# 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 |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Attendance Plan (for DHH students only):**

Start Date: _____

Days of Attendance: ☐M ☐T ☐W ☐TH ☐F (circle)

☐Full Day ☐Part Day (circle)

If Part Day, list arrival time _____ departure time _____

EMERGENCY INFORMATION

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

Preferred Hospital:_____

---

**In-area emergency contacts when parents cannot be reached:**

*Emergency contacts will be asked for photo ID at pick up*

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:_____

CAOS | CARLE AUDITORY ORAL SCHOOL

Carle

**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. Authorized contacts will be asked for photo ID upon pick up.**

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

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

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

**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:**

_____ _____

Signature 1 Signature 2

The CAOS PTO publishes a family directory that is useful for planning events and activities with other CAOS families. If you would like to be included in this directory, please provide consent to provide the following information to the CAOS PTO:

Parent 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.

They create a second directory for all ECHO families birth to 21 years of age. You will have the opportunity to include your family's information in either or both directories.

_____ _____

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

_____ _____

Signature 1 Signature 2

# 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.<br><br>How would you like us to support your child in trying new foods? Please indicate your choice below:<br>☐ Encourage child to taste food before saying 'no thank you'.<br>☐ Child can say 'no thank you' without first tasting. |

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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, a 90 minute nap time 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.

_____ _____

Signature 1 Date

_____ _____

Signature 2 Date

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# 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 1 Date Signature 2 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 |
|---|---|---|
| | | |
| | | |
| | | |

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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.

# Biweekly Payment Timetable for 2024-2025

| Payment Dates: | |
|---|---|
| Aug 16 | Tuition Express deductions will occur on the dates listed. Tuition payments will be processed across 20 billing periods for the 2024-2025 school year, with two payments being processed monthly from August 2024 to May 2025. January 3, 2025 payment will be skipped. |
| Aug 30 | |
| Sep 13 | |
| Sep 27 | |
| Oct 11 | |
| Oct 25 | |
| Nov 8 | |
| Nov 22 | |
| Dec 6 | |
| Dec 20 | |
| Jan 17 | Regarding child care, families will need to anticipate child care needs for the months ahead. You will receive a child care form each month for the next month. Please complete and return these forms by the 1st of the month (before the coverage month). Once your child care needs have been determined, you will then be notified of the payment amounts for the following month. Please understand that biweekly deduction amounts will vary based on the amount of child care services utilized. June 2025 child care payments will be processed on June 6th and 20th. |
| Jan 31 | |
| Feb 14 | |
| Feb 28 | |
| Mar 14 | |
| Mar 28 | |
| Apr 11 | |
| Apr 25 | |
| May 9 | |
| May 23* | |
| *May 23 will be FINAL payment date for any remaining balances for the 2024-25 school year. | |
| | Summer camp charges will be processed on July 7th (due to holiday) and 18th. |

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Carle

# CAOS Tuition Policy Exception Request Form

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

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:

Signature 1:_____ Date:_____

Signature 2:_____ Date:_____

Staff Signature:_____ Date:_____

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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 # _____

Address _____

City _____ State _____ Zip _____

DEPOSITORY - Bank or Credit Union Name _____

Bank or Credit Union Address _____

City _____ State _____ Zip _____

Type: ☐ Checking ☐ Savings

**Routing Transit Number** (see sample below) _____

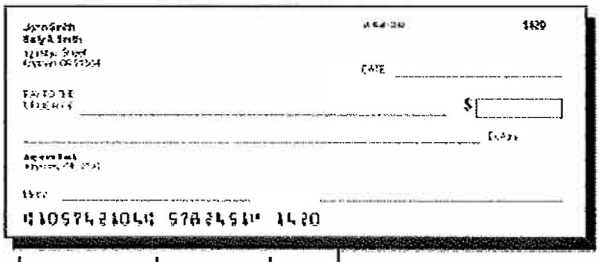
**Account Number** (see sample below) _____

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.

# Welcome to CAOS!

The Carle Auditory Oral School PTO would like to welcome you to CAOS! The CAOS PTO is a volunteer organization made up of parents, teachers, administrators, and support staff who are all dedicated to the education of our children. The PTO works to help make the school year enjoyable and exciting for all. Our purpose is to aid the students and staff by providing support for educational and recreational needs.

We enjoy getting to know all of our families and encourage you to not only join our organization, but to participate in our many events as well! Everything we do is based on volunteers and we are always looking for help and input to make a difference in the CAOS community. Many hands make the job easier.

You can participate and help us make this school year great! Our group meets monthly through Zoom, to discuss events, plan fundraisers, and share ideas. We would love to see and hear from you and we look forward to getting to know you, and your family.

If you have any questions or want more information, you can reach out via email, caospto@gmail.com. We are so excited you are here!

Sincerely,

The CAOS PTO

# 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: |

| How can you help make this year the best? |
|---|
| ☐ More information about joining CAOS PTO please. (Once a month meeting attendance not required, but appreciated.) |
| ☐ Feel free to check with me for volunteer opportunities. |
| ☐ I have a special skill or connection that could be helpful. (Ex. Graphic design, photography, other arts, event planning, grant writing, business sponsorship/ discounts, yoga certification, musician, fundraising, etc.) |
| ☐ Thank you for all you do, but it's just not my thing. |

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 (CAOS)

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: photos, videos, and/or audio recordings and transmissions of me/my child and reproductions of the same, beginning on date of enrollment at Carle Auditory Oral School.

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*

Carle

# Social Media Permission Form

Dear CAOS Parents,

CAOS has a private Facebook group, a public Facebook page, and an Instagram account.

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.

The public Facebook and Instagram accounts are 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. Individual and group photos and videos will be shared on these accounts. 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.

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 and videos in social media 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 members to be posted in:
_____ Individual and group photos and videos on the private Facebook group.
_____ Individual and group photos and videos on the public Facebook page and Instagram account.

No, please do not post my child/family member's photos or videos on the public CAOS Facebook page, Instagram account, or 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

If your child will be absent, please contact the school immediately and report the reason for your child's absence, sharing specific symptoms or diagnoses with your child's teacher, program director or the school voicemail box, so that we can inform other parents of symptoms to look out for.

Since COVID-19 has not gone away, school administration reserves the right to request a COVID test when children present with symptoms associated with COVID, or if there have been other COVID cases identified at the school within the past few weeks. We will contact the parent/guardian to request testing, if warranted.

COVID-19 ILLNESS POLICY

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
- Nausea or vomiting
- Diarrhea

Children will be excluded from school if they experience vomiting, diarrhea, or a fever of 100.4 degrees Fahrenheit. Children may return to school when they have been free from vomiting, diarrhea, and/ or fever for 24 hours without the aid of medication.

Additionally, children and staff will be asked to mask if they are exhibiting respiratory symptoms at school, in an attempt to reduce transmission of all respiratory illnesses

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 contact the school prior to returning to schedule 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.

Examples include, but are not limited to, being cranky, less active, crying, sleeping more, loss of appetite, generally uncomfortable, experience a stomach ache, headache, watery eyes, have trouble swallowing, etc. to the point that they are unable to engage in learning.

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.

# CAOS 2024-2025 School Supply List**

| Preschool (Label)** | Pre-K/ PK2 (Label)** | K/ Primary (Label) |
|---|---|---|
| 1 package of 10 count BOLD washable classic Markers^ | 1 package of 10 count BOLD washable classic Markers^ | 1 package of 8-count washable classic color markers (bold)^ |
| Nap mat & blanket** | Nap mat & blanket** | 1 package of 8-count washable classic color markers (skinny)^ |
| Fat Crayola® crayons | 1 box of 24-count Crayola® crayons^ | 1 box of 24-count Crayola® crayons^ |
| Backpack (11" x 15" minimum) | Backpack (11" x 15" minimum) | Backpack (11" x 15" minimum) |
| 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)** |
| 10 glue sticks | 10 glue sticks | 10 glue sticks |
| 2 bottles white school glue | 2 bottles white school glue | 2 bottles white school glue |
| Plastic pencil box | 1 pair of child's scissors | Plastic pencil box |
| 1 pair of child's rounded scissors | 2 bottles sunscreen (suggested Coppertone® Kids Continuous Spray ^^due to skin allergies) | 1 pair of child's scissors |
| 1 bottle sunscreen (suggested Coppertone® Kids Continuous Spray ^^due to skin allergies) | 1 large oversized t-shirt for art smock | 2 bottles sunscreen (suggested Coppertone® Kids Continuous Spray ^^due to skin allergies) |
| 1 large oversized t-shirt for art smock | 1 tray of watercolor paints^ | 1 large oversized t-shirt for art smock |
| Shaving cream | Play-Doh® - a pack of 3 large (4 oz) or more | 1 tray of watercolor paints^ |
| Play-Doh® - a pack of 3 large (4 oz) or more | 4 boxes of Kleenex® | Play-Doh® - a pack of 3 large (4 oz) or more |
| 4 boxes of Kleenex® | 4 packages unscented baby wipes (classroom use | 1 box colored pencils |
| 4 packages unscented baby wipes (classroom use) | 1 box Ziploc baggies quart size | 12 pack Ticonderoga pencils |
| 1 box Ziploc baggies quart size | 1 box Ziploc baggies gallon size | 4 boxes of Kleenex® |
| 1 box Ziploc baggies gallon size | 1 box Ziploc snack size baggies | 4 packages unscented baby wipes |
| 1 box Ziploc snack size baggies | 1 box Ziploc baggies sandwich size | 1 box Ziploc baggies quart size |
| 1 box Ziploc baggies sandwich size | 1 box Ziploc baggies 2 gallon size | 1 box Ziploc baggies gallon size |
| 2 gallon Ziploc bags | **If potty training, send diapers/velcro pull-ups and additional wipes** | 1 box Ziploc snack size baggies |
| **If potty training, send diapers/velcro pull-ups and additional wipes** | | 1 box Ziploc baggies sandwich size |
| | | 1 box Ziploc baggies 2 gallon size |
| | | **If potty training, send diapers/velcro pull-ups and additional wipes** |

^ Suggest Crayola® brand

^^Due to skin allergies

| Suggested School Donations | | | |
|---|---|---|---|
| White paper lunch bags | Food Coloring | Vegetable Oil | Aluminum foil |
| Napkins | Cornstarch | Cream of Tartar | Parchment paper |
| Flour | Standard white coffee filters | Salt | Sugar |
| Baking Soda | Brown paper lunch bags | Small thin white paper plates | Large thin white paper plates |
| | | | Unscented dye-free paraben free lotion in pump bottle |

**Nap mats (plastic and foldable that can be wiped down), pillows, blankets, and sleeping toy (if applicable) required for nappers.

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

We start to run out of tissues in the second half of the school year. We may request donation to replenish our supply.

CAOS | CARLE AUDITORY ORAL SCHOOL

Carle

X5499-0424

# State of Illinois
# Certificate of Child Health Examination

| Student's Name<br>Last First Middle | Birth Date<br>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<br>MO DA YR | DOSE 2<br>MO DA YR | DOSE 3<br>MO DA YR | DOSE 4<br>MO DA YR | DOSE 5<br>MO DA YR | DOSE 6<br>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?<br>Child wakes during night coughing? | Yes☐ No☐<br>Yes☐ No☐ | | Loss of function of one of paired organs? (eye/ear/kidney/testicle) | Yes☐ No☐ | |
| Birth defects? | Yes☐ No☐ | | Hospitalizations?<br>When? What for? | Yes☐ No☐ | |
| Developmental delay? | Yes☐ No☐ | | | | |
| Blood disorders? Hemophilia, Sickle Cell, Other? Explain. | Yes☐ No☐ | | Surgery? (List all.)<br>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 _____<br>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.<br>**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:<br>☐ Quick-relief medication (e.g. Short Acting Beta Agonist)<br>☐ 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

---

**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**
Illinois Department of Public Health

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

License Number _____

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.

Signature 1:_____ Date Signed:_____
Signature 2:_____ Date Signed:_____

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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<br>☐ Abstract<br>☐ Complete Stay<br>☐ History and Physical<br>☐ Consult(s)<br>☐ Progress Note(s)<br>☐ Operative Report(s)<br>☐ Discharge Summary<br>☐ Cardiology<br>☐ Reports ☐ Images | ☐ Immunization Record<br>☐ Laboratory Report(s)<br>☐ Pathology<br>☐ Report(s) ☐ Slides<br>☐ Radiology (X-ray)<br>☐ Reports ☐ Images<br>☐ Therapy Services<br>☐ Other_____<br>☐ Billing Records | ☐ Cardiology<br>☐ Reports ☐ Images<br>☐ Immunization Record<br>☐ Laboratory Report(s)<br>☐ Pathology<br>☐ Report(s) ☐ Slides<br>☐ Radiology (X-ray)<br>☐ Reports ☐ Images | ☐ Office Visits (Specify Provider)<br>_____<br>_____<br>☐ Emergency Department Visit(s)<br>☐ Home Care/Hospice<br>☐ One-Day Surgery<br>☐ Therapy Services<br>☐ Other _____<br>☐ 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.

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**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

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.

_____ Support child in wearing hearing device at least 10 hours per day, but preferably for 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 Attendance and Equipment Agreement for Students who are Deaf and Hard of Hearing

The following attendance and equipment agreement was developed so each student may receive optimal benefit from their enrollment at Carle Auditory Oral School. Please read this policy carefully and sign at the bottom of the form. If you have any questions, please discuss them with your child's teacher, therapist, or the director, Danielle Chalfant.

The educational/therapeutic services that students receive at Carle Auditory Oral School have the potential to dramatically change future outcomes for them. The full cost of providing these intensive, specialized, and individualized services is not affordable for most families. Therefore, we rely on donations and the support of other funding sources to keep the program running effectively. To ensure that we are fully maximizing our use of donated dollars and maintaining levels of productivity that will further enhance your child's education and therapy, families should demonstrate a strong commitment to the program and this can be done with consistent attendance, timely arrivals, and providing back-up equipment to ensure students have maximum auditory access while in attendance.

I/We agree:

1. To drop child off between scheduled times (unless enrolled in before care).
2. To pick child up between scheduled times (unless enrolled in after care).
3. To notify the school by 8:30 if child will be absent.
4. To notify the school as soon as you are aware the child will be tardy or leaving early.
5. That no more than three absences are expected each semester. A series of missed days due to an extended illness is considered one absence.
6. To provide back-up equipment (batteries, cables, headpieces, etc.)

Our educational programs are very intense and may exceed family needs and priorities. Often this mismatch is made obvious by inconsistent attendance, repeated late arrivals, and absence of back-up equipment, particularly batteries. If attendance and/ or tardiness become a problem, we will work with each family to design a program that better matches family needs and priorities.

I/We have read and understand the above policy. I/We agree to meet the terms of the policy outlined.

Signature 1 _____ Date _____

Signature 2 _____ Date _____

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Child's Name: _____

Child's Date of Birth: _____

☐ Carle Foundation Hospital ECHO / CAOS
☐ Carle Physician Group_____
☐ Champaign Surgery Center_____
☐ Danville Surgery Center_____
☐ Carle Hoopeston Regional Health Center_____
☐ Carle Richland Memorial Hospital_____
☐ Carle BroMenn Medical Center_____
☐ Carle Eureka Hospital_____

# INFORMED CONSENT FOR TELEHEALTH CONSULTATION - ECHO/CAOS

CONSENT

## UNDERSTANDING AND ACKNOWLEDGMENT

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 to and/or a telehealth session with** ECHO / CAOS staff *(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.

## CONSENT FOR TREATMENT

| *Signature of Patient or Authorized Person* | *Date* | *Time* |
|---|---|---|
| *Signature of Witness* | *Date* | *Time* |

## INTERPRETER SERVICES

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

| *Interpreter Name (print full name)* | *Badge #* | *Date* | *Time* |
|---|---|---|---|
| *Signature (or if remote source, indicate company used)* | | | |

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# One Drive Permission Form

Dear CAOS Parents,

CAOS staff created the CAOS One Drive to be an online location where parents and staff can collaborate, share materials and updates with one another. Please sign below to give permission for the creation of a folder for your child. Once permission is granted, access to that folder will be shared with the child's team (i.e., parents, deaf educator, and therapists). Each member of the team can read information, add their own updates and provide input into goal selection. This collaboration used to occur on the Google Drive but has now shifted to Microsoft One Drive.

If you choose to opt out of the CAOS One 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 One Drive, that the 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 One Drive is outside Carle's encrypted network, but is protected by Microsoft 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 One Drive for the coming school year.

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

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# CAOS Child Care Costs

Child care includes care provided before school, after school, and on days that school is not in session. Child care sign up forms are sent home at the beginning of each month to reserve care for the following month. Forms are due back by the 1st of each month to reserve care for the following month. Care that is requested after the 1st of the previous month will be charged at the drop-in rate, which is $1 more than the charges listed below.

## Child Care Costs for First Child 2024-2025

| | Number of Days Care is Available | | | Annual Cost | Monthly Cost | Biweekly Cost | Daily Cost |
|---|---|---|---|---|---|---|---|
| **Before Care on School Days ($7.74/day)**<br>Once reserved, care charges are non-refundable.<br>(7 - 9 a.m. drop off any time in this range for this cost.) | 200 | | | $1548.00 | $154.80 | $77.40 | $7.74 |
| **After Care on School Days ($11.46/day)**<br>Once reserved, care charges are non-refundable.<br>(3 - 5:15 p.m. pick up any time in this range for this cost.) | 199 | | | $2280.54 | $228.05 | $114.03 | $11.46 |
| ***Choose Your Own Hours Care ($6.80/ hour)**<br>Families might consider this option if they need care for a short time before and after school. Family provides exact times care is needed, CAOS office staff will round up to the next hour and bill reserved care at an hourly rate. For example, a family needing care from 8 - 8:40 and 3 - 4:15 would be billed for 2 hours of hourly care, $13.60, rather than paying for both before care ($7.74) and after care ($11.46), $19.20.<br>Once reserved, care charges are non-refundable. | # of hours | # of days | Total Extended Care Hours | Annual Cost | Monthly Cost | Biweekly Cost | Daily Cost |
| | 2 | 199 | 398 | TBD | TBD | TBD | *per hour rate $6.80 |
| **Summer Camp ($56.81/day)**<br>Open for 17 days in July. Hours of Summer Camp are 7 a.m. - 5:15 p.m. | 17 | | | N/A | $965.85 | N/A | $56.81 |

*Your actual cost will be determined by the amount, timing and type of child care you reserve.

Tuition billing is processed every two weeks on Fridays. Automatic payments through Tuition Express are deducted at this time.

To ensure a safe environment for the children and staff, child care staffing is based on the number of children reserving care each month. As space allows, we will be happy to accommodate unexpected needs for child care throughout the semester. Please communicate directly with the school office to determine whether ratios allow for your child to be safely included in child care on any given day. The best way to ensure that your child will be guaranteed a spot in child care is to reserve your child care needs each month by the child care sheet submission deadline.

Reserved care will be billed at the rates listed above in your bi-weekly child care automatic payment. Any care that is not reserved by the child care form submission deadline, the 1st of each month, will be due by drop-off the day after care is provided.

Carle employees receive a 10% discount for each child who attends Carle Auditory Oral School. The sibling discount is available to Carle employees, though it should be noted that the ten percent sibling discount is calculated after the employee discount is applied.

**Sibling Discounts** - All families will receive 10% off tuition, before care and after care for any additional children attending the school.

Child Care Resource Service offers financial support so that families with lower incomes can access high quality programs for their children while they work or attend school. Our school is credentialed with CCRS. Individual families can apply to CCRS to determine whether their income and family size qualifies for CCRS support. Eligible families will be assigned a monthly family co-pay. The CCRS payment, and assigned co-pay, are deducted from the cost of attendance. The family pays the difference between the full cost and the CCRS payment and co-pay. For example, if CCRS paid $35/day, and the family co-pay covered $5/day, the family would be responsible for the remaining $16.81/day for summer camp costs.

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## Child Care Costs for Additional Children 2024-2025

| | Number of Days Care is Available | | | Annual Cost | Monthly Cost | Biweekly Cost | Daily Cost |
|---|---|---|---|---|---|---|---|
| **Before Care on School Days ($6.97/day)**<br>Once reserved, care charges are non-refundable.<br>(7 - 9 a.m. drop off any time in this range for this cost.) | 200 | | | $1,394.00 | $139.40 | $69.70 | $6.97 |
| **After Care on School Days ($10.02/day)**<br>Once reserved, care charges are non-refundable.<br>(3 - 5:15 p.m. pick up any time in this range for this cost.) | 199 | | | $1,993.98 | $199.40 | $99.76 | $10.02 |
| ***Choose Your Own Hours Care ($6.12/ hour)**<br>Families might consider this option if they need care for a short time before and after school. Family provides exact times care is needed, CAOS office staff will round up to the next hour and bill reserved care at an hourly rate. For example, a family needing care from 8 - 8:40 and 3 - 4:15 would be billed for 2 hours of hourly care, $12.24, rather than paying for both before care ($6.97) and after care ($10.02), $16.99.<br>Once reserved, care charges are non-refundable. | # of hours | # of days | Total Extended Care Hours | Annual Cost | Monthly Cost | Biweekly Cost | Daily Cost |
| | 2 | 199 | 398 | $2435.76 | $243.58 | $121.79 | *per hour rate $6.12 |
| **Summer Camp ($51.13/day)**<br>Open for 17 days in June / July. Hours of Summer Camp are 7 a.m. - 5:15 p.m. | 17 | | | N/A | $869.21 | $434.61 | $51.13 |

*Your actual cost will be determined by the amount, timing and type of child care you reserve.

# 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.

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