New Vision Student Packet
2021-2022

Please complete the documents in this packet and return to us on August 18, 2021 at the Mandatory New Vision Registration Day.

Wilber Hall SUNY Oswego
Parking Lot Commuter P8

- 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

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 315-963-4346
Marla Berlin, Director of College and Career Education 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) 9/8/21 through 6/30/22. 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 – Home
**Hospitalization Coverage:**

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<th>Name of Insurance Company/Government Program</th>
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**Physicians’ Information:**

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<th>Name</th>
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**Does your child have any current medical conditions?**

If “YES,” please explain:

**Does your child have any allergies?**

If “YES,” please explain:

If “YES,” what reactions occur?

**Does your child take any medication at the present time?**

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?**

If “YES,” please explain:
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)
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
2021-2022 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: cdefren@citiboces.org

Ms. Marla Berlin
Director of College Career 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