Project LIFE Referral Packet

Purpose:

The purpose of this referral packet is to collect all necessary information and documentation prior to a student beginning Project LIFE at Goodwill of Southwestern Pennsylvania. To best connect students with services and prepare them for participation in Project LIFE, Goodwill is requesting the following materials:

☐	Project LIFE Referral Form
☐	Parent-Guardian-School Agreement
☐	Emergency, Medical Information & Consent for Treatment
☐	Emergency Plan of Action for Medical Conditions (if applicable)
☐	Current Individual IEP
☐	Current Special Education Evaluation (ER/RR)

Please scan and email all application materials to Clare Hann, Transition Services Coordinator at clare.hann@goodwillswpa.org by Friday, May 6, 2022 for admittance on a first-come, first-served basis.

Cover Sheet for:

Student Name	
Student Phone	
Referring School District	
Date of Referral	

Project LIFE

Referral Form

*Please note: This form MUST be filled out **completely** prior to student start date. If form is not complete student will NOT begin workforce readiness training program.*

Student Information	
Name:	
Street Address:	
City, State, Zip:	
Phone:	
School:	
School Main Office Phone:	
Student Date of Birth:	

Referral Information	
Referred by:	
Title:	
School Year Contact:	
Address:	
Phone:	
Email:	
Preferable days of attendance (Half or Full Day)	

Transportation Information	
Bus Company:	
Contact Person:	
Phone:	
Arrival Time:	
Departure Time:	

Billing Information	
School to Bill:	
Contact Name:	
Billing Address:	
Phone:	

Transition Planning Information	
Primary Disability	
Secondary Disability	
Physical Limitations	
Accommodations Needed (Physical and Learning)	
Method of Communication	
Current IEP Date	
Anticipated Diploma Acceptance Date	
Vocational Assessment Yes or No Where?	

Other Provider Information	
OVR Counselor:	
Email:	
Phone:	
Supports Coordination Provider:	
ISC Name:	
Email:	
Phone:	

To help us with the coordination of services would you:

List any behaviors that may impact the student's workforce readiness training experience?

List any student strengths that may benefit them during their workforce readiness and vocational experiences.

List any safety concerns you may have of this student.

Additional Comments

_____ _____

Transition Coordinator Date

Project LIFE

Parent/Guardian and School Agreement

It has been agreed that _____, a student from _____ will begin a workforce readiness training program at Goodwill of Southwestern Pennsylvania on _____.

By signing this agreement, all parties understand and agree to the following terms:

- Parent/Guardian gives permission for participation in Goodwill's workforce readiness training program and will support the student in meeting the requirements of the program.
- The Transition Services staff person will monitor the student's progress and consult regularly with the student, student's parents/guardians, and school representatives.
- All parties participate in any progress meetings and communicate information vital to the success and development of the student.
- All parties understand that the student will not receive any wages and is not guaranteed a job or community training placement during or at the conclusion of their participation in the program.

_____	_____
Student	Date
_____	_____
Parent/Guardian	Date
_____	_____
School Representative	Date
_____	_____
Goodwill Transition Services Coordinator	Date

Project LIFE

Emergency Information, Medical Information, and Consent for Treatment Form

*Please note: This form MUST be filled out **completely** prior to student start date. If form is not complete student will NOT begin workforce readiness training program.*

Student Name:	
Street Address:	
City, State, Zip:	
Phone Number:	
Date of Birth:	

School	
School Contact	
School Contact Phone:	
School Contact Email:	
Parent/Legal Guardian:	
Address:	
Home Phone:	
Work Phone:	
Cell Phone:	
Email: Parent/Guardian	
Email: Student	
Student Facebook Page	

Emergency Contacts	**Please list at least 2 Emergency Contact Numbers that can be reached during the school day**
Name:	
Phone Number:	
Relation:	
Name:	
Phone Number:	
Relation:	
Name:	
Phone Number:	
Relation:	

Disability Information	
Primary Disability	
Secondary Disability	

Medication Information	*Mark "N/A" if not applicable:*
Medication Name:	
Diagnosis:	
Dosage/Frequency:	
Special Instructions:	

Medication Name:	
Diagnosis:	
Dosage/Frequency:	
Special Instructions:	

Medication Name:	
Diagnosis:	
Dosage/Frequency:	
Special Instructions:	

Medication Name:	
Diagnosis:	
Dosage/Frequency:	
Special Instructions:	

**Medication Side Effect Information attached. **For additional medications please attach separate sheet.*

Medical Information	
Allergies:	
Bee Sting Allergies:	
Date of Last Tetanus Shot:	
Does the individual have: *(Check all that apply)*	***Explanation/Special Instructions* – If any checked, please complete the Emergency Plan of Action for Medical Conditions**
❑ Seizures ❑ Heart Condition ❑ Diabetes ❑ Other (specify)	

Dietary Needs	*N/A*	*Explanation/Special instructions:*
Special Dietary Requirements:		
Food Allergy:		
Other (Specify):		

Physical Accommodations	*N/A*	*Explanation/Special instructions:*
Wear eyeglasses:		
Use hearing aid:		
Use wheelchair or walker:		
Use speech augmentation device:		
Other (Specify):		

On-Site Needs	*N/A*	*Explanation/Special Instructions:*
Requires medication assistance:		
Safety Concerns:		
Cultural Needs		
Other (Specify):		

In order for a student to take a prescribed medication at Goodwill, the medication MUST be in its original bottle or packaging, accompanied by a prescription from their doctor, as well as a Goodwill of Southwestern Pennsylvania Dispensation of Medication form.

Goodwill Staff Signature	Title	Date

Consent for Goodwill Health Center Treatment

Please mark the appropriate box.

Goodwill 's Health Center has my permission to administer over the counter Acetaminophen to my child.

☐ **YES**
☐ **NO**

Goodwill's Health Center has my permission to administer over the counter Maalox to my child.

☐ **YES**
☐ **NO**

Do you wish to be called before medication is given?

☐ **YES**
☐ **NO**

Printed Student's name: _____

Signature of Parent/Guardian: _____ Date: _____

Consent For Emergency Treatment

In the event that my child is unable, due to their condition, to give proper authority at the scene of an incident:

1. Goodwill staff members are authorized to administer emergency first aid services that are necessary and appropriate while in their care.
2. If necessary, Goodwill staff members are authorized for transportation to a licensed hospital emergency room via paramedics or Goodwill staff.
3. At the licensed hospital emergency room, I consent to immediate emergency medical treatment for my child.

Print Student's Name: _____

Signature of Parent/Guardian: _____ Date: _____

Signature of Student: _____ Date: _____

Project LIFE

Emergency Plan of Action for Medical Conditions

Created On: ___ / ____ / _____

A: Personal Information	
Student Name	
Student Date of Birth	
Student SSN	
Primary Contact Number	
Home Address	
Personal Email	
Treating Healthcare Provider	
Preferred Hospital	
Has the Student's treating healthcare provider been consulted	**___ YES ___ NO**

B: Personal Emergency Contact Information	
Contact's Name	
Relationship	
Primary Contact Number	
Secondary Contact Number	
Contact's Name	
Relationship	
Primary Contact Number	
Secondary Contact Number	

C. Purpose of Plan of Action	
Medical Impairment(s) Prompting Plan (e.g., seizure disorder, food allergy, respiratory impairment, etc.):	
Symptoms/Limitations Requiring Response (e.g., seizure, allergic reaction, dizziness/instability, etc.):	
On-site Designated Responder Contact (e.g., *if applicable* - supervisor, human resources personnel, onsite medical personnel, etc.):	
When to Contact Designated Responder (e.g., after a seizure lasting longer than 5 minutes, upon exposure to allergen, etc.):	

D. Warning Signs

Warning signs are symptoms/limitations that precede the onset of a possible medical emergency and prompt action. For example, blank staring, involuntary jerking, or nausea before a seizure occurs, or redness, swelling, or difficulty breathing in response to an allergic reaction, etc. The plan should include signs/symptoms to be aware of and that will require response. For example:

a. John will experience nausea.
b. John's face or shoulder/arm will begin to jerk involuntarily.
c. The warning signs give John 3-4 minutes before seizure activity begins.
d. John will signal designated co-worker using 2-way radio (with texting) to inform of oncoming seizure.

E. Action Plan

The action plan will include information about when and how to respond to a student participant's specific emergency medical situation (e.g., move individual to safe place, contact 911, administer first aid or medication, contact designated responder, etc.). Using the example started above, in the event of a seizure:

a. Using his hand or arm, gently lead John to designated safe area.
b. If necessary, help John into a seated or lying position.
c. If necessary, loosen any restrictive clothing (such as a tie or scarf).
d. During seizure (which lasts from 2 - 5 minutes), John will not need medical attention.
e. When seizure subsides, offer John a cool cloth for his face or a cool drink.
f. If John is disoriented, identify yourself and identify his location/surroundings.

Additional Comments

Additional information may be needed to supplement the plan and communicate expectations for action after the medical emergency. For example:

1. Two designated co-workers will carry radios to hear John's emergency signal.
2. Supervisor will call John's emergency contact person.

Based upon John's documentation provided by his neurologist, ambulance/medical attention is not required unless John falls or hits his head.

When will documentation from a healthcare provider be needed in order to return to training after the medical emergency specified in this plan? Check applicable requirements:

☐ Only in accordance with the employer's documented attendance policy

☒ **After an absence of three or more consecutive days, due to the medical emergency for which action plan is required**

☒ **After hospitalization following medical emergency**

☐ All of the above apply

☐ Documentation will not be necessary

_____ _____

Individual's Printed Name Date

_____ _____

Individual's Signature Date

_____ _____

Preparer's Printed Name Date

_____ _____

Preparer's Signature Date