

Anderson **AFTER SCHOOL**

Medical Information

Child's Name _____

Doctor _____ Phone _____

Health Ins. Co. _____ Group Number _____

Dentist _____ Phone _____

Dental _____ Group Number _____

Allergies _____

Other Medical Concerns _____

Medication(s) taken daily at home or at Anderson After School _____

I give the staff of Anderson After School permission to administer prescription and non-prescription medication to my child. When needed and authorized by written note or phone call.

Signature of Parent or Guardian Date _____

Emergency Authorization and Release Information

I, the undersigned, do hereby authorize the staff of Anderson After School to contact directly the persons named on this form, and do authorize the named physician(s) to render such treatment as may be deemed necessary in an emergency, for the health of said child. I authorize release of any information on this form to medical personnel to insure proper treatment of my child.

In the event the parents, physician(s), or other contact person(s) named on the data sheet cannot be contacted, the staff of Anderson After School is authorized to take whatever action is deemed necessary in their judgement, for the health of the aforesaid child.

I will not hold Anderson After School responsible for emergency care and/or transportation for said child.

Signature of Parent or Guardian Date _____