

EMERGENCY AUTHORIZATION, 2009-2010

Student Information:

 (Last Name) (First Name)

 (Date of Birth)

 (Address)

 (City) (State) (Zip)

Parent #1
 Name _____
 Home Phone _____
 Business Phone _____
 Cell Phone _____

Parent #2
 Name _____
 Home Phone _____
 Business Phone _____
 Cell Phone _____

Address (if different from student):

Address (if different from student):

Child's Doctor _____
 Child's Dentist _____

Telephone _____
 Telephone _____

Fax _____
 Fax _____

Emergency Information: Legal Guardian: Father Mother Both Other _____
 (Name & Relationship)

Local Contacts (other than those listed above):

(1) _____ (2) _____
 (Name) (Phone) (Relationship) (Name) (Phone) (Relationship)

I give permission for the following people to remove my child from school:

(1) _____ (2) _____
 (Name) (Phone) (Relationship) (Name) (Phone) (Relationship)

Medical Information:

Allergies (specify) _____

Special Health Problems (please explain): _____

Medications (at home or school): **If taken at school, a Medication Authorization Form must be completed.**

Daily: _____ As Needed: _____

In an emergency situation or if I cannot be reached, I hereby authorize the staff of Pardes Jewish Day School to seek appropriate medical treatment for my child at the nearest available hospital.

(Parent Signature)

(Date)

PARDES JEWISH DAY SCHOOL

**PARENTAL PERMISSION FOR MEDICAL TREATMENT
2009-2010**

Student's Name: _____

Age: _____

I hereby give permission for my child (named above) to receive the following medication during school hours. I hereby release Pardes Jewish Day School and its agents and employees from any and all liability that may result from my child taking the medication.

My child is permitted the following medication treatment. (Please check all medications you wish available to your child.)

_____ Acetaminophen (Tylenol), every four hours, as needed, for pain or fever.

_____ Ibuprofen (Advil, Motrin), every six hours, as needed, for pain or fever.

_____ Throat Lozenges, every two hours, as needed, for sore throat.

_____ Please contact me before medication is administered. However, if I am unable to be contacted my child may receive the medication according to the recommended guidelines.

Only the above medications will be provided by the school. If you would like the office to administer any other OTC medications (Benadryl, Tums, etc.), please provide them to the school office, marked clearly with your child's name and instructions. *Prescription* medications require a Medication Authorization Form.

Signature of Parent

Date