

Region 9	School
Region Director(s) Leah Ann Williams and Robert Penrose	Responsible Adult at PJAS Meet

**Pennsylvania Junior Academy of Science Authorization for Medical Treatment**  
Please type or print information.

Name of Student	Date of Birth	
Name of Parent or Legal Guardian	Phone #1	Phone #2
Address	City, State, Zip	
Health Coverage Plan	I.D. or Contract Number	
Family Physician & Phone Number		

May PJAS Nurses administer medications to your child? Please check yes OR no for each.						
Medication or its Generic Equivalent	Yes	No		Medication or its Generic Equivalent	Yes	No
Advil				Benedryl		
Tylenol				Claritin Over the Counter		
Aleve				Sudafed - Non-Drowsy		
Kaopectate				Robatussin Cough Syrup DM		
Pepto Bismal				Robatussin Cough Syrup PM		
Maalox				Sucrets/Cepacol Throat Lozenges		

Special Medical Condition	Yes	No	Additional Information (Use back if needed)
Diabetes			
Asthma			
Allergies			
Allergic reactions			
Other (please indicate)			

<b>Please list all prescription medications that your child is taking, dosage, and time(s).</b>

Infectious Disease Notice: The Pennsylvania Junior Academy of Science (PJAS) will send home students with the following symptoms: elevated temperature, diarrhea or vomiting, undiagnosed rash, sore or discharging eyes or ears, profuse nasal discharge, or diagnosed contagious diseases such as strep throat or chicken pox.

Except in a true emergency, medical, dental or hospital services may be rendered to a child only with the consent of the parent or legal guardian. It is important to prepare this form carefully, especially if it may be difficult to reach you. Please make sure the person named above as sponsor or chaperon is the person who will be attending the PJAS Meet. If your child needs unexpected medical treatment, the responsible adult will present this document to the appropriate person - nurse, physician, dentist, or hospital representative. Please prepare three originals of this form with signatures.

I/We being the parent(s) or legal guardians of the above named student, do hereby appoint the region director(s) and sponsor or chaperon named above to act in my/our behalf in authorizing unexpected medical, dental, surgical care, and hospitalization for the above named student for the period from May 15-17, 2011. I/We agree to the release of any records necessary for treatment, referral, billing, or insurance purposes to the appropriate medical care provider.

Parent/Guardian Signature	Date
Person to be contacted if parents can't be reached	Phone