



T S B V I

TEXAS SCHOOL FOR THE BLIND AND VISUALLY IMPAIRED

STUDENT MEDICAL / DIETARY HISTORY FORM

Information for Parent: So that we can safely care for your child, please provide complete and specific information on every question. If a section does not apply, you must check that there are no such conditions before going to the next section. If we do not have this form by the February 14 deadline, your application will be considered late. This form is required for every student without exception, even if the student already attended TSBVI at an earlier time.

Student Name: _____ Today's Date: _____

Date of Birth: _____

STUDENT MEDICATIONS

If your child is accepted, he or she must bring all prescription medications in their original pharmacy container.

Prescription Medication		
Prescription	Dosage	When to Administer (Frequency & Time)

Vitamins and Other Supplements		
Name	Dosage	When to Administer (Frequency & Time)

EYES

Please describe your child's eye condition, including when it began or when you became aware of it, and how your child is affected by the vision loss, to the best of your knowledge. (Example 1: My child has retinitis pigmentosa. My child began to lose his vision at age 16. He has lost most of his vision but still has some central vision. Example 2: I do not know the cause of my child's vision problems. She seems to see some light.)

- Describe below any conditions or any changes:
- No eye conditions (Go to next Section: Communicable Diseases)

Please check below

My child has glasses:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
My child has contact lenses:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, in which eye(s)?	<input type="checkbox"/> Right Eye	<input type="checkbox"/> Left Eye
My child has prosthetic (artificial) eyes:	<input type="checkbox"/> Yes	<input type="checkbox"/> No;
If yes, which eye(s):	<input type="checkbox"/> Right Eye	<input type="checkbox"/> Left Eye

CONDITIONS AND DISEASES (PAST AND CURRENT)

➔ You do not need to include any information about medications or vitamins. Information about medications and vitamins will be covered in a later section.

COMMUNICABLE DISEASES		
<p>➤ If your child <u>has not</u> previously attended a TSBVI Short-Term or Summer Program please complete all information below:</p> <p>➤ If your child <u>has</u> attended a Short-Term or Summer Program, indicate one of the following:</p> <p><input type="checkbox"/> My child has none of the following conditions. (Go to next section: Gastrointestinal)</p> <p><input type="checkbox"/> Describe below any conditions or changes:</p>		
Name of Condition or Disease	Has the student had the disease?	Describe Complications, Long-Term Effects, Ongoing Treatment or Other Important Information.
Chickenpox (varicella)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Measles (rubella)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diphtheria	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Whooping Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Meningitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Encephalitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	
AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cytomegalovirus (CMV)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hepatitis A	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hepatitis B	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hepatitis C	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hepatitis (other form): _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	

GASTROINTESTINAL

- If your child has not previously attended a TSBVI Short-Term or Summer Program, complete all information below, or check: No needs in this area
- If your child has attended a Short-Term or Summer Program, indicate one of the following:
 - My child has none of the following conditions. (Go to next section: Muscle, Bone)
 - Describe below any conditions or changes:

Type of Problem	Does the Student Have a Problem in This Area?	Describe Complications, Long-Term Effects, Ongoing Treatment or Other Important Information (e.g., Colostomy, Urostomy, feeding, "G" Tube)
Chewing or Swallowing Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Frequent Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Frequent Constipation	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Recurring Hemorrhoids	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Encopresis (involuntary bowel movement)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other:		

MUSCLE, BONE

- If your child has not previously attended a TSBVI Short-Term or Summer Program, complete all information below, or check: No needs in this area
- If your child has attended a Short-Term or Summer Program, indicate one of the following:
 - My child has none of the following conditions. (Go to next section: Respiratory)
 - Describe below any conditions or changes:

Type of Problem	Does the Student Have a Problem in This Area?	Describe Complications, Long-Term Effects, Ongoing Treatment or Other Important Information (e.g., orthopedic aids: walker, wheelchair, cane)
Joint Pain or Stiffness	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Missing Arm, Leg, Finger, Toe	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other:		

RESPIRATORY

- If your child has not previously attended a TSBVI Short-Term or Summer Program, complete all information below, or check: No needs in this area
- If your child has attended a Short-Term or Summer Program, indicate one of the following:
 - My child has none of the following conditions. (Go to next section: Blood, Heart)
 - Describe below any conditions or changes:

Type of Problem	Does the Student Have a Problem?	Describe Complications, Long-Term Effects, Ongoing Treatment or Other Important Information (e.g., tracheotomy)
Frequent Colds, Coughs, Sore Throats	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Reactive Airway Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other:		

BLOOD, HEART, AND CIRCULATORY

- If your child has not previously attended a TSBVI Short-Term or Summer Program, complete all information below, or check: No needs in this area
- If your child has attended a Short-Term or Summer Program, indicate one of the following:
 - My child has none of the following conditions. (Go to next section: Endocrine)
 - Describe below any conditions or changes:

Type of Problem	Does the Student Have a Problem?	Describe Complications, Long-Term Effects, Ongoing Treatment or Other Important Information (e.g., Stint)
Prolonged Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Bruises Easily	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hypertension	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sickle Cell Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other:		
Has your child ever had a blood transfusion? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe circumstances:		

ENDOCRINE

- If your child has not previously attended a TSBVI Short-Term or Summer Program, complete all information below, or check: No needs in this area
- If your child has attended a Short-Term or Summer Program, indicate one of the following:
 - My child has none of the following conditions. (Go to next section: Skin)
 - Describe below any conditions or changes:

Type of Problem	Does the Student Have a Problem in This Area?	Describe Complications, Long-Term Effects, Ongoing Treatment or Other Important Information
Thyroid or Pituitary Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Acanthosis Nigricans (define?)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diabetes Type I or II	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diabetes Insipidus	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hypoglycemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other:		

SKIN

- If your child has not previously attended a TSBVI Short-Term or Summer Program, complete all information below, or check: No needs in this area
- If your child has attended a Short-Term or Summer Program, indicate one of the following:
 - My child has none of the following conditions. (Go to next section: Nervous System)
 - Describe below any conditions or changes:

Type of Problem	Does the Student Have a Problem in This Area?	Describe Complications, Long-Term Effects, Ongoing Treatment or Other Important Information
Eczema	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other:		

NERVOUS SYSTEM, NEUROLOGICAL

- If your child has not previously attended a TSBVI Short-Term or Summer Program, complete all information below, or check: No needs in this area
- If your child has attended a Short-Term or Summer Program, indicate one of the following:
 - My child has none of the following conditions. (Go to next section: Bladder, Kidney, Liver)
 - Describe below any conditions or changes:

Type of Problem	Does the Student Have a Problem?	Describe Complications, Long-Term Effects, Ongoing Treatment or Other Information
Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Last Seizure: _____ Description of Seizures: Frequency: _____ Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No
Cerebral Palsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cystic Fibrosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Muscular Dystrophy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Multiple Sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Traumatic Brain Injury (TBI)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Tourette's Syndrome	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other:		
If you checked "yes" in any box, has your child ever had a neurological exam? If so, when: _____		
Does your child have a shunt? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both Sides		
Is the shunt(s) currently functioning? <input type="checkbox"/> Yes <input type="checkbox"/> No		

BLADDER, KIDNEY, LIVER

- If your child has not previously attended a TSBVI Short-Term or Summer Program, complete all information below, or check: No needs in this area
- If your child has attended a Short-Term or Summer Program, indicate one of the following:
 - Has none of the following conditions (Go to next section: Behavioral, Psychological)
 - Describe below any conditions or any changes:

BLADDER, KIDNEY, LIVER (continued)		
Type of Problem	Does the Student Have a Problem in This Area?	Describe Complications, Long-Term Effects, Ongoing Treatment or Other Important Information
Urination Problems (pain, burning, frequency)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Bedwetting	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Enuresis (involuntary urination)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other:		

CANCER		
<p>➤ If your child <u>has not</u> previously attended a TSBVI Short-Term or Summer Program, complete all information below, or check: <input type="checkbox"/> No needs in this area</p> <p>➤ If your child <u>has</u> attended a Short-Term or Summer Program, indicate one of the following:</p> <p><input type="checkbox"/> My child has none of the following conditions. (Go to next section: Allergies)</p> <p><input type="checkbox"/> Describe below any conditions or changes:</p>		
Type	Does the Student Have a Problem in This Area?	Describe Complications, Long-Term Effects, Ongoing Treatment or Other Important Information
Leukemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Retinoblastoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other:		

ALLERGIES		
<p>➤ If your child <u>has not</u> previously attended a TSBVI Short-Term or Summer Program, complete all information below, or check: <input type="checkbox"/> No needs in this area</p> <p>➤ If your child <u>has</u> attended a Short-Term or Summer Program, indicate one of the following:</p> <p><input type="checkbox"/> My child has none of the following conditions. (Go to next section: Ear)</p> <p><input type="checkbox"/> Describe below any conditions or changes:</p>		
Type of Problem	Does the Student Have a Problem in This Area?	How Does Your Child React to Allergies Checked? Does Child Use an "EpiPen"? <input type="checkbox"/> Yes <input type="checkbox"/> No
Environmental/Seasonal Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Insect Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Medical Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	

ALLERGIES (continued)	
Food Allergies	will be described in a later section
Other:	

EAR		
<p>➤ If your child <u>has not</u> previously attended a TSBVI Short-Term or Summer Program, complete all information below, or check: <input type="checkbox"/> No needs in this area</p> <p>➤ If your child <u>has</u> attended a Short-Term or Summer Program, indicate one of the following:</p> <p><input type="checkbox"/> My child has none of the following conditions. (Go to next section: Behavioral)</p> <p><input type="checkbox"/> Describe below any conditions or changes:</p>		
Type	Does the Student Have a Problem in this Area?	Describe Complications, Long-Term Effects, Ongoing Treatment or Other Information
Hearing Problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Ear Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Wears Hearing Aid or Cochlear Implant	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Needs earplugs when swimming	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other:		

BEHAVIORAL, PSYCHOLOGICAL, PSYCHIATRIC		
<p>➤ If your child <u>has not</u> previously attended a TSBVI Short-Term or Summer Program, complete all information below, or check: <input type="checkbox"/> No needs in this area</p> <p>➤ If your child <u>has</u> attended a Short-Term or Summer Program, indicate one of the following:</p> <p><input type="checkbox"/> My child has none of the following conditions. (Go to next section: Miscellaneous)</p> <p><input type="checkbox"/> Describe below any conditions or changes:</p>		
Type	Does the Student Have a Problem in This Area?	Describe Effects of This Condition
Attention Deficit (Hyperactivity) Disorder (ADD; ADHD)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Autism	<input type="checkbox"/> Yes <input type="checkbox"/> No	

BEHAVIORAL, PSYCHOLOGICAL, PSYCHIATRIC (continued)

Behaviors:		
* Difficulty following adult direction (defiant)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
* Difficulty changing from one activity to another	<input type="checkbox"/> Yes <input type="checkbox"/> No	
* Difficulty getting along with other children	<input type="checkbox"/> Yes <input type="checkbox"/> No	
* Difficulty being away from home	<input type="checkbox"/> Yes <input type="checkbox"/> No	
* Difficulty expressing anger in an acceptable manner	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other:		

MISCELLANEOUS

➤ If your child has not previously attended a TSBVI Short-Term or Summer Program, complete all information below, or check: No needs in this area

➤ If your child has attended a Short-Term or Summer Program, indicate one of the following:

My child has none of the following conditions. (Go to next section: Menstrual)

Describe below any conditions or changes:

Type	Does the Student Have this Problem?	Describe Complications, Long-Term Effects, Ongoing Treatment or Other Important Information
Frequent Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Obesity	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Unusual Weight Gain or Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Problems with Appetite	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other:		

MENSTRUAL

- If your child has not previously attended a TSBVI Short-Term or Summer Program, complete all information below, or check: No needs in this area
- If your child has attended a Short-Term or Summer Program, indicate one of the following:
 - My child does not menstruate. (Go to next section: Dental)
 - Describe below any conditions or changes:

For students who have menstrual periods:

Are they regular?

Yes: How often do they occur (e.g., every 28 days) _____

No: Describe: _____

Does your daughter take any medications to control menstrual pain, to regulate hormones, for birth control, or for any other use related to menstruation?

Does your daughter need any assistance in order to manage her menstrual needs? Yes No
If so, please describe:

Describe any other information that might be useful to school staff:

DENTAL

- If your child has not previously attended a TSBVI Short-Term or Summer Program, complete all information below, or check: No needs in this area
- If your child has attended a Short-Term or Summer Program, indicate one of the following:
 - My child has none of the following conditions. (Go to next section: Diet and Eating)
 - Describe below any conditions or changes:

Type	Does the Student Have this Problem?	Describe Complications, Long-Term Effects, Ongoing Treatment or Other Information
Problems with Teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Problems with Gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dental Retainer or other appliance	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other:		

DIET AND EATING

PROHIBITED AND/OR LIMITED FOOD AND DRINK

- If your child has not previously attended a TSBVI Short-Term or Summer Program, complete all information below, or check: No needs in this area
- If your child has attended a Short-Term or Summer Program, indicate one of the following:
 - My child has no food or drink prohibitions or limitations (Go to next section)
 - Describe below any conditions or changes:

Type of Food and/or Drink that is Prohibited, Restricted or Limited	Reason	Directions, Comments
	<input type="checkbox"/> Allergy <input type="checkbox"/> Weight Control <input type="checkbox"/> Religious <input type="checkbox"/> Other	
	<input type="checkbox"/> Allergy <input type="checkbox"/> Weight Control <input type="checkbox"/> Religious <input type="checkbox"/> Other	
	<input type="checkbox"/> Allergy <input type="checkbox"/> Weight Control <input type="checkbox"/> Religious <input type="checkbox"/> Other	

REQUIRED FOOD, DRINK AND/OR SUPPLEMENT (NOT INCLUDING VITAMINS)

- If your child has not previously attended a TSBVI Short-Term or Summer Program, complete all information below, or check: No needs in this area
- If your child has attended a Short-Term or Summer Program, indicate one of the following:
 - My child has no required food, drink, or supplements (Go to next section)
 - Describe below any conditions or changes:

Type of Food, Drink and/or Supplement that is Required	Reason	Directions, Comments
	<input type="checkbox"/> Medical Condition <input type="checkbox"/> Other	
	<input type="checkbox"/> Medical Condition <input type="checkbox"/> Other	
	<input type="checkbox"/> Medical Condition <input type="checkbox"/> Other	

SPECIAL FOOD PREPARATION

- If your child has not previously attended a TSBVI Short-Term or Summer Program, complete all information below, or check: No needs in this area
- If your child has attended a Short-Term or Summer Program, indicate one of the following:
 - Has no need for special food preparation -- food consistency, bite size or preparation (Go to next section)
 - Describe below any conditions or changes:

Required Bite Size, Food Consistency, or Preparation

Requires food cut to the following bite size: <input type="checkbox"/> 1/8 " ● <input type="checkbox"/> 1/4" ● <input type="checkbox"/> 1/2" ●	Comments:
Requires food of the following consistency: <input type="checkbox"/> mashed/ground (like mashed potatoes) <input type="checkbox"/> pureed (like baby food or apple sauce) <input type="checkbox"/> liquified or almost liquified (like syrup, honey, cream)	Comments:
Other Food Preparation Needs:	

ADDITIONAL INFORMATION RELATED TO DIET OR EATING

- No additional information
- Additional Information
Describe Here:

OTHER MEDICAL INFORMATION

If there is any medical issue that you have not addressed or fully addressed above (e.g., any other type of medical procedure, surgery, injury, treatment) please provide additional information here:

PARTICIPATION IN PHYSICAL ACTIVITIES

TSBVI students may be scheduled to participate in activities such as walking, running, jumping, climbing, skating, trampoline, bicycle riding, weight lifting, ball sports, swimming, and other water activities.

Does your child have any restrictions or need any special assistance (other than support for vision loss) when participating in physical activities (e.g., limited physical stamina, potential for retinal detachments):

- My child can participate in physical activities with no restrictions
- My child has the following restrictions with regard to physical activities:

SWIMMING

Student Skills Assessment Prior to Any Swimming Activity. Prior to participating in any instructional or recreational swimming activity, each student will be required to take a swimming skills test given by a TSBVI Lifeguard. Student swimming activities will be provided based on the student skills as determined by the assessment.

Student with Seizure Disorder. Any student with any type of seizure disorder (other than in infancy only) is required to wear a life jacket during all recreational and instructional swim activities except when the student is within immediate physical reach of a staff member whose only responsibility during the time that the student is not wearing a life jacket is to supervise the student.

An exception to this requirement can be requested in the following limited situations: students in grades 6-12 who are participating in either a Short-Term Program class or an academic summer program (Academic Secondary Enrichment or SWEAT), who have not had a seizure within the past three years, may waive the life jacket requirement by completing the "Life Jacket Waiver" form. This form requires the written approval of the student's parent and physician, stating that the student may safely participate in swimming activities in a swimming pool without wearing a life jacket (see form for more specific information). The form will be part of the application packet for appropriate programs.

MEDICAL INSURANCE

What type of medical insurance does your child have?

None

Medicaid; Recipient Number: _____ Case Number: _____

Other: Name of Insurance Company: _____

Name of Policy Holder: _____

Policy Number: _____

MEDICAL PROVIDERS

Primary Care Doctor: _____

Phone Number: _____

Address: _____

Specialty Doctor (if applicable): _____

Phone Number: _____

Area of Specialty: _____

Address: _____

PERMISSION TO CONTACT MEDICAL/DENTAL PROVIDERS

During the course of caring for your child, it may be necessary or beneficial for TSBVI to contact one or more of the above-listed medical providers. Please indicate below whether you give TSBVI permission to contact the provider.

I give permission for TSBVI to contact any of the above-listed medical providers Yes No

PERMISSIONS

Staff Administration of Student Medication on Fieldtrips

Yes No I give permission for a TSBVI staff member who is not a licensed nurse or doctor to administer my child's medicine on field trips according to the medical instructions provided by the prescribing physician.

Comment (if desired):

Routine Medical And Health-Related Evaluation; Treatment of Minor Injuries and Illnesses

Yes No I give permission for the above-named student to receive routine medical and health-related evaluation and treatment of minor injuries and illnesses including physician-prescribed medication and non-prescription medication.

Comment (if desired):

Emergency Medical and Surgical Treatment

Yes No I give permission for my child to receive emergency medical and surgical treatment determined necessary by an attending physician. I understand that the Texas School for the Blind and Visually Impaired will make every reasonable effort to contact me before any prescriptions, doctor appointments or emergency treatment is administered.

In the event that further permission is needed during such treatment, please contact the following person who has the authority to make medical decisions for the student:

Name: _____

Relationship to Student: Parent Guardian Foster Parent

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Comment (if desired):

Blood Testing

Yes No In the event a staff member or student is exposed to my child's blood or body fluids, I give permission for TSBVI to conduct a blood test on my child for infectious diseases.

Comment (if desired):

I, _____, verify this information is correct and up to date on _____
Parent, Guardian or Student Date
(18 yrs. of age or older)

TVI Name: _____ (For verifying information was provided to you by the above signed.)

Please Save this form with the student's name as the filename and email the completed form to Cathy Olsen (OlsenC@tsbvi.edu)