

## Appendix 18

Region <b>8</b>	School
Region Director(s) <b>Rebecca Papsen</b>	Sponsor or Chaperon at PJAS Meet



### Pennsylvania Junior Academy of Science Authorization for Medical Treatment. Please type or print information.

Name of Student	Date of Birth
Name of Parent or Legal Guardian	Day Phone Evening Phone
Address	City, State, Zip
Health Coverage Plan	I.D. or Contract Number
Family Physician and Phone Number	

**Please check YES or NO for each medication PJAS Nurses may administer to your child**

Medication or its Generic Equivalent	Yes	No
Aspirin		
Advil		
Tylenol		
Aleve		
Kaopectate		
Pepto Bismal		

Medication or its Generic Equivalent	Yes	No
Benadryl		
Claritin Over the Counter		
Sudafed – Non-Drowsy		
Rolaids		
Robatussin Cough Syrup DM		
Robatussin Cough Syrup PM		

Special Medical Condition	Yes	No	Additional Information (Use back if needed)
Diabetes			
Asthma			
Allergies			
Allergic Reactions			
Other (please indicate)			

**Please list all prescription medication that your child is taking – include dosage and time(s)**

Except in a true emergency, medical, dental or hospital services may be rendered to a child only with the consent of the parent or legal guardian. It is important to prepare this form carefully, especially if it may be difficult to reach you. Please make sure the person named above as sponsor or chaperon is the person who will be attending the PJAS Meet. If your child needs unexpected medical treatment, the responsible adult will present this document to the appropriate person - nurse, physician, dentist or hospital representative. **Please prepare three originals of this form with signatures.**

I/We being the parent(s) or legal guardians of the above named student do hereby appoint the region director(s) and sponsor or chaperon named above to act in my/our behalf in authorizing unexpected medical, dental, surgical care, and hospitalization for the above named student for the period from **May 15 – 17, 2011**. I/We agree to the release of any records necessary for treatment, referral, billing, or insurance purposes to the appropriate medical care provider.

Parent/Guardian Signature	Date
Person to be contacted if parents can not be contacted	Phone