Health Forms for Students with Allergies (Including Food Allergies)

Please complete packet and return to your child’s school nurse.

What is in this packet?

1) STUDENT ALLERGY HISTORY FORM – for parent to describe student’s allergy history and list current medications.

2) MEDICATION AUTHORIZATION FORM / GENERAL MEDICATION FORM
   - Guidelines for Medications at School – On Page 2 of Medication Authorization Form
   - This form includes a section for epinephrine auto-injector orders including self-carry option if ordered by your child’s Health Care Provider (HCP)
   - Most oral allergy medications can be given at home before or after school, but if an oral asthma medication must be given at school, please complete this form
   - Must be signed by parent and Health Care Provider (HCP)
   - Signed form and medication should be brought to school by a responsible adult
   - Both the parent (in Parent/Guardian Authorization section) and HCP (in Prescriber authorization section) need to check the box for self-carry if inhaler is not kept in the clinic

3) ALLERGY ACTION PLAN
   - Your Health Care Provider’s Allergy Action Plan form works (but Medication Authorization Form / General Medication Form is also needed) or you may use the SCHOOL ALLERGY ACTION PLAN included. This form combines the ALLERGY ACTION PLAN with the Medication Authorization form so you won’t need form #2 above.

If your child already has a current Allergy Action Plan, please bring it in for the school nurse to copy. If not, please ask for one at your child’s next appointment.

4) SPECIAL DIET ORDER FORM – FOR NUTRITIONAL SERVICES - Please have this form completed and signed by your Health Care Provider and turn in to the school nurse each school year. Your school nurse will email/fax the form to nutrition services and keep a copy for your child’s health records.

5) AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Questions? - Please call your school nurse

STUDENT ALLERGY HISTORY
Parents: Please complete information below so your school nurse can provide care and create an Emergency Action Plan for your child, if needed. Please return this form to your school nurse.

**CONTACT INFORMATION:**

Student’s Name: ___________________________ Date of Birth: ___________ School Year: __________

School: ___________________________ Grade: ___________ Homeroom: __________

Parent/Guardian Name: ___________________________ Email: ___________________________

Parent/Guardian Tel: (H) ___________________________ (W) ___________________________ (C) ___________________________

Allergy Physician: ___________________________ Tel: ___________________________

Primary Care Doctor: ___________________________ Tel: ___________________________

Significant medical history or conditions: ________________________________________________

**ALLERGY INFORMATION:**

1. **Has your child been diagnosed with allergies/anaphylactic reactions by a healthcare provider?**
   - No
   - Yes
   If yes, at what age or year? ___________________________________________________________  

2. **Please list all of your child’s allergies, including foods:** __________________________________

3. **Is it necessary to avoid physical contact or inhalation of allergen(s)?**
   - No
   - Yes

4. **How soon after exposure does your child react?** ______________________________________

5. **What are the early signs and symptoms of your student’s allergic reaction?**
   (Be specific; include things the student might say.)
   ____________________________________________________________

6. **List any symptoms your child has had in the past?**
   ____________________________________________________________

7. **How responsible is your child in preventing and responding to an allergen(s)?**
   (Check all that apply)
   - My child knows what allergen(s)/foods to avoid
   - My child knows to immediately tell an adult if exposed to an allergen
   - My child knows to ask about ingredients in food, if unsure
   - My child knows to always have someone go with them for help if having an allergic reaction or after having administered their emergency medication
   - My child can give their own injection with an epinephrine auto-injector (EpiPen) if prescribed by their healthcare provider
   - Other ______________________________________________________

8. **Does your child wear a medic alert?**
   - No
   - Yes

9. **Does your child require emergency medication at school?**
   - No
   - Yes
   If Yes, Indicate Medication Needed:  
   - Epinephrine auto-injector
   - Benadryl
   - Other ___________________________

   **Note:** ☑ A school Medication Authorization Form is required if any medication is given at school and must be completed/signed by a Health Care Provider (HCP) and parent.
   ☑ New forms are required each school year.
   ☑ For a student to “self-carry” their epinephrine auto-injector if prescribed by a HCP and a back-up epinephrine auto-injector must be kept in the clinic per ORC 3313.718.

**STUDENT ALLERGY HISTORY**

Page 2 of 2
10. What medical care was given in the past? (Check and complete all that apply)

- Oral medication prescribed: What oral med was used? 
- Injection prescribed: What was used? 
- Treatment in doctor’s office 
- Treatment in the Emergency Room 
- Kept in hospital as in-patient 
- Cold compress (in cases of a sting) and Removal of insect stinger 
- Other 

I authorize Dayton Public Schools to communicate and share health information with appropriate school personnel to create an emergency action plan if necessary and to aid in present and future educational decisions.

Parent Signature: _______________________________ Date: __________

Reviewed by School Nurse: _______________________________ Date: __________

- Original in student medical folder 
- Copy in medication book if medications given at school

April 2020
# Medication Authorization Form

**General Medication Form**

**(Includes Asthma Inhaler and Epinephrine Auto-Injector Use)**

## Student Information

<table>
<thead>
<tr>
<th>Student name</th>
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<tr>
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<thead>
<tr>
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<tr>
<th>School Name</th>
<th>Phone</th>
<th>Fax</th>
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## Prescriber Authorization

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<tr>
<th>Name of medication</th>
<th>Diagnosis</th>
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<th>Dosage</th>
<th>Route</th>
<th>Time/Interval</th>
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Date to begin medication: Date to end medication:

### Special Instructions

- **Treatment in the event of an adverse reaction**
  - **Epinephrine Auto-Injector (self-carry)**: [ ] Not applicable
    - [ ] Yes, as the prescriber I have determined that this student is capable of possessing and using this auto-injector appropriately and have provided the student with training in the proper use of the auto-injector.
  - **Asthma Inhaler (self-carry)**: [ ] Not applicable
    - [ ] Yes, if conditions are satisfied per O.R.C. 3311.716, the student may possess and use the inhaler at school or any activity event or program sponsored by or in which the student’s school is a participant.

- **Procedures for school employees if the student is unable to administer the medication or if it does not produce the expected relief**
  - Possible Severe Adverse Reaction(s) per O.R.C. 3311.716 and 3311.718
    - [ ] To the student for whom it is prescribed (that should be reported to the prescriber)
    - [ ] To a student for whom it is not prescribed who receives a dose

- **List any known drug allergies and reaction.**

### Prescriber Information

<table>
<thead>
<tr>
<th>Prescriber signature</th>
<th>Date</th>
<th>Phone</th>
<th>Fax</th>
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## Parent/Guardian Authorization

- [ ] I authorize an employee of the school board to administer the above medication. [ ] I understand that additional parent/guardian signed statements will be necessary if the dosage of medication is changed. [ ] I also authorize the school nurse for the school year to order, with the licensed prescriber, all medication prescribed for the student in accordance with the school’s medication management policy.

- **Medication form must be received by the principal, teacher designated, or the school nurse.** [ ] I understand that the medication must be in the original container and be properly labeled with the student’s name, prescriber’s name, date of prescription, name of medication, dosage, strength, time, interval, name of administration and the date of drug expiration when appropriate.

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<thead>
<tr>
<th>Parent/Guardian signature</th>
<th>Date</th>
<th>#1 contact phone</th>
<th>#2 contact phone</th>
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## Parent/Guardian Self-Carry Authorization

- For **Epinephrine Auto-Injector** as the parent/guardian of this student, I authorize my child to possess and use a preloaded epinephrine auto-injector, as prescribed, at the school and any activity, event, or program sponsored by which the student’s school is a participant. I understand that school employees/mid, immediately request assistance from a medical professional, service provider or this medication’s administration. I will provide a backup to this medication to the school principal or another appropriately trained individual.

- For **Asthma Inhaler**, as the parent/guardian of this student, I authorize my child to possess and use an asthma inhaler prescribed, at the school and any activity, event, or program sponsored by or in which the student’s school is a participant.

<table>
<thead>
<tr>
<th>Parent/Guardian signature</th>
<th>Date</th>
<th>#1 contact phone</th>
<th>#2 contact phone</th>
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**Received by:** (school nurse): Date:

Adapted from Ohio Department of Health; Revised May 2018, Reviewed Feb 2020

Page 1 of 2
Guidelines for Medications at School

- DPS has one Medication Authorization form for all medications—oral, injectable, emergency (ex. Epinephrine Auto-Injector, asthma inhalers), and student self-carry medications.
- Any student needing to take medication during school hours must have a Medication Authorization form completed and signed by the parent and physician/prescribing healthcare provider.
- All medication must be in the container in which it was dispensed by the pharmacist or healthcare provider.
- The medication and Medication Authorization form must be brought together to the school by a parent or responsible adult.
- School personnel may not give over-the-counter medications unless prescribed by a healthcare provider. A Medication Authorization form must be completed and signed.
- No new medication can be given until the school nurse has reviewed it and checked it in.
- Routine injectable medication can only be given by a school nurse, parent (or parent-designated adult), or self-administered by the student.
- Changes in medication must be provided by the healthcare provider.
- Routine daily medication ordered three times a day or less may not need to be taken at school. The medication should be given before school, after school and at bedtime unless it is time-specific for during the school day. It is best for morning medication to be given at home.
- All medication orders must be renewed each school year.
- Parents are notified in writing to pick up all remaining medications at the end of the school year. Per DPS policy, any unused medications not claimed by the last day of school each year will be destroyed.
- Parents will be required to pick up all medications with the exception of inhalers and Epinephrine Auto-Injectors that the student already has written permission from their primary healthcare provider to carry on him/herself.
FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: ____________________________  D.O.B: ____________________________
Address: ____________________________  School Building/Class: ____________________________
Allergy to: ____________________________

Weight: ______________ lbs.  Asthma:  □ Yes (higher risk for a severe reaction)  □ No

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: ____________________________

THEREFORE:

□ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.
□ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR ANY OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. INJECT EPINEPHRINE IMMEDIATELY.
2. Call 911. Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.
   • Consider giving additional medications following epinephrine:
     » Antihistamine
     » Inhaler (bronchodilator) if wheezing
   • Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
   • If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
   • Alert emergency contacts.
   • Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR MILD SYMPTOMS FROM MORE THAN ONE SYSTEM AREA, GIVE EPINEPHRINE.

FOR MILD SYMPTOMS FROM A SINGLE SYSTEM AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: ____________________________

Epinephrine Dose:  □ 0.1 mg IM  □ 0.15 mg IM  □ 0.3 mg IM

Antihistamine Brand or Generic: ____________________________

Antihistamine Dose: ____________________________

Other (e.g., inhaler-bronchodilator if wheezing): ____________________________

__________________________  ____________________________  ____________________________
PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE  DATE  PHYSICIAN/HCP AUTHORIZATION SIGNATURE  DATE

ADAPTED FOR DPS MARCH 2020 FROM FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2018
FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO
1. Remove Auvi-Q from the outer case.
2. Pull off red safety guard.
3. Place black end of Auvi-Q against the middle of the outer thigh.
4. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
5. Call 911 and get emergency medical help right away.

HOW TO USE EPIPen® AND EPIPen Jr® (EPINEPHRINE) AUTO-JECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPen®, USP AUTO-JECTOR, MYLAN AUTO-JECTOR, MYLAN
1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-jector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, remove the blue safety release by pulling straight up.
4. Swing and push the auto-jector firmly into the middle of the outer thigh until it ‘clicks’.
5. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
6. Remove and massage the injection area for 10 seconds.
7. Call 911 and get emergency medical help right away.

HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-JECTOR, IMPAX LABORATORIES
1. Remove epinephrine auto-jector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip.
3. Grasp the auto-jector in your fist with the red tip pointing downward.
4. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh.
5. Press down hard and hold firmly against the thigh for approximately 10 seconds.
6. Remove and massage the area for 10 seconds.
7. Call 911 and get emergency medical help right away.

HOW TO USE TEVA’S GENERIC EPIPen® (EPINEPHRINE INJECTION, USP) AUTO-JECTOR, TEVA PHARMACEUTICAL INDUSTRIES
1. Quickly twist the yellow or green cap off of the auto-jector in the direction of the “twist arrow” to remove it.
2. Grasp the auto-jector in your fist with the orange tip (needle end) pointing downward.
3. With your other hand, pull off the blue safety release.
4. Place the orange tip against the middle of the outer thigh (upper leg) at a right angle (perpendicular) to the thigh.
5. Swing and push the auto-jector firmly into the middle of the outer thigh until it ‘clicks’.
6. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
7. Remove and massage the injection area for 10 seconds.
8. Call 911 and get emergency medical help right away.

ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-JECTORS:
1. Do not put your thumb, fingers or hand over the tip of the auto-jector or inject into any body part other than mid-outter thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911
RESQ EUARD: _______________________ PHONE: _______________________
DOCTOR: _______________________ PHONE: _______________________
PARENT/GUARDIAN: _______________________ PHONE: _______________________ OTHER EMERGENCY CONTACTS
SPECIAL DIET FORM – NUTRITION SERVICES

Please Return Form to Building School Nurse
(School Nurse Will Forward to Nutrition Services)

| PART A – Please complete this form if your child requires special meals. Current information must be submitted at the beginning of each school year |
|---|---|
| Does the child have a disability as defined in Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act (ADA) of 1990? | Yes (Disability) | No (Disability) |
| If Yes, describe the major life activities affected by the disability. |  |
| Does the child have special nutritional or feeding needs? | Yes (Special Nutritional Needs) | No (Special Nutritional Needs) |
| If Yes, have Health Care Provider complete and sign Part B. |  |
| If the child is not disabled, does the child have special nutritional or feeding needs? | Yes (Medical Reasons – No Disability) | No (Medical Reasons – No Disability) |
| If Yes, please have your Health Care Provider complete and sign Part B. |  |
| If the child does not have a disability, does the child have special dietary needs? | Yes (Religious Reasons – No Disability) | No (Religious Reasons – No Disability) |
| If Yes, please complete Part B and have it signed by the Parent/Legal Guardian. |  |

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<tr>
<th>PART B – TO BE COMPLETED BY A PHYSICIAN OR PRESCRIBING HEALTH CARE PROVIDER</th>
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<tbody>
<tr>
<td>Please check mark any food allergies or intolerances child has and list the foods that are to be omitted &amp; substituted. Please make notation if it is a SEVERE/LIFE-THREATENING allergy. Note: Beverage substitutions may be limited due to regulations.</td>
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**Milk Allergy**
- [ ] Severe/Life-Threatening
- Milk and uncooked dairy products only
  - (Ex. Fluid milk, yogurt, cheese, etc.)
- Milk, dairy, and ALL milk products (includes cooked & denatured milk products. Ex. Breads, cookies, etc.)
- Fluid milk only
- Lactose Intolerant

**Egg Allergy**
- [ ] Severe/Life-Threatening
- Eggs only (Ex. Boiled, scrambled, individualized eggs)
- Eggs and ALL egg products (This includes cooked and denatured egg products. Ex. Breads, muffins, etc.)

Foods to omit:

Substitutions:

**Nut Allergy**
- [ ] Severe/Life-Threatening
- Peanuts
- Tree nuts
- Other

**Soy Allergy**
- [ ] Severe/Life-Threatening
- Soy only (Ex. Soy milk, soy yogurt, etc.)
- Soy and ALL soy products (This includes cooked and denatured soy products. Ex. Taco meat, chicken tenders, burger patty, etc.)

Foods to omit:

Substitutions:

Do foods need to be modified in texture?
- Yes (Texture Modified)
- No (Texture Modified)

Additional Dietary Restriction or Special Diet or Comments on child’s eating/feeding concerns? Please describe:

Religious Restrictions (Does not need to be completed by a physician or medical authority) Please list foods restricted:

Parent/Guardian Signature

Best Daytime Phone

Date

Physician, or Medical Authority’s Signature

Phone

Date

Please have Health Care Provider complete the Medication Authorization Form if medication(s) are ordered.

☑ Reviewed by school nurse & forwarded to Nutrition Services on __________ (date) __________ (School Nurse Signature)

April 2020
## Authorization for Release of Student Medical Information

### Patient Information

<table>
<thead>
<tr>
<th>Last name</th>
<th>First name</th>
<th>Middle</th>
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<th>Other possible names</th>
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<th>Home Room:</th>
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### Information Requested

| Immunization record | Neurological |
|                     |             |
| General / Medical   | Surgical    |
| Counseling Record   | Orthopedic  |
| Emergency / Urgent care record | Otolaryngology (ENT) |
| Other:              | Ophthalmology |

### Action

<table>
<thead>
<tr>
<th>Mail Copies</th>
<th>Fax copies</th>
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<thead>
<tr>
<th>This information may be disclosed to and used by Dayton Public Schools.</th>
<th>The following individual or organization is authorized to make the disclosure:</th>
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<tbody>
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<table>
<thead>
<tr>
<th>School Representative</th>
<th>Title</th>
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<th>Continuity of Medical Care</th>
<th>Legal Reasons</th>
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<tbody>
<tr>
<td>At request of the Individual</td>
<td>Special Education</td>
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<tr>
<td>School Related</td>
<td>Other</td>
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### Reason Needed

I hereby authorize Dayton Public Schools (DPS) to release and/or receive medical information, to/from the above party. This authorization may include release of information concerning treatment of drug or alcohol abuse, drug related conditions, Human Immunodeficiency Virus (HIV) test results, diagnosis of AIDS related conditions, alcoholism, and/or psychiatric/psychological conditions.

I understand that this authorization shall remain in effect for the school year 20____ - 20____, unless an earlier expiration date is specified in this space (_______). I also understand that I may withdraw this authorization at any time by written notification to the above parties involved. However, this written notification cannot effect actions that have taken place based on my prior authorization.

I understand that if the person or entity that receives the above information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

### Authorization

<table>
<thead>
<tr>
<th>Signature of Parent or Guardian</th>
<th>Date</th>
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<tr>
<th>Relationship to Student</th>
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<table>
<thead>
<tr>
<th>Signature of School Representative</th>
<th>Date</th>
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