



Calhoun County Schools

*Focused on success for all*

Camp Kindergarten is for students with disabilities entering Kindergarten in the CCS district. The goal is to ease the transition to kindergarten by teaching campers the “readiness” skills necessary to engage in academic and social activities.

Camp Locations: Alexandria, Weaver, Wellborn, and Saks  
Elementary

\*Dates will vary according to the school  
8:00 AM - 12:00 PM

*\*All entering K students zoned for CCS are eligible to apply*

For more information, scan the QR code or  
contact Dr. Shannon Romano (256) 741-7433





## Calhoun County Schools Camp Kindergarten Application Packet

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Calhoun County Schools is excited to accept applications for Camp Kindergarten, a transition camp for students with disabilities who are preparing to enter kindergarten during the 2026-2027 school year! Camp Kindergarten is free of charge for students who are zoned for the Calhoun County School district and who require additional assistance in the areas of communication, self-regulation, and adaptive skills.

The goal of the program is to ease the transition to kindergarten by teaching our campers the "readiness" skills necessary to engage in academic and social activities. Camp Kindergarten will be staffed by special education teachers and paraprofessionals employed by the district and who are trained to provide intensive and individualized support.

Skills taught at Camp Kindergarten will include:

- Transitioning appropriately between activities and locations
- Following a visual schedule to teach daily routines
- Structured work activities (task box systems) for independent work
- Using functional communication systems to make requests/express needs
- Social skills

Upon completion of Camp Kindergarten, you will meet with your child's camp instructor to review a comprehensive report that identifies your child's strengths, needs, and recommended strategies for supporting your child in kindergarten! This list will also be given to the kindergarten teacher and special education case manager. The recommendations in the report should be reviewed and considered by the child's IEP team when making decisions about appropriate supports and services.

### *Who is eligible for Camp Kindergarten?*

Students can be referred by school personnel, parents, local daycare and pre-school programs, or related service providers and will be selected based on applications and interviews. Criteria for participation are students who:

1. Have been determined to be eligible or who are in referral to determine their eligibility for special education services
2. Have deficits in self-help skills, communication, and self-regulation
3. Exhibit difficulty transitioning between locations/activities
4. Have reliable transportation to and from the program

personnel directly by the parent/ guardian.

\*\*\*NOTE: THE PARENT/GUARDIAN OR PARENT- DESIGNATED RESPONSIBLE ADULT MUST DELIVER ALL MEDICATIONS DESIGNATED CONTROLLED SUBSTANCES (SUCH AS RITALIN) TO THE SCHOOL NURSE OR UNLICENSED MEDICATION ASSISTANT. ALL SHARP ITEMS SUCH AS SYRINGES AND LANCETS MUST BE TREATED AS CONTROLLED SUBSTANCES FOR PURPOSES OF THIS PROVISION. STUDENTS MUST NOT DELIVER CONTROLLED SUBSTANCES, INCLUDING SHARP ITEMS, TO THE SCHOOL. Whether a prescribed medication is a controlled substance should be indicated by the physician in the appropriate location on the physician's statement form.

3. The parent or guardian must sign a consent form (available in the school office) before any medication is given at school authorizing the School Nurse or Unlicensed Medication Assistant to administer or assist in the administration of the medication.

### *Parent Training*

A parent or guardian **MUST** attend one of two required training sessions. The purpose of the parent training is to review the in's and out's of the program, to train parents on how to work on similar skills at home, and to invite local agencies who support children with disabilities to provide information about their services.

We all know that it takes a village, and the most successful transitions happen when everyone working with the student is on the same page.

### *Camp Attendance*

Attendance is critical for those who are accepted to Camp Kindergarten! There are many students in our community who would benefit from this program, and only 10 campers will be accepted per site.

If a child misses more than 2 days of camp without a medical excuse, their slot will be offered to another child.

### *Application Process*

Below is a timeline for the application process. All components must be submitted and parents must participate in interviews in order for their child to be considered for the program. These can be done in-person or via Zoom. If your child attends or has attended a daycare or preschool program, there is an Input Packet that must be completed and submitted.

The dates below are subject to change.

April 3, 2026	Application packets due
April 10, 2026	Preschool/Daycare Input forms due
April 13 - April 30, 2026	Parent interviews

## Camp Kindergarten Application

Child's Name: \_\_\_\_\_ Gender \_\_\_\_\_ DOB \_\_\_\_\_

Address: \_\_\_\_\_

School your child will attend in kindergarten \_\_\_\_\_

Primary contact's name and phone number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Ethnicity (circle): White Black Indian Pacific Islander Asian Multi-Race

Language(s) Spoken at Home: \_\_\_\_\_ Child's Primary Language: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Working Phone Number: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Working Phone Number: \_\_\_\_\_

Other Contact's Name: \_\_\_\_\_ Working Phone Number: \_\_\_\_\_

Who is completing this form: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

What is your primary concern regarding your child's development?  
\_\_\_\_\_  
\_\_\_\_\_

Will your child have consistent transportation to and from camp? Yes No

Is the parent/guardian willing to attend a required training to learn more about carrying over the skills learned at Camp Kindergarten and to learn about the community agencies and resources available to support your child? Two sessions will be made available.

YES NO

### Medical History

Was the child born prematurely or was the child born as the result of a full term pregnancy? \_\_\_\_\_

Were there any conditions present during or after birth that you feel were significant?  
\_\_\_\_\_

Where? \_\_\_\_\_ When? \_\_\_\_\_

How often did your child attend this program? \_\_\_\_\_

Does your child have an Individual Education Plan? Yes No

Services child has received or is receiving	Provider	How often?	Location where services were provided
Speech Therapy			
Occupational Therapy			
Physical Therapy			
Behavioral Therapy			
Other			

Please sign the attached *Consent to Release Records* form. This form will be used to obtain medical, behavioral, and/or therapeutic information relevant to supporting your child at Camp Kindergarten.

Please initial beside each statement:

I understand that I am required to attend 1 of 2 available parent training sessions in order for my child to attend Camp Kindergarten. If I do not attend, my child will not be able to participate. \_\_\_\_\_

I understand that transportation to and from camp is not provided by Calhoun County Schools, and I will be responsible for transporting my child. \_\_\_\_\_

I understand that my child cannot miss more than 2 days of camp without a medical excuse or else their slot will be made available to another applicant. \_\_\_\_\_

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Participates in adult-directed activities				
Engages appropriately with peers				
Shares with others				
Throws temper tantrums				
Engages in aggressive behavior (please provide more details, if yes)				
Please use this space to add additional/clarifying information:				

Communication	Yes	No	With Support	Additional Comments
Uses verbal language				
Engages in reciprocal conversations				
Follows verbal directions				
Speech is understood by most listeners				
Asks questions				
Uses words to express emotions				
Uses words to ask wants/needs				
Please use this space to add additional/clarifying information:				



## Preschool/Daycare Input Form

This child has applied to attend a kindergarten transition program this summer. Your input is very important and will be helpful in supporting student's needs! Thank you for taking the time to assist with this application.

Child's Name: \_\_\_\_\_

Person completing the form: \_\_\_\_\_

Contact number or email: \_\_\_\_\_

Name of program (daycare or preschool): \_\_\_\_\_

How long has the child attended this program? \_\_\_\_\_

Strengths	
Interests/Favorite activities/Preferred items  What motivates the child?	
Does the child exhibit any concerning behaviors? If so, please describe:	
Effective strategies for supporting the child:	

most listeners				
Asks questions				
Uses words to express emotions				
Uses words to ask wants/needs				
Please use this space to add additional/clarifying information:				

Play Skills	Yes	No	With Support	Additional Comments
Plays cooperatively with others				
Engages in games with rules				
Can enter and engage in play with others				
Participates in large group activities				
Participates in small group activities				
Please use this space to add additional/clarifying information:				

Self-Help/Motor Skills	Yes	No	With Support	Additional Comments
Uses the toilet				
Indicates the need to use the toilet				



**PERMISSION CONCERNING PUBLICATION  
OF STUDENT'S NAME, IMAGE, AND / OR SELECTED WORK**

Students who attend Calhoun County Schools are sometimes featured in local newspaper publications, on television, in school system newsletters or similar publications, or on the system website as part of the school system's efforts to communicate regarding awards, honors, or special school activities. When used on the website, student images will not include full names, but may include first names. Images on the school system website typically portray students in classrooms, assemblies, sporting activities, clubs, or as part of groups receiving special recognition.

To ensure that your privacy is protected, we request your permission to use your child's name, likeness, voice, or selected work in connection with communication efforts by the school system. Permission regarding publication on the school system website is stated separately below. Please complete this form and return it to your child's teacher.



Printed name of student \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Please check all that apply and sign below:

**YES**            **NO**  
\_\_\_\_\_  
\_\_\_\_\_

**Written publications and television:**

I give permission for my child's name, photograph or other likeness, and / or selected work to be used in system publications, local newspaper articles, other written publications, or on television, in connection with the school system's efforts to promote or publicize student accomplishments and / or school system activities.

\_\_\_\_\_  
\_\_\_\_\_

**Website:**

I give permission for my child's likeness, first name, voice, and /or selected school work to be used on the school system's website, which I understand may be accessible to anyone using the Internet.

Please note that this permission form applies only to communication efforts initiated by the school system and over which system personnel retain control. The school system cannot and does not guarantee or ensure that your child's name or likeness will not be used by news media in their coverage of public events, such as school sports events, public performances, or in other settings where the media operates independently and outside the control of the school system.

Signature of Parent / Guardian \_\_\_\_\_ Date \_\_\_\_\_

**The student or parent / guardian may withdraw this permission at any time by providing written notice to the school principal.**

**NOTE: Please detach this page after signing and have the student return it to the homeroom or other designated teacher. This form will become part of the student's cumulative folder.**



PLEASE RETURN TO: Calhoun County Board of Education  
 School Health Services Department  
 4400 McClellan Blvd. Anniston, AL 36202  
 FAX: 256-741-6991 PHONE: 256-741-6950

**CALHOUN COUNTY SCHOOL HEALTH SERVICES  
 AUTHORIZATION FOR RELEASE OF INFORMATION**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_  
 (Last, First, Middle Initial)

**Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**This authorization applies to the following information:**

- o All information. I understand that the information may contain psychiatric/psychological, alcohol/drug abuse, AIDS/HIV information, and/or other sensitive health information and I expressly consent to the release of the information.
- o Only the following records or types of Information: \_\_\_\_\_

**Treatment Dates:** From (month/day/year) \_\_\_\_/\_\_\_\_/\_\_\_\_ To (month/day/year) \_\_\_\_/\_\_\_\_/\_\_\_\_

**The Information may be released as follows:**

**From:** \_\_\_\_\_  
 (Physician Office/School Health Services/Agency/Organization)

**To :** Calhoun County Schools, Attention: Shannon Romano, Director of Special Education, (256) 741-7433, sromano@ccboe.us

**Purpose of the release:** (Please specify) Medical, behavioral, and therapeutic information relevant to the child's participation in camp.

I understand the information released will be limited to information necessary to fulfill the need or purpose for the disclosure. If I have authorized the disclosure of information to a recipient who is not subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), then the recipient may re-disclose it and it may no longer be protected under HIPAA, a federal privacy law. This Authorization only applies to treatment occurring before the date of signature. I may decline to sign this Authorization. I understand I may revoke this authorization in writing at any time. If I revoke this authorization, the revocation will not apply to information that has already been released in response to this authorization. I understand that the student's health care will not be affected if I do not sign this form. I understand I may see and copy the Information described on this form if I ask for it, and I may receive a copy of this form after I sign it free of charge. I represent that I have the authority and voluntarily grant permission for the information as described above.

\_\_\_\_\_  
 Patient/Parent/Legal Guardian Printed Name

\_\_\_\_\_  
 Patient/Parent/Legal Guardian Signature      Date

\_\_\_\_\_  
 Patient Signature if 16 or over

\_\_\_\_\_  
 Witness Signature      Date



ALABAMA STATE DEPARTMENT OF EDUCATION  
SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

School Year \_\_\_\_\_ - \_\_\_\_\_

STUDENT INFORMATION

Student's Name: \_\_\_\_\_ School: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

\_\_\_\_ No known drug allergies \_\_\_\_ Allergies (please list) \_\_\_\_\_

Over-The-Counter Medication Authorization

Medication Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Route: \_\_\_\_\_

Frequency/Time(s) to be given: \_\_\_\_\_ Start Date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

Reason for taking medication: \_\_\_\_\_

Potential side effects/contraindications/adverse reactions: \_\_\_\_\_

Treatment order in the event of adverse reaction: \_\_\_\_\_

PARENT AUTHORIZATION

I authorize the school Nurse, the registered nurse (RN) or licensed practical nurse (LPN), to administer or to delegate to unlicensed school personnel the task of assisting my child in taking the above medication in accordance with the administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed.

**Prescription Medication** must be registered with the School Nurse or Trained Medication Assistant. Prescription medication must be properly labeled with student's name, prescriber's name, name of medication, dosage, time intervals, route of administration and the date of drug's expiration when appropriate.

**Over the Counter Medication** must be presented to the School Nurse or Trained Medication Assistant. OTCs must be in the original, unopened, and sealed container. **OTC medication may not be kept for more than 2 weeks without written authorization from an authorized licensed healthcare provider.** Local Education Agency Policy for OTC medication must be followed.

Parent's/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_



ALABAMA STATE DEPARTMENT OF EDUCATION  
SCHOOL MEDICATION PRESCRIBER/PARENT AUTHORIZATION

School Year \_\_\_\_\_ - \_\_\_\_\_

**STUDENT INFORMATION**

Student's Name: \_\_\_\_\_ School: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_  
\_\_\_\_\_ No known drug allergies \_\_\_\_\_ Allergies (please list) \_\_\_\_\_

**PRESCRIBER AUTHORIZATION** (To be completed by licensed healthcare provider)

Medication Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Route: \_\_\_\_\_

Frequency/Time(s) to be given: \_\_\_\_\_ Start Date: \_\_\_\_\_ Stop Date: \_\_\_\_\_

Reason for taking medication: \_\_\_\_\_  
Potential side effects/contraindications/adverse reactions: \_\_\_\_\_  
Treatment order in the event of adverse reaction: \_\_\_\_\_

**SPECIAL INSTRUCTIONS:**

Is the medication a controlled substance?  Yes  No

Is self-medication permitted and recommended?  Yes  No

- If "yes" I hereby affirm this student has been instructed on the proper self-administration of the prescribed medication.

Do you recommend this medication be kept "on person" by student?  Yes  No

Cake Icing Gel ONLY FOR Diabetic Student during Bus Transportation?  Yes  No

Printed Name of Licensed Healthcare Provider: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_ - \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ - \_\_\_\_\_

Signature of Licensed Healthcare Provider: \_\_\_\_\_ Date: \_\_\_\_\_

**PARENT AUTHORIZATION**

I authorize the school Nurse, the registered nurse (RN) or licensed practical nurse (LPN), to administer or to delegate to unlicensed school personnel the task of assisting my child in taking the above medication in accordance with the administrative code practice rules. I understand that additional parent/prescriber signed statements will be necessary if the dosage of medication is changed.

**Prescription Medication** must be registered with the School Nurse or Trained Medication Assistant. Prescription medication must be properly labeled with student's name, prescriber's name, name of medication, dosage, time intervals, route of administration and the date of drug's expiration when appropriate.

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Parent's/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_

**SELF-ADMINISTRATION AUTHORIZATION**

(To be completed ONLY if student is authorized for complete self-care by licensed healthcare provider.)

I authorize and recommend self-medication by my child for the above medication. I also affirm that he/she has been instructed in proper self-administration of the prescribed medication by his/her attending physician. I shall indemnify and hold harmless the school, the agents of the school, and the local board of education against any claims that may arise relating to my child's self-administration of prescribed medication(s).

Parent's/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_