

**Student Information:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Student Home Address: \_\_\_\_\_

Student City, State, Zip: \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Parent/Guardian \_\_\_\_\_

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Cell # \_\_\_\_\_ Work# \_\_\_\_\_ Cell# \_\_\_\_\_ Work# \_\_\_\_\_

Employer: \_\_\_\_\_ Employer: \_\_\_\_\_

**\*\*\*\*Please provide alternate contacts in case we are unable to reach you.\*\*\*\***
**Alternate Contact # 1**
**Alternate Contact # 2**

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone # \_\_\_\_\_ Phone # \_\_\_\_\_

**Medical Information:**

Note: All prescription and long-term medications to be given at school require an order from your child's physician.

Physican's Name/Clinic: \_\_\_\_\_ Phone # \_\_\_\_\_

<b>List All Allergies:</b> such as bee sting, food, medication, latex, pollens, etc.	<b>Medical Conditions:</b> such as Asthma, ADD/ADHD, diabetes, seizures, chronic conditions etc.	<b>Medications:</b> List all medications your child is currently taking and star* the ones to be taken at school.

**Non-prescription Pain Medication Self Administration for 7-12th Grade students only:**

 My 7<sup>th</sup>-12<sup>th</sup> grade student has permission to self-administer non-prescription pain relief, subject to the conditions below:

- Medication is in original container and student is knowledgeable in proper dosage, use and administration.
- Student may not possess medication containing ephedrine or psudoephedrine (i.e. Sudafed).
- Student may not share medication with other students.
- The non-prescription pain medication must be accompanied by a signed note from the parent
- So if these rules are abused, the school may rebuke the privilege.

**Parents/Guardians of 7<sup>th</sup>-12<sup>th</sup> grade students only:**
 **YES**                       **NO**
**Parent/Guardian Initial: \_\_\_\_\_**
**NOTE: 6<sup>th</sup> Grade students are not allowed to self-administer prescription OR non-prescription pain medications.**
**6<sup>th</sup> Grade Parent  
 Parent/Guardian Initial: \_\_\_\_\_**

 Permission: My Child, \_\_\_\_\_  
 has my permission to participate in all the activities of Trinity School from **August 23, 2022 to August 23, 2023**. I agree not to hold Trinity School, its faculty, other adult chaperones or sponsors liable in case of accident involving my child. The faculty of Trinity School has my permission to seek any necessary emergency treatment and to adminsiter first aid as needed for my child during these activities.

**Parent/Guardian Signature(s):**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If needed, list additional medical information below:

A large, empty rectangular box with a thin black border, intended for the user to provide additional medical information. The box is currently blank.