MEDICATION PERMISSION SLIP

Please fill in the following, sign, and return it to school

Child's Name _____

Home phone _____ Parent cell phone _____

From time to time, we also have students who come in with minor health complaints: scrapes, scratches, headaches, cramps, etc. We keep some over-the-counter pain medications on hand to help these students. Please check all medications your child has permission to take at school. If your child is running a fever or vomiting, you will be notified to come get them. They must be fever free for 24 hours before returning to school.

[] Acetaminophen (Tylenol) [] Ibuprofen (Advil)

[] Motrin [] Midol

We will not give any medication to your child without your permission. We make a log entry each time we administer medication to a child, so if you have questions regarding dosage or time given, please let us know.

Please list any medication(s) that you know your child is allergic to, or that you do not want us to give to your child:

I, _____(print your name) give the staff of P.A.C.S. my permission to give the above medications to my child(ren) except as noted in the spaces above or below.

_____ (signature)

Additional information _____

_____

Medical History

It is mandatory that pupils who show symptoms of communicable disease be excluded from classes until readmission is acceptable to the Church's Educational leaders. Your cooperation will be greatly appreciated. Thank you!

Student's name _____ Birth Date _____ Gender _____

Past Diseases (If your child has had any of the following, state age when he had them.)

Mumps_____	Scarlet Fever_____	Convulsions_____
Measles_____	Rheumatic Fever_____	Heart Disease_____
Whooping Cough_____	Chicken Pox_____	Diabetes_____
Asthma_____	Pneumonia_____	Discharging Ears_____
Hay Fever_____	Syphilis_____	Gonorrhea_____
Diphtheria_____	Polio_____	

Recent Disabilities (Please check any one of the following noted recently.)

4 or more colds yearly_____	Fainting spells_____	Hearing difficulty_____
Frequent sore throat_____	Abdominal pains_____	Tires easily_____
Poor vision_____	Frequent urination_____	Breath shortness_____
Frequent leg pains_____	Allergy_____	Hernia (rupture)_____
Dizziness_____	Persistent cough_____	Ringworm_____
Frequent sties_____	Speech difficulty_____	Nose bleeding_____
Dental defects_____	Crippling conditions_____	Growing pains_____

Personal Record (Please answer all of the following.)

Is he/she shy?_____	Overactive?_____	Bite fingernails?_____
Suck thumb?_____	Have excessive fears?_____	Have temper tantrums?_____
Like school?_____	Play well with others?_____	Eat breakfast?_____

Does your child have any disability due to disease or accident, if so please list any instructions or restrictions:

_____

_____

List any allergies and any special instructions:

_____

_____

List all medications that your child is currently taking and times they are administered (If the school staff will be administering the medication, please give specific instructions.):

_____

_____

Special instructions in case of emergency:_____

_____

Doctor_____ Hospital Preference_____

Name Phone

Park Avenue Christian School
Student Transport Authorization Form

Student Name: _____

Birth Date: ____/_____/_____

Please fill out the names of people authorized to pick up your student(s).

Name: _____

Relationship to the child _____

Name: _____

Relationship to the child _____

My child(ren) **MAY NOT** be picked up by:
Name:_____

Name:_____

Your child will not be allowed to leave with anyone not on this list. This form must be filled out for each individual child. We realize that emergencies do arise. In the case of an emergency, please send written authorization each time someone not on the list needs to pick up your child. Our student's safety is of the utmost importance to us. Thank you for your cooperation.

If your student is authorized to transport another student or be transported by another student each parent must sign this authorization:

I _____, authorize my student _____ to transport/be transported by _____as necessary, and only with each individual student's parent consent form signed.

Signed:_____

Park Avenue Christian School
Contact Information

We communicate weekly with a newsletter and information updates by email. Please provide an email address for each parent/guardian that needs to be contacted.

Email:_____

Email:_____

Sometimes we send out a text with reminders. Please list your name and cell phone number and verify that you have texting on this number.

Name:_____

Cell phone:_____ Text: □Yes □No

Name:_____

Cell phone:_____ Text: □Yes □No

Especially during the winter months when we may need to close school, we use a system called *One Call Now*. It phones everyone at the same time with our prerecorded message to give urgent updates and information. Please list the **one** number you always answer or check the voice mail that you would like to use for this phone call.

Name:_____

Phone:_____

By submitting this information, you are giving us permission to send calls/information through our automated service. We will not publish or give out this information, it is for school use only.