

# PLEASE COMPLETE BOTH SIDES OF THIS FORM

## BROOME-TIOGA BOCES INSTRUCTIONAL PROGRAMS STUDENT INFORMATION - HEALTH DATA/PERMISSION

Please Complete, Sign, & Return this form to BOCES

School Year: **2022-2023** School District: \_\_\_\_\_ Bus#: \_\_\_\_\_

BOCES Site & Program: \_\_\_\_\_

Session: **AM PM ALL DAY** Teacher: \_\_\_\_\_ Team/Room: \_\_\_\_\_

**Student:** \_\_\_\_\_  M  F  
*Last First Initial*

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Home Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_  
*Street, City, State, & Zip*

Parent/Guardian1 Name: \_\_\_\_\_

Employer: \_\_\_\_\_ / \_\_\_\_\_ Email: \_\_\_\_\_  
*Work Hours*

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Parent/Guardian2 Name: \_\_\_\_\_

Employer: \_\_\_\_\_ / \_\_\_\_\_ Email: \_\_\_\_\_  
*Work Hours*

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### **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:** Identify the specific allergen (*peanuts, bees, etc.*) and explain Reaction & Treatment.

Allergen: \_\_\_\_\_ Reaction: \_\_\_\_\_ Treatment: \_\_\_\_\_

Allergen: \_\_\_\_\_ Reaction: \_\_\_\_\_ Treatment: \_\_\_\_\_

Allergen: \_\_\_\_\_ Reaction: \_\_\_\_\_ Treatment: \_\_\_\_\_

Allergen: \_\_\_\_\_ Reaction: \_\_\_\_\_ Treatment: \_\_\_\_\_

**Current Medical Conditions:** \_\_\_ Asthma \_\_\_ Diabetes \_\_\_ Seizures \_\_\_ Other (explain):

**Hospitalizations** (Year, Hospital, Reason/Outcome): \_\_\_\_\_

**Serious Illness/Injuries** (Date, Outcome): \_\_\_\_\_

**AUTHORIZATION FOR MEDICAL TREATMENT OF A MINOR:**

(I), (WE), the undersigned parent(s) of \_\_\_\_\_ a minor, do 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 professionals deemed necessary.

**USE OF SUNSCREEN:**

(Article 19 Section 907) Supervised Students (self-directed) may carry and apply sunscreen products from home. Sunscreen that is not outdated, with student's full name written on the bottle by the parent may be carried by the student. A student who is unable to apply sunscreen may ask BOCES staff to apply. Written permission by parent/ guardian is needed. **Note: Non self-directed students would need both provider order and parental written permission.**

I give permission for my child to use FDA topical sunscreen products:  YES  NO

**FIELD TRIP PERMISSION:**

I give permission for my child to be transported during assigned class time to and from educational activities away from their BOCES Educational Site:  YES  NO

\_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Relationship to Student)

**PROMOTIONAL RELEASE NOTIFICATION:**

Broome-Tioga BOCES may record my child's image and/or voice for use in promotional and educational materials. This includes print, social media, broadcast media and/or inclusion on the BOCES Web Page. I must submit a letter in writing, to my child's program, if their image and/or voice is not to be used.

**PLEASE BE SURE TO SIGN THIS FORM**