WISE SCHOOL

DUE August 20, 2014

GRADE LEVEL_____

CHILD'S NAME_____
LAST FIRST MIDDLE

BIRTHDATE_____ Sex_____
Mo Day Year

Parent's Name _____ _____
Parent 1 Parent 2

Address _____
Street City Zip

Email Address _____
Parent 1 Parent 2

Home Phone- Parent 1 ( ) _____ Parent 2 ( ) _____

Business Phone- Parent 1 ( ) _____ Parent 2 ( ) _____

Cell Phone- Parent 1 ( ) _____ Parent 2 ( ) _____

Person Responsible for Child _____

Additional Persons to call in an Emergency or Authorized person(s) to pick up child from School other than parents (INCLUDING CARPOOL)

Name_____Relationship:_____

Phone # _____

Name_____Relationship:_____

Phone # _____

Name_____Relationship:_____

Phone # _____

Name_____Relationship:_____

Phone # _____

SPECIAL INSTRUCTIONS FOR SCHOOL NURSE

Chronic Illness _____

Daily Medication _____

ALLERGIES _____

SYMPTOMS _____

TREATMENTS _____

EMERGENCY INFORMATION

TO THE DIRECTOR or SCHOOL NURSE: In case of a medical emergency, you are authorized to contact and, if necessary, release my child to any of the following:

Physician_____
Name Address Phone

Dentist_____
Name Address Phone

Relative_____
Name Address Phone

Neighbor _____
Name Address Phone

If Physician cannot be reached, what action should be taken?

___ Transport to Hospital

___ Other -Explain: _____

STEPHEN S. WISE TEMPLE
AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

(I/We), the undersigned, parent(s) or Authorized Representative (s) of

_____
a minor, do hereby give consent to Wise School Early Childhood to obtain all emergency medical or dental care prescribed by a duly licensed Physician (M.D.), Osteopath (D.O.), or Dentist (D.D.S.) in the case of an emergency. This care may be given under whatever conditions are necessary to preserve the life, limb, or well being of the child named above.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

This authorization shall remain in effect from SEPTEMBER through SEPTEMBER and will cover attendance at all authorized functions.

Signature of Parent 1 _____Date_____

Signature of Parent 2 _____Date_____

Guardian_____Date_____

Signatures above authorize all information provided on this emergency card

❒ Please check if you **DO NOT** want your address & phone included in the school roster

WISESCHOOL

Due August 20, 2014

Medication Form

This form must be returned before the beginning of the school year and whenever the prescription changes

Student Name: _____ Date of Birth: _____ Grade: ____

California Education Code 49423 allows the School Nurse or other designated school personnel to assist students who are required to take medication during the school day. Medication, including any over-the-counter medicines, may be administered only after the school receives the following:

1. Written instructions from the physician. 2. Written permission from the parent or legal guardian

PARENT PERMISSION

_____ I authorize the school nurse or other designated personnel to administer any prescription or non-prescriptive medication as ordered by my child's physician.
If YES, please have your physician complete the form below and sign. The form requires a parent signature as well.

_____ I request that **no** medication be administered to my child at school.
If NO, please sign and date the form and return it to school by August 23, 2013.

TO BE COMPLETED BY A LICENSED PHYSICIAN:

Non-prescription medication(s) that may be administered according to labeled indications and directions:

Acetominophen (i.e. Tylenol): Yes ____ No ____
Ibuprofen (i.e. Advil, Motrin): Yes ____ No ____
Benadryl (for allergic reaction only: Yes ____ No ____
Sudafed (for congestion due to allergy or common cold without fever Yes ____ No ____
Other (i.e. Claritin, cough syrup, etc. – must be supplied by parent) Yes ____ No ____

Prescription medication(s) that may be administered according to written directions below:

Medication _____ Diagnosis _____

Dosage, form, route _____ Time Schedule _____

Additional Instructions _____

Please print or stamp: Physician's Name: _____

Address:_____

_____

Telephone: _____ FAX _____

Physician's Signature _____ Date: _____

TO BE COMPLETED BY PARENT/GUARDIAN:

I understand that the administration of medications at school requires a physician's written order including non-prescriptive medications (i.e. Tylenol/Advil). I will comply with the policies and procedures determined by SSWT Schools. I recognize that the administration of medications is a service, which the School is not legally required to perform, and I agree to hold the school and its personnel free from all liability that may arise out of this service.

_____ _____

Parent/Legal Guardian's Signature **Date**