# Illness/Injury Form

The following is a list of policies for illness at the After-School Program, procedures to be followed by our program staff, and procedures for picking up your child in case of illness or injury. Also included is a list of medications available to your child for minor medical complaints.

You will be notified if the following is exhibited:

1. Elevated temperature of 100 or higher.
2. Vomiting or diarrhea.
3. Frequent complaints for the same problem.
4. Injury requiring a doctor or hospital attention.

Medicines will be administered under the following conditions ONLY.

1. Signed permission of the parents.
2. Discernment of the Program Director.
3. Documentation of medication administered.

Procedure for medicinal disbursement:

1. Completion of this authorization form.
2. Medication must be in the original pharmacy labeled container.
3. Parent must provide the medication.

You will be expected to pick up your child if:

1. An elevated temperature of 100 or higher is experienced
2. The child vomits or has diarrhea while at After-School.
3. The child exhibits signs of a contagious illness (chicken pox, mumps, etc.)

Initial the medications that you give permission to the After-School Program staff to administer to your child:

___ Benadryl Cream

___ Ibuprofen

___ Tylenol

___ Aloe (sunburn)

___ Antibiotic Ointment

___Other (Please specify in the space below)

I give the After-School Program staff permission to administer the medications initialed above.

Parent's Signature _____ Date:_____

# Medication Authorization

**MEDICATION REQUIREMENT**

PRESCRIPTION MEDICATION SHALL BE IN THE ORIGINAL CONTAINER AND LABELED WITH THE CHILD'S NAME, INSTRUCTIONS, INCLUDING TIMES AND AMOUNTS FOR DOSAGES, AND THE PHYSICIAN'S NAME. ALL NON-PRESCRIPTION MEDICATION SHALL BE IN THE ORIGINAL CONTAINER AND LABELED BY THE PARENT(S) WITH THE CHILD'S NAME AND INSTRUCTIONS FOR ADMINISTRATION, INCLUDING TIMES AND AMOUNTS FOR DOSAGES. A SEPARATE FORM IS NEEDED FOR EACH MEDICATION. THIS FORM IS VALID ONLY FOR THE DATES INDICATED BELOW.

I authorize Children of God After School Program Staff and Personnel to administer the following medication to my child:

Proper Name of Medication: _____

Child's Full Name:_____Date_____

Medication Taken From: _____ Until: _____

Dosage:

_____

Time(s) of Day

_____

_____

Possible Side Effects

_____

_____

Notes/Special Instructions:

_____

_____

Parent's Signature _____ Date:_____

# Medical History/Emergency Form

Student's Name _____

Birth Date _____

Address _____

Mother _____ Phone _____

Father _____ Phone _____

Do other children attend our Program? YES ___ NO___

If so, please list names

_____

Physician _____ Phone _____

Dentist _____ Phone _____

In case doctor or parent cannot be reached, the child will be taken to Phelps Health in Rolla by ambulance

Emergency Contacts (other than parent/guardian)

Name _____Phone _____

Name _____Phone _____

Explain IN DETAIL any health considerations:

_____

_____

_____

Medications:

_____

_____

_____

Allergies:

_____

_____

Parent's Signature _____ Date:_____