

Family Physician or Child's Pediatrician

Name _____ Phone () _____

Child's Dentist

Name _____ Phone () _____

Allergies--please list:

Allergies to medications _____

All other allergies _____

Permission is hereby granted for the Roslyn-Trinity Cooperative Day School director and staff to have access to health information about my child and to seek emergency medical treatment for my child,

_____ in the event that I cannot be contacted immediately.

Parent's signature _____ Date _____