

PARENTAL RELEASE AND CONSENT FOR TREATMENT FOR:

Name of Child \_\_\_\_\_

I/We, the parent(s) or legal guardian(s) of the above-named student who is under my/our care, custody and control, voluntarily delegate my/our legal authority to consent to health care on behalf of such student to The Sycamore School, Inc., its agents, servants, and employees. This delegation is made in accordance with Indiana law and is made subject to the condition that I/we cannot be contacted to personally provide the consent. The telephone number(s) provided on this form should be used to attempt to contact me/us. I/We agree to allow The Sycamore School to act on my/our behalf as a parent/guardian at any time when I am not readily available in any matter regarding the health, safety and well being of the student. I/We hereby release and hold harmless The Sycamore School, Inc., its agents, servants and employees from any and all costs, damages, claims, actions and liability of whatsoever nature or kind that may occur as a result of The Sycamore School, Inc. personnel exercising the duties as delegated hereunder.

The Sycamore School assumes no responsibility for administration of any medication and specifically disclaims any evaluation of the child for any contraindication to administration of directed medication or observation for adverse effects after administration. The school reserves the right to refuse to administer any medication.

\_\_\_\_\_ I want my child to be given Tylenol, Benadryl, or Caladryl or the generic substitutes by the recommended allowance in accordance with the above stated conditions and I do not require the school to contact me by telephone prior to the medication being given.

\_\_\_\_\_ I do not want my child to be given Tylenol, Benadryl or Caladryl or the generic substitutes under any conditions.

Mother's Name: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Mother's Work Phone: \_\_\_\_\_

Father's Work Phone: \_\_\_\_\_

Mother's Cell Phone: \_\_\_\_\_

Father's Cell Phone: \_\_\_\_\_

Please list any Allergies or Medical Conditions:

\_\_\_\_\_  
\_\_\_\_\_

**SUMMER 2010 CARPOOL PICK-UP INFORMATION**

Children will be permitted to leave with either parent unless a copy of a court order is attached to this form. Please list the name of each child in your carpool.

Children in carpool: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other authorized drivers: please list the names of anyone you would like to be authorized to pick up your child(ren) from camp. The school is not permitted to allow your child to leave the school with anyone without written authorization. For the safety of your child we cannot accept phone authorization. **Parent/Guardian may fax permission to add another authorized driver to: 317-202-2501.** The following list will serve as written authorization for the drivers named below:

Names and phone numbers of authorized drivers:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

