



**STUDENT DISMISSAL FORM
FOR ACADEMIC YEAR 2018-19**

Student Name: _____ Grade: _____

Home Address: _____

Postal Address: _____

Main Email Address: _____

Home Telephone: _____

Student's Cell Phone: _____ Date of birth: _____

Contact Person for Pick-up Information:

Mother or Guardian's Name: _____ Cellular: _____

Father or Guardian's Name: _____ Cellular: _____

Please indicate the names and telephone number(s) of the person(s) who is/are authorized to pick up your youngster at school at any time during school hours or at the end of the day. If you need more space, continue on the back of this page:

Name:	Telephone or Cell Phone:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____

Signature of Parent or Guardian: _____ Date: _____



EMERGENCY HOME CONTACT FORM
FOR ACADEMIC YEAR 2018-19

Student Name: _____ Grade _____

Sex _____ Age _____ Birthdate _____

Home Address _____

City _____ State _____ Zip Code _____ Home Telephone _____

Does child live with both parents? _____ mother? _____ father? _____ guardian? _____

Father/Guardian _____ School Hours Telephone No. _____

Mother/Guardian _____ School Hours Telephone No. _____

If unable to reach parents in case of emergency, please call Emergency Contact Person:

Name _____ Telephone _____ Relationship _____

Name _____ Telephone _____ Relationship _____

TO BE COMPLETED BY PARENT OR GUARDIAN:

List all childhood diseases, allergies, operations, and /or other illness:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

List any and all medical restrictions or conditions:

Important medication child is on _____

Important Medication that should be at school with child for this condition:

Information school should know:



PERMISSION FOR OVER-THE-COUNTER MEDICATIONS FOR ACADEMIC YEAR 2018-19

When students are ill, it is often deemed wise to provide them with over-the-counter medication for symptom relief. At TASIS Dorado, the Registered Nurse will decide which medications are indicated and can administer over-the-counter medications to your child. Occasionally, main office administrators will administer over-the-counter medications to students after consulting with the Registered Nurse. If there are any medications that you do not wish your child to have, please follow the instructions below.

Medications needed at the moment will be provided to your child. If your child requires long term use of an over-the-counter medication or any specific prescription medication parents need to provide them to the Registered Nurse Health Office with the required forms. As clearly stated in the TASIS Dorado policy, no medication may be kept in the student's classrooms or backpacks, unless authorized by the School Nurse. This form is only for the medications listed below and will only be administered per manufacturer's recommended dosing.

Student Name

Date of Birth

Parent Name

All Over-the-Counter Medications Below

No Over-the-Counter Medications Below

Or indicate which medications may be administered by checking below:

Tylenol/Acetaminophen

Dimettap Cold & Allergy

Advil/ Ibuprofen

Cough Syrup

Claritin/Loratadine

Tums

Benadryl Liquid or tabs

Cough Drops/Halls

Cold Tylenol/Cold Relief

Antibiotic Ointment

Pepto Bismol

Hydrocortisone / Benadryl Cream

I give permission for the School Nurse to dispense the above checked medicine(s) to my child:

Parent Signature

Date



2018 MEDICAL FORM

PHYSICAL EXAMINATION to be performed by a Licensed Physician.

Puerto Rico State Law #235 requires that all immunization records be kept in the student's file. Please ask your doctor to fill in the PVAC-3 Form (the green form) and return it to School with this document.

Student's Name _____ Age: _____ Grade _____

Birth Date _____ Height _____ Weight _____

General Appearance: _____ Chest and Lungs _____

Eyes _____ Heart _____ Abdomen, Hernia _____

Vision with Glasses: R _____ L _____ Color Vision _____

Hearing: R _____ L _____

Extremities _____ Skin _____ Teeth and Gums _____

Posture, Gait, Spine _____ Coordination _____

Nutrition _____ Blood Pressure _____ Neurological _____

Scalp, Neck, Head _____ Ears _____ Nose _____

Physical and Emotional Challenges _____

Diagnosis and Recommendations _____

Recommended activity for physical education and sports: Full _____ Limited _____

If Limited, Please Explain _____

Physician: _____ License No.: _____

Date: _____