Dumont Summer Enrichment Program / Student Emergency/Medical Form
Wednesday, June 27 – Tuesday, July 24, 2018
DUE BY Thursday, June 7, 2018

Student Name: ____ Date of Birth: ___/___/___
Last First
Student's School: ______________________________ Grade entering in September: _____
Parent/Guardian Name: _________________________________
Home # _______________ Cell # ___________________ Work # ______________
Parent/Guardian Name: _________________________________
Home # _______________ Cell # ___________________ Work # ______________

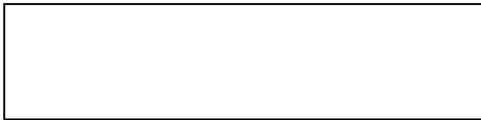
If your child does not attend Dumont Public Schools, you must submit a copy of your child's A45 immunization record (available from your school nurse) when you register. This form may also be faxed directly to Donna Pleus, RN @ 201.387.0742.

My child is under a doctor's care at the present time: yes ___ no ___ (check one)
If yes, please explain: ____
My child can participate fully in all activities: yes ___ no ___ (check one)
If no, please explain: ____
My child is allergic to: ____
My child has asthma / diabetes / seizure disorder: yes (circle all that apply) ____ no ____
My child takes medication daily or on an as-needed basis: yes ____ no ____ (check one)
Name of medication(s): ____
My child requires the use of epipen, glucagon, diastat, insulin, inhaler or other emergency medication: yes (circle all that apply) ____ no ____
My child is currently using the following medications on an **emergency basis** *and may need them given during the time the enrichment program is in session:*

Name of Medication	Dosage	Route	Frequency	***physician use** only**
________________________	__________	_____	q _________ prn	
________________________	__________	_____	q _________ prn	
________________________	__________	______	q _________ prn	

Please note: School policy prohibits the administration of medication, including over the counter medications, without a signed doctor's order. **Medication orders and all medication in the original container(s) MUST be received by the first day your child starts the program.** The doctor may sign and stamp below or fax medication orders to Donna Pleus, RN @ 201.387.0742.

_______________________ ____/____/____
Physician Signature Date
***required only if student taking medication**


Physician Office Stamp

I acknowledge that the school district shall have no liability for any good faith act or omission consistent with the law that results in any injury arising from the administration of the above-designated medications. I shall indemnify and hold harmless the Dumont Board of Education, its officers, employees or agents against any and all claims, suits or causes of action arising out of the administration of medication to my child.

I understand that should a serious injury or illness occur, medical and/or hospital care will be sought for my child. If a parent/guardian cannot be contacted, I give permission to pursue a course of action that is deemed to be in the best interest of my child. I hereby authorize a member of the Dumont Public School staff to secure medical treatment that may be necessary for my child. I further understand that I will be responsible for all medical/surgical/transportation costs that may be incurred.

Parent/Guardian Signature: ______________________________ Date: ____/____/____
Reviewed by: ____ Date: ____/____/____
Signature of school nurse