

Child's Name \_\_\_\_\_

**Our Lady of Sorrows  
After School Program Medical Form  
The OLS After School Program is a "peanut free environment".**

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 \_\_\_\_\_