

IN CASE OUR CHILD BECOMES ILL AT SCHOOL AND WE CANNOT BE CONTACTED, THE FOLLOWING PEOPLE (AND ONLY THESE PEOPLE) ARE AUTHORIZED TO EXCUSE HIM/HER FROM SCHOOL AND CARE FOR HIM/HER UNTIL WE CAN BE CONTACTED.

NAME: _____ PHONE: _____ RELATIONSHIP: _____

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IN CASE OF ACCIDENT OR SERIOUS ILLNESS, I REQUEST THAT THE SCHOOL CONTACT ME. IF THE SCHOOL IS UNABLE TO REACH ME, I HEREBY AUTHORIZE THE SCHOOL TO CALL THE PHYSICIAN INDICATED BELOW AND TO FOLLOW HIS/HER INSTRUCTIONS. IF IT IS IMPOSSIBLE TO CONTACT THIS PHYSICIAN THE SCHOOL MAY MAKE WHATEVER ARRANGEMENTS SEEM NECESSARY.

LOCAL PHYSICIAN'S NAME: _____

ADDRESS: _____ OFFICE PHONE: _____ HOME PHONE: _____

HOSPITAL: _____ INSURANCE COMPANY: _____

DOES THE STUDENT HAVE ANY MEDICAL CONDITIONS? IF SO, PLEASE EXPLAIN: _____

IS THE STUDENT CURRENTLY TAKING ANY MEDICATIONS? (YES/NO)

PLEASE LIST ANY MEDICATIONS: _____

WILL THE STUDENT BE TAKING THESE MEDICATIONS DURING SCHOOL HOURS OR BRINGING ANY MEDICATIONS TO SCHOOL? _____

PLEASE LIST ANY LEARNING DISABILITIES: _____

PLEASE LIST HISTORY OF TESTING, REMEDIATION AND/OR THERAPY FOR LEARNING DISABILITIES:

MAY WE GIVE YOUR CHILD ACETAMINOPHEN (TYLENOL) WITHOUT CONTACTING YOU?
YES ___ NO ___

PERSON RESPONSIBLE FOR CHILD'S FINANCIAL OBLIGATIONS _____

SIGNATURE OF FATHER: _____ DATE: _____

SIGNATURE OF MOTHER: _____ DATE: _____

NOTE: APPLICATION FEE WILL BE REFUNDED ONLY IF STUDENT IS NOT ACCEPTED