

Trinity School at Greenlawn  
Emergency Information and General Permission Form 2010-2011



**Address:**  
\_\_\_\_\_  
\_\_\_\_\_

**Family Name:(Print)**  
\_\_\_\_\_  
**Family Phone:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
**Family E-mail:** \_\_\_\_\_ (for publication)

**Parent's/Guardian's Name(s)**

**Father:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **E-mail:** \_\_\_\_\_  
**Father's Place of Employment** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
**Mother:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **E-mail:** \_\_\_\_\_  
**Mother's Place of Employment** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

► **In case my child becomes ill or is injured at school and parents cannot be reached, please call:**

<b>Contact Name and relationship (DO NOT LEAVE BLANK)</b>	<b>Phone (include area code)</b>
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**Medical Information**

All prescription & long term non-prescription medications to be given at school require an order from your physician.

<b>Physician Name</b>	<b>Clinic</b>	<b>Phone</b>
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<b>Name of Health Insurance</b>	<b>Policy #</b>
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**Hospital of Choice:** \_\_\_\_\_

Child Name _____ Gr. _____	Child Name _____ Gr. _____	Child Name _____ Gr. _____
<b>Allergies</b> (bee sting, food, medication, latex, pollens) (Please fill in <b>Epi Pen and allergic reaction form</b> ) <b>Medical Conditions</b> (asthma, ADD/ADHD, diabetes, seizures, chronic conditions, etc.) <b>Medications</b> (list all medications your child is on, and star[*] the ones given at school.)	<b>Allergies</b> (bee sting, food, medication, latex, pollens) (Please fill in <b>Epi Pen and allergic reaction form</b> ) <b>Medical Conditions</b> (asthma, ADD/ADHD, diabetes, seizures, chronic conditions, etc.) <b>Medications</b> (list all medications your child is on, and star[*] the ones given at school.)	<b>Allergies</b> (bee sting, food, medication, latex, pollens) (Please fill in <b>Epi Pen and allergic reaction form</b> ) <b>Medical Conditions</b> (asthma, ADD/ADHD, diabetes, seizures, chronic conditions, etc.) <b>Medications</b> (list all medications your child is on, and star[*] the ones given at school.)
_____ _____ _____ _____ _____	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____

**Non-prescription Pain Medication Self-Administration Permission**

My student has permission to self administer non-prescription pain relief, subject to the conditions below (Trinity School does not supply medication): The student is knowledgeable in proper dosage, use, and administration. ~Student may not possess medication containing ephedrine or pseudoephedrine (i.e. Sudafed). ~Student may **not** share medication with other students.

<input type="checkbox"/> <b>Yes</b>	<b>Parent Initials</b> <input style="width: 40px; height: 20px;" type="text"/>
<input type="checkbox"/> <b>No</b>	

~ **The non- prescription pain medication must be accompanied by a signed note from the parents.** ~ Medication should be in original container. If these rules are abused, the school may revoke this privilege.

**Permission to Participate—My Child/ren**

has/have my permission to participate in all the activities (field trips, field day, etc.) of Trinity School from August 23, 2010 to August 22, 2011. In the event of a medical emergency, I authorize my child's teachers or adult supervisor to act on my behalf in providing, arranging and consenting to medical care. I understand that Trinity School does not provide insurance coverage for field trips. Therefore, I assume responsibility for any medical expense, personal injury or other loss sustained by my child, and I agree to hold harmless and indemnify Trinity School at Greenlawn from any such loss or liability. Transportation on field trips is provided by Trinity School. Trinity School does not provide transportation on field day.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_