PAST, PRESENT, FUTURE: Where We've Been, Where We Are, Where We're Going!

Gifted Education Summer 2018 June 18-20

Student Registration

Return by: Friday, May 4, 2018 **Late Registrations will not be accepted.**

Return to: Felicia Lowman-Sikes
fsikes@wcs.k12.va.us or 812 Thompson Drive Abingdon, VA 24210

Student Name: **Rising Grade-Level:**

Student Address:

Parent Name: **Parent Phone 1:**
Parent Email: **Parent Phone 2:**

Additional Contact Name: **Contact Phone 1:**
Contact Email: **Contact Phone 2:**

Emergency Medical Consent

In the event that reasonable attempts to contact me and the two alternate individuals that I have designated at the phone numbers that I have provided on this form have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by the physician, dentist, and/or hospital, as applicable, listed below:

____________________________________ __________________________
Preferred Physician Phone Number

____________________________________ __________________________
Preferred Hospital Phone Number

In the event that the designated preferred physician, dentist, and/or hospital, as applicable, is not available, I hereby give my consent for the administration of any treatment deemed necessary by another licensed physician or dentist at any hospital

reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists (as applicable), concurring in the necessity for such surgery, are obtained before surgery is performed.

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Parent/Guardian Signature Date

Emergency Medical Refusal

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to:

____

____

(Do not sign if Emergency Medical Consent was authorized above.)

____

Parent/Guardian Signature Date

Participant Medical Information

Allergies (food, medication, etc.): ____

Activity restrictions or precautions: ____

List any medication child is currently taking: ____

☐ My child is attending with an epinephrine syringe to be administered in the event of a severe allergic reaction. *(Physician's order has been completed at the bottom of this form.)*

☐ My child is carrying an inhaler and is authorized to self-administer as needed. *(Physician's order has been completed at the bottom of this form.)*

List any special needs, important medical history/behavior, and/or accommodations that can be made to make your child's experience more successful:

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Physician's Order for Prescribed Oral Medication

All medication must be delivered in the original container in which it was dispensed and administered by a pre-authorized individual designated by the parent/guardian.

I have arranged, and hereby authorize, the administration of prescribed medication for my child to be handled as follows:

________________________ ________________________

Name of Medication Dosage

________________________ ________________________

Name of Authorized Individual to Administer Medication Date(s) and Time(s) of Administration (by aforementioned individual)

________________________ ________________________

Name of Issuing Physician Issuing Physician Emergency Phone Number

Special instructions for use of drug, including storage: ____

________________________ ________________________

Issuing Physician Signature Date Parent/Guardian Signature Date