TRINITY Services, Inc.

Trinity School
www.trinity-services.org
1361 East Lincoln Highway
New Lenox, IL 60451
(815) 463-0719
Fax (815) 463-0726

INFORMATION FOR THE 2020-2021 SCHOOL YEAR

Dear Parents/Guardians:

In this packet you will find annual forms that we need you to fill out for the 2020-2021 school year.

The packet contains:
Emergency Information sheet (blue sheet): It is essential that we have this form returned with all the information completed. In case of an emergency it is critical that we have your current phone numbers. *If the information changes during the school year you must contact the school and provide the updated information.*
Community Instruction Opportunities Form: Since Trinity School does go into the community on a regular basis, a new permission slip must be in your child's file each year.
Information Release: This form lets you know that we will not disclose any information about your child unless agreed to in writing. Personal information will only be provided to your school district.
Photo/Video Release: Filling out this form allows Trinity School to take photos and video of your son/daughter.
Physical Form: Students that will be entering 6th or 9th grade must have a physical prior to August 12th, 2020. If you have any questions regarding the physical, contact Joy at (815) 463-0719. Your son/daughter may miss school if the forms are not returned by the first day of school.
Dental Form: Students that will be entering K, 2nd or 6th grade must have a dental examination prior to August 12th, 2020. Your son/daughter may miss school if the forms are not returned by the first day of school.
Seizure Information: Please complete if your child has, or has had a history of seizures.
Current Medications: Please fill in this form with your child's current medication information.
Consent for Administration of Medication: Fill in this form with your child's medication that is taken *at school.* THIS FORM MUST BE FILLED OUT IF YOU NEED YOUR CHILD TO TAKE MEDICATIONS AT THE SCHOOL. If your child does not take medication at school please fill out the bottom portion of the form.
Parent Questionnaire: Please fill out this questionnaire and return with the other forms.
Classroom Supply List: This list was completed by the classroom teacher. Please have your son/daughter bring the items with them the first week of school.
Strides Participant Application and Health History: Students will attend this session in rotations throughout the 2020-2021 school year. If you would like your child to participate in this program, please fill this form out along with your child's physician.
Health Guidelines: This form will give you instructions on reporting your child absent.
School Calendar: Information regarding the school year.

If you have any questions, please call the school at (815) 463-0719. You may also fax the forms to the school at (815) 463-0726.

Please submit the filled out forms by August 12, 2020.

Have a good summer!

TRINITY
Services, Inc.

Allergies (List):_____

_____

Seizures: Yes No
(Circle one)

Emergency Information

The information that is provided within this document will be used by the staff of Trinity Services, Inc. in case of an emergency, program closure, or any other unforeseen situation that may occur.

Name:_____ **Birth date:**_____ **Sex:** _____

Address:_____
Street City State Zip

Student Social Security Number: _____/____/_____ **Home Phone Number:** _____-_____-_____

Legal Guardian:_____ _____
First Name Last Name Relationship

Home Phone Number: _____-_____-_____ **Work Phone Number:** _____-_____-_____

Cell Phone Number: _____- _____-_____

Please list other local persons who are authorized to act for a parent/legal guardian in an emergency situation:

1._____
Name

_____
Relationship

_____
Home Phone Number

_____
Work Phone Number

2._____
Name

_____
Relationship

_____
Home Phone Number

_____
Work Phone Number

Medical Doctor: _____ **Phone Number:** _____-_____-_____

Address:_____
Street City State Zip

Dentist: _____ **Phone Number:** _____-_____-_____

Address:_____
Street City State Zip

Hospital: _____ **Phone Number:** _____-_____-_____

Address:_____
Street City State Zip

(PLEASE TURN OVER TO COMPLETE PAGE 2)

Primary Disorder:_____ **Secondary Disorder:**_____

Prescription Medications: Please list all currently prescribed medications:

Name	Purpose	Daily Dosage/Times Taken	Prescribed By	Phone#

Other Medical Concerns (eg. allergies to medication, cardiac condition, diabetic etc.)_____

_____

Insurance Information:

Private Medical Insurance: _____ **Company Name:**_____

Policy Number:_____ **Insured's name:** _____

Medicare Number:_____ **Medicaid Number:**_____ **Recipient Number:**_____

Dental Insurance: _____ **Company Name:**_____

Policy Number:_____ **Insured Name:**_____

I understand that if the indicated physician of choice or myself cannot be reached in an emergency situation and if, in the judgment of the program administrators, immediate medical and/or hospital attention is necessary, the individual will be transported to an available hospital or physician for treatment.

Signature_____ **Relationship**_____ **Date**_____

TRINITY
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COMMUNITY BASED INSTRUCTION CONSENT FORM

Dear Parent or Guardian,

As part of the student's school learning opportunities, your child will be going into the surrounding community. Your child must have a signed and dated permission slip to be able to participate in this community based instruction.

_____ has my permission to participate in all school
(Student's name)
sponsored community trips during the 2020-2021 school year and 2021 summer session. Community based instruction will include, but not be limited to, trips to nearby stores, restaurants, and parks. This permission also includes special event field trips. The students will be transported by authorized staff, when necessary, in a car, bus or van.

_____ _____
Parent/Guardian Signature Date

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INFORMATION RELEASE

INFORMATION RELEASE:

I understand that Trinity Services will not release any personal information on a child or his/her family unless specifically agreed to in writing by that child's guardian. If information is needed by an outside a party (e.g. SSI, Physicians, etc) I will contact school and submit a written consent. I authorize student's academic progress, family contact information, and/or concerns about the student can be provided to the student's home school, emergency personnel and bus company.

_____ _____

Parent/Guardian Signature Date

TRINITY
Services, Inc.

Consent to use Photos, Audio, Digital/Video Images, or Written Story

Images tell stories. At Trinity Services the primary purpose of sharing any image is to tell a story—to celebrate the successes and achievements of the organization and the people it serves. Images are an effective means of communicating Trinity's core values and mission of helping people live full and abundant lives to the public, who like to see the impact of their donations. Photos/stories often inspire others to contribute as well. The images Trinity chooses to use are always meant to be dignified and uplifting. Every effort is given to respect the privacy of the people we serve. No last names will be added to any image/video/audio/written stories used.

Trinity Services may also wish to use photos/video/audio/written stories for any of the following purposes:

- Marketing and promotional activities (brochures, annual reports, fundraising presentations)
- Sharing stories electronically or via hardcopy (newspapers, Trinity newsletters and/or website)
- Social media (for example, Trinity's YouTube channel, Facebook Page, or Instagram)

Please initial your choice	Consent Options
	Yes: I hereby give my consent to Trinity Services, its agents, or representatives to use my photograph/audio recording/video footage/written story for the above stated purposes. Also: To assist teachers and therapists in providing the most effective services and supports for Trinity school students, videotaping a lesson may be used for staff training. This consent does not include people outside of Trinity School viewing the video. This is only for the purpose of providing feedback to staff on the delivery of the instruction or data collection.
	Yes, with exception(s): I hereby give my consent to Trinity Services, its agents, or representatives to use my photograph/audio recording/video footage/written story for the above stated purposes **with the exception of (please list):**
	No: I do not give consent to use any photo/audio recording/video footage/written story for any purpose.

Signature of parent or guardian

Street Address

Date

City, State, Zip Code

What if I give my consent and later change my mind?
The consent will continue for one year from date of signing, or until the individual revokes consent by contacting Trinity Services' Development Office at 815-717-3750 or via email at sladislas@trinity-services.org.

State of Illinois
Certificate of Child Health Examination

Student's Name Last First Middle	Birth Date 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 MO DA YR	DOSE 2 MO DA YR	DOSE 3 MO DA YR	DOSE 4 MO DA YR	DOSE 5 MO DA YR	DOSE 6 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						
Varicella (Chickenpox)						
Meningococcal conjugate (MCV4)						
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

Comments: * indicates invalid dose

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? Child wakes during night coughing?	Yes No Yes No			Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No		
Birth defects?	Yes No			Hospitalizations? When? What for?	Yes No		
Developmental delay?	Yes No						
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No			Surgery? (List all.) 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 _____ 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. **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: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ 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

To be completed by the parent (please print):

Student's Name: Last	First	Middle		Birth Date: (Month/Day/Year) / /
Address: Street	City	ZIP Code		Telephone:
Name of School:		Grade Level:		Gender: ☐ Male ☐ Female
Parent or Guardian:		Address (of parent/guardian):		

To be completed by dentist:

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present**

☐ 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 **Soft Tissue Pathology**

☐ Yes ☐ No **Malocclusion**

Treatment Needs (check all that apply)

☐ **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

☐ **Restorative Care** — amalgams, composites, crowns, etc.

☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis

☐ **Other** — periodontal, orthodontic

Please note _____

Signature of Dentist _____ Date of Exam _____

Address _____ Telephone _____
Street City ZIP Code

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.idph.state.il.us

IOCI 0600-10

Printed by Authority of the State of Illinois

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Seizure Information

Student's Name: _____

Birth date: _____

If your child has seizures or a history of seizures, type or types of (according to the most revision of the International Classification of Epileptic Seizures):

_____

_____

If a seizure occurs, how many minutes/seconds before contacting EMS:_____ _____

(Guardian Initials)

Frequency of seizures over the past year: _____

If no seizures have occurred in the past 5 years, is there a plan in effect for drug withdrawal? If drug therapy is continued, please state the reason:

_____

_____

Physician's Name: _____

Address: _____

Office Phone: _____

Emergency Phone: _____

Neurologist's Name: _____

Address: _____

Office Phone: _____

Emergency Phone: _____

_____ _____

Parent/Guardian Date

TRINITY
Services, Inc.

CURRENT MEDICATIONS

List ALL medications taken

Name of Medication and Date First prescribed	Dosage and Times	Reason for Medications	Side Effects or Precautions	Restrictions and Limitations

Parent/Guardian

Date

TRINITY
Services, Inc.

CONSENT FOR ADMINISTRATION OF MEDICATION

Student's Name: _____ Date: _____

If your son/daughter will be taking any medication while at school:

- This form must be filled out and signed
- The medication must come in a pharmacy approved bottle with a label
- The dosage and times must be listed
- If there are any changes (eg. dosage, time, medication) a new form must be filled

I give consent for _____ to receive the following medications as prescribed by his/her doctor:

Medication Name: _____
Time medication needs to be administered:_____ Dosage:_____
Purpose of the medication: (please list why it was prescribed)
_____

Medication Name: _____
Time medication needs to be administered:_____ Dosage:_____
Purpose of the medication: (please list why it was prescribed)
_____

Medication Name: _____
Time medication needs to be administered:_____ Dosage:_____
Purpose of the medication:
_____

I understand that I will be contacted regarding any changes in health. I also understand that I may withdrawal my consent at any time.

If any of the medications change it is the responsibility of the parent to notify the school and update the necessary medication forms immediately.

_____
Parent/Guardian Date

My son/daughter does not take any medication during the school hours. If this information changes I will notify the school immediately and fill out the necessary information.

_____
Parent/Guardian Date

TRINITY
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Parent/Guardian Questionnaire

Please complete this questionnaire so that we may communicate better with you, and best serve the needs of your student when planning for the daily school needs, meetings and activities.

Parent/Guardian Name:_____ Date _____

Student: _____

Siblings: Name & Age

_____ _____ _____ _____

Email Address: _____

Best Phone Number to Contact You: _____

Best Time of Day to Reach You: _____

What does your son/daughter like?

Toys	Food	Games	Movies
1.			
2.			
3.			
4.			
5.			
6.			
7.			

What information would you like to see included on the daily progress sheet (blue sheet)?

_____

_____

We may offer parent trainings at the school which topic would you be interest in? (Put an **X** in the box for the one(s) you would like to attend.)

- ☐ Sign language
- ☐ Picture Exchange Communication System PECs
- ☐ Toilet training
- ☐ Non-compliance
- ☐ Behavior Management 101
- ☐ Community Resource-What to do after graduation
- ☐ The ins and outs of IEPs
- ☐ Guardianship: What to do before your student turns 18
- ☐ Your idea:_____

Would you be interested in participating or being involved in classroom activities or events? (Please Check)

_____ Helping provide classroom support _____ Chaperone on field trips
_____ Assist with fundraising events _____ Other: _____ _____

Do you, or do you know someone with a special talent? If so what is it and do you think they would share it with us?_____

Do you have suggestions for special events or field trips? _____

_____

Thank you for your input!

STRIDES
Therapeutic Riding Center
27655 S. Gougar Road
Manhattan, IL 60442
(815) 263-0085
www.trinity-services.org
jbays@trinity-services.org

Authorization for Emergency Medical Treatment Form

_____ Participant _____ Staff _____ Volunteer

Name: _____ D.O.B.: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Physician's Name: _____ Medical Facility: _____

Health Insurance Company: _____ Policy No.: _____

Allergies to medications: _____

Current medications: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize STRIDES Therapeutic Riding Center to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

CONSENT PLAN:
This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

Consent Signature: _____ **Date:** _____
Client, Parent or Legal Guardian (To be signed in the presence of center staff)

NON-CONSENT PLAN:
I do not give my consent for emergency medical treatment/aid in the case of illness during the process of receiving services or while being on the property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

_____

_____

_____

Consent Signature: _____ **Date:** _____
Client, Parent or Legal Guardian (To be signed in the presence of center staff)

A COPY OF THE COMPLETED MEDICAL/HEALTH HISTORY SHOULD BE ATTACHED TO THIS FORM.

TRINITY Services, Inc.

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(815) 263-0085
www.trinity-services.org
jbays@trinity-services.org

Participant's Application and Health History

GENERAL INFORMATION

Participant: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ Male / Female

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Alternative: _____

Employer / School: _____

Address: _____

Phone: _____

Parent / Legal Guardian: _____

Address (if different from above): _____

Phone: _____

Referral Source: _____

Contact Numbers: _____

How did you hear about the program? _____

HEALTH HISTORY

Please indicate current or past problems in the following areas:

	Y	N	COMMENTS
Vision			
Hearing			
Tactile Sensation			
Communication			
Heart			
Breathing			
Digestion			
Elimination			
Circulation			
Emotional			
Behavioral			
Pain			
Bone / Joint			
Muscular			
Thinking / Cognition			
Allergies			

HEALTH HISTORY *(continued)*

What medications are you currently taking, including over-the-counter medications?

_____

_____

_____

_____

Describe your abilities / difficulties in the following areas (include assistance required or equipment needed):

Function: *(i.e. Mobility skills such as transfers, walking, wheelchair use, driving/bus riding)*

_____

_____

_____

Social: *(i.e. Work/school including grade completed, leisure interests, relationships- family structure, Support systems, companion animals, fears/concerns, etc.)*

_____

_____

_____

Goals: *(i.e. Why are you applying for participation? What would you like to accomplish?)*

_____

_____

_____

Experience with Horses: *(How familiar are you with horses, have you been horseback riding before)*

_____

_____

_____

Photo Release:

I ____ DO / _____ DO NOT consent to and authorize the use and reproduction by STRIDES Therapeutic Riding Center of any and all photographs and any other audio / visual materials take of me for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____ **Date:** _____

Client, Parent or Legal Guardian (To be signed in the presence of center staff)

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PARTICIPANT LIABILITY RELEASE FORM

_____ (Client's Name) would like to participate in the STRIDES Therapeutic Ridging Program. I acknowledge the risks and potential for risks associated with equine activities. However, I feel this opportunity will be a beneficial and enjoyable activity for myself / my son / my daughter / my ward and the benefits outweigh the risks involved. I hereby, intend to be legally bound for myself, my heirs and assigns, executors or administrators, volunteers or employees for any and all injuries and/or losses I/my son/daughter/ward may sustain while visiting and/or participating in activities at STRIDES Therapeutic Riding Center.

I hereby release STRIDES Therapeutic Riding Center and Trinity Services, Inc., it's employees, volunteers, administrators, or board of directors, from all liability as stated in the Illinois Equine Liability Law, Illinois Statute Chapter 745 § 47/1.

Printed Name: _____

Signature: _____ **Date:** _____
Client, Parent or Legal Guardian
Signed in the presence of center staff

STRIDES Staff Person:

Printed Name: _____

Signature: _____ **Date:** _____

TRINITY Services, Inc

STRIDES Therapeutic Riding Center
27655 S. Gougar Road
Manhattan, IL 60442
(815) 263-0085
www.trinity-services.org

STRIDES

Participant's Medical History & Physician's Statement

Participant: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ Male / Female

Address: _____ City: _____ State: _____ Zip: _____

Diagnosis: _____ Date of Onset: _____

Past/Prospective Surgeries: _____

Medications: _____

Seizure Type: _____ Controlled: Y N Date of Last Seizure: _____

Shunt Present: Y N Date of last revision: _____

Special Precautions/Needs: _____

_____

Mobility: Independent Ambulation: Y N Assisted Ambulation: Y N Wheelchair: Y N

Braces / Assistive Devices: _____

For those with Down Dyndrome: AtlantoDens Interval X-rays, Date: _____ Result: +

Neurologic Symptoms of AtlantoAxial Instability: _____

Please indicate current or past difficulties in the following systems/areas, including surgeries:

	Y	N	COMMENTS
Auditory			
Visual			
Tactile Sensation			
Speech			
Cardiac			
Circulatory			
Integumentary / Skin			
Immunity			
Pulmonary			
Neurologic			
Muscular			
Balance			
Orthopedic			
Allergies			
Learning Disability			
Cognitive			
Emotional/Psychological			
Pain			
Others			

To my knowledge, there is no reason why this person cannot participate in supervised equestrian activities. However, I understand that the therapeutic riding center will weigh the medical information above against the existing precautions and contraindication. I concur with a review of this person's abilities/limitations by a licensed/credentialed health professional (e.g. PT, OT, Speech, Psychologist, etc.) in the implementations of an effective equestrian program.

Name / Title: _____ MD DO NP PA

Signature: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (___) _____ License/UPIN Number: _____

Trinity School Health Guidelines

School Phone Number: 815-463-0719

Deciding when to keep your child home from school can be difficult. In order to provide as healthy a school environment for all students and staff, the following guidelines have been prepared to assist you with decisions relating to your child's health and school attendance.

If your child is not feeling well and you are uncertain about sending him/her on any given school day, it is best to keep your child home and observe him/her for further symptoms.

Upon making the decision to keep your child home, please notify the school that the student will be absent and state the nature of the illness. Please call the school number listed above.

Colds	Student should remain at home if he/she: 1.) has an excessive cough 2.) has an excessive runny nose or green nasal discharge 3.) has an elevated temperature 4.) is too uncomfortable to function at school.
Chicken Pox	Inform the school. The student must be excluded from school for 5-7 days until all vesicles are dried and crusted over.
Coxsackie Virus	Also known as Hand, Foot, and Mouth disease. Student can attend school unless fever or weeping lesions are present, or student is unable to participate in school activities.
Diarrhea	Student should remain at home if diarrhea occurs 2 times a day, or if accompanied by other symptoms such as fever, vomiting, fatigue.
Ear Infections	Student should be evaluated by a doctor if he/she complains of ear pain. Early treatment can prevent possible hearing complications.
Eye Infections	Conjunctivitis (Pink Eye) needs to be determined and treated by a medical doctor. Student may return after 24 hours if symptom free and has a doctor's note.
Fever	Students must remain home if temperature is 100 degrees or above. In an overabundance of caution because of Covid-19, students may return to school after being fever free for 3 days with no medication. This is a precaution to make sure that the fever is not a symptom of Covid-19.
Fifth Disease	The student is no longer contagious once the rash (looks as if cheeks have been slapped) appears. Notify school and anyone who might be pregnant who came in contact with the student before the rash appeared.
Fractures and Surgeries	Notify the school to determine additional modifications your student might need after a fracture or surgical procedure.
Head Lice	Notify the school if you find lice in your child's hair. If found at school, the student will be sent home and parents should treat immediately. Information will be given and a letter will be sent home to the students in that classroom. The student must be nit free before returning to school.
Impetigo	This is a contagious skin infection characterized by sores covered with a brownish/yellowish crust. The student must remain home and may return 24 hours after treatment with a note from his/her MD.
Nosebleeds	Parents will be called to pick up their child if the nosebleed lasts for more than 10 minutes.
School Injuries	The teacher and staff will assess the injury and administer first aid. Parent will be

	notified by a note or a phone call.
Rashes	Student is to remain at home with any undiagnosed skin rash unless a doctor's note stating that the rash is not contagious is presented.
Strep Throat	Student may return 24 hours after antibiotics have been started if the student is able to participate and is fever free.
Vomiting	Student should remain at home if he/she vomited within the past 24 hours until resolved, and it is determined the vomiting is not due to another illness such as the flu or strep throat.

Trinity School

1361 E. Lincoln Highway, New Lenox, Il 60451 (815) 463-0719

School Calendar 2020-2021

AUGUST (14 days)

M	T	W	T	F
[3]	[4]	[5]	[6]	[7]
{10}	{11}	{12}	13	14
17	18	19	20	21
24 31	25	26	27	28

SEPTEMBER (20.5 days)

M	T	W	T	F
	1	2	3	4
[7]	8	9	10	11
14	15	16	17	18
21	22	23	24	(25)
28	29	30		

OCTOBER (20 days)

M	T	W	T	F
			1	2
5	6	7	8	9
[12]	13	14	15	16
19	20	21	22	{23}
26	27	28	29	30

NOVEMBER (16 days)

M	T	W	T	F
2	3	4	5	{ 6 }
9	10	[11]	12	13
16	17	18	19	20
23	24	[25]	[26]	[27]
30				

DECEMBER (13.5 days)

M	T	W	T	F
	{1}	2	3	4
7	8	9	10	11
14	15	16	17	(18)
[21]	[22]	[23]	[24]	[25]
[28]	[29]	[30]	[31]	

2021 JANUARY (18.5 days)

M	T	W	T	F
				[1]
{4 }	5	6	7	8
11	12	13	14	(15)
[18]	19	20	21	22
25	26	27	28	29

FEBRUARY (18.5 days)

M	T	W	T	F
1	2	3	4	5
8	9	10	11	(12)
[15]	16	17	18	19
22	23	24	25	26

MARCH (17.5 days)

M	T	W	T	F
1	2	3	{ 4 }	{ 5 }
8	9	10	11	12
15	16	17	18	(19)
22	23	24	25	26
[29]	[30]	[31]		

APRIL (18 days)

M	T	W	T	F
			[1]	[2]
{5}	6	7	8	{9}
12	13	14	15	16
19	20	21	22	{23}
26	27	28	29	30

MAY (19.5 days)

M	T	W	T	F
3	4	5	6	7
10	11	12	13	(14)
17	18	19	20	21
24	25	26	27	[28]
[31]				

JUNE (17 days)

M	T	W	T	F
	[1]	[2]	[3]	[4]
{7}	8	9	10	11
14	15	16	17	{18}
21 28	22 29	23 30	24	25

JULY (10 days)

M	T	W	T	F
			1	(2)
{5}	6	7	8	9
12	13	14	15	{16}
[19]	[20]	[21]	[22]	[23]
[26]	[27]	[28]	[29]	[30]

First Day of School/Last Day of School/Classes Resume

[ ] = Holiday/No School

{ } = Teacher In-Service or P/T Conferences -No School

( ) = Early Release Day for Students (11:45 a.m.)

TRINITY Services, Inc.

Important Dates

AUGUST
10-11 Teacher's Institute Day- **No Students**
12 **First Day** of School for students

SEPTEMBER
7 **No School** – Labor Day
25 Early Release Day for Students 11:45am

OCTOBER
12 **No School** – Columbus Day
23 Parent/Teacher Conferences-**No Students**

NOVEMBER
6 Teacher In-Service – **No Students**
11 **No School** - Veterans Day
25-27 **No School** - Thanksgiving Break

DECEMBER
1 Classes Resume
18 Early Release Day for Students 11:45am
21-31 Winter Break

JANUARY *2021*
1-3 Winter Break
4 Classes Resume
15 Early Release Day for Students 11:45am
18 **No School** - Martin Luther King Jr. Day

FEBRUARY
12 Early Release Day for Students 11:45am
15 **No School** - President's Day

MARCH
4-5 Teacher In-Service - **No Students**
19 Early Release Day for Students 11:45am
29-31 **No School –** Spring Break

APRIL
1-2 **No School –** Spring Break
5 Classes Resume
9 Parent/Teacher Conferences-**No Students**
23 Teacher In-Service – **No Students**

MAY
14 Early Release Day for Students 11:45am
28 Last Day before Break- Graduation Day
31 **No School** - Memorial Day

JUNE
1-4 End of Year Break
7 **First Day** of Summer School
18 Teacher In-Service – **No Students**

JULY
2 Early Release Day for Students 11:45am
5 **No School-** July 4th Holiday Observed
16 **Last Day** of Summer School
19-31 Summer Break

Trinity School Office.....(815) 463-0719
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