DEARBORN PUBLIC SCHOOLS
SUMMER STAND PROGRAM

APPLICATION/PERMISSION TO PARTICIPATE & ACCIDENT WAIVER FORM

(PLEASE PRINT) Age _____

Student's Name: _____ Date of Birth: _____

Street Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ School: _____

Mother/Guardian's Name: _____ Home Phone : _____

Email Address: _____ Cell Phone : _____

Place of Employment: _____ Work Phone: _____

Father/Guardian's Name: _____ Home Phone : _____

Email Address: _____ Cell Phone : _____

Place of Employment: _____ Work Phone: _____

Relative/Neighbor who will assume temporary care of your child if you cannot be reached.

Name:_____ Daytime Phone: _____

Name:_____ Daytime Phone: _____

List any and all physical/medical conditions which may affect participation in any SUMMER STAND Program physical activity. Please explain:

_____

_____

List any learning differences, psychiatric issues or family issues your child is dealing with: _____

_____

List any medication student is taking*: (If your child is taking medication for ADD or ADHD, please don't take him/her off of their medication for the summer.)*

_____

_____

Family Doctor _____ Phone # where doctor can always be reached _____

Doctor's Address _____

PARENT/LEGAL GUARDIAN

I, _____, give my permission for my child to participate in the SUMMER STAND Program and release the Dearborn Public Schools SUMMER STAND Program from any and all liabilities or responsibilities pertaining to accidents, injuries, or complications resulting from activities, or while transporting participants to activities. Transportation may consist of bus, van, or car. Activities will include field trips within city limits and extended field trips away from Dearborn Public Schools. A schedule will be provided.

I authorize the SUMMER STAND Program leadership to transport the above name participant to the nearest hospital in case of injury or suspected injury while the participant is involved in a SUMMER STAND Program activity.

I authorize the hospital attending physician to administer necessary emergency professional medical care to the above named participant upon his/her arrival at the hospital.

_____

PARENT/GUARDIAN SIGNATURE DATE

NOTE: THIS FORM MUST BE COMPLETED, SIGNED, AND RETURNED BEFORE THE NAMED PARTICIPANT CAN BE ASSIGNED TO THE PROGRAM.

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Medication Authorization Form

(Fill out only if student will be taking medication during program time.)

Medication administered during program hours by program personnel requires written orders from a physician. Medication must be brought to the program site in a labeled pharmacist bottle each time a supply is sent.

Physician Authorization

_____ _____
Student's Name Age

_____ _____
Medication Dosage

_____ _____
Method Time Frequency

_____ _____
For period from (date) to

Reason for Medication: _____

_____

Relevant Side Effects: _____

_____

Special Instructions to SUMMER STAND staff: _____

_____

_____ _____
Physician's Signature Physician's Name (printed please)

_____ _____
Street Address City State Zip

_____ _____
Telephone Date

Parent Authorization

I request that the SUMMER STAND Program personnel give my child:

_____
(The medication ordered above by his/her physician)

_____ _____
Parent/Guardian Signature Date

For medication to be administered at school, it must be supplied in original container, clearly labeled with the student's name, doctor's name, dosage, name of medication, and specific instruction on the time(s) for administering the medication.