



2010 Extended School Year Information

Eligibility: A student’s eligibility is determined at a student’s IEP meeting.

Required Documentation on the IEP: According to the new Illinois regulations, there must be a statement in a student’s IEP as to whether the child requires extended school year services in order to receive a free appropriate public education and, if so, a description of those services that includes their amount, frequency, duration, and location.

ESY Programs:	SASED ESY Programs:
Locations:	Southeast School 6S 331 Cornwall Road, Naperville Prairieview School , District 66 699 Plainfield Road, Downers Grove Westmont Transition Center 825 N. Cass Ave., Suite 117, Westmont
Times and Dates:	July 6 – July 30, 2010 19 days from 8:30 am. - noon REGISTRATION DEADLINE - FRIDAY, May 14, 2010
Contacts:	Shannon Cribaro – scribaro@sased.org Laura Neal – 630 778-4502

Low Incidence Programs:	VI/DHH ESY Programs:
Location:	Swartz School , District 48 17W- 160 16 th Street, Oakbrook Terrace
Times and Dates:	July 6 – July 30, 2010 19 days from 8:45 am. – 12:15 p.m. REGISTRATION DEADLINE - FRIDAY, May 14, 2010
Contacts:	Joan Allison – jallison@sased.org Kim Dunk - 630 834-0694

Medication: If your child requires medication to be administered during the ESY program, you must complete the “School Medication Permission” form which must be signed by a physician and submitted with the medication in its original container.

Transportation: Transportation will be coordinated between the districts and the ESY program. If the student moves over the summer, it is the parent’s responsibility to register in the new district so that a determination can be made as to whether or not the student can participate in the SASED ESY programs.

School Checklist: (You must attach the following documents with the application.)

- _____ ESY application form
- _____ Current IEP
- _____ Behavior Management Plan (if applicable)
- _____ Emergency Health Care Plan (if applicable)
- _____ Transition Form

SASED
School Association for Special Education in DuPage
EXTENDED SCHOOL YEAR PROGRAM INFORMATION FORM

(Circle Services and Disabilities)

Related Services: (Must be on IEP)

OT PT S/L T.A. 1:1 T.A. Share Classroom T.A. Medical Assistant Bus Aide Other: _____

Disability: HI VI PH Autism DD ED CD OHI OI LD TBI MD

SASED Program: _____ Yes _____ No Specify: _____

Current Teacher: _____ School: _____

******IMPORTANT**** A COPY OF STUDENT'S IEP SHOULD BE SENT WITH THIS INFORMATION TO:
 LAURA NEAL, SASED CENTRAL OFFICE, 6S331 CORNWALL ROAD, NAPERVILLE, IL 60540-3699 FOR
 MULTI NEEDS/DISTRICT PROGRAMS OR KIM DUNK, 1110 SOUTH VILLA AVENUE,
 VILLA PARK, IL 60181 FOR VI/DHH/PH PROGRAMS.**

Participant's Name: _____ District: _____

Age: _____ Date of Birth: _____ Sex: _____

Address: _____ City: _____ Zip: _____

Parent's Names: _____ Home Phone: _____

Work Phone (Mom): _____ Cellular Phone: _____ Pager: _____

Work Phone (Dad): _____ Cellular Phone: _____ Pager: _____

Emergency Contact: _____ Phone: _____

Address: _____ City: _____

Doctor's Name: _____ Phone: _____

GROUP HOME CLIENTS

Case Manager: _____ Work Phone: _____ Pager: _____

Case Worker: _____ Work Phone: _____ Pager: _____

***TRANSPORTATION**

NO TRANSPORTATION NEEDED _____

CHILD CARE: (Indicate child care only if participant is to be picked up or dropped off at an address {within your District} other than home address.)

Babysitter/Child Care: _____ Phone: _____

Address: _____ City: _____

List Days at Different Address: _____

List if pick-up and/or drop-off is at different address: _____

Special Transportation Needs: (must be on IEP)

Ramp _____ Vest _____ (Child's Weight _____) Bus Aide _____ Med. Asst. _____ A/C Bus _____

The following individuals are authorized to pick-up my child:

Name: _____

Name: _____

***Transportation for SASED Low Incidence ESY Program will be solely handled by the districts.**

Participant's Name: _____

District: _____

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PHYSICAL HEALTH:

	YES	NO	COMMENTS:
Asthma:	_____	_____	_____
Blood clotting disorder:	_____	_____	_____
Chronic illness:	_____	_____	_____
Diabetes:	_____	_____	_____
- Controlled by diet, injections?	_____	_____	_____
Down Syndrome:	_____	_____	_____
Down ASC testing:	_____	_____	_____
Heart condition:	_____	_____	_____
Shunt:	_____	_____	_____

PHYSICAL IMPAIRMENTS:

	YES	NO	COMMENTS:
Manual wheelchair:	_____	_____	_____
Electric wheelchair:	_____	_____	_____
Stroller:	_____	_____	_____
Walker:	_____	_____	_____
Cane/crutches:	_____	_____	_____
Prosthetic Device:	_____	_____	_____
AFO's	_____	_____	_____
Removal from chair for activity:	_____	_____	_____
Special Positioning:	_____	_____	_____

SEIZURES:

	YES	NO	COMMENTS:
Tonic-Clonic (Grand Mal):	_____	_____	_____
Absence (Petit Mal):	_____	_____	_____
Complex Partial (Temporal Lobe):	_____	_____	_____
Myoclonic:	_____	_____	_____
Other:	_____	_____	_____
Aware of impending seizure:	_____	_____	_____
Care required during/after seizure:	_____	_____	_____
Behavior after seizure:	_____	_____	_____

PERSONAL/PHYSICAL REQUIREMENTS:

	YES	NO	COMMENTS:
Assistance eating:	_____	_____	_____
Assistance toileting:	_____	_____	_____
Assistance dressing:	_____	_____	_____
Bowling ramp:	_____	_____	_____

Participant's Name: _____

District: _____

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Please check the appropriate blank. If "Yes", provide additional information.

ALLERGIES:

	YES	NO	COMMENTS
Food:	_____	_____	_____
Medications:	_____	_____	_____
Insect Bites	_____	_____	_____
Other:	_____	_____	_____
Describe reactions:			_____

DIETARY:

	YES	NO	COMMENTS:
Restricted Diet:	_____	_____	_____
Unusual Eating Habits:	_____	_____	_____
Favorite foods:			_____
Least favorite foods:			_____

BEHAVIOR AND COMMUNICATION:

Complies with verbal requests/ directions:	YES / NO
<i>Comments:</i> _____	
Responds to specific verbal/ non-verbal directions:	YES / NO
<i>Comments:</i> _____	
Responds to reinforcement device:	YES / NO
<i>Comments:</i> _____	
Responds to specific behavior techniques:	YES / NO
<i>Comments:</i> _____	
Communication board:	YES / NO
<i>Comments:</i> _____	
Facilitated communication:	YES / NO
<i>Comments:</i> _____	
Alternative communication:	YES / NO
<i>Comments:</i> _____	

SOCIAL SKILLS:

Favorite Activities:	_____
Least Favorite Activities:	_____
Indicate friends attending SASED:	_____

Participant's Name: _____

District: _____

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VISUAL IMPAIRMENTS:

	YES	NO	COMMENTS:
Glasses:	_____	_____	_____
Prosthetic Eye:	_____	_____	_____
Cane User:	_____	_____	_____

HEARING IMPAIRMENTS:

	YES	NO	COMMENTS:
Hearing Aids (right, left, both):	_____	_____	_____
Reads Lips:	_____	_____	_____
Cochlear Implants:	_____	_____	_____

CONSENT:

	YES	NO
Field Trip/Community Experiences	_____	_____
Publicity Photo Permission:	_____	_____
Permission to participate in ESY:	_____	_____

I recognize and acknowledge that there are certain risks of physical injury in connection with my child attending the ESY programs. I hereby fully release or discharge SASED, and its officers, agents, employees, and volunteers from any and all claims from injuries, damages, and losses the participant may have, arising out of, connected with, incidental to, or in any way associated with the participation in ESY programs. I further agree to indemnify, hold harmless, and defend SASED and its officers, agents, employees, and volunteers from any and all claims resulting from injuries, damages, and losses sustained by the participant and arising out of, connected with, incidental to, or in any way associated with my child participating in the SASED ESY programs.

Parent's Signature: _____ Date: _____

Please list any information that would aid our staff in ensuring a safe and enjoyable program for him/her. Remember, the more you tell SASED, the better we can meet each participant's needs.

Coordinator's Signature _____ Date: _____

Participant's Name: _____

District: _____

MEDICATION INFORMATION

CURRENT MEDICATIONS:

List all current medications:

Drug Name	Dose	Time	Reason	Side Effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Will any of these medications listed above need to be given during school hours? Yes No

If any of these medications will need to be given during summer school hours, a physician signature is required.

Physician's Signature: _____ Date: _____

Will your child require a Gastrostomy Tube Feeding or water flush during summer school hours? Yes No

If yes, complete the section below.

Tube Feeding Type: _____ Amount/hour: _____

Amount of water flush: _____ Time tube feeding is to be given: _____

Does your child have an emergency health care plan in place? Yes No

If yes, please attach with registration papers.

I understand that it is my responsibility to give the medication directly to SASSED staff with full instructions in original prescription bottles. In all cases, medication dispensing can only be changed or modified by amending this form. I hereby acknowledge that the above information provided for the dispensing of medication for the participant is accurate. I also understand that it is my responsibility to inform SASSED if any changes in the dispensing of medication occur.

In all cases the recommended dosage of any medication will not be exceeded. If after administering medication there is an adverse reaction, I give my permission to SASSED to secure from any licensed hospital physician and/or medical personnel any treatment deemed necessary for immediate care. I agree to be responsible for payment of any and all medical services rendered.

I recognize and acknowledge that there are certain risks of physical injury in connection with the administering of medication to the participants. In consideration of SASSED administering medication, I hereby fully release or discharge SASSED, and its officers, agents, employees, and volunteers from any and all claims from injuries, damages, and losses the participant may have, arising out of, connected with, incidental to, or in any way associated with the administering of medication. I further agree to indemnify, hold harmless, and defend SASSED and its officers, agents, employees, and volunteers from any and all claims resulting from injuries, damages, and losses sustained by the participant and arising out of, connected with, incidental to, or in any way associated with the administering of medication.

Parent's Signature: _____ Date: _____

****This form must be signed and returned with Parent Information Form.****

**EXTENDED SCHOOL YEAR PROGRAM
IMPORTANT INFORMATION & WARNING OF RISK**

SEASPAR is committed to conducting its recreational activities in a safe manner and holds the safety of participants in high regard. SEASPAR continually strives to reduce such risks and insists that all participants follow safety rules and instructions that are designed to protect the participant's safety. However, participants and parents/guardians of minors registering for activities must recognize that there is an inherent risk of injury when choosing to participate.

You are solely responsible for determining if you or your minor child/ward is physically fit and/or skilled for the activities contemplated by this agreement. It is always advisable, especially if the participant is pregnant, disabled in any way, recently suffered an illness, injury, or impairment, to consult a physician before undertaking any physical activity.

Warning of Risk

Recreational activities are intended to challenge and engage the physical, mental, and emotional resources of the participant. Despite careful and proper preparation, instruction, medical advice, conditioning, and equipment, there is still a risk of serious injury when participating in any recreational activity. Understandably, not all hazards and dangers can be foreseen. Depending on the particular activities, participants must understand that certain risks, dangers, and injuries due to inclement weather, slipping, falling, poor skill level or conditioning, carelessness, horseplay, unsportsmanlike conduct, premises defects, inadequate or defective equipment, inadequate supervision, instruction, or officiating, and all other circumstances inherent to indoor and outdoor recreation activities exist. In this regard, it must be recognized that it is impossible for SEASPAR and SASSED to guarantee absolute safety.

Waiver and Release of All Claims and Assumption of Risk

Please read this information carefully and be aware that in signing up and participating in activities, you will be expressly assuming the risk and legal liability and waiving and releasing all claims for injuries, damages, or loss which you or your minor child/ward might sustain as a result of participating in any and all activities connected with and associated with these activities (including transportation services/vehicle operation, when provided).

I recognize and acknowledge that there are certain risks of physical injury to participants in these activities, and I voluntarily agree to assume the full risk of any and all injuries, damages, or loss, regardless of severity, that my minor child/ward or I may sustain as a result of said participation. I further agree to waive and relinquish all claims my minor child/ward or I may have (or accrue to my child/ward or me) as a result of participating in these activities against SEASPAR and SASSED, including their officials, agents, volunteers, and employees (hereinafter collectively referred as "parties").

I do hereby fully release and forever discharge the parties from any and all claims for injuries, damages, or loss that my minor child/ward or I may have or which may accrue to me or my minor child/ward and arising out of, connected with, or in any way associated with these activities.

I understand that SEASPAR carries no medical insurance and the participant's family must cover any medical costs incurred. I have read and fully understand the above important information, warning of risk, assumption of risk and waiver, and release of all claims.

Student: _____
(Print Name)

District: _____

Parent's Signature: _____

Date: _____

Participant's Signature _____
(18 or older or Parent/Guardian):

Date: _____