

Please identify all persons with permission to pick up child/children. Anyone coming to pick up the child other than the people listed on this form will not be permitted to leave with the student unless arrangements have been made in advance of the pick up date. They will be responsible for providing the staff with photo identification.

Name:	Relationship:	Phone #:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any thing you would like us to know about your child for example; allergies, special accommodations, concerns, dietary needs, or any other relevant information below.

Please Return all Paperwork To:

Leah Shaffer
Lewisburg Area School District
1951 Washington Avenue
Lewisburg, PA 17837
570-522-3207
shaffer_l@lasd.us

SACC Health Update Form

Student's Name: _____

Birthdate: _____ Gender: _____

Doctor's Name: _____ Phone # _____

List all medications allergies: _____

List all food allergies: _____

Has your child ever needed emergency treatment for an insect/bee sting? _____

Does your child need a Special Diet? _____

List any Illnesses/Health concerns of your child: _____

Is your child under medical treatment for any of the above? _____

Has your child been admitted to the hospital in the past year? _____

If yes, please explain: _____

List the year of any diseases, operations, or major injuries your child has had:

Please list any medications your child takes at home: _____

Please list any medications your child will need to take at school:

The above information is provided to ensure that my child will have a safe and healthy school experience. At times, confidential information may need to be shared with others on a need to know basis. I give permission for this information to be shared if necessary with emergency/hospital personnel, chaperones during school sponsored trips, teachers, bus drivers, administration, counselors, playground/cafeteria aides, coaches, and/or as needed with other school personnel involved with my child. (Please circle those whom may not receive health information.)

Parent Signature: _____ Date: _____

SACC Ambulance Permission Form

In case of an emergency, LASD SACC program is required to have your permission to transport your child via ambulance. Please complete the form below.

I, _____ (Parent's Name)

give permission for my child, _____ (Child's Name)

to be transported via ambulance to _____ (Hospital Name)

hospital.

Parent/Guardian Signature _____ Date _____

SACC Emergency Form

Student's Name: _____

Birthdate: _____ Gender: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Mother: _____ Father: _____

Mother's Address: _____ City: _____ State: _____ Zip: _____

Father's Address: _____ City: _____ State: _____ Zip: _____

Mother's Phone# _____ Father's Phone# _____

Mother's Employer: _____ Father's Employer: _____

If the school must contact a parent, please indicate first choice: _____

Emergency Contacts

In the event of an emergency or illness, the parent/guardian will be contacted first. Please list several other contacts, who can, in your behalf, discuss your child's health issues with school personnel, and/or can take your child home in the event that we cannot reach you.

Contact #1: _____ Phone: _____ Relationship: _____

Contact #2: _____ Phone: _____ Relationship: _____

Contact #3: _____ Phone: _____ Relationship: _____

Family Healthcare Provider/Physician: _____ Phone #: _____

Hospital of choice: _____

The above information can be shared in emergency situations, during school sponsored trips, or as needed with school personnel involved with my child. I give permission to the staff at Lewisburg Area School District to transport or to make arrangements for the transportation of my child to emergency care and to sign permission or treatment declared necessary immediately by a physician in the event that the persons above cannot be reached.

Parent/Guardian Signature: _____ Date: _____

****We also require a copy of your child's most recent**
Health Update from his or her Family Doctor**

SACC Payment Invoice, Week of: _____

Parent Name: _____

Childs Name: _____

Child's Name: _____

Child's Name: _____

Monday:

Morning only \$7.00 _____ Afternoon only \$10.00 _____ Both morning and afternoon \$16.00 _____

In-Service/Vacation/Snow \$24.00 _____ 2 Hr. Delay \$7.00 _____ Early Dismissal \$12.00 _____

Tuesday:

Morning only \$7.00 _____ Afternoon only \$10.00 _____ Both morning and afternoon \$16.00 _____

In-Service/Vacation/Snow \$24.00 _____ 2 Hr. Delay \$7.00 _____ Early Dismissal \$12.00 _____

Wednesday:

Morning only \$7.00 _____ Afternoon only \$10.00 _____ Both morning and afternoon \$16.00 _____

In-Service/Vacation/Snow \$24.00 _____ 2 Hr. Delay \$7.00 _____ Early Dismissal \$12.00 _____

Thursday:

Morning only \$7.00 _____ Afternoon only \$10.00 _____ Both morning and afternoon \$16.00 _____

In-Service/Vacation/Snow \$24.00 _____ 2 Hr. Delay \$7.00 _____ Early Dismissal \$12.00 _____

Friday:

Morning only \$7.00 _____ Afternoon only \$10.00 _____ Both morning and afternoon \$16.00 _____

In-Service/Vacation/Snow \$24.00 _____ 2 Hr. Delay \$7.00 _____ Early Dismissal \$12.00 _____

Total Amount Paid: _____

Check# _____ **Cash** _____