

Medical Information for After-School Program

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Known allergies (please list):

\_\_\_\_\_

The After School Program staff cannot dispense medication.

Should your child require medication, please make arrangements for it to be administered during regular school hours. Is there any special health information we should know about your child?

\_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

**Emergency Contact Information**

Please note: All families must provide at least 2 emergency contacts, in the event both parents are unable to be reached, to be enrolled in the program. While we do have your emergency contacts in PowerSchool, please repeat them here so the after-school staff can have immediate access in the case of an emergency situation. You may add additional contacts as necessary for the afternoon period from 3:00-5:30 P.M. If these people are the same as those on the previous page, please write that on the first line.

1. Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation to Student: \_\_\_\_\_

2. Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation to Student: \_\_\_\_\_

3. Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation to Student: \_\_\_\_\_

**Emergency Medical Release**

In case of emergency, I understand that every effort will be made to contact the parent(s)/guardian(s) of the child. In the event that I cannot be reached, I hereby authorize emergency medical care for my child during attendance of the Shickley Public School After School Program if, in the judgement of the staff, treatment is required for an injury or illness. I hereby give permission to the physician selected by the After School Program Coordinator to hospitalize and secure the proper treatment for my child, and I also authorize the administering of anesthesia and surgery, as well as recourse to other procedures as deemed necessary by the attending physician. I understand that I am financially responsible for any expense for medical care or transportation incurred on my child's behalf. I hereby release the Shickley Public School and its employees from any responsibilities for injuries incurred during my child's participation in the After School Program.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Shickley Public School  
After-School Enrollment  
Form 2018-2019

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian #1 Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Email(s): \_\_\_\_\_ Relation to Student: \_\_\_\_\_

Preferred Method of Contact (please circle one): Call Text Email

Parent/Guardian #2 Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Email(s): \_\_\_\_\_ Relation to Student: \_\_\_\_\_

Preferred Method of Contact (please circle one): Call Text Email

ATTENDING DAYS: (Please circle the days your child will be attending.) Monday Tuesday  
Wednesday Thursday Friday Occasionally (less than twice per month)

In Case of Emergency PICK-UP INFORMATION: The following individuals have permission to pick up my child from the SPS After School Program (other than guardians listed above). Please note: In order to be enrolled in the program, all families must provide at least 2 emergency contacts in the event both guardians are unable to be reached. You may attach another sheet if needed.

1. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relation to Student: \_\_\_\_\_

2. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relation to Student: \_\_\_\_\_

3. Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relation to Student: \_\_\_\_\_

I understand that I must notify the school office by 12:00 P.M. of any change in plans for that day. I acknowledge that it is my responsibility to check the school calendar regarding program availability on half days and to make note of early closings on Fridays as listed.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_