

ILLNESS/EMERGENCY PROCEDURE

Student's Name: _____ Advisor: _____ Home Tel: _____ School Year: _____

Mailing Address: _____ Town: _____ Date of Birth: _____

Street Address: _____ Town: _____ Student Cell Phone # _____

Legal Guardian 1: Name _____ Mailing Address (if different) _____ Phone: Cell _____

_____ E-mail _____ Home _____

Legal Guardian 1: Employer _____ Phone _____

Legal Guardian 2: Name _____ Mailing Address (if different) _____ Phone: Cell _____

_____ E-mail _____ Home _____

Legal Guardian 2: Employer _____ Phone _____

If neither parent can be reached, contact these alternates:

Name 1.: _____ Relationship: _____ Phone: work _____ home _____ cell _____

Name 2.: _____ Relationship: _____ Phone: work _____ home _____ cell _____

*The student named has my permission to use the Internet according to the acceptable use policy posted on the school's website and included in the August mailing Yes ___ No ___

Field trip permission is hereby granted for this student to participate in school sponsored field trips, car pools, both on and off island to places of educational interest during the school year. It is understood that I will be given prior notification of any educational field trips. No student will be permitted to participate in a field trip unless this permission is on file with the school.

Parent Signature: _____ Date: _____

Do you have medical insurance Yes ___ No ___ Company Name _____


In case of serious illness, I request the school to contact me and I authorize the school to obtain whatever medical attention seems appropriate including the use of EMT's; via 911 services.

Parent Signature: _____ Date: _____

I give the Martha's Vineyard Public Charter School permission to use my child's likeness in all MVPCS media outlets.

As well as media outlets of all organizations the MVPCS collaborates with.

Parent Signature: _____ Date: _____

OVER 

Name _____ Grade _____

List medications taken by student and reason for taking: _____

List any illnesses, injuries, surgeries, immunizations or other, since last school year: _____

List chronic conditions, allergies or other information which might be important for your child's care: _____

Does student use eyeglasses? _____ Contact lenses? _____ Hearing Aid? _____

Indicate by check mark () if you give permission for the following to be given to your child:

- () Acetaminophen () Ibuprophen () Calagel Lotion () Throat lozenges () Antacids () Sudafed
() Arnica () Decaffeinated herbal teas () 1% Topical Hydrocortisone () Sunscreen () Benadryl () Other
() Hand Sanitizer of 60% Ethyl Alcohol or 70% Isopropyl Alcohol _____

Specify medications you may send in for your child's use: _____

I give my permission to the school nurse to communicate with any and all health care providers regarding my child. Yes ___ No ___

*Parent's / Guardian's Signature _____

Physician _____ Dentist _____

Exemption from immunization: My child shall be exempt from the vaccination and immunization requirements on religious grounds in accordance with the provisions of Chapter 76, Section 15C, General Laws of Massachusetts as per school policy.

THIS MUST BE SIGNED ANNUALLY

Parent Signature: _____