



New Jersey School of Conservation
 1 Wapalanne Rd
 Branchville, New Jersey 07826
 800-624-7780 or 973-948-4646
 973-948-5131 (Fax)
<http://www.csam.montclair.edu/njsoc>

**Authorization for Medical Treatment of a Minor
 Temporarily Separated from His/Her Parent(s) or Guardian(s)**

Dear Parent or Guardian:

While your child is attending the New Jersey School of Conservation, he/she may need medical attention. To avoid delay in obtaining your consent, to make clear your choice of physician, and to provide other information about your child's health care needs, please complete this form and sign it. This form should be left with the person or institution that will be in charge of your child while at the New Jersey School of Conservation. This authorization will be effective if the School Nurse is unable to reach the parents or guardian.

I (We) _____
 (Parents/Guardians)

 (City) (County) (State) (Zip Code)

 (Home Phone Number) (Cell/Business Number)

do hereby state that I am/we are the parent(s)/guardian(s) having legal custody of:

 (Child's Name)

is a minor child, age _____, born on _____

who resides with me/us at: _____
 (Address)

If I/We cannot be reached, I/We authorize the following person to authorize medical services for my child:

 (School Representative)

an adult who works at _____
 (School Address)

in the City of _____ County of _____ State of _____

to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered to the minor, at a recognized medical facility, under the general or special supervision of a licensed physician or surgeon.

This authorization will expire on _____

Dated this _____ day of _____, 20_____

 Parent(s)/Guardian(s) Witness

Additional Medical Information

Child's Name: _____

Daytime Phone Number: _____ Evening Phone Number: _____

In an emergency, if unable to reach parent or guardian, please contact:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Insurance Company: _____

Group Number: _____ ID Number: _____

Child's Allergies, if any: (medications, insects, foods, etc.) _____

Describe reaction: _____

Usual treatment: (i.e.: Epipen, Benadryl 25 mg., etc.) _____

Existing medical problems of child, if any: _____

Medicines child is taking: (list schedule of medications) _____

Dietary Restrictions: (low fat, lactose intolerant, etc.) _____

Can your child have Tylenol, Pepto Bismol, or Benadryl as Needed?

Tylenol: yes no Pepto Bismol: yes no Benadryl: yes no

Date of last Tetanus Shot: _____

Medical Permission Slip

Dear Parent or Guardian:

Please complete and sign this permission slip if your child will be requiring medication, prescription or over the counter, while at Montclair State University's School of Conservation.

All medications should be in the original pharmacy container with the label intact. Each should include your child's full name, name of medication and proper dosage.

All medications must be given to: _____ By: _____
(Coordinator or School Nurse) (Date)

Thank you for your cooperation.

(Cut along dotted line)

Medication Permission Slip and Dosage Information

Dear NJ School of Conservation Nurse:

You have my permission to give: _____
(Child's name)

her/his medication while at the New Jersey School of Conservation.

Name of Medication: _____

Reason for Giving Medication: _____

Dosage: _____ Time to be given: _____

Name of Medication: _____

Reason for Giving Medication: _____

Dosage: _____ Time to be given: _____

Name of Medication: _____

Reason for Giving Medication: _____

Dosage: _____ Time to be given: _____

Signature of Parent or Guardian

Date