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			Sudefed – 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 - Physical or Mental			

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

Infectious Disease Notice: Students who develop flu-like symptoms (fever and sore throat, cough, respiratory symptoms, or gastrointestinal symptoms) will be sent to the PJAS Nurses' Office for evaluation. Based on public health guidelines from the CDC and the PA Department of Health, these students will be distanced from other students and sent home to recuperate.

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 19-21, 2019. I/We agree to the release of any records necessary for treatment, referral, billing, or insurance purposes to the appropriate medical care provider. When needed, students will be transported to the hospital by designated PJAS personnel.

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