

# Out of Town Form

DARIEN PUBLIC SCHOOLS

Copy to be given to School Nurse

Grade \_\_\_ Home Room Teacher \_\_\_\_\_

(For school nurse only- when both parents are going out of town)

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_  
last first middle

Medical Insurance Co. \_\_\_\_\_ Phone Number \_\_\_\_\_

Group # \_\_\_\_\_ Plan \_\_\_\_\_ Subscriber \_\_\_\_\_ ID# \_\_\_\_\_

Family Physician: (1<sup>st</sup> choice) \_\_\_\_\_ Phone \_\_\_\_\_ Hospital of choice:  
(2<sup>nd</sup> choice) \_\_\_\_\_ Phone \_\_\_\_\_ Stamford

Family Dentist \_\_\_\_\_ Phone \_\_\_\_\_ Norwalk

*Information for Health Care Providers in case of Emergency: Please check all that apply.*

No  Yes **Allergic to:** \_\_\_\_\_ Usual treatment \_\_\_\_\_

No  Yes **Medications** (taken at school or home) \_\_\_\_\_ Used for: \_\_\_\_\_

No  Yes **Other health issue(s)** which may affect student in school, sports, or on field trips: \_\_\_\_\_

Parents/Guardians \_\_\_\_\_ are away in (location) \_\_\_\_\_ from – to (dates) \_\_\_\_\_ and can be reached at (phone #s) \_\_\_\_\_

This is to certify that (name) \_\_\_\_\_ (phone #s) \_\_\_\_\_ has my permission to act in my stead as temporary guardian. If they are unable to reach us at the numbers listed above, they have my permission to act in my stead should my child require emergency medical diagnosis and treatment. This consent does not cover major surgery unless the medical opinions of two licensed physicians or dentists are obtained prior to the performance of such surgery.

Printed Name of Parent or Guardian

Signature

Date

# Out of Town Form

DARIEN PUBLIC SCHOOLS

Copy to be given to Temporary Guardian

School \_\_\_\_\_ Grade \_\_\_ Home Room Teacher \_\_\_\_\_

School Phone # \_\_\_\_\_

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_  
last first middle

Medical Insurance Co. \_\_\_\_\_ Phone Number \_\_\_\_\_

Group # \_\_\_\_\_ Plan \_\_\_\_\_ Subscriber \_\_\_\_\_ ID# \_\_\_\_\_

Family Physician: (1<sup>st</sup> choice) \_\_\_\_\_ Phone \_\_\_\_\_ Hospital of choice:  
(2<sup>nd</sup> choice) \_\_\_\_\_ Phone \_\_\_\_\_ Stamford

Family Dentist \_\_\_\_\_ Phone \_\_\_\_\_ Norwalk

*Information for Health Care Providers in case of Emergency: Please check all that apply.*

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Parents/Guardians \_\_\_\_\_ are away in (location) \_\_\_\_\_ from – to (dates) \_\_\_\_\_ and can be reached at (phone #s) \_\_\_\_\_

This is to certify that (name) \_\_\_\_\_ (phone #s) \_\_\_\_\_ has my permission to act in my stead as temporary guardian. If they are unable to reach us at the numbers listed above, they have my permission to act in my stead should my child require emergency medical diagnosis and treatment. This consent does not cover major surgery unless the medical opinions of two licensed physicians or dentists are obtained prior to the performance of such surgery.

Printed Name of Parent or Guardian

Signature

Date