**4J Title I Summer School 2014**





**Registration Form**

***\*\*Deadline to Register: May 16, 2014\*\****

**\* Title Coordinators please provide Student ESIS # : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Student Information:**

|  |  |
| --- | --- |
| Student’s Name: |  |
| Home School: |  | Current Grade: |  |
| Parent’s Name: |  |
| Home Address: |  |
| Home Phone: |  | Work Phone: |  |
| Cell Phone: |  | E-mail: |  |
| Emergency Contact: |  | Emergency Phone: |  |

Please share any relevant information of which we should be aware such as custodial concerns, etc:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**4J Title I Summer School 2014 School Bus Transportation Information Form**

 *Students living within a mile of Chavez Elementary will not qualify for busing, nor will students living outside the Eugene School District’s boundaries. The bus stop will be as close as possible to the address you have designated.*

**My child needs to be picked up, as close to this address as possible, to go to school in the morning:**

**My child needs to be delivered, as close to this address as possible, after school:**

**I give my permission for my child to be dropped off at this address without an adult being present:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Parent/Legal Guardian Signature*

**List name, phone number and relationship of people authorized to receive your child at the bus stop.**

|  |  |  |
| --- | --- | --- |
| **NAME** | **RELATIONSHIP** | **PHONE NUMBER(s)** |
|  |  |  |
|  |  |  |

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# MEDICAL FORM AND HEALTH HISTORY

**Please indicate below if any of these conditions apply to your child:**

* Asthma
* Severe bee sting allergy
* Severe food allergy: which food? \_\_\_\_\_\_\_\_
* ADHD
* Diabetes
* Heart problems
* Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication Information:**

Does your child take any medication? \_\_\_ Yes \_\_\_ No

 **MEDICATIONS AMOUNT TAKEN HOW OFTEN?**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Please complete “AUTHORIZATION FOR MEDICATION ADMINISTRATION” below if medication needs

to be taken during the Summer School school day.

## PHYSICIAN’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AMBULANCE PERMIT**

I give my consent for the Summer School administrator, district nurse or other school-appointed personnel to use their judgment in securing further medical aid and to call an ambulance to take my son/daughter: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_ hospital in case the parent/guardian cannot be reached. The above information may be shared with ambulance personnel.

Parent/Guardian Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

### AUTHORIZATION FOR MEDICATION ADMINISTRATION BY SCHOOL PERSONNEL

To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (School Administrator) (Name of school/program)

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am giving school personnel permission to administer medications to my child per the following:

(Parent/Guardian or Physician please complete)

Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose (how much): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency (how often): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medication is taken by (circle one): Mouth Ear Eye Nose Skin

Duration: Start date: \_\_\_\_\_\_\_\_\_\_\_\_\_ End date: \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Nonprescription

\_\_\_ Prescription Rx Number

\_\_\_ Please allow my child to self-administer this medication (refer to district policy on self–medication)

Reason for Medication:

Special Instructions:

I understand I am responsible to provide this medication and maintain the supply as needed. I understand I am responsible to notify the school in writing of any changes. Parents are required to pick up all unused medication by the last day of Summer School. All medication left at the school will be discarded.

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_

PHYSICIAN’S NAME (Please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHYSICIAN’S SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**All medication must be in the properly labeled pharmacy bottle or the original manufactured packaging. A staff member will be assigned to administer and monitor all student medications.**