PEAK Gifted and Talented Program Permission Form 2023-2024

I give permission for my child, _____, to participate in the PEAK Gifted and Talented Program.

Signature _____ Date _____

Print Name _____

CONTACT INFORMATION:

Student's Home School _____ Grade _____

Student's Home School Teacher _____

Student's Email (*optional*) _____

Parent 1 _____ Parent 2 _____

Address _____ Address _____

Phone _____ Phone _____

Email _____ Email _____

☐ I DO NOT wish for my student to be published in photographs, videos, and/or web pages for the purpose of promoting PEAK programs or otherwise. *Only provide signature if you do not want your student published:*

Signature _____

STUDENT HEALTH RECORD 2023 – 2024

Student Name (last, first, initial) _____ Date of Birth: _____Age____

Home Address: _____ City _____ Zip Code: _____

Parent/Guardian: _____ Phone (daytime)_____(night)_____

Cell Phone: _____E-Mail Address: _____ Fax _____

Person to Notify in Emergency: _____ Phone _____

Name of Doctor: _____Doctor's Phone No. _____

Name of Dentist: _____ Dentist's Phone No. _____

Other Phone Numbers (Friends/Relatives) _____

Medical Information

Diseases (√)

___ Chicken Pox
___ Measles
___ German Measles
___ Mumps
___ Whooping Cough
___ Other:_____

Medical Problems (√)

___ Diabetes
___ Seizures
___ Orthopedic Problems
___ Asthma
___ Cardiac Problems
___ Other:_____

Allergies (√)

___ Latex
___ Hay Fever
___ Milk
___ Aspirin
___ Penicillin
___ Insect Stings
___ Other:_____

Chronic or Recurring Illness (√)

___ Ear Infections
___ Nose Bleeds
___ Sleep Disturbance
___ Fainting
___ Car Sickness
___ Constipation
___ Other:_____

Date of last tetanus shot: _____

Other information or details of above: _____

Operations, hospitalizations or serious injuries (dates): _____

Comments where applicable:

Fainting_____ Sleep Disturbances_____ Nose Bleeds_____

Menstruation_____ Constipation_____ Car Sickness_____ Other_____

Special medical or dietary regimen to be continued (specify)_____

Do you know of any **special needs or disabilities** that make it advisable for your child to follow a limited program of physical activity or to refrain from participating in any of the activities? If yes, please explain. Mention any recent surgery, illness, broken bones, injuries, allergies (other than medication) or any physical conditions. _____

_____

EMERGENCY MEDICAL AUTHORIZATION

In the event reasonable attempts to contact me at the above phone numbers have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by a licensed physician or dentist; and (2) the transfer of the child to St. Peter's Community Hospital or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Signature: _____ Date: _____