New Vision Student Packet
2020-2021

Please complete the documents in this packet and return to us on August 18 at the Mandatory New Vision Registration Day.

Included documents:

- CITI BOCES Emergency Treatment Release Form - Due Aug 18
- CITI BOCES Student Information Form - Due Aug 18
- New Vision Confidentiality Statement - Due Aug 18
- Summer Contact Sheet *keep this*
- Allied Health Only - Medical Records Form - Due Aug 18
- Allied Health Only - Minor Background Check Form - Due Aug 18

Authorization for Emergency Treatment of Minors

Center for Instruction, Technology & Innovation

I/We, being the parent(s) or legal guardian(s) of

Name of Minor

Birth date of Minor

do hereby appoint the following person(s) to

Name of Faculty/Staff Chaperones – CiTi 179 County Route 64 Mexico, NY 13114		
New Vision Teachers:	Dianna Nesbitt-315-573-6270	Emily Kirch-315-720-8549

Name of Faculty/Staff Chaperones – CiTi 179 County Route 64 Mexico, NY 13114	
Cayla Defren, New Vision Program Administrator	315-491-0694
Marla Berlin, Regional Program Administrator	315-963-4262

to act in my/our behalf in authorizing medical, dental, surgical, and/or hospitalization for the above named minor during the period of my/our absence for the period of/on the following day(s) 9/9/20 through 6/30/21. This document shall be presented to a physician, dentist, or appropriate hospital representative at such time as emergency medical, dental, surgical care, or hospitalization may be required.

Name of Parent/Guardian	Name of Witness
Signature of Parent/Guardian	Signature of Witness
Address	
Phone Number – Work	Phone Number - Cell
Phone Number – Home	

Hospitalization Coverage:

Name of Insurance Company/Government Program

Identification/Contract #

Physicians' Information:

Name	Phone #
Name	Phone #
Name	Phone #

Does your child have any current medical conditions? NO YES

If "YES," please explain:

Does your child have any allergies? NO YES

If "YES," please explain:

If "YES," what reactions occur?

Does your child take any medication at the present time? NO YES

If "YES," what is the medication and what is the dosage?

If "YES," does your child require medication during the school day? (List times and dosage.)

Is there any other information regarding your child's health or medical condition that the teachers/chaperones should know? NO YES

If "YES," please explain:

Center for Instruction, Technology & Innovation

First Name _____ **MI** _____ **Last Name** _____

CTE Class _____

-----TO BE COMPLETED BY PARENT/GUARDIAN (*Please Print Clearly*) -----

A. STUDENT INFORMATION

Social Security Number _____ - _____ - _____ (optional) Male/Female _____

Street Address: _____

Mailing Address: _____

City _____ State _____ Zip Code _____ Ext. _____

Student Email Address _____

Student Home Number ( ) _____ - _____ Student Work Number ( ) _____ - _____

Student Cell Number ( ) _____ - _____ Birth Date _____ / _____/ _____

B. SCHOOL INFORMATION

Present Grade _____ School District _____

Career Objective:

_____ Attend 2 or 4 Year College (Tech Prep) _____ Attend Trade/Technical School (Tech Prep)

_____ Enter Work Force _____ Armed Forces _____ Unknown

C. STUDENT CONTACT INFORMATION

Parent/Guardian 1 Information

Relationship to Student _____ (Circle One: Mr. Mrs. Miss Ms.)

First Name _____ MI _____ Last _____

Street Address: _____

Mailing Address: _____

City _____ State _____ Zip Code _____ Ext. _____

Parent Email Address _____

Parent Home Number ( ) _____ - _____ Parent Work Number ( ) _____ - _____

Parent Cell Number ( ) _____ - _____

Parent/Guardian 2 Information

Relationship to Student _____ (Circle One: Mr. Mrs. Miss Ms.)

First Name _____ MI _____ Last _____

Street Address: _____

Mailing Address: _____

City _____ State _____ Zip Code _____ Ext. _____

Parent Email Address _____

Parent Home Number ( ) _____ - _____ Parent Work Number ( ) _____ - _____

Parent Cell Number ( ) _____ - _____

Emergency Contact Person 1 (Other than Parent/Guardian)

(Mr. Mrs. Miss Ms.) First Name _____MI _____ Last _____

Home Number ( ) _____ - _____ Work Number ( ) _____ - _____

Cell Number ( ) _____ - _____

Emergency Contact Person 2 (Other than Parent/Guardian)

(Mr. Mrs. Miss Ms.) First Name _____MI _____ Last _____

Home Number ( ) _____ - _____ Work Number ( ) _____ - _____

Cell Number ( ) _____ - _____

Additional Information

Required medication:

_____

Medical or physical limitations:

_____

Previous B. Ramer Technical Course(s):

_____

_____

_____

D. PARENT/GUARDIAN SIGNATURE

_____ DATE _____

Return this form to instructor
within 5 days or mail to:
CiTi (Center for Instruction, Technology & Innovation)
CTE Office
179 County Route 64
Mexico, NY 13114

(Parent/Guardian – Please notify the CTE Office anytime contact information changes)

Center for Instruction, Technology & Innovation

New Vision Program

Confidentiality Statement

As a student in the New Vision Program, you will be in various situations where information is either shared with you or is visibly or audibly accessible. In the specialized careers, law and government, and health care fields, information is considered confidential, privileged and private. Under no circumstances should information be shared or communicated to anyone on any platform outside that specific moment.

Sharing information in an inappropriate way is called a "breach of confidentiality" and is the greatest concern of professionals who allow New Vision students into their facilities. Any New Vision student who has breached confidentiality, may be removed from the program. Legal action may also be initiated for violating confidentiality. This confidentiality does not end when your rotation ends; rather, the information remains private forever.

If there are opportunities to share your experiences with classmates or family, you must maintain total anonymity of the patient or client involved; no identifiable information may be shared. You can say "I sat in on an interview with a victim of abuse" or "I saw a C-Section today". You cannot share specific information of where the person lives, works or goes to school, nor can you hint at their appearance. Further, if you think you are going into a situation where you or a loved one knows this patient, you are encouraged to remove yourself from that case, out of respect for their privacy.

I have read the above statement and understand the importance of confidentiality to the success of this program. I agree that as a New Vision student, I will maintain confidentiality during and after my experience in the program. I also understand that any violation of confidentiality may result in my immediate removal from the program.

Student Signature:_____

Parent Signature:_____

New Vision Programs
2020 -2021 Contact Sheet

For the Allied Health Program:
Ms. Emily Kirch, MST
New Vision Allied Health Instructor
Adjunct Professor of English
Adjunct Professor of Professional Studies (GST)
Phone: 315.720.8549
Email: ekirch@citiboces.org

For the Specialized Careers Programs:
Ms. Dianna Nesbitt, MS
New Vision Specialized Careers Instructor
Adjunct Professor of Psychology
Adjunct Professor of Professional Studies (GST)
Phone: 315.573.6270
Email: dnesbitt@citiboces.org

For Scheduling and Administrative Concerns:
Ms. Cayla Defren
New Vision Program Administrator
Phone: 315.491.0694
Email: rproud@citiboces.org

Ms. Marla Berlin
Director of Career and Technical Education
Phone: 315.963.4262
Email: mberlin@citiboces.org

For SUNY Application/Course Registration/Payment:
Ms. Daniela Mosko
High School Programs Coordinator for SUNY Oswego
Phone: 315.312.2270
Email: highschoolprograms@oswego.edu

New Vision Program Office - Lower Level Wilber Hall, SUNY Oswego