Del Mar Pines School Emergency Instructions For Summer Discoveries 2018

Please print legibly.

Name of child: last ______________________first ______________ D.O.B.________grade **fall '18**: _____
last ______________________first ______________ D.O.B.________grade **fall '18**: _____
last ______________________first ______________ D.O.B.________grade **fall '18**: _____

Name of Parent/Guardian: last ________________________ first ___________________
Name of Parent/Guardian: last ________________________ first ___________________

Residence Address: ______________________________________ city:______________ zip:________
Mailing Address: ____ city:______________ zip:________
Email Address: ☐ father: __________________________ ☐ mother: ___________________________

Residence Telephone: (____) ______________________
Business Telephone: father: (____) __________________ mother: (____) ______________________
Cellular Telephone: father: (____) __________________ mother: (____) ______________________

In the event that my child(ren) becomes ill at school and needs to be taken home and ***neither*** parent can be reached, I authorize Del Mar Pines School personnel to call:
Full Name _________________________ Telephone: (____) _____________ Relationship ______
Full Name _________________________ Telephone: (____) _____________ Relationship ______

In the event my child(ren) is ill at school, I authorize the office to administer:
Jr. Tylenol/Ibuprofen (circle one) *YES NO* Cough Drops (circle one) *YES NO* Tums *YES NO*
Eye Wash YES NO Medication Supplied by Parent YES NO

Epi Pen? _________________ ***Asthma Inhaler?*** _____________ ***Severe Nut Allergy*** ______________

My child is allergic to latex (circle one) *YES NO*
My child has food allergies (circle one) *YES NO*
Please list food allergies:
Child:____
Child:____
My child is allergic to bee stings (circle one) *YES NO UNKNOWN*

In the event of an emergency that requires immediate medical attention, when ***neither*** parent can be reached. I authorize Del Mar Pines School personnel to call 911 and have my child(ren) transported to the nearest medical facility.
Name of Family/Child's Physician: _______________________ Telephone (____) ________________
Name of Insurance Carrier: ____

The following people have permission to pick up my child(ren) from Del Mar Pines School.
You still need to notify the school on the day your child(ren) is going home with a person not listed below.
Name ______________________________Telephone (____) ___________________

Name ______________________________Telephone (____) ____________________
Name ______________________________Telephone (____) ____________________

Parent's Signature ___________________________________ Date_______________________

Authorization for Administration of Medication

Please fill out if your child requires medication during school hours.

Date: ___________________________

Name of Student: last_______________________, first___________________ m.i. _____

Medication: ___________________________________ Dosage: ____________________

When is the medication to be given? ____

Del Mar Pines will administer prescribed medication (or non-prescribed medication) by his/her physician if the following conditions are adhered to:

1) Parents must complete & sign this release statement before any medication will be administered.
2) Students take medication on an as-needed or designated day/time basis.
3) Medication must include the following information:
   a) *Student's name*
   b) *Prescribing physician's name*
   c) *Medication's name*
   d) *Amount of medication to be administered*
   e) *Vessel for administering*
   f) *Time to give medication*
   g) *Taken with/without food, refrigerated, and etc.*
4) It is the parent's responsibility to refill medications and update expiration dates. With the exception of Epi Pens and Asthma Inhalers, we will not keep more than one week's supply of medication at school.
5) If the student is taking an antibiotic for a short period of time, you must bring it to the office for delivery to student.
6) Remember, we will not administer Tylenol or cough drops unless you have given us permission on your child's emergency release form.

I, ______________________, do hereby authorize Del Mar Pines personnel to administer the medication listed. I recognize that this is a service that the school is providing which it is not legally required to perform. Therefore, I agree to save and hold Del Mar Pines School, it's officers, employees or agents, harmless from any and all liability, suits or claims of whatever nature or kind, which might arise as a result of administering the medication in accord with this request.

It is the legal responsibility of the parent to keep Del Mar Pines personnel abreast of any and all changes regarding his/her child's changes in medication in writing.

Parent's name ***printed***___________________________________

Parent's signature_______________________________________

Office: _________________________