

CDS Summer Program information form

Student Name: _____ Birth Date: _____

Address: _____

Nickname: _____

**Health Data / Allergies: _____

Physician _____ Office Number _____

Preferred Hospital _____ Insurance Policy # _____

Over the Counter
Medication Grades K-8

Sign here for authorization to dispense over the counter medication to your child(ren): _____

••If your child needs to receive daily maintenance medication please stop by the school office to turn in the prescribed medication and sign the appropriate permission form. Thank you. ••

Parent/Guardian Information

Information from this section will appear in CDS parent/student directory for your convenience. Please provide your family's information as you would like it to appear in the directory.

Name: _____ Relationship: _____

Work Phone: _____ Cell Phone: _____

Email: _____

Employer _____

Name: _____ Relationship: _____

Work Phone: _____ Cell Phone: _____

Email: _____

Employer _____

1st Child's Name: _____ Grade: _____

2nd Child's Name: _____ Grade: _____

3rd Child's Name: _____ Grade: _____

Person other than Parent or Guardian to contact in case of an emergency:

Name _____ Cell Phone _____

Address _____ Home Phone _____

Employer _____ Work Phone _____

In case of emergency, if the school is unable to reach the above listed people, I grant to the teacher and/or the Head of Capital Day School, the power to act in loco parentis and seek medical attention for my child.

Child's Name _____ Signature _____

Approved Pick Up List

Please include anyone that you might need to pick-up your child from school or from the Extended Day programs in case of an emergency or unforeseen event, for example, the names of relatives, friends, neighbors and coworkers. With the exception of parents all persons will be required to show a picture ID.

Name	Relationship	Phone Number

Sunscreen Permission Form

Parent's/Guardian's Permission to apply Bug Spray to Child

Name of Child (first and last): _____

As the parent or guardian of the above child, I give permission for personnel at Capital Day School to apply the Bug Spray that I have listed below, between the daily times of 7.30 a.m. and 5 p.m. and during the months of June, July and August. I understand that bug spray may be applied to exposed skin. I have checked all applicable information regarding the type and use of bug spray for my child:

___ I do not know of any allergies my child has to bug spray.

___ I have provided the following brand/type of bug spray for use on my child: _____

___ For medical or other reasons, please do not apply bug spray to the following areas of my child's body:

Bug Repellent release form

Date: _____

Child's Name: _____

Name of Sunscreen and SPF #: _____

Please apply sunscreen to your child every morning before drop off. As needed throughout the day, your child's care provider will assist with applying sunscreen to bare surfaces including the face, tops of ears and bare shoulders, arms, legs, and feet 15-30 min before outdoor activity. Sunscreen will not be applied to any broken skin or if a skin reaction has been observed. Any skin reaction observed by staff will be reported promptly to the parent/guardian.

Parent Signature