Registration/Emergency Contact

This form may be duplicated. Please use a separate form for each child. Please print clearly. **Date**_____

Student Name_____Current Grade_____School_____
Address_____ Phone_____
Parent/Guardian Name_____Daytime Phone_____
Email _____
Emergency Contact: Persons who may remove your child from school and arrange for medical treatment, if necessary.

Name Phone

1._____
2._____
Current health conditions summer school staff should know (ex. Asthma, diabetes, allergies. Please see back if your child needs a doctor's order for medicines IE: Epi Pen)
_____
_____
Signature Parent/Guardian_____

Extended Learning Experience: My child has been invited to participate in:
Please check appropriate subject- _____Reading/Writing _____ Math _____ ELL

Enrichment Program Choices
Program_____Dates_____ Time_____ Fee_____
Program_____Dates_____ Time_____ Fee_____
Program_____Dates_____ Time_____ Fee_____
Program_____Dates_____ Time_____ Fee_____
Bus Fee $10.00- please add if your child will be riding the bus: _____

Total _____

There is a $10.00 charge per student this summer for Bus service.
Will your child need bus transportation? Yes No
Buses are only available at the times shown, please check appropriate times- ☐ Before 8:30AM programs
☐After programs end at 12:00PM

Will you be driving your child to his/her program? Yes No

Will you be picking up your child from his/her program? Yes No
If yes, please circle pick-up time- at 10:00 at 11:30 at 12:00 at 2:30

Will your child be going to **Park and Rec. Camps** after a BEST program (Grades 1-4 Only)?
Children need to be paid and registered through the Park and Rec. office for the Park and Rec. camps.
Yes No If yes, please circle- at 10:00 or at 12:00

For publicity reasons, do you allow your child to be photographed for the newspaper? Yes No

For enrichment programs, please make checks payable to: Summer's BEST
If registering by mail please send check or money order to:
Summer BEST c/o Bethel Board of Education PO Box 253 Bethel, CT 06801

BETHEL PUBLIC SCHOOLS
HEALTH SERVICES DEPARTMENT

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINES BY SCHOOL PERSONNEL

The Connecticut State Law and Regulations 10-212(a) require a written order from an authorized prescriber (physician, dentist, advanced practiced registered nurse or physician assistant) and a parent/guardian authorization for a nurse to administer medication. The principal or trained staff may administer medication. Medications must be in pharmacy prepared containers and appropriately labeled. This law also applies to over-the-counter medications.

MEDICATION ORDER

Name of Child:_____

Address: _____Date of Birth:_____

Condition for which drug is being administered during school hours:_____

Drug Name:_____ Strength:_____ Dose: _____ Route:_____

Time(s) of administration: _____ If PRN, frequency _____

Relevant Side Effects: ☐ None Expected ☐ Specify: _____

ALLERGIES: ☐ NO ☐ YES, specify: _____

Medication shall be administered from: _____to _____
Month/Day/Year Month/Day/Year

Student may self-administer: **Inhaler** ☐ YES ☐ NO **Epi-Pen** ☐ YES ☐ NO

Prescriber's Name/Title: _____

Prescriber's Signature: _____ Date: _____

Address: _____
Phone/Fax:
_____

_____

PARENT/GUARDIAN AUTHORIZATION

I hereby request that the above ordered medication be administered by school personnel. I understand that I must supply the school with no more than a 45 day supply of medication. I understand that this medication will be destroyed if not picked up within one week following termination of the order or the last day of school, whichever comes first.

Parent/Guardian Signature: _____

My child may self-administer: **Inhaler** ☐ YES ☐ NO **Epi-Pen** ☐ YES ☐ NO

Telephone (home)_____(work)_____(cell)_____

School Nurse authorization for student's self administration: _____
Inhaler ☐ YES ☐ NO **Epi-Pen** ☐ YES ☐ NO School Nurse's Signature / Date