The Leadership School at Kieve

Kieve Wavus Education, Inc, PO Box 169, Nobleboro, Maine 04555
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Participant Information Form

Participant's Name ______________________________ School or Organization ________________

Address ___________________________ City ____________________ State _____ Zip ______

Phone ____________________ Sex - **M F** Age __________ Birth date _______________Grade:___

Parent/Guardian______________________ Day Phone ____________ Evening Phone ___________

Does your child have any special needs (educational, behavioral, medical, or dietary) that we should be aware of or take any daily medication?

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Parent/Guardian Authorization for Health Care:

This form is correct and accurately reflects the health status of the child. The child has permission to participate in all Kieve-Wavus activities except as noted by me and/or an examining physician. I authorize the Kieve-Wavus staff to provide routine healthcare, dispense medications, and seek emergency treatment for the child. I give permission to the physician selected by Kieve-Wavus to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for the child. I understand the information on this form will be shared on a “need to know” basis with Kieve-Wavus staff. I give permission to photocopy this form. In addition Kieve-Wavus has permission to obtain a copy of my child’s health record from providers who treat my child and these providers may talk with the program’s staff about my child’s health status. Kieve-Wavus is not responsible for any medical costs incurred on behalf of the child.
I give permission to Kieve-Wavus to use my son’s/daughters photo and/or video to publicize Kieve-Wavus programs.

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Signature of Parent/Guardian

The medications listed below may be administered to your child on an as needed basis per Kieve-Wavus protocol and standing orders. If you wish your child to receive a medication that is not listed, including prescription medication, please complete the additional medication form. If you do not want your child to receive any of the listed medications, please indicate by drawing a line through the item with parent’s initials next to the item.

Acetaminophen(pain reliever)
Benadryl (for allergies)
Ibuprofen (pain reliever)
Antacid (indigestion)
Cough Drops (for cough/ sore throat)
Sunscreen
Antibiotic Ointment (prevents skin infection)
Hydrocortisone 1% ointment (for skin itchiness)

Family Physician’s Name________________________________ Phone______________________

Health Insurance Plan and Number____