PERMISSIONS AND RELEASE

Student Name: ____

Date of Birth: ________________ **Entering Grade:** ________________

TO BE FILLED OUT BY PARENT/GUARDIAN

First Aid Treatment: I hereby authorize BYDS personnel to use their judgement to administer the following first aid treatment to my child:

Antiseptic Rinse ☐ Yes ☐ No
For minor cuts and scrapes
Hydrogen peroxide 3% mixed with sterile water

Antibacterial Ointment ☐ Yes ☐ No
For minor cuts and scrapes
Polymyxin, bacitracin, or neomycin

Itch Relief Ointment ☐ Yes ☐ No
For insect stings
Hydrocortisone acetate 1%
Diphenhydramine hcl 1% & Zinc acetate 0.1%

Petroleum Jelly ☐ Yes ☐ No
For dry skin or chapped lips
Vaseline or White Petrolatum

Cough Drop (5 years or older) ☐ Yes ☐ No
For frequent cough and mild sore throat
Menthol

Medications

Medication & Dosage	At School?
____________________________	☐ No ☐ Yes*
____________________________	☐ No ☐ Yes*
____________________________	☐ No ☐ Yes*

***IF YES, PLEASE FILL OUT MEDICATION PERMISSION FORMS**
In compliance with the Texas School Health Guideline, school districts cannot dispense any original medication for students, unless parents **provide the medication in the original bottle**.

Pickup and Dismissal Other than Parent
The persons listed below have standing permission to pick up my child from the clinic. I will inform the school in writing of any other pick-up arrangements.

Name ___________________________________
Relation _________________________________
Cell phone _______________________________

Name ___________________________________
Relation _________________________________
Cell phone _______________________________

Name ___________________________________
Relation _________________________________
Cell phone _______________________________

Special Instructions________________________

Authorization & Release
In the event that I (or those designated by me to act on my behalf) cannot be reached to make arrangements for emergency medical attention for my child, I authorize the principal (Cynthia Kirsch or Alexis Bare) and any person designated by her to act on behalf of the school to do so. They have my full consent to take my child to the physician of her choice or can transport my child to the nearest emergency or hospital facility. That physician in charge has my consent for any and all necessary treatment for my child when in his/her care. I hereby release the Beth Yeshurun Day School, Cynthia Kirsch, Alexis Bare, and each of their designees from any and all claims or causes of action arising out of the direction of my child to any physician or other emergency medical personnel in accordance with this Authorization and Release. ☐ Agree

____
Parent/Guardian Name

____
Relationship to student

____
Parent/Guardian Signature

____
Date

STUDENT HEALTH HISTORY

Student Name: ____

Date of Birth: _______________ **Entering Grade:** _______________

TO BE FILLED OUT BY PARENT/GUARDIAN & SIGNED BY PHYSICIAN

In accordance with the laws of the state of Texas and Harris County, this health certificate must be completed and submitted to the school clinic prior to the beginning of the school year.

1. Does your child have allergies? ☐ No ☐ Yes (Food, drugs, environmental, insects, other)

Allergic to______________________________________ Reaction/Severity_________________________________

Allergic to______________________________________ Reaction/Severity_________________________________

Is an epinephrine injection required for allergies? ☐ No ☐ Yes➡ Physician must fill out or provide an *Allergy Care Plan*

2. Has your child been diagnosed with the following health conditions?

ADD/ADHD ☐ No ☐ Yes➡ If treatment needed during school hours, physician must fill out *Permission Form for Prescribed Medicine* or provide a written prescription along with the medication in the original bottle.		
Asthma ☐ No ☐ Yes➡ Physician must fill out or provide an *Asthma Action Plan Form*		
Diabetes ☐ No ☐ Yes➡ Physician must fill out or provide a *Diabetes Management Care Plan Form*		
Seizure disorder ☐ No ☐ Yes➡ Physician must fill out or provide a *Seizure Emergency Care Plan Form*		
Physician must provide a health care plan of the following conditions if treatment is needed during school hours		
Heart condition ☐ No ☐ Yes	Sickle Cell ☐ No ☐ Yes	Deafness ☐ No ☐ Yes

3. Vision impairment? ☐ No ☐Glasses ☐Contacts

4. Does your child have any physical disabilities, limitations, or other concerns? ☐ No ☐ Yes

If yes, please explain: ____

I allow permission of the physician listed below to verify my child's health information and medical needs.

Parent/Guardian Signature: ______________________________________Date:_______________

Physician Health Statement

This is to certify that the student listed above has been examined by me on _______________ **(date)** and found to be in good health and able to attend The Beth Yeshurun Day School as well as participate in age appropriate activities.

Please attach a copy of the student's immunization record & fill out any care plan needed for health conditions.

Physician Information

Name: ____Tel. Number (_____) ___________________

Address: ____

Signature: _____________________________________Date:___________________________