WYOMING NEXT STEP ASSESSMENT CLINIC

**October 10, 2014**

Application Process

**Checklist**

*The Following Information Must be Submitted No Later Than*

*September 15, 2014*

Check/voucher for **$400.00** Made out to **“Wyoming Deaf-Blind Project”**

* Application
* **Wheel chair Assessment** – If asking to have the wheelchair repaired or worked on, please fill out the wheelchair form
* Student’s Daily Schedule
* IEP/IFSP with Goals and Objectives
* School Interview Form – **completed by teacher**
* **CD /JUMP DRIVE/ or emailed video** – ***5-15 minutes*** depicting areas of concern that you want the Wyoming Educational Intervention Assessment team to be aware of prior to the clinic. This is also an introduction of the student to the team – aiding the team in development of the assessment process.
* If the team has feeding concerns: 5 minute video with segments containing the student participating in those areas of concern with mealtime at home & school
* Family Interview – **completed by family**
* Signed Release of Information
* Photo Release
* **Medical Information** – This information is vital in determining how to assess the student.

*I realize that we are asking for a lot of information on the child and the forms are lengthy, however the more information we receive prior to the clinic, the better we can assess the needs and develop recommendations during the clinic.*

If you have any questions, please feel free to contact the office at 307.324.5333, fax at 307.324.3743, joanne.whitson@wyo.gov for more information about the clinic, check out our Web Page [www.edu.wyoming.gov](http://www.edu.wyoming.gov) under programs, Deaf-Blind Project.

Applications and CDs / Jump Drives should be mailed to:

Joanne B. Whitson, Project Director

Wyoming Project for Children and Youth who are Deaf-Blind

215 West Buffalo

Carbon Building, Room 325

Rawlins, WY 82301

**Wyoming Next Step Assessment Clinic**

**Wyoming Department of Education**

**October 10, 2014**

# Application is Due February 21, 2014

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| Name of Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_  Student’s Height \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student’s weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  student’s WISER ID Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male  Female   Mailing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, WY Zip \_\_\_\_\_\_\_\_\_  Telephone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Caregiver’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Pre) School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact Person\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  School District/ Preschool Region:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone & Fax no.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Pre) School Mailing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, WY Zip \_\_\_\_\_\_\_\_  Student’s diagnosis (if any) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Check the Areas for Student Assessment**

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| --- | --- | --- | --- | --- | --- |
| Medical Staff | | **Nutritional Mealtime**  **Management Team** | | **WEIAT – Wyoming Educational Intervention Assessment Team** | |
| Audiologist  Psychologist  Low Vision Specialist  Optometrist |        | Nutritionist/Dietitian  Occupational Therapist  Speech Language Pathologist  **If checked, make sure to fill out the Mealtime Management form**  **attached** |      | Augmentative Communication Specialist  Deaf / Hard of Hearing Educator  Occupational Therapist Orientation & Mobility Physical Therapist Speech/Language Pathologist Vision Therapist  Assistive Technology |                |

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| **Additional Assessments** | | | |
| Nutritional Mealtime Assessment / Strategies  IQ (for school age students)  Behavior Concerns / Strategies |      | Functional Vision  Learning Media  Wheel Chair Assessment |      |

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| * Please state your reason for attending the WY Next Step Assessment Clinic   + Prioritize the areas that you want addressed by the teams, 1, 2, 3, 4 etc. * What are your expectations * Why did you select the appointments and assessments that you checked | | | |
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| **Vision Concerns** | | | |
| Blindness Low Vision  Light Sensitivity  CVI  Glasses **(Bring to the Clinic)** |          | Field Loss Unsure of Vision  Visual Aids used **(If hand held bring to the Clinic)** |      |

### List other vision concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Hearing Concerns | | | |
| Unsure of Hearing Deaf  Deaf / Hard of Hearing  **If have current audiogram, please attach it to the clinic application** |      | Personal Hearing Aid **(Bring To Clinic)** Amplified Systems Classroom System  Cochlear Implants Right Left |        |

List other Hearing Concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Communication Concerns Check all that apply | | | |
| Unsure of Communication Method Verbal \***(Sounds, Words, Sentences)**Non – Verbal \***(facial, gestures, eye gaze)** |      | Sign Language Objects **\*(Pictures, Symbols)** Augmentative Communication |      |

List equipment being used and if transportable – bring to Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List other Communication Concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Assistive Technology *Check all that apply* | | | |
| Low Tech Adaptations \*(Communication Boards, Pictures, Schedules/ Calendar Boxes, Eye Gaze Boards, Switches) Computers iPad |      | **High Tech Adaptations**  \*(Intelitools, Word Predication, Software Voice, Voice Recognition Systems, Voice output Devices, Educational Software) |  |

If using computers please list the software: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List other assistive technology being used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Gross & Fine Motor Concerns *check all that apply* | | | |
| Non Ambulatory Walks  Walks With Assistance  Braces / Orthotics  Postural Concerns  Seating / Positioning **(Stander, Adapted Chair, Side-Lyer, Prone Wedge, Quad Wedge)** |            | Wheelchair **(Date of Purchase \_\_\_\_\_\_\_\_\_\_\_)** Eye – Hand Coordination Sensory Processing / Sensory Integration  Developmental Concerns  O&M  **List Devices:** |          |

List other Motor Concerns:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Nutritional Concerns *Check all that apply –*  **Nutritional Mealtime Management Form (at the end of the application) must be completed.** | | | |
| Nutritional  Growth / Height / Weight  Sensory Issues  Respiratory |        | Feeding  Oral  Tube |    |

List other Nutritional Concerns:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Behavior Concerns** | | | |
| Acting Out  Toileting |    | In-appropriate Behaviors: list |  |

List other Behavioral concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Medications student is currently taking:** |
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Please list anything else that you want the teams to know about the student:

SCHOOL INTERVIEW FORM

# Name of Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Teacher(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Position(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

# Qualifying Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does student receive: Occupational Therapy: Yes \_\_\_\_ No \_\_\_ How Much \_\_\_\_

Physical therapy: Yes \_\_\_\_ No \_\_\_ How Much \_\_\_\_

Speech Therapy: Yes \_\_\_\_ No \_\_\_ How Much \_\_\_\_

Counseling Services Yes \_\_\_\_ No \_\_\_\_ How Much \_\_\_\_

1. Describe how the student uses vision or compensates for visual loss if applicable: **(Magnification/ O&M/ does the child use a preferred eye/ light sensitivity/ Braille or large print/ when was the last eye exam)**
2. Describe how the student uses their hearing and amplification (if applicable): (**Degree of hearing loss/ use of sign, oral or manual language/ what system do they use)**
3. Do you have any fine or gross motor concerns? If yes, please list:
4. Is the student in a wheelchair? Yes \_\_\_\_\_ No \_\_\_\_\_

SCHOOL INTERVIEW FORM Continued

1. Do you have concerns regarding the wheelchair? If so please list:
2. How does the student use communication skills – verbal or non verbal: **(who can understand them/ use of words or sentences/ is speech therapy provided)**
3. Describe how the student uses Assistive technology/ augmentative communication devices (if applicable):
4. How does the student make their wants, needs and emotions known and how do they interact with their peers and adults: **(Describe behavior plans/ schedule systems implemented/ what strategies have/have not worked)**
5. Describe areas in which the student functions independently: **(Daily living/ meals/ choice making – decision making/ where is assistance needed)**
6. Does the student receive lunches / snacks at school? Yes \_\_\_ No \_\_\_\_ **(Cafeteria, special classroom, oral / non oral intake, position before / during / after meals)**

List any concerns that you have:

SCHOOL INTERVIEW FORM Continued

1. Is the student independent in their environment and how do they move from place to place:
2. Describe the positions the student is in during the school day and what equipment is used:
3. Do you have transportation concerns? Yes \_\_\_\_\_ No \_\_\_\_\_ **(To and from school/ field trips/ between classes)**
4. List any health or safety concerns that you have:
5. List the student’s strengths:

Comments and Concerns that you wish to share with the team:

# Family Interview

# Wyoming Next Step Assessment Clinic

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Person Completing Form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please fill in each area and check or circle areas that apply:**

What is (are) your child’s disability or medical condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_

Please prioritize your main concerns you would like addressed at the clinic:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Vision Concerns:**

Do you have any concerns about your child’s vision? Yes \_\_\_\_ No \_\_\_\_

Has your child had a vision exam? Yes \_\_\_\_ No \_\_\_\_

If yes, when was your child’s last vision exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you received a diagnosis on your child’s vision? Yes \_\_\_\_ No \_\_\_\_\_

If yes – what is the name of the visual condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child sensitive to light? Yes \_\_\_\_ No \_\_\_\_\_

Does your child have a preferred eye? Yes \_\_\_ No \_\_\_ If so which one? Right \_\_\_ Left \_\_\_

Does your child receive mobility services (using a cane or mobility device)? Yes \_\_\_\_ No \_\_\_

Does your child use any of the following? Circle all that apply:

Magnifiers Braille Large Print Cane CCTV

**Family Interview Form Continued**

**Hearing Concerns:**

Do you have any concerns about your child’s hearing? Yes \_\_\_\_ No \_\_\_\_

Is your child prone to ear infections? Yes \_\_\_\_ No \_\_\_\_

Is your child prone to ear infections? Yes \_\_\_\_ No \_\_\_\_

Does your child have tubes in his / her ear(s)? Yes\_\_\_\_ No\_\_\_\_\_

If yes, which ear? Right\_\_\_\_\_\_ Left\_\_\_\_\_\_\_ Both\_\_\_\_\_\_\_\_\_

Has your child had his /her hearing tested? Yes \_\_\_\_ No \_\_\_\_

If yes, when was the last visit to the audiologist? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have a diagnosed hearing loss? Yes\_\_\_\_\_ No\_\_\_\_\_

If yes, do you know the degree of loss? Right\_\_\_\_\_\_\_\_\_\_\_\_\_ Left\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child favor one ear over the other? Yes\_\_\_\_\_ No\_\_\_\_\_\_

If yes, which ear does your child favor? Right\_\_\_\_\_\_\_ Left\_\_\_\_\_\_\_ Unsure\_\_\_\_\_\_

Does your child wear hearing aids? Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_

If yes which ear has the hearing aid? Right\_\_\_\_\_\_ Left\_\_\_\_\_\_\_ Both\_\_\_\_\_\_\_\_\_

Does your child have a cochlear implant? Yes \_\_\_\_\_ No \_\_\_

If yes, which side is the implant on or both: Right\_\_\_\_\_\_ Left\_\_\_\_\_\_\_ Both\_\_\_\_\_\_\_\_\_

**Communication:**

Does your child use any of the following communication systems, Check all that apply:

\_\_\_\_ Oral language

\_\_\_\_ Sign Language - If so, ASL or Signing Exact English"

\_\_\_\_ Both Oral Language and Sign Language

\_\_\_\_ Communication Devices - Please list if using. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Interview Form continued**

Is your child verbal? Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_ If yes, check all that apply:

\_\_\_\_ I have a difficult time understanding my child \_\_\_\_ uses words

\_\_\_\_ speaks in sentences \_\_\_\_ receives speech and /or language therapy

Is your child is non-verbal? Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_ If yes, check all that apply:

\_\_\_\_ Uses gestures to be understood \_\_\_\_ Uses eye gaze to make wants known

\_\_\_\_ Uses objects / symbols / pictures \_\_\_\_ Uses AAC devices, if so list the types: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you talk with your child? Check all that apply:

\_\_\_\_ Single words \_\_\_\_ Complex sentences

\_\_\_\_ Simple Sentences \_\_\_\_ Routine Phrases

**Feeding / Meal time Concerns:**

Do you have any concerns with meal time / snack time? Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Behavior Concerns:**

Do you have any concerns about your child’s behavior? Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any safety concerns? Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all medications that your child takes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Interview Form Continued**

**Mobility Concerns:**

How does your child move from place to place? Check all that apply

\_\_\_\_ Crawls \_\_\_\_ wheelchair \_\_\_ Scoots (either forward or backwards)

\_\_\_\_ Uses adapted mobility devices \_\_\_\_ Walks \_\_\_\_ Has braces

\_\_\_\_ Uses a walker \_\_\_\_ Is non-mobile

**Family Information:**

Do you have a support group or network? Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_

\_\_\_\_ Friends \_\_\_\_ church \_\_\_\_ family \_\_\_\_ respite

What is your child’s favorite toy or activity? (Please bring your child’s favorite toy if possible)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your child’s favorite family activity? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your child’s strengths?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your child’s favorite activities? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any other children? Yes\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_ If yes, how do they get along? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who lives in the home? (i.e. grandparents, siblings aunts, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Interview Form Continued:**

What are your expectations for the next 6-months? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your expectations for the next year? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear of the Clinic? What made you decide to come? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there anything else that you want the teams to know about your child? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you for taking the time to fill out the application - the more we know about your child, the better job we can do at the clinic.

# Likes Information: Tell us what your child likes!

|  |  |  |
| --- | --- | --- |
| Child: | Date: | MCj04257620000[1] |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Foods Taste / Texture | Smells | Touch Texture/ hugs  Fabrics  Light-heavy | Movement Rock / bounce  Swing | Vibration car ride  toys/ appliances | Sights | Sounds Voices / music  Pitch / loudness  environmental |
|  |  |  |  |  |  |  |

# Dislikes Information: Tell us what your child doesn’t like!

|  |  |  |
| --- | --- | --- |
| Child: | Date: |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Foods Taste / Texture | Smells | Touch Texture/ hugs  Fabrics  Light-heavy | Movement Rock / bounce  Swing | Vibration car ride  toys/ appliances | Sights | Sounds Voices / music  Pitch / loudness  environmental |
|  |  |  |  |  |  |  |

WHEELCHAIR COMMUNITY EQUIPMENT MAINTENANCE/REPAIR REQUEST

Please include with WY Next Step Clinic Assessment Application

Name of Individual using equipment:

Name, address and phone number of person making referral and relationship to individual:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name, address and phone number of Case Manager: \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_*\_\_\_\_*

Identify equipment needing repair:

wheelchair shower chair walker stroller  stander  other

Provide the following information:

Brand name of equipment \_\_\_\_\_\_\_\_\_\_\_

Approximate age of equipment

Serial number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Make \_\_\_\_\_\_\_\_

Model \_\_\_\_\_\_

PLEASE DESCRIBE anything that needs repair, replacement or service:

*For the health and safety of our staff:*

*ALL EQUIPMENT MUST BE CLEAN PRIOR TO BRINGING IT TO THE CLINIC*

*Please put any further information on the back.*

Thank you!

Wyoming Next Step Assessment Clinic

Wyoming Department of Education

# RELEASE OF INFORMATION AND PERMISSION FOR EVAULATION

## Child’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I give permission for my child to be evaluated and photographed at the Wyoming Next Step Assessment Clinic. This includes evaluation by all the team members. In addition, I give my permission for the report to be shared with the school and WDH Maternal Child and Health.

I authorize any person, physician, hospital, clinic, (pre)school, county, state or federal program to share **medical and educational** information concerning my child to aid in his/her evaluation at the Wyoming Deaf-Blind Diagnostic Clinic.

Signature date

Relationship to child

***Medical information that is on file at the school or preschool is considered part of the student’s EDUCATIONAL FILE and can therefore be copied and sent to the Next Step Assessment Clinic to be used to determine educational strategies***

Wyoming Department of Education Media Release

Release for use of photographs, audio, video recording, or publication and information to the Wyoming Department of Education, Wyoming Nest Step Assessment Clinic Parent or guardian must sign if under age 18

Name of Participant:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Name of Parent/Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

I hereby authorize the Wyoming Department of Education (“Department”), and those acting under its permission and on its authority, to take photographs, audio or video recording of me, and/or my child, in which I/my child may be included in whole or in part, and to use such photographs, audio or video record­ings or reproductions thereof, made through any medium, for Department logos, programs, presentations, services, activities or publications in conjunction with the Department I hereby waive any right to inspect or approve such photograph, audio or video recording or publication, and release any copyright interest or claim for royalty therein that may accrue to me, irrespective of fees that may be generated by the use of the same. I waive any right or privilege of confidentiality that I hold in such photographs, audio or video recordings to the extent that they appear in logos, programs, presenta­tions, services, activities or publications.

I hereby release and discharge the Department, its Administrators, its successors, and those acting under its permission and authority from any liability which may result from the taking or use of such photo­graphs, audio or video recordings. Sovereign Immunity. By signing this release, I acknowledge that the State of Wyoming and the Depart­ment do not waive sovereign immunity, and specifically retain immunity and all defenses available to them as sovereigns pursuant to Wyo. Stat. § 1-39-104(a) and all other state law.

Applicable Law/Venue. The construction, interpretation, and enforcement of this waiver shall be governed by the laws of the State of Wyoming. The Courts of the State of Wyoming shall have jurisdiction over this waiver and the parties, and the venue shall be the First Judicial District, Laramie County, Wyoming. The parties intend and agree that the State of Wyoming and the Department do not waive sovereign immu­nity by entering into this Contract and specifically retain immunity and all defenses available to them as sovereigns pursuant to Wyo. Stat. § 1-39-104(a) and all other applicable law.

I grant this authorization as a voluntary contribution in the interest of fostering the programs, services and activities of the Department.

I do (\_\_\_), do not (\_\_\_) include the authorization to use my name in connection with such photographs, audio or video recordings. I do (\_\_\_), do not (\_\_\_) include the authorization to use any photographs, audio or video recordings, or likenesses which might identify me, such as those that show my face. I have read the above and am competent to grant such authority.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

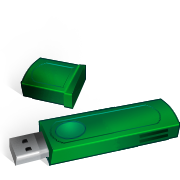
*Participant Signature Age*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Parent Signature Date*

DIRECTIONS FOR MAKING

CD / JUMP DRIVE!

MM900284064[1]

* **INTRODUCE THE STUDENT AT THE BEGINNING OF the CD / Jump Drive!** This will allow for those viewing the tape to be aware of which student to be observing.
* **Be clear on what you want the team to focus on during the clinic.** List your concerns at the beginning so that we will know what to watch for.
* **The clip only needs to be 10 – 15 minutes long**. Have segments containing the student participating in those areas of concern
* **For the Nutritional Meal Time TEAM:** The clip only needs to be 5 minutes long. Have segments containing the student participating in those areas of concern with mealtime at home & school for NMMT Team.

It is very beneficial for the school staff members to attend the clinic so that they can provide input to the clinic team on the strategies being recommended.