OUR LADY OF GOOD COUNSEL
Emergency and Release Authorization Form

The information set forth on this form must be completed for two purposes: (1) To insure that your child will receive emergency medical care in the event that you are unavailable; and (2) To identify the persons to whom your child may be released in both emergency and non-emergency situations. Please print neatly and provide all the information requested.

Name of Student: _____
Last First Middle

Address: _____
Street Address City/Town Zip Code

Date of Birth: _____ Gender: □ Male □ Female Grade: _____

Parent/Legal Guardian Name: _____ Relationship to Student:_____

Address: _____
Street Address City/Town Zip Code

Parent name_____ Cell Number: _____

Parent Name_____ Cell Number:_____

List emergency names, in order to be called, in the event a parent cannot be reached!

Emergency Contact 1 Name: _____ Relationship:_____ Phone #_____

Emergency Contact 2 Name: _____ Relationship:_____ Phone # _____

Siblings: Name: _____Grade:___ Name:_____ Grade ___

Name:_____ Grade: ___ Name: _____ Grade ___

List any medical conditions that should be known to the school: _____

_____

If your child has asthma, do they use an Inhaler? Yes ___ No ___

Does he/she need Inhaler before gym? ___Yes ___ No – If yes ***Please fill out Asthma Action Plan***

Does he/she need Inhaler before recess? ___ Yes ___ No - If yes ***Please fill out Asthma Action Plan***

List any allergies the student has and the reaction your child has to that allergen: _____

_____

Do they use an Epi Pen? ___Yes ___No if yes ***Please Fill out Allergy Action Form***

List any medication and dosage the student is presently taking: _____

_____

Does the child wear Glasses or Contacts or wear hearing aids – Instructions/Limitations: _____

Name of Child's Doctor _____ Phone Number: _____

Students Participating in All School Physical Activities

The above mentioned student has no restrictions in physical activities. He/she may participate fully in Field Day, Recess, Walk-a-thons, Physical Education classes (including the mile run).

_____ _____
Signature of Parent or Guardian Relationship to student

OR

The above mentioned student has restrictions in physical activities. ****Must attach a note from the child's private health care provider outlining those restrictions.****

Restrictions _____

_____

_____

_____ _____
Signature of Parent or Guardian Relationship to student

Illness Policy

Reminder to all families of the following guidelines to prevent the spread of infection to our school community is listed below.

- Your child **may not come to school if he/she has had a fever in the past 24 hours.** They must be fever free for 24 hours without the use of fever reducing medicine such as Tylenol or Motrin.
- If an antibiotic is prescribed by your physician, your child must be on the medication for a minimum of 24 hours before returning to school. The 24 hours begins at the start of the first dose.
- Your child **may not come to school if they have vomited or have diarrhea in the past 24 hours.**

I have read and acknowledge the above illness policy. _____
Signature of Parent or Guardian