TASIS
DORADO

STUDENT DISMISSAL FORM
FOR ACADEMIC YEAR 2019-20

Student Name: _____ Grade: _____

Home Address: _____

_____

Postal Address: _____

Main Email Address: _____

Home Telephone: _____

Student's Cell Phone: _____ Date of birth: _____

Contact Person for Pick-up Information:

Mother or Guardian's Name: _____ Cellular: _____

Father or Guardian's Name: _____ Cellular: _____

Please indicate the names and telephone number(s) of the person(s) who is/are authorized to pick up your youngster at school at any time during school hours or at the end of the day. If you need more space, continue on the back of this page:

Name:	Telephone or Cell Phone:
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____
6._____	_____
7._____	_____
8. _____	_____

Signature of Parent or Guardian: _____ Date: _____

Revised: June 01, 2018

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EMERGENCY HOME CONTACT FORM
FOR ACADEMIC YEAR 2019-20

Student Name: _____ Grade_____

Sex_____ Age_____ Birthdate _____

Home Address_____

City_____ State_____ Zip Code_____ Home Telephone_____

Does child live with both parents? _____ mother?_____ father?_____ guardian?_____

Father/Guardian_____ School Hours Telephone No._____

Mother/Guardian_____ School Hours Telephone No._____

If unable to reach parents in case of emergency, please call Emergency Contact Person:

Name_____ Telephone_____Relationship_____

Name_____ Telephone_____Relationship_____

TO BE COMPLETED BY PARENT OR GUARDIAN:
List all childhood diseases, allergies, operations, and /or other illness:

1._____2._____

3._____4._____

5._____6._____

List any and all medical restrictions or conditions:

Important medication child is on_____

Important Medication that should be at school with child for this condition:

_____

Information school should know:

_____

Revised: June 01, 2018

TASIS
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PERMISSION FOR OVER –THE – COUNTER MEDICATIONS FOR ACADEMIC YEAR 2019-20

When students are ill, it is often deemed wise to provide them with over-the-counter medication for symptom relief. At TASIS Dorado, the Registered Nurse will decide which medications are indicated and can administer over-the-counter medications to your child. Occasionally, main office administrators will administer over-the-counter medications to students after consulting with the Registered Nurse. If there are any medications that you do not wish your child to have, please follow the instructions below.

Medications needed at the moment will be provided to your child. If your child requires long term use of an over-the-counter medication or any specific prescription medication parents need to provide them to the Registered Nurse Health Office with the required forms. As clearly stated in the TASIS Dorado policy, no medication may be kept in the student's classrooms or backpacks, unless authorized by the School Nurse. This form is only for the medications listed below and will only be administered per manufacturer's recommended dosing.

_____ _____
Student Name Date of Birth

_____
Parent Name

____ All Over-the-Counter Medications Below

____ No Over-the-Counter Medications Below

Or indicate which medications may be administered by checking below:

__ Tylenol/Acetaminophen
__Advil/ Ibuprofen
__Claritin/Loratadine
__Benadryl Liquid or tabs
__Cold Tylenol/Cold Relief
__Pepto Bismol
__Dimettap Cold & Allergy
__Cough Syrup
__Tums
__Cough Drops/Halls
__Antibiotic Ointment
__Hydrocortisone / Benadryl Cream

I give permission for the School Nurse to dispense the above checked medicine(s) to my child:

_____ _____
Parent Signature Date

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2019 Medical Form

PHYSICAL EXAMINATION to be performed by a Licensed Physician.

Puerto Rico State Law #235 requires that all immunization records be kept in the student's file. Please ask your doctor to fill in the PVAC-3 Form (the green form) and return it to School with this document.

Student's Name_____ Age:_____ Grade_____

Birth Date_____ Height_____ Weight_____

General Appearance:_____ Chest and Lungs_____

Eyes_____ Heart_____ Abdomen, Hernia_____

Vision with Glasses: R_____ L_____ Color Vision_____

Hearing: R_____ L_____

Extremities_____ Skin_____ Teeth and Gums_____

Posture, Gait, Spine_____ Coordination_____

Nutrition_____ Blood Pressure_____ Neurological_____

Scalp, Neck, Head_____ Ears_____ Nose_____

Physical and Emotional Challenges _____

_____

Diagnosis and Recommendations _____

_____

_____

Recommended activity for physical education and sports: Full_____ Limited_____

If Limited, Please Explain_____

_____

Physician: _____ License No.:_____

Date: _____

Revised: June 01, 2018