Name of student: ________________  Date: ________________

**Dismissal Information:**
Please list all other persons who are authorized to pick up your child/children:

1. First and Last name: _______________________________ Relationship: ________________________
   Phone number: ________________________________       Cell phone: _________________________

2. First and Last name: _______________________________ Relationship: ________________________
   Phone number: ________________________________       Cell phone: _________________________

3. First and Last name: _______________________________ Relationship: ________________________
   Phone number: ________________________________       Cell phone: _________________________

- **Please note:** If there is a change in dismissal information, (i.e. someone other than the authorized is to pick up your child, please notify the office of the change in writing (Please see the parent handbook).

**Emergency Information**

**Emergency Contact #1**
In case of an emergency, please contact: ________________________________

Relationship: _____________________ Home phone: _____________________
Work phone: _____________________ Cell phone: _____________________

**Emergency Contact #2**
In case of an emergency, please contact: ________________________________

Relationship: _____________________ Home phone: _____________________
Work phone: _____________________ Cell phone: _____________________

**Emergency Contact #3**
In case of an emergency, please contact: ________________________________

Relationship: _____________________ Home phone: _____________________
Work phone: _____________________ Cell phone: _____________________
Health History Form

Last Name of Student: ________________________    First Name: ______________________________

Pediatrician: __________________________________Phone Number :(______)____________________

Insurance Company: ___________________________ Group Number: ___________________________

Member Number:______________________________ Policy Holder’s Name:_____________________

In order for a child to attend school, the State of Maryland requires that all students must be current on all immunizations.

1. Please provide last date and month of student’s last:
   Tetanus or DTP shot: __________________ Date of Booster: ___________________

2. List any medications and purpose or other health aid that is in present use by the student:
   __________________________________________________________________________
   __________________________________________________________________________

3. List any medical conditions, emotional/psychological, chronic or recurring illnesses:
   __________________________________________________________________________
   __________________________________________________________________________

4. List any allergies:
   __________________________________________________________________________
   __________________________________________________________________________

I understand that the Leo Bernstein Jewish Academy of Fine Arts does not offer a medical plan or any medical insurance. I have checked my family’s policy and guarantee that my child is properly covered while at school. (Initial here)__________

The information on this form is correct and complete to the best of my knowledge. The student herein described has permission to engage in all school activities except where noted on this application. (Initial here)__________

I hereby give permission to the Leo Bernstein Jewish Academy of Fine Arts to seek any medical treatment including x-rays or routine tests. I agree to release any records necessary for insurance purposes. I give permission for Leo Bernstein Jewish Academy of the Fine Arts to arrange any necessary related transportation for my child. I understand that the Leo Bernstein Jewish Academy of Fine Arts cannot administer prescription drugs to my child unless there is written parental consent and the medication is sent in a properly labeled container by a pharmacy and accompanied by specific written authorization to the Leo Bernstein Jewish Academy of the Fine Arts from the prescribing physician. (Initial here)__________

I authorize The Leo Bernstein Jewish Academy of Fine Arts to administer Children’s Tylenol/Regular Tylenol (circle one) to my child. Approximate weight of child _______. (Initial here)________________________

In the event a child is sick, parents will be informed immediately.

Signature of Parent/Guardian: __________________________________________________________

Printed Name:________________________________________________________________________ Date: __________________________
Field Trip Permission Form

I hereby give permission for my child_______________________ to travel on school sanctioned field trips during the school year. I agree that the school, its teacher’s and any other person accompanying the group shall not be liable for any damage or injury that my child may sustain.

Signature of parent/legal guardian: ___________________________________

Printed name: _____________________________________________________
Date: __________________________________________________________

Responsibility for Lost or Damaged Personal Item

The school will not be held accountable for children’s personal items that are lost or damaged during school hours or events.

Signature of parent/legal guardian: ___________________________________ Date: ________________

Publicity

During the school year, photographs are taken by our staff. Photos are used in a variety of publications, including but not limited to: newsletters, press releases, marketing and our websites.

_____ I give the Leo Bernstein Jewish Academy School of Fine Arts consent to use photographs of my child/children on its websites and in future publicity materials.

_____ No, I do not consent for the Leo Bernstein Jewish Academy school of Fine Arts to use photographs of my child/children on its websites and in future publicity materials.

_____ I give the Leo Bernstein Jewish Academy School of Fine Arts consent to identify my child/children by name in printed publicity materials.

_____ No, I do not consent for the Leo Bernstein Jewish Academy School of Fine Arts to identify my child/children by name in printed publicity materials.

Signature of parent/legal guardian: _________________________________

Printed name: ___________________________________________________
Date: __________________________________________________________________
Authorization to Administer Prescribed Medication

1. To Be Completed By the Parent/Guardian

Name of Student: _________________________  Birth date: ______________
Prescription: new___ renewal ___ if new, the first full day’s dosage was given at home on: ______________
List all medication(s) student is taking, including over the counter medication(s):
_____________________________________________________________________________________
_____________________________________________________________________________________
Parent/Guardian Signature: ______________________________________________________________
Phone Number___________________________________ Date_____________________________

2. To Be Completed By the Physician

Name of medication: _________________________________ Diagnosis:__________________________
Dosage: _______________________ Time(s) to be given at School: ______________________________
Side Effects:
_____________________________________________________________________________________

If PRN, specify:
When indicated (signs/symptoms)
_____________________________________________________________________________________
Frequency of administration
_____________________________________________________________________________________
Physician’s Name: ______________________________________________________________________
Physician’s Signature: ___________________________________________________________________

3. To Be Completed By the Director

Check as appropriate:
___ Parts 1 and 2 above are completed, including signatures
___ Prescription medication is properly labeled by the pharmacist.
___ Medication label and physician order are consistent.
___ over the counter medication is in an original container with the manufacturer’s dosage label and safely seal intact.
___/___/___ Date any medication is to be collected by the parent/guardian (within one week after expiration of the physician’s order).

Director’s Signature: ___________________________________________________________________
Date: ________________________________________________________________________________