

2010-2011 SCHOOL YEAR ~ ALCOTT SCHOOL - EMERGENCY MEDICAL RELEASE / EMERGENCY DISMISSAL PLAN

NB: the information below will be used if your child has an accident, sudden illness, or medical emergency in school.

Child's Full Name: _____ Date of Birth _____ Sex: Male Female
 Child's Home Address: _____ Telephone # _____

PARENT #1: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Foster		PARENT #2: <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Foster	
Name		Name	
Home Phone Number		Home Phone Number	
<input type="checkbox"/> Cell <input type="checkbox"/> Beeper		<input type="checkbox"/> Cell <input type="checkbox"/> Beeper	
Home Address		Home Address	
E-mail		E-mail	
Fax Number <input type="checkbox"/> home <input type="checkbox"/> work		Fax Number <input type="checkbox"/> home <input type="checkbox"/> work	
Employer		Employer	
Business Address		Business Address	
Business Phone Number		Business Phone Number	
Work hours/day		Work hours/day	

Guardian's Name: _____ Relationship to Child: _____
 (If other than Mother or Father (i.e., foster mother or foster father))
 Home Telephone # _____ Work # _____

Address _____


If child is in foster care: Agency holding guardianship _____ Worker Assigned: _____

Address: _____ Telephone # _____ Emergency #: _____

EMERGENCY CONTACTS

NOTE: In the event of hazardous weather conditions or other school emergency, your child may be dismissed from school earlier than his/her scheduled time. No child will be transported on an earlier bus unless you or your designated emergency contacts have been contacted directly by a staff member. If no one can be reached, your child will remain at school under supervision until contact can be made. Please indicate the names and phone numbers of designated others whom you would like contacted in the event of a medical, weather, or school emergency. Be sure that these people are available during school hours.

I Agree to Allow those listed to transport my child to and from the Alcott School (this form is invalid if not signed).

X _____ Parent signature 

CONTACT #1 NAME		CONTACT #2 NAME	
Relationship to child		Relationship to child	
Home Phone #		Home Phone #	
<input type="checkbox"/> Beeper <input type="checkbox"/> Cell phone #		<input type="checkbox"/> Beeper <input type="checkbox"/> Cell phone #	
Work phone #		Work phone #	
CONTACT # 3 NAME		CONTACT #4 NAME	
Relationship to child		Relationship to child	
Home Phone #		Home Phone #	
<input type="checkbox"/> Beeper <input type="checkbox"/> Cell phone #		<input type="checkbox"/> Beeper <input type="checkbox"/> Cell phone #	
Work phone #		Work phone #	

PLEASE COMPLETE & SIGN OTHER SIDE >>>>

PARENT RELEASE FOR EMERGENCY MEDICAL TREATMENT

I authorize Alcott School to refer my child _____ for emergency medical treatment to a physician or nearest hospital in the event of an injury, sudden illness, or catastrophic event at a time when I cannot be reached.

(date)

(Parent/Guardian Signature)

Child's Physician's Name: _____ Phone # _____

Family Medical Insurance Company: _____

Policy # _____ Medicaid # (if applicable) _____

MEDICATIONS:

If your child does **not** presently take medication, please check this box

If your child does take medication, please complete the following information:

Name of Medication: _____

Dosage: _____ # of Times per Day _____

Duration of Medication: (complete one)

a. Temporary: indicate Start Date: _____ Discontinue Date: _____

b. Continuous: (Please check the appropriate box)

Will this medication be administered regularly through the school year? Yes No

Will this medication need to be administered during school hours? Yes No

(If "yes" to this question, see the school office for the proper forms/permissions.)

ALLERGIES TO FOOD OR MEDICATION: No Yes (please list below)**

How is it controlled _____

Describe allergic reaction _____

Additional pertinent health information _____

** If your child has an allergy to a common food, which may cause an anaphylactic reaction, please obtain medication forms from the school office and arrange to supply the school with Benadryl and 2 Epi-pens. A form must be completed by you and your child's physician for each medication. All medications must be in their original containers with package inserts and valid expiration dates. Prescriptions must be rewritten every six months.

* Please note that the term Guardian applies to the child's LEGAL guardian, e.g. DSS or natural parents are the usual legal guardians for foster children.

PLEASE COMPLETE & SIGN OTHER SIDE >>>>>