THE Oaks

OFFICE USE ONLY			
Date Received			
Date Updated			
Contact Info.		Medical Info.	
Discipline Form (K-5)		Pic. Release	
		New Student	Update (6th)
Immunization Records			

The Oaks Release Form

RELEASE OF ALL CLAIMS AGAINST THE OAKS EDUCATION ASSOCIATION

In consideration of permission granted by my child/ward to participate in:

ALL ACTIVITIES
(Including but not limited to: Field Trips, Soccer, Cross Country, Basketball, Volleyball, Physical Education Classes, Recess Games)

I, the parent or guardian of the below-named child, hereby release and discharge The Oaks Education Association (OEA) Board of Directors, officers, agents, employees, and volunteers from all claims, demands, actions, judgments, and executions which the parent or guardian ever had, or now has, or may have, or which the parent or guardian's heirs, executors, administrators, or assigns may have, or claim to have, against the OEA, its successors or assigns, for all personal injuries, known or unknown to my child/ward, and injuries to property, real or personal caused by or arising out of, directly or indirectly, all school activities. I, the parent or guardian, have read this release and understand all its terms, I execute it voluntarily and with full knowledge of its significance.

LEGAL AUTHORIZATION FOR EMERGENCY CARE
AND
ACKNOWLEDGEMENT RELEASE OF ALL CLAIMS STATEMENT

NAME OF CHILD____ DATE _______________
First Middle Last

GRADE ENTERING__________________________ SCHOOL YEAR _________________________

SIGNATURE OF PARENT OR GUARDIAN ____

THE OAKS PARTICIPATION AND MEDICAL FORM

CONTACT INFORMATION

Child's Name ___ ____________________________________ Date of Birth ___________ Gender________

Home Address ______________________________________ City _____________State _____ Zip ________

Mailing Address____________________________________ City _____________State _____ Zip ________

Father's Name _____________________________ Father's Employer_________________________________

Father's Business Phone _________________________ Father's Cell Phone __________________________

Father's Email Address ____

Mother's Name _____________________________ Mother's Employer________________________________

Mother's Business Phone ________________________ Mother's Cell Phone _________________________

Mother's Email Address ____

Home Phone _________________________ Preferred Phone____

Family's Church __________________________________ Family's Pastor___________________________

Secondary Contacts: Please contact the following person(s) if I cannot be reached.
(Do <u>NOT</u> put parent names in this area – we must have <u>other names</u> in case you cannot be reached.)

Name ____ Relationship _______________________________

City/State ________________________________ Phone ____

Name ____ Relationship _______________________________

City/State ________________________________ Phone ____

CONSENT TO ADMINISTER MEDICATION

We require permission from a parent/guardian before any medication will be administered to a student. Please indicate your preference by checking and signing the following statement. I authorize the school to administer nonprescription medication (Ibuprofen, Tylenol, Tums or cough drops) to my child/ward as needed.

Yes No

Prescription medication will not be administered by the school without written permission from a parent/guardian.

USE OF STUDENT ACTIVITY PICTURES RELEASE

Throughout the school year The Oaks uses school activity pictures for marketing. Please initial the appropriate space below:

You MAY use pictures of my student You may NOT use pictures of my student

IN CASE OF MEDICAL EMERGENCY

TO WHOM IT MAY CONCERN:

The undersigned parent(s)/legal guardian(s) give permission for our/my child/ward

____ to participate in all school activities sponsored by The Oaks unless I have notified the teacher or Head of School to the contrary.

In case of medical or dental emergency, we/I give our/my consent and authorization for any necessary treatment, to include treatment by a licensed physician or dentist and transfer to any hospital reasonably accessible.

The following information is provided for any licensed physician, dentist, or hospital not having access to our/my child's medical history:

____ ________________________

Family Physician Phone

____

Address

____ ________________________

Family Dentist Phone

____

Address

Insurance Provider ____ Policy (ID) # ___________________

Please check any of the spaces below which describe a health problem your child/ward has which might require attention. If your child has no such health problems, check "None of the Above."

- Allergies
- Blood disease (sickle cell anemia, aplastic anemia, malaria, hemophilia, etc.)
- Heart problems requiring limitations
- Diabetes
- Food Allergy requiring immediate attention
- Digestive disorder (ulcers, colitis, etc.)
- Hearing impairment or complete hearing loss
- Insect sting allergy – severe requiring immediate attention
- Malignancy (leukemia, sarcoma, Hodgkin's disease, etc.)
- Neurological problem (cerebral palsy, hydrocephalus, etc.)
- Orthopedic problem – severe requiring limitations (brittle bone disease, etc.)
- Respiratory problem – severe requiring limitations (asthma, cystic fibrosis, etc.)
- Seizure disorder (epilepsy, etc.)
- Urinary tract disorder (nephritis, absence of kidney or bladder, etc.)
- Vision impairment or complete vision loss
- None of the Above

Please check any past illnesses your child/ward has had and give the approximate dates.

______________ Chicken Pox
______________Three-Day "German" Measles (Rubella)
______________Epilepsy
______________Rheumatic Fever
______________Whooping Cough
______________Diabetes
______________Ten-Day Measles (Rubeola)
______________Mumps
______________Asthma
______________Hay Fever
______________Poliomyelitis

Medications being taken: ____

Additional information/instructions (including serious or severe illness or accidents, known allergies, or special dietary considerations):

School policy requires that all children attending The Oaks must show and maintain on file proof that they have been immunized for diphtheria, tetanus, polio, measles, hepatitis B, and rubella. Verification of these shots or a signed exemption waiver must be in The Oaks office prior to the beginning of school.

In an emergency, parents will be contacted for immediate consultation. If parents cannot be reached and medical attention is needed, please initial the appropriate following statement:

I hereby allow the faculty and staff of The Oaks, including parents volunteering for transportation duties, to seek and secure emergency medical treatment for my child.

I do not wish the faculty and staff of The Oaks, including parents volunteering for transportation duties, to seek and secure emergency medical treatment for my child.

We(I) shall be liable for and agree to pay all costs and expenses incurred in connection with any medical or dental treatment rendered pursuant to this authorization. Further, should it be necessary for our(my) child to return home due to medical reasons, disciplinary action or otherwise, we(I) agree to pay transportation costs.

Finally, in consideration for our(my) child's participation in the activities, we(I) release, discharge, and agree to hold harmless OEA and their officers, Board of Directors, agents, employees, and volunteers from any and all liability, claim or demands for personal injury, illness or death; as well as property damage and expenses, of any nature whatsoever which may be incurred by us(me) and/or our(my) child while our(my) child is participating in these activities (including transportation to and from events), hereby assuming all risk of personal injury, illness, death, damage and expense as a result of participation of these activities.

We(I) have read this form in entirety and sign it voluntarily with knowledge of its terms and conditions.

____ ______________

Mother (Legal Guardian) Date

____ ______________

Father (Legal Guardian) Date

Name of Child ______________________________