Academic Challenge Info Sheet

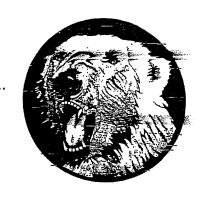
Name:				
Email:				
Your cell:				
Parent/guardian:				
Their phone:	·			
Home address:				
Other extra-curricula	rs:			
Academic Challenge	subjects that you feel are	strengths for you (circle all that apply):		
AMERICAN LI	TERATURE	ENGLISH/WORLD LITERATURE		
MATH		AMERICAN GOVERNMENT		
WORLD HISTORY		PHYSICAL SCIENCE		
FINE ARTS		WORLD GEOGRAPHY		
LIFE SCIENCE		U.S. HISTORY		
Are you available for matches most Monday and Wednesday afternoons, from November through January?				

HEALTH ALERT		
--------------	--	--

Student Name				Bus #
Address				
Address Change Y N Birth Date			=	Room
Residential Parent or Guardian				
Acsidential Latent of Guardian				
Mother				
Email				
Father				
Email				
Other Name			Cell #	
Name of Relative or Childcare Provider				·
Address				
I hereby give consent for the following medic	al care providers and local h			
Doctor	=	-		
Dentist				
Medical Specialist				
Hospital				
Below check any <u>CURRENT</u> health condition				
☐ Allergies (be specific) ☐ Foods ☐ Medicines ☐ Pag Stings	=			cific)
•		☐ Previous	conquesion/head injur	y-year
	cy inhaler Yes No	☐ Hearing		
☐ Cancer	10		•	Tras hearing ards res re
☐ Diabetes		vision pi	colomo (co specime) _	
Seizures		Wea	ars: Glasses	☐ Contacts
☐ Heart problems (be specific)		_	ADD/ADHD	
Physical disability (be specific)			.	
		☐ No currer	nt health conditions	
List all medications and dosages your child re	ceives on a continual basis:			
DI EAGE COA	APLETE PART	I OD DAI		
Part I — TO GRANT CONSENT In the event reasonable attempts to contact me necessary by the designated physician or dent and (2) the transfer of the child to the designated This authorization does not cover major surge such surgery, are obtained prior to the performance of the per	e have been unsuccessful, I h tist, or in the event the design ted hospital or any hospital re ry unless the medical opinion	ereby give my conated practitioner easonably accessi	onsent for: (1) the adm r is not available, by a ible.	ninistration of any treatment deemed nother licensed physician or dentist;
Date	_			
Part II — REFUSAL TO CONSENT				nergency treatment, I wish the school

Jackson Local Schools





PARENT CONSENT FOR TRIP

(Parent's Name)				
permit my child (Child's Name)				
To participate in the trip to:				
I understand that this trip is part of the District's education learning experience of educational value to my child.	nal program and provides a			
I further understand that the staff member(s) who will accomise the necessary and appropriate duty Board Policy #3213, including, but not limited to, administrates or seeking emergency medical attention, if need be.	of care for them pursuant to			
Parent's Signature	Date			

© NEOLA 2003

dc