Referral-Permission for Nature-Based Services

Participant Name: _____ Age: _____ Date of Birth: _____

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

Parent/Care Provider(s): _____

Phone Contact(s): _____

Legal Guardian (if different than above): _____

Legal Guardian Phone/Email: _____

MANDATORY FORM COMPLETION

*The following **mandatory** forms have been completed, signed, and submitted. Participation in any Layers of Life Programming is prohibited without completion of the following documentation.*

- ☐ Referral-Permission for Nature-Based Services (this form)
- ☐ Consent for Release/Obtain Information
- ☐ Emergency Medical Authorization (ORC33312.712)
- ☐ Medical, Health and Safety
- ☐ Participant Profile
- ☐ Photo Release
- ☐ COVID Screening

Parent-Guardian Permission to Participate / Liability Waiver

____(initial) I possess and have reviewed the Layers of Life Participant Handbook

I give permission for the participant named above, to participate in the Layers of Life nature-based program. I have completed all requested information and acknowledge that the information in the registration and health history is complete and accurate. I am aware of the benefits and risks of nature-based services which is provided outdoors in a range of weather conditions and exposure to a range of plants, terrains, equine (horses) and small animals. **Because of the benefits of nature-based programing, I waive any claim which I or my participant may have against Layers of Life Program (LOL in Nature, LLC) and its employees, volunteers or partners and partner agencies arising out of injury sustained during on-site programming.**

Legal Guardian Printed Name: _____ Relationship to Participant: _____

Legal Guardian Signature: _____ Date: _____

Discrimination Disclosure: *It is the policy of Layers of Life to provide equal opportunities for all persons and to prohibit unlawful discrimination because of because of race, color, religion (creed), gender, gender expression, age, national origin (ancestry), disability, marital status, sexual orientation, or military status, in any of its activities or operations. This policy applies to all participants, potential participants, volunteers, and employees. Layers of Life will accommodate services according to ADA regulations CFR; 28;35-36. Layers of Live reserves the right to deny service to anyone not meeting the requirements set forth by Layers of Life/LOL in Nature, LLC policies or to anyone posing a threat or harm to themselves, others, animals, program equipment. For further information refer to the lolinnature.com policies and participant handbook.*

Consent to Release/Obtain Information

Date of Request: _____

Participant Name: _____Date of Birth: _____

I hereby authorize the release of information by the agencies identified below. This authorization will remain in effect for: ☐ *One (1) Year, or* _____*(date).*

Agency/Name: _____

Address and Phone: _____

_____

☐ *to release information to:*

☐ *to obtain information from:*

Kim Hale
Layers of Life Nature-Based Services
3750 Old State Route 56, New Marshfield, OH 45766
740-591-9041 khale@lolinnature.com www.lolinnature.com

For the following purposes:

- ☐ To develop a plan to meet the participant's needs and address any health and safety concerns for participation in selected nature-based services. These activities may include but are not limited to individual therapy; group learning activities; as well as the small animal and equine services with appropriate permission.
- ☐ Coordination of services
- ☐ Other_____

The following information to be released is listed below.

- ☐ Early Intervention (Individual Family Service Plans)
- ☐ School Age (Educational Team Reports-ETR; Individual Education Plans -IEP ; 504 etc.)
- ☐ Mental Health and Behavior Support Services Reports
- ☐ Outside Diagnostic Evaluations and Therapy Reports (I.e. Children's Hospital, Centers etc.)
- ☐ Other: _____

Legal Guardian Printed: _____ Relationship to Participant: _____

Legal Guardian Signature: _____ Date: _____

HIPPA DISLOSURE: *Layers of Life (LOL in Nature, LLC) is a private entity that coordinates the development of nature-based services for general life skills, learning and therapeutic skills with local agencies. Information shared between location agencies require written permission for disclosure. We will never share any evaluation or treatment records without your written permission."*

REVOCATION:
This consent has been revoked on: Date: _____ Signature: _____

Emergency Medical Authorization

This form meets the requirement for Ohio Revised Code Section 3313.712.

Participant Name: _____ Phone: _____

Address: _____ DOB: _____

Purpose - To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under our program's authority, when parents or guardians cannot be reached.

Residential Parent or Guardian:

Mother's Name: _____ Daytime Phone: _____

Father's Name: _____Daytime Phone: _____

Other's Name: _____ Daytime Phone: _____

Name of Relative or Childcare Provider: _____

Relationship: _____ Daytime Phone: _____

Address: _____

Emergency Contact[1] #1: _____ Daytime Phone: _____

Address: _____

Emergency Contact #2: _____ Daytime Phone: _____

Address: _____

Emergency Contact #3: _____ Daytime Phone: _____

Address: _____

PART I OR II MUST BE COMPLETED:

PART I - *TO GRANT CONSENT* I hereby give consent for the following medical care providers and local hospital to be called:

Doctor: _____Phone: _____

Dentist: _____Phone: _____

Medical specialist: _____Phone: _____

Local Hospital: _____Emergency Room Phone: _____

[1] Emergency contact information is required in accordance with Ohio Administrative Code Rule 3301-37-08 (for preschool programs) and Rule 3301-32-10 (for school aged childcare programs).

Please complete both pages of this form

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

_____

_____

_____

Signature of Parent/Guardian: _____ Date: _____

Address: _____

PART II - *REFUSAL TO CONSENT* I do **NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action (written instructions must be completed):

_____

_____

_____

Signature of Parent/Guardian: _____ Date: _____

Address: _____

Please complete both pages of this form

Medical, Health, and Safety Information

Participant Name: _____ DOB: _____

Medical Conditions/Diagnosis/Disability: _____

_____

Date of Onset Primary Disability: _____ Height: _____ Weight: _____ Gender: _____

Current medications: _____

_____

Allergies:

_____

_____

Emergency Medical Information: *(ex. Epi-Pen, Midazolam, inhaler)*

_____

_____

Medical and Adaptive Equipment: (*List any medical devices that must be available during a session such as wheelchairs, walkers, cane, service animal, special seating needed for balance, shoe inserts, speech-device, hearing aids, etc.*)

_____

_____

_____

Needed Medical Personnel: (*List any support person who is required to be present for services such as nurse, trained provider, interpreter, etc.*)

_____

Thing we should know: (Ex. *likes to run and hide, falls easily, sensitive - watch for mild redness or rash, speaks limited English, etc.*)

_____

_____

In the role of parent/guardian of the participant, I acknowledge that the information submitted is accurate and up to date to be used for medical, health, and safety for nature-based services.

Signature: _____ **Date:** _____

Printed Name: _____ **Relationship**_____

Photo Release

Participant Name: _____ Age: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

PERMISSION FOR PHOTO USE (Initial all boxes that apply)

I grant permission for the use and production of photos and videos by Layers of Life/LOL in Nature, LLC in the following manner (initial by each):

_____ On site program materials for enrolled participation of nature-based activities

_____ Disbursement of photos materials of my participant enrolled in a nature-based activity to be sent home in journals, memory books, communication displays of other enrolled participants of the program.

_____ Promotional materials for local agencies, community awareness and advertisement of the nature-based programming

_____ Social Media

_____ Presentations at professional state and national conferences.

Commercial Use

_____ Commercial use for promotional materials, advertisement locally.

_____ Commercial use on the Layers of Life website at www.lolinnature.com

I DO NOT grant permission for any photos of _____ to be used for any reason. I understand that my participant may not receive the same type of journals and other materials from nature-based activities.

_____ I will supply a photo for use in nature-based activities and request that it be returned to me upon completion of the program.

Parent or Legal Guardian Permission:

Legal Guardian Printed Name: _____ Relationship: _____

Legal Guardian Signature: _____Date: _____

Layers of Life

Participant Profile – Parent/Care Provider

Profile for (name): _____ likes to be called: _____

DOB: _____ Age: _____ Lives in (town): _____

I would like to see the participant's nature-based experience to learn to: (*ex. focus on academic and other activities, leave an event calmly, learn to play with another child, just have fun, etc.)*

_____

_____

The most wonderful things about the participant are:

_____

_____

The most challenging thing about the participant is:

_____

_____

The best way to support the participant is: (*ex. give a firm hug or give plenty of space*)

_____

_____

The participant loves to: (*preferred activities such as play with play-doh, singing, water, dogs, etc.*)

_____

_____

The participant does not like, react well to, be around: (*loud sounds, things that are slimy, dogs, et…etc.*)

_____

_____

The participant's preferred social support person or persons: (*Ex. Most comfortable with Dad.)*

_____

_____

List any nature-based activities or environments do you think the participant will enjoy: (*Ex. loves the rain, plays in the grass with our dog, etc.*)

_____

_____

List any nature-based activities/environment that you think the participant would be uncomfortable: (*Ex. does not like cats, uncomfortable in the rain, etc*.)

_____

Clothing Challenges: Does the participant have any resistance to coats, shoes, gloves, etc.

_____

Layers of Life

COVID-19 Screening

Name of Person Screened: _____

1. Have you received the full COVID Vaccine? Yes☐ No☐ If yes, date of vaccination: _____

2. You are required to take your temperature before entering the programming area. Your temperature **must be below 100.4.** Did you take your temperature before you left home or upon arrival to the parking lot?

   ☐Yes or ☐No* *If you answered **NO** to this question you many not entering the programming area. Please take your temperature. If it is below 100.4 please continue.

3. Do you have any of these symptoms?

   ☐ Fever (100.3 +) in the last 24 hours ☐ Unusual Headache ☐ Chills

   ☐ Cough ☐ Sore Throat ☐ Repeated shaking with chills

   ☐ Difficulty breathing ☐ Unusual Diarrhea ☐ Unusual muscle pain

   ☐ Congestion or runny nose

   ☐ Yes* ☐ No

4. In the past 14 days, have you had close contact (within 6 feet or without a mask) with any individual diagnosed with COVID-19?
   ☐ Yes* ☐ No

5. Have you traveled outside of the United States within the past 14 day?
   ☐ Yes* ☐ No

6. Have you traveled outside of Ohio in the last 14 days to any of the Ohio Travel Advisory states at coronavirus.ohio.gov (COVID-19 Travel Advisory)?
   If you answered **YES to any of these questions you may not enter the programming area. Please leave and call your health care provider.*

7. Are you a necessary worksite visitor or an authorized visitor by an administrator of the Layers of Life Program or the Perry County Board of Developmental Disabilities?
   ☐ Yes ☐ No

8. If you answered YES to this question, what is the name of the individual that you are here to see or your role? _____

9. Signature: _____ Date: _____ Time: _____