REACH ACADEMY CHARTER SCHOOL

REGISTRATION CHECKLIST:

- ☐ Registration Form
- ☐ Home Language Questionnaire
- ☐ Residency Form
- ☐ Birth Certificate
- ☐ IEP/504 (Special Ed plans)
- ☐ Transportation Form
- ☐ Physical (within 12 months)
- ☐ Immunization Record
- ☐ Recent Dental Exam
- ☐ Court Paperwork (pertaining to the child)
- ☐ TB-1

☐ 2 Proofs of Residency (copies of Mail, your lease, your driver's license, anything with your name and address)

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REACH ACADEMY CHARTER SCHOOL

STUDENT REGISTRATION FORM

Entering Grade: _____ **20 ___ - 20 ___ School Year**

STUDENT PROFILE:

First:	Middle:	Last:
Date of Birth: / /	Gender: ☐ Male ☐ Female	
Born outside the United States? ☐ YES ☐ NO	If Yes, date student entered the US? / /	
If Yes, City of Birth:	If Yes, Country of Birth:	If Yes, # years in US schools:
Is the student Hispanic? ☐ YES ☐ NO	Race--Please check all that apply: ☐ American Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Black ☐ White	
Has the student ever received any Special Services? ☐ **YES** ☐ **NO** **Please indicate which service(s):** ☐ **Special Education** ☐ **ESL** ☐ **Speech** ☐ **OT** ☐ **PT**		
Previous School Attended:	Check to allow us to contact this school to request your child's records. ☐	

STUDENT ADDRESS (2 PROOFS WILL BE REQUIRED):

Street:		
City:	State:	Zip:
Home Phone:	School District Home is Located In:	
Student Lives With: ☐ Both Parents ☐ Mother ☐ Father ☐ Guardian		

PARENT PROFILE:

Mother	Father
Name:	Name:
Address (If Different from Student):	Address (If Different from Student):
Receive Joint Mailings? ☐	Receive Joint Mailings? ☐
CELL PHONE #:	CELL PHONE #:
E-MAIL ADDRESS:	E-MAIL ADDRESS:

Guardian Name (If Guardian checked above):	
Have You Provided *Up-To-Date* Legal Paperwork? ☐ YES ☐ NO	
CELL PHONE #:	E-MAIL ADDRESS:

SIBLING PROFILE	
Are there any siblings currently attending RACS? * ☐ **Yes** ☐ **No**	
Name:	**Grade:**
Name:	**Grade:**
Are there any younger siblings at home?	
Name:	**Date of Birth:**
Name:	**Date of Birth:**

EMERGENCY CONTACT INFORMATION

I GIVE PERMISSION FOR THE FOLLOWING PEOPLE TO BE CALLED If A PARENT/GUARDIAN CAN'T BE REACHED IN AN EMERGENCY. THOSE LISTED HERE ARE ALSO PERMITTED TO PICK UP MY CHILD FROM SCHOOL.

NAME	PHONE NUMBER	RELATIONSHIP

PERMISSIONS

☐ I understand that I must provide a copy of my child's previous Final Report Card in order to help RACS determine proper grade placement. (If applicable)

☐ I give permission for my child's photo to be taken for school related purposes.

Office Use: ☐ BC ☐ POR 1 ☐ POR 2 ☐ HLQ ☐ M-V ☐ IEP ☐ Court ☐ Release Consent

***To qualify for sibling preference, this student must share a Legal Guardian with a currently enrolled RACS student.**

I/We understand that fraudulent information provided above may result in the non - acceptance / removal of my child from the RACS enrollment roster.

Parent Signature: _____ Date: _____

STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234
Office of P-12

Lissette Colón-Collins, Assistant Commissioner
Office of Bilingual Education and World Languages

55 Hanson Place, Room 594
Brooklyn, New York 11217
Tel: (718) 722-2445 / Fax: (718) 722-2459

89 Washington Avenue, Room 528EB
Albany, New York 12234
(518) 474-8775 / Fax: (518) 474-7948

Home Language Questionnaire (HLQ)

Dear Parent or Guardian:
In order to provide your child with the best possible education, we need to determine how well he or she understands, speaks, reads and writes in English, as well as prior school and personal history. Please complete the sections below entitled Language Background and Educational History. Your assistance in answering these questions is greatly appreciated. Thank you.

Please write clearly when completing this section.

STUDENT NAME:

First *Middle* *Last*

DATE OF BIRTH:

Month *Day* *Year*

GENDER:

❑ Male
❑ Female

PARENT/PERSON IN PARENTAL RELATION INFO:

Last Name *First Name* *Relation to Student*

HOME LANGUAGE CODE

Language Background
(Please check all that apply.)

1. What language(s) is(are) spoken in the student's home or residence?	❑ English	❑ Other *specify*	
2. What was the first language your child learned?	❑ English	❑ Other *specify*	
3. What is the Home Language of each parent/guardian?	❑ Mother *specify*	❑ Father *specify*	
	❑ Guardian(s) *specify*		
4. What language(s) does your child understand?	❑ English	❑ Other *specify*	
5. What language(s) does your child speak?	❑ English	❑ Other *specify*	❑ Does not speak
6. What language(s) does your child read?	❑ English	❑ Other *specify*	❑ Does not read
7. What language(s) does your child write?	❑ English	❑ Other *specify*	❑ Does not write

THIS SECTION TO BE COMPLETED BY DISTRICT IN WHICH STUDENT IS REGISTERED:

SCHOOL DISTRICT INFORMATION:

District Name (Number) & School *Address*

STUDENT ID NUMBER IN NYS STUDENT INFORMATION SYSTEM:

Home Language Questionnaire (HLQ)—Page Two

Educational History

8. Indicate the total number of years that your child has been enrolled in school _____

9. Do you think your child may have any difficulties or conditions that affect his or her ability to understand, speak, read or write in English or any other language? If yes, please describe them.

*Yes** ❑ *No* ❑ *Not sure* ❑ ***If yes,** please explain: _____

How severe do you think these difficulties are? ❑ Minor ❑ Somewhat severe ❑ Very severe

10a. Has your child ever been *referred* for a special education evaluation in the past? ❑ **No** ❑ **Yes*** **Please complete 10b below*

10b. **If referred for an evaluation,* has your child ever *received* any special education services in the past?
❑ **No** ❑ **Yes – Type of services received:** _____

Age at which services received *(Please check all that apply):*
❑ **Birth to 3 years (Early Intervention)** ❑ **3 to 5 years (Special Education)** ❑ **6 years or older (Special Education)**

10c. Does your child have an Individualized Education Program (IEP)? ❑ **No** ❑ **Yes**

11. Is there anything else you think is important for the school to know about your child? *(e.g., special talents, health concerns, etc.)*

12. In what language(s) would you like to receive information from the school? _____

_____ Month: Day: Year: _____
Signature of Parent or of Person in Parental Relation ***Date***

Relationship to student: ❑ **Mother** ❑ **Father** ❑ **Other:** _____

OFFICIAL ENTRY ONLY - NAME/POSITION OF PERSONNEL ADMINISTERING HLQ

NAME: _____ POSITION: _____

IF AN INTERPRETER IS PROVIDED, LIST NAME, POSITION AND CREDENTIALS:

NAME/POSITION OF QUALIFIED PERSONNEL REVIEWING HLQ AND CONDUCTING INDIVIDUAL INTERVIEW

NAME: _____ POSITION: _____

ORAL INTERVIEW NECESSARY: ❑ NO ❑ YES

DATE OF INDIVIDUAL INTERVIEW: _____ (MO DAY YR.)

OUTCOME OF INDIVIDUAL INTERVIEW:
❑ ADMINISTER NYSITELL
❑ ENGLISH PROFICIENT
❑ REFER TO LANGUAGE PROFICIENCY TEAM

NAME/POSITION OF QUALIFIED PERSONNEL ADMINISTERING NYSITELL

NAME: _____ POSITION: _____

DATE OF NYSITELL ADMINISTRATION: _____ (MO. DAY YR.)

PROFICIENCY LEVEL ACHIEVED ON NYSITELL: ❑ ENTERING ❑ EMERGING ❑ TRANSITIONING ❑ EXPANDING ❑ COMMANDING

FOR STUDENTS WITH DISABILITIES, LIST ACCOMMODATIONS, IF ANY, ADMINISTERED IN ACCORDANCE WITH IEP PURSUANT TO CSE RECOMMENDATION:

Residency Form

Name of School: _____

Name of Student: _____
Last First Middle

Gender: ☐ Male ☐ Female

Date of Birth: _____ /_____ /_____ (Month / Day / Year)

Grade: _____ (preschool-12)

ID#: _____ (optional)

Address: _____

Phone: _____

The answer you give below will help the district determine what services you or your child may be able to receive under the McKinney-Vento Act. Students who are protected under the McKinney-Vento Act are entitled to immediate enrollment in school even if they don't have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services.

Where is the student currently living? (*Please check **one** box.*)

- ☐ In a shelter
- ☐ With another family or other person because of loss of housing or as a result of economic hardship (sometimes referred to as "doubled-up")
- ☐ In a hotel/motel
- ☐ In a car, park, bus, train, or campsite
- ☐ Other temporary living situation (Please describe): _____
- ☐ In permanent housing

_____
Print name of Parent, Guardian, or Student (for unaccompanied homeless youth)

_____
Signature of Parent, Guardian, or Student (for unaccompanied homeless youth)

_____
Date

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REACH Academy Charter School

Please complete one form per family and return to school. Thank you

Community Eligibility Provision (CEP)/Provision 2 non-base year
Household Income Eligibility Form

REACH Academy Charter School is participating in the Community Eligibility Provision (CEP) or Provision 2 in a non-base year. All children in the school will receive meals/milk at no charge regardless of household income or completion of this form. This form is to determine eligibility for additional State and Federal Program benefits that your child (ren) may qualify for. Read the instructions on the back, complete only one form for your household, sign your name and return it to the school named above. Call 716-248-1485, if you need help.

1. List all children in your household who attend school:

Student Name	School	Grade /Teacher	Foster Child	No Income
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐
			☐	☐

2. SNAPITANF/FDPIR Benefits:
If anyone in your household receives either SNAP, TANF or FDPIR benefits, list their name and CASE# here. Skip to Part 5, and sign the application.

Name:________________________ CASE #________________________

3. Household Gross Income: List all people living in your household, how much and how often they are paid (weekly, every other week, twice per month, monthly). Do not leave income blank. If no income, check box. If you have listed a foster child above, you must report their personal income.

Name of household member	Earnings from work before deductions *Amount / Haw Often*	Child Support, Alimony *Amount / How Often*	Pensions, Retirement Payments *Amount / How Often*	other Income, Social Security *Amount / How Often*	No Income
	$____/____	$____/____	$____/____	$____/____	☐
	$____/____	$____/____	$____/____	$____/____	☐
	$____/____	$____/____	$____/____	$____/____	☐
	$____/____	$____/____	$____/____	$____/____	☐
	$____/____	$____/____	$____/____	$____/____	☐
	$____/____	$____/____	$____/____	$____/____	☐
	$____/____	$____/____	$____/____	$____/____	☐
	$____/____	$____/____	$____/____	$____/____	☐

4. Signature: An adult household member must sign this application.

I certify (promise) that all the information on this application is true and that all income is reported. I understand that the information is being given so the school may receive federal funds. The school officials may verify the information and if I purposely give false information, I *may* be prosecuted under applicable State and federal laws, and my children may lose meal benefits.

Signature:________________________ Date:____________

Email Address:________________________

Home Phone________________________

Work Phone________________________

Home Address________________________

DO NOT WRITE BELOW THIS LINE - FOR SCHOOL USE ONLY

Annual Income Conversion {Only convert when multiple income frequencies are reported on application}
Weekly X 52; Every Two Weeks (bi-weekly) X 26; Twice Per Month X 24; Monthly X 12

SNAPffANF/Foster Income   Total Household Income/How Often: Household Size:

Free Eligibility   Reduced Eligibility   Denied Eligibility

Signature of Reviewing Official

CEP/Provision 2 Non-Base Year Household Income Form INSTRUCTIONS

PART1	ALL HOUSEHOLDS MUST COMPLETE STUDENT INFORMATION. DO NOT FILL OUT MORE: THAN ONE FORM FOR YOUR HOUSEHOLD. (1) Print the names of the children, including foster children, for whom you are applying on one form. (2) List their grade and school. (3) Check the box to indicate a foster child living in your household, and check the box for each child with no income.
PART2	HOUSEHOLDS GETTING SNAP, TANF OR FDPIR SHOULD COMPLETE PART 2 AND SIGN Part 4. (1) List a current SNAP (Supplemental Nutrition Assistance Program), TANF (Temporary Assistance for Needy Families) or FDPIR (Food Distribution Program on Indian Reservations) case number of anyone living in your household. Do not use the 16-digit number on your benefit card. The case number is provided on your benefit letter. (2) An adult household member must sign the form in PART 4. SKIP PART 3 - Do not list names of household members or income ii you list a SNAP, TANF or FDPIR number.
PARTS3 &4	ALL OTHER HOUSEHOLDS MUST COMPLETE ALL OF PARTS 3 AND 4. (1) Write the names of everyone in your household, whether or not they get income. Include yourself, the children you are completing the form for, all other children, your spouse, grandparents, and other related and unrelated people living in your household. Use another piece of paper if you need more space. (2) Write the amount of current income each household member receives, before taxes or anything else is taken out, and indicate where it came from, such as earnings, welfare, pensions and other income. II the current income was more or less than usual, write that person's usual income. Specify how often this income amount is received: weekly, every other week (bi-weekly), 2x per month, monthly. If no income, check the box. The value of any child care provided or arranged, or any amount received as payment for such child care or reimbursement for costs incurred for such care under the Child Care and Development Block Grant, TANF and At Risk Child Care Programs should not be considered as income for this program.

PRIVACY ACT STATEMENT

Use of Personal Information

REACH Academy Charter School does not collect any personal information unless you voluntarily provide it by sending us e-mail, participating in a survey, or completing a form. Personal information submitted will not be transferred to any non-affiliated third parties unless otherwise stated at the time of collection. When a user submits personally identifiable information it is used only for the purpose stated at the time of collection.

TB-1 Parent Request / Authorization
New York State Textbook Loan Program
2018-2019

TEXTBOOK REQUEST FORM

Student Name: _____

Student Address: _____

Name of Public School District residing in: _____

LOAN OF TEXTBOOKS

I hereby request the Loan of Texbooks in the name of:

_____
(Student's Name)

I authorize _____ to act on behalf of this student in
(Non-Public School)
Identifying and ordering textbooks. I understand that in order for the Buffalo Public Schools to provide textbooks through this program all students must reside in the City of Buffalo. I also understand that it is the student's responsibility to maintain in good condition each book received. If books are damaged or lost, the student will be responsible for replacing the books.

Signature of Parent or Guardian: _____

Date: _____

This form should be kept on file in the individual non-public school for the duration of enrollment and made available to the Buffalo Public Schools upon request.

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REACH ACADEMY CHARTER SCHOOL

DATE: _____

YOUR CHILD'S PREVIOUS SCHOOL:

_____

Fax # OF PREVIOUS SCHOOL: _____

Phone # OF PREVIOUS SCHOOL: _____

To Whom It May Concern:

Please forward the following information for the students listed below:

- All academic records to include assessment scores and report cards
- Special Education records to include IEPs and psychological testing
- Medical, health, and attendance records
- All disciplinary records

LAST NAME	FIRST NAME	DOB	GRADE

I give permission for you to forward the requested records to:

REACH Academy Charter School
Attn: Robin Nellis
115 Ash Street
Buffalo, NY 14204
Fax 716-248-2833

Parent Signature: _____

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REACH ACADEMY CHARTER SCHOOL

Dear Parent/Guardian,

Your child's health is very important to us. New York State requires that children have the following exams:

New Entrant:	Physical, Up to Date immunization record, and Dental exam (optional)
Kindergartners:	Physical, Up to Date Immunization record, and Dental exam (optional)
1st graders:	Physical, Up to Date Immunization record, and Dental exam (optional)
2nd graders:	Up to Date Immunization record

An "Up to Date" Immunization record means that all children in K-2nd grade have the following mandatory immunizations:

DTaP: 5 doses

IPV (polio): 4 doses

MMR: 2 doses

Varicella: 2 doses

Hep B: 3 doses

If you notice that your child is missing the required number of vaccines,

Please contact your child's health provider to make an appointment immediately

so that they can get caught up.

If your child will need medication administered while at school (daily meds, inhalers, epipens, etc...) please complete the "Authorization to Administer Medication" form. A doctor must also sign this form. An adult will need to bring the medication to school in its original container with the child's name clearly on the label. Do NOT send the medication in a backpack.

Health Office REACH Academy Charter School

Lisa Cowperthwait, RN

716-248-1485 ext 1570

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REACH ACADEMY CHARTER SCHOOL

Student Health History

Name:_____ Grade:_____

Parent/Guardian:_____ Date of Birth:_____

Please indicate if your child has the following conditions:

	YES	NO	If yes, please explain
Allergy to food, insect, latex, or medication?	◯	◯	_____
Does child require an Epi-Pen?	◯	◯	_____
Seizures? When was last seizure?	◯	◯	_____
Asthma?	◯	◯	_____
Diabetes?	◯	◯	_____
Heart Condition?	◯	◯	_____
Been Hospitalized overnight?	◯	◯	_____
Had an operation?	◯	◯	_____
Vision Problems?	◯	◯	_____
Hearing Problems?	◯	◯	_____
Require a special Diet?	◯	◯	_____
Does your child require any assistive equipment Such as wheelchair, crutches, etc?	◯	◯	_____
Does your child take daily medication?	◯	◯	_____
Will your child need medication administered while at school?	◯	◯	_____

**Please note that if medication needs to be administered at school, an "Authorization to Administer Medication" Form needs to be signed by doctor and parent. Medication will need to be brought to school in its original container.*

Please list any additional concerns:_____

_____

Parent/Guardian Signature:_____ Date:_____

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NYSED requires an annual physical exam for new entrants, students in Grades K, 2, 4, 7 and 10, sports, working permits and triennially for the Committee on Special Education (CSE).

HEALTH APPRAISAL FORM

Name: _____ **Date of Birth:** _____

School: _____ **Gender:** ☐ M ☐ F **Grade:** _____

IMMUNIZATIONS / HEALTH HISTORY

☐ Immunization record attached
☐ No immunizations given today
☐ Immunizations given since last Health Appraisal:

Sickle Cell Screen: ☐ Positive ☐ Negative ☐ Not done Date: _____
PPD: ☐ Positive ☐ Negative ☐ Not done Date: _____
Elevated Lead: ☐ Yes ☐ No ☐ Not done Date: _____
Dental Referral ☐ Yes ☐ No ☐ Not done Date: _____

Significant Medical/Surgical History: ☐ See attached _____

Specify current diseases: ☐ Asthma Diabetes: ☐ Type 1 ☐ Type 2 ☐ Hyperlipidemia ☐ Hypertension
☐ Other: _____

Allergies: ☐ LIFE THREATENING ☐ Food: _____ ☐ Insect: _____ ☐ Other: _____
☐ Seasonal ☐ Medication: _____ _____

PHYSICAL EXAM

Height: _____ Weight: _____ Blood Pressure: _____ Date of Exam: _____

			Referral
Body Mass Index: _____ _____ . _____	Vision - without glasses/contact lenses	R	L	
Weight Status Category (BMI Percentile):	Vision - with glasses/contact lenses	R	L	
☐ less than 5th ☐ 5th through 49th ☐ 50th through 84th	Vision - Near Point	R	L	
☐ 85th through 94th ☐ 95th through 98th ☐ 99th and higher	Hearing ☐ Pass 20 db sc both ears or:	R	L	

☐ **EXAM ENTIRELY NORMAL** Tanner: I. II. III. IV. V. Scoliosis: ☐ Negative ☐ Positive: _____

Specify any abnormality (use reverse of form if needed): _____

_____

_____

MEDICATIONS

Medications (list all): ☐ None ☐ Additional medications listed on reverse of form

Name: _____ Dosage/Time: _____

Name: _____ Dosage/Time: _____

If AM dose is missed at home: _____

I assess this student to be self-directed ☐ Yes ☐ No Student may self carry and self administer medication ☐ Yes ☐ No
Note: Nurse will also assess self-direction for the school setting. Please advise parent to send in additional medication in the event that emergency sheltering is necessary at school or if the morning medication has not been given.

PHYSICAL EDUCATION / SPORTS / PLAYGROUND / WORK QUALIFICATION / CSE CONSIDERATION

☐ **Free from contagions & physically qualified for all physical education, sports, playground, work & school activities OR only as checked:**
___ Limited contact: cheerlead, gymnastics, ski, volleyball, cross-country, handball, fence, baseball, floor hockey, softball.
___ Non-contact: badminton, bowl, golf, swim, table tennis, tennis, archery, riflery, weight train, crew, dance, track, run, walk, rope jump.

☐ **Specify medical accommodations needed for school:** _____ ☐ None

☐ **Known or suspected disability:** _____ ☐ Please monitor

☐ **Restrictions:** _____ ☐ Please monitor

☐ **Protective equipment required:** ☐ Athletic Cup ☐ Sport goggles/impact resistant eyewear ☐ Other: _____

(Stamp below)

Provider's Signature: _____ Phone: _____

Provider's Name/Address: _____ Fax: _____

Parent Signature: _____ Date: _____

This exam complies with NYSED requirements above and is valid for twelve months, with the exception of any illness or injury lasting more than five days that will require review by private healthcare provider and the school medical director. *Rev. 10/3/07*

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Dental Health Certificate - Optional

Parent/Guardian: Please complete Section 1 and take the form to your dentist/dental hygienist for an assessment. Request your dentist/dental hygienist to fill out Section 2. Return the completed form to your child's teacher as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first visit to a dentist? ☐ Yes ☐ No

School: Name

Grade

Section 2. To be completed by the Dentist/Dental Hygienist

I. Oral Health Status (check all that apply)

☐ Yes ☐ No **Caries Experience/Restoration History –** Has the child ever had a cavity (treated or untreated?

[A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

☐ Yes ☐ No **Untreated Caries –** Does this child have an open cavity?

[At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

☐ Yes ☐ No **Dental Sealants Present**

☐ Yes ☐ No **Soft Tissue Pathology**

☐ Yes ☐ No **Malocclusion**

II. Treatment Needs (check all that apply)

☐ **No need for Treatment**

☐ **Urgent Treatment –** abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

☐ **Restorative Care –** amalgams, composites, crowns, etc.

☐ **Preventive Care** – sealants, fluoride treatment, prophylaxis, mouthguard etc.

☐ **Other** – periodontal, orthodontic treatments

Please note _____

The Dental Health condition of _____ **on** _____ **(date of exam) Check one:**

☐ **Yes, The student listed above *is* in fit condition of dental health to permit him/her attendance at the public schools.**

☐ **No, The student listed above *is not* in fit condition of dental health to permit him/her attendance at the public schools.**

Dentist's Name and Address (Please Print or Stamp):

Dentist/Dental Hygienist Signature:

Date of Exam: / /

* The dental health condition of the student when the exam is made and the date of exam shall not be more than 12 months prior to the commencement of the school year in which the exam is requested.

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REACH ACADEMY CHARTER SCHOOL

Authorization to Administer Medication

Date:_____

To Physicians and Parents of Children Requiring Medication in school:

You are requested to complete this form so that required medication may be administered in school in compliance with the rules and regulations of the New York State Education Department.

Name of School: REACH Academy Charter School, 115 Ash St, Buffalo, NY 14204

Name of Child: _____

Address of Child: _____

Diagnosis: _____

Name of Medication: _____

Dose and Time: _____

Expected Effect: _____

Possible Side Effects _____

Time Duration of Order_____

Date Order is Effective_____

Physician's Signature_____ Date:_____

PARENT REQUEST FOR SCHOOL TO ADMINISTER MEDICATION

I HEREBY REQUEST THAT MY CHILD_____BE GIVEN THE MEDICATION ABOVE, AS PRESCRIBED BY THE PHYSICIAN.

Parent/Guardian Signature_____

Date:_____