

Simsbury Public Schools
Dept of Continuing Education
155 Firetown Road Simsbury CT 06070

Program (circle one):	
SAA	Pre-School
Gateway	ELEM
Driver's Ed	Academic
PE	Invention

Nursing Services are NOT available at ALL sites.

Course Code _____

Parent/Guardian of ALL students under the age of 18 must complete this form!

STUDENT INFORMATION

Student's Name: _____ Home Phone: _____
Address: _____ Cell Phone: _____
City: _____ Zip Code: _____ Business Phone: _____
Email Address: _____

EMERGENCY CONTACT INFORMATION

Please list contact information for the Parent/Guardian should they need to be reached in the event of an emergency.

Parent/Guardian: _____ Employer: _____
Business Phone: _____ Cell Phone: _____

Parent/Guardian: _____ Employer: _____
Business Phone: _____ Cell Phone: _____

ALTERNATE CONTACT INFORMATION

Please list an alternate contact should the Parent/Guardian not be available in the event of an emergency.

Name: _____ Relationship to student: _____
Phone: _____ Cell Phone: _____

Name: _____ Relationship to student: _____
Phone: _____ Cell Phone: _____

UNAUTHORIZED INDIVIDUAL(S)

Please list the name of any individual(s) that you do not authorize to pick up your child. Please include a copy of any court orders if necessary.

Name: _____ Relationship to student: _____
Name: _____ Relationship to student: _____

ALLERGY & MEDICAL INFORMATION

Allergic to:

- Bee Stings
- Medication: _____
- Food: _____
- Other (please indicate): _____

Medical Concerns:

- Diabetic
- Seizure Disorder
- Other: _____

Special Services: IEP 504

In case of accident or serious illness, I give permission that the standing orders for emergency procedures will be followed. I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated below and to follow his/her instructions. If it is impossible to contact this physician, the school may make whatever arrangements seem necessary.

Preferred Hospital: _____

Dentist's Name: _____ Phone: _____

Physician's Name: _____ Phone: _____

Insurance Company Name: _____

Group#: _____ ID#: _____

MEDICATIONS & PROCEDURES

* List any medication or procedures (tube feedings, etc.) that need to be administered **DURING SUMMER PROGRAM HOURS** (indicate the name and dosage). A current **physician's medical authorization form** must be submitted for any medications or procedure listed below; otherwise the medication or treatment cannot be administered. **Forms MUST be submitted prior to the start of your child's summer program in order for your child to attend.**

Emergency medication prescribed (e.g. epipen, etc.): Yes No

Medication/Procedure	Time Administered and Dosage

I hereby request the medication listed above be administered to my child by the school nurse in accordance with State regulations and the Farmington Public Schools standing orders. *

If your child REQUIRES medication or treatments (tube feedings, etc.) during the summer, please arrange time to discuss your child's need with your current school nurse prior to the end of this school year.

Any additional concerns or issues that you need to share about your child: _____

Parent/Guardian Signature: _____ Date: _____