Please 3-hole punch these documents

Region #3	School
Region Director: Karen Iobst	Chaperone/Sponsor:

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	Telephone Number (Day & Evening)
Address	City, State, Zip Code
Health Coverage Plan	I.D. or Contract Number
Family Physician and Telephone Number	

May PJAS Nurses administer medications to your child? Check Yes or No for each.

Medication or its Generic Equivalent	**Yes**	**No**		**Medication or its Generic Equivalent**	**Yes**	**No**
Aspirin				Benadryl®		
Aleve®				Claritin® Over the Counter		
Advil®				Sudafed® – Non-Drowsy		
Tylenol®				Rolaids®		
Kaopectate®				Robitussin® Cough Syrup DM		
Pepto Bismol®				Robitussin® Cough Syrup PM		

Special Medical Condition	**Yes**	**No**	**Additional Information (Use back if needed)**
Diabetes			
Asthma			
Allergies			
Allergic Reactions			
Prescription Medications			
Other (Please Indicate)			

List all prescription medications your child is taking, dosage and time(s).

Infectious Disease notice: Students who develop flu-like symptoms will be sent to the PJAS Nurse's Office for evaluation. Based on public health guidelines from the CDC and the PA Department of Health, these students will be distanced from other students and sent home to recuperate.

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 that the person named above as sponsor or chaperone is the person that will be attending the PJAS Meeting. If your child needs unexpected medical treatment, the responsible adult will present this document to the appropriate person- nurse, physician, dentist, or hospital representative. **Prepare 3 originals of this form with original signatures on each one.**

I/We being the parent(s) or legal guardian(s) of the above named student, do hereby appoint the region director(s) and the sponsor or chaperone named above to act in my/our behalf in authorizing unexpected medical, dental, surgical care, and/or hospitalization for the above named student for the period from May 14th to May 16th, 2017.

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Parent/ Guardian Signature *Date*

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Person to be contacted if parents cannot be reached. *Telephone of emergency contact person*