

1401 Arcola Avenue, Silver Spring, MD 20902 www.lbja.org | office@lbja.org Tel. 301-592-8433 | Fax. 301-649-12174

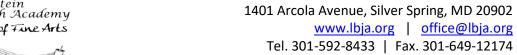
Name of student:		Date:
Dismissal Informat	ion:	
Please list all other persons	s who are authorized to pick up	your child/children:
1. First and Last name:		Relationship:
Phone number:		Cell phone:
2. First and Last name:		Relationship:
Phone number:		Cell phone:
		Relationship:
Phone number:		Cell phone:
Emergency Inform Emergency Contact #1	•	
	ease contact:	
	Home phone:	
	Cell phone :	
Emergency Contact #2		
In case of an emergency, pl	ease contact:	
Relationship:	Home phone:	
Work Phone:	Cell phone:	
Emergency Contact #3		
In case of an emergency, pl	ease contact:	
Relationship:	Home phone:	
Work Phone:		



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Health History Form

Last Na	me of Student:	First Name:
Pediatr	ician:	Phone Number :()
		Group Number:
		Policy Holder's Name:
In orde	r for a child to attend sch	ol, the State of Maryland requires that all students must be current
on all ir	mmunizations.	
1.	Please provide last date a	nd month of student's last:
Tetanus or DTP shot: Date of Booster:		Date of Booster:
2.	List any medications and	urpose or other health aid that is in present use by the student:
3.	List any medical condition	s, emotional/psychological, chronic or recurring illnesses:
4.	List any allergies:	
The info		t and complete to the best of my knowledge. The student herein described activities except where noted on this application. (Initial here)
x-rays or Bernstei understa unless th and acco	r routine tests. I agree to rele in Jewish Academy of the Fin and that the Leo Bernstein Je here is written parental cons	ernstein Jewish Academy of Fine Arts to seek any medical treatment including see any records necessary for insurance purposes. I give permission for Leo Arts to arrange any necessary related transportation for my child. I wish Academy of Fine Arts cannot administer prescription drugs to my child not and the medication is sent in a properly labeled container by a pharmacy authorization to the Leo Bernstein Jewish Academy of the Fine Arts from the
		cademy of Fine Arts to administer Children's Tylenol/Regular Tylenol (circle of child (Initial here)
In the e	event a child is sick, parent	will be informed immediately.
Signatu	re of Parent/Guardian: _	
Drinted	l 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: ______ **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: ______





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: _____ Time(s) to be given at School: Dosage: 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: _____