VISITOR CONTACT INFORMATION FORM

EMERGENCY CONTACT INFORMATION		
Student Name: (Full Name)		
Parent/ Guardian Contact Information		
First Contact: (Full Name)	Relationship:	
Home Phone:	Work Phone:	Cell Phone:
Second Contact: (Full Name)	Relationship:	
Home Phone:	Work Phone:	Cell Phone:
Third Contact: (Full Name)	Relationship:	
Home Phone:	Work Phone:	Cell Phone:

MEDICAL INFORMATION	
Allergies:	Medications/Treatments:
Medical Conditions:	

CONSENT TO ADMINISTER OVER-THE-COUNTER MEDICATIONS

The Project School has a *health aide* on staff. Students who require medication must have a signed parental consent form in order for school personnel to administer the medication. This includes over-the-counter medicines, homeopathic remedies, and supplements. Prescription medication must be in the original container, labeled with the child's name, date, dosing instructions, and the prescribing physician's name. Non-prescription medication must be labeled with the child's name and the date. It must be left in the original container, and will be administered according to the label directions. All medication must be picked up by a parent/guardian. The health aide will dispose of any medications left in the health office at the end of the school year. ***By initialing next to each over-the-counter medication, you are authorizing Project School Staff to administer the medication to your student.***

Acetaminophen: (Tylenol)	Ibuprofen:	Tums:	Diphenhydramine HCL: (Benadryl)

CONSENT TO SEEK EMERGENCY MEDICAL ASSISTANCE

I, _____, give my permission to The Project School faculty and
Print Parent/Guardian Name

Staff to seek emergency medical assistance for my child, _____.
Print Student Name

_____ _____

Parent/Guardian Signature **Date**