antihistamines & Inhalers are not to be depended upon to treat a severe reaction (anaphylaxis). **USE EPINEPHRINE**

IF MILD SYMPTOMS ONLY:

Mouth: Itchy mouth

Skin: A few hives around mouth/face, mild itching

Gut: Mild nausea/discomfort

1. **Give Antihistamine**
2. Stay with student; Call parent/guardian
3. If symptoms progress:
   USE EPINEPHRINE (see above)
4. Begin monitoring (see below)

MONITORING: Stay with student; call 911 first then call parent/guardian

Note dose/time epinephrine administered and give information to EMS

A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur

Consider keeping student lying on back with legs raised (if vomiting roll student to his/her side)

Treat student even if parent/guardian cannot be reached.

I am in agreement and authorize the medication/plan as stated in both pages 1 and 2 of this *Allergy Action Plan*

Physicians Signature:_____ **Date:**_____

Print Physicians Name:_____ Phone:_____

Address:_____

City/State:_____ Zip Code:_____

Parent/Guardian Signature:_____ **Date:**_____

EPILEPSY FOUNDATION®
Not another moment lost to seizures

Seizure Action Plan

Effective Date

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student's Name _____ Date of Birth _____

Parent/Guardian _____ Phone _____ Cell _____

Other Emergency Contact _____ Phone _____ Cell _____

Treating Physician _____ Phone _____

Significant Medical History _____

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a seizure:

Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

Does student need to leave the classroom after a seizure? ❒ Yes ❒ No

If YES, describe process for returning student to classroom:

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

Emergency Response

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol
(Check all that apply and clarify below)

- ❒ Contact school nurse at _____
- ❒ Call 911 for transport to _____
- ❒ Notify parent or emergency contact
- ❒ Administer emergency medications as indicated below
- ❒ Notify doctor
- ❒ Other _____

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator?** ❒ Yes ❒ No If YES, describe magnet use:

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

DPC772

Seizure Action Plan

Effective Date

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student's Name | Date of Birth

Parent/Guardian | Phone | Cell

Other Emergency Contact | Phone | Cell

Treating Physician | Phone

Significant Medical History

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a seizure:

Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

Does student need to leave the classroom after a seizure? ❒ Yes ❒ No

If YES, describe process for returning student to classroom:

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

Emergency Response

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol
(Check all that apply and clarify below)

- ❒ Contact school nurse at _____
- ❒ Call 911 for transport to _____
- ❒ Notify parent or emergency contact
- ❒ Administer emergency medications as indicated below
- ❒ Notify doctor
- ❒ Other _____

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator?** ❒ Yes ❒ No If YES, describe magnet use:

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

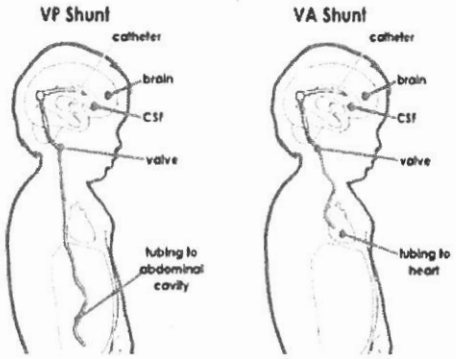
DPC772

Ventricular Shunt Action Plan

Student Name:_____DOB:_____

Does the student have a shunt? Yes___ No___ If yes what type: VP__ VA__

A ventricular shunt is a drainage tube inserted into the ventricular system of the brain. It allows excess cerebral spinal fluid to drain into a deposit site within the body. The deposit site or the opposite end of the drainage tube is usually within the peritoneal (abdominal) cavity (VP) but can also drain into the right atrium of the heart (VA) or the pleural space surrounding the lungs



In the event of a shunt malfunction, the excess cerebrospinal fluid is unable to drain and intracranial pressure builds. This can become life threatening so recognition and response to signs and symptoms of increasing intracranial pressure is vital.

Potential Warning Signs: Notify School Nurse/Parent

- Behavior-persistent irritability, personality changes, decline in school performance, lethargy/fatigue, uncontrollable/unusual crying or whining
- Digestive-complaints of stomach pain, nausea, loss of appetite, forceful or projectile vomiting not related to feeding
- Neurological-dizziness, complaints of headache, blurred vision (abnormal eye movements), seizures (or increased seizure activity)
- Shunt Tract-bulging, redness or fullness along the tract, complaints of stiff neck (unable or unwilling to bend head forward)

❖ **Call 911 immediately: If above warning signs are progressing quickly and/or student experiences loss of consciousness.**

If student experiences even a minor head or neck injury while at school staff should notify school nurse/parent. Carefully monitor for the above signs throughout the remainder or the school day and act accordingly.

Signing this form means you have read and agree to the information stated above. Please add any further information that you would like to add regarding your student:

_____

_____

Parent/Guardian Signature:_____**Date:**_____

Phone: (h)_____**(c)**_____