Child's Name ______________________________

Our Lady of Sorrows
After School Program Medical Form

Date of Birth ___/___/___ Sex M F Grade in September ________Teacher_______________________

Is your child under any medical/physical restrictions? ____Yes ____ No If yes, please note:
____

Please list ALL medications your child is taking on a daily or as needed basis, i.e., epi-pen, inhaler, allergy medicine etc.

If medication is needed during the hours of the After School Program, an authorization form must be completed, available from the site supervisor.

Is your child allergic to any medications/foods/insect stings? ____Yes ____No If yes, please list:

Child's Physician_______________________________________ Telephone Number_________________

Physician's
Address____

* Parent must immediately notify the After School Supervisor if your child is exposed to any communicable diseases during the school year.
* Parent must immediately notify After School Supervisor if any medical conditions arise during the school year.

As Parent/Guardian of the above participating child, I certify that he/she is in good physical health and may participate in all of the activities of the After School Program, except as noted above.

Parent/Guardian Signature ____Date _________

1. The Parent/Guardian will be contacted immediately.
2. If the Parent/Guardian cannot be reached, we will attempt to contact him/her through the emergency persons listed on the child's registration form.
3. If the Parent/Guardian still cannot be reached, the child's physician will be contacted.
4. If none of the above can be contacted, we will do any or all of the following:
   a. Call for emergency first aid assistance/transportation.
   b. Call another physician.
   c. Have the child transported to an emergency hospital in the company of a OLS staff member. (Robert Wood Johnson University Hospital at Hamilton).

I (We) state that we are the Parent(s)/Guardian(s) having legal custody of the above child and attest that the information at the top of this form is correct. I (We) authorize Our Lady of Sorrows staff to obtain emergency treatment for our child. I (We) consent to an x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered to the minor at a recognized medical facility, under the general or special supervision of a licensed physician or surgeon.

Parent Name (print) ____ Date of Signature ____________

Parent Signature ____