



Del Mar Pines School Emergency Instructions For Summer Discoveries 2020

Please print legibly.

Name of child: last _____ first _____ D.O.B. _____ grade fall '20: _____
last _____ first _____ D.O.B. _____ grade fall '20: _____
last _____ first _____ D.O.B. _____ grade fall '20: _____

Name of Parent/Guardian: last _____ first _____
Name of Parent/Guardian: last _____ first _____

Residence Address: _____ city: _____ zip: _____
Mailing Address: _____ city: _____ zip: _____
Email Address: • father: _____ • mother: _____
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 (circle one) YES NO Ibuprofen (circle one) YES NO Cough Drops (circle one) YES NO
Tums (circle one) YES NO Canker Sore Oral Analgesic (circle one) YES NO Eye Wash (circle one) YES NO

Medication supplied by parent. Please complete Authorization for Administration of Medication form.

EpiPen? (circle one) YES NO **Asthma Inhaler?** (circle one) YES NO

Severe Nut Allergy (circle one) YES NO

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. Medications are supplied by parents.

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(s) 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 by an Administrator to the student.
- 6) Remember, we will not administer over the counter medication (Tylenol, Ibuprofen, cough drops, eye wash, etc.) 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, its 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: _____