



# Phoenix Christian Unified Schools

## NOTARIZED EMERGENCY CONTACTS / ACTIVITY PERMISSION FORM 2012—2013

Student's Last Name	First Name	MI	
Birthdate	Gender	Grade	Home Phone
Home Address		City	Zip Code
Mother/Guardian Name	Home #	Cell #	Work #
Father/Guardian Name	Home #	Cell #	Work #
<b>Name of Relative/Friend in Case You Cannot be Contacted</b>	Home #	Cell #	Work #

Date of last Tetanus Booster: \_\_\_\_\_  
 Name of Family Insurance: \_\_\_\_\_  
 Did you purchase School Insurance?  Yes  No  
 To which medicines/ foods is student allergic? \_\_\_\_\_  
 Medications now being taken: \_\_\_\_\_

**YOU MUST INITIAL** beside each medication you would like available to your student while at school. [JH/SH Students Only]

- |  |   |
|--|---|
| _____ <b>Benadryl</b> (or its generic equivalent) : 25 mg tablets<br>recommended dose: 1-2 tablets every 4-6 hrs   | _____ <b>Sudafed</b> (or its generic equivalent): 30 mg tablets<br>2-4 tablets hourly as needed                 |
| _____ <b>Advil</b> (or its generic equivalent): 200 mg tablets recom-<br>mended dose: 1-2 tablets every 4-6 hours  | _____ <b>Tums</b> (or its generic equivalent): 2-4 tablets hourly as<br>needed                                  |
| _____ <b>Midol</b> (or its generic equivalent): 200 mg tablets recom-<br>mended dose: 1 tablet initially; if pain does not respond,<br>2 tablets may be used | _____ <b>Tylenol</b> (or its generic equivalent): 325 mg tablets<br>recommended dose: 2 tablets every 4-6 hours |

**List any individual(s) who SHOULD NOT pick up and/or have contact with your student:**

1. \_\_\_\_\_

2. \_\_\_\_\_

*The undersigned hereby give permission for the above named student to attend any school-related function for the period from August 1, 2012 to July 31, 2013. In the event there is any emergency involving him/her, permission is hereby granted for **Phoenix Christian Unified Schools** personnel to consent to any x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care to be rendered to the minor under the general or special supervision and on the advice of any physician or surgeon or dentist licensed to practice in any state, and school personnel shall not be held personally liable.*

*If emergency service involving medical action or treatment is required, and neither the parent nor guardian can be contacted, the undersigned herewith consents for the student named above to be given medical care by a doctor selected by the school. Any intentional omission or falsification of this form may subject the parent/guardian to full liability for any subsequent injury, or may cause the student to be removed from sports participation.*

*The undersigned gives consent for the above over-the-counter medications (if initialed above) to be administered by a designated school employee as needed, as determined by the employee. The parent/guardian must complete a written authorization form provided by the school for prescription medications that will be taken at school. All prescription medications must be turned in to the nurse's office in the container dispensed by the pharmacy.*

\_\_\_\_\_  
 Signature of Parent or Legal Guardian  
**(Must Sign in Presence of Notary Public)**

State of Arizona, County of Maricopa  
 Subscribed and sworn to before me

This \_\_\_\_\_ day of \_\_\_\_\_,

Notary Public \_\_\_\_\_

My Commission Expires \_\_\_\_\_