PLEASE COMPLETE BOTH SIDES OF THIS FORM

BROOME-TIOGA BOCES 2021
COOPERATIVE SUMMER SCHOOL

STUDENT INFORMATION – HEALTH DATA/PERMISSION FORM

District _____Home School _____ Student ID# _____

Student's Name: _____ **Mo** ___ **Day** ___ **Year** _____
Last First Initial

M ☐ F ☐ Home Phone_____ Student Cell Phone: _____

Home Address: _____
Street, City, State, & Zip

Father/Guardian Name: _____Cell Number_____

Employer: _____/_____ Phone: _____
Work Hours

Mother/Guardian Name: _____Cell Number_____

Employer: _____/_____ Phone: _____
Work Hours

Family Status: ☐ Married ☐ Divorced ☐ Separated ☐ Foster ☐ Family ☐ Single

Who should be the primary contact person?_____

PROMOTIONAL RELEASE

YES or NO *I GIVE PERMISSION TO Broome-Tioga BOCES to record my child's image and/or voice for use in promotional and educational materials. This includes print and broad cast media and/or inclusion on the BOCES Web Page.*

ATTENDANCE POLICY

Daily attendance is expected. There are no excused absences. No credit is awarded once a student exceeds three absences for any reason. There are no make-up classes. Students are expected to arrive on time. Thirty minutes of missed class time will equal a full absence.

(I), (WE), the undersigned parent(s) having read and understood the rules of order AND all of the above do grant permission for our son/daughter to enroll in Broome-Tioga BOCES Cooperative summer school.

_____ _____ _____

(Parent(s)/Guardian Signature) ***Date*** ***(Relationship To Student)***

EMERGENCY/MEDICAL INFORMATION

Doctor's Name: _____ Phone: _____

Home Health Care Company: _____ Phone: _____

Medicaid Service Coordination: YES or NO Agency: _____

Medicaid Service Coordinator: _____ Phone: _____

Current Medications: _____

_____

Allergies:	**Explain Reaction**	**Explain Treatment**
___ Bee/Insect	_____	_____
___ Environmental	_____	_____
___ Food	_____	_____
___ Medication	_____	_____

Please check conditions you have or have had in the past:

___ Asthma ___ Epilepsy/Seizure Disorder ___ Heart Disease

___ Migraine Headaches or Others ___ Psychiatric Care ___ Suicide Attempt

*_Permission Form for Medication,_ available in the summer school office, must be completed for medication to be dispensed at school.

Hospitalizations (Year, Hospital, Reason/Outcome):

_____

Serious Illness/Injuries (Date, Outcome):

_____

AUTHORIZATION FOR MEDICAL TREATMENT OF A MINOR

EMERGENCY CONTACT INFORMATION (if parent/guardian can not be reached)

(I), (WE), the undersigned parent(s) of _____ a minor, do grant permission for, and hereby authorize (names of 3 persons who are 21 years of age or older)

1. _____ _____ _____
   Name *Relationship* *Phone*

2. _____ _____ _____
   Name *Relationship* *Phone*

3. _____ _____ _____
   Name *Relationship* *Phone*

4. BOCES School Personnel, as agents for the undersigned to consent to any emergency medical treatment of hospital care by licensed medical professional deemed necessary.