



## After Care Program

### MEDICATION FORM

**FAMILYNAME:** \_\_\_\_\_

Primary contact name: \_\_\_\_\_

Relation to student: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Alternate phone: \_\_\_\_\_

Preferred contact number: **H W A** (circle one)

Secondary contact name: \_\_\_\_\_

Relation to student: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Preferred contact number: **H W A** (circle one)

Emergency contact name: \_\_\_\_\_

Relation to student: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_ Alt Phone: \_\_\_\_\_

Preferred contact number: **H W A** (circle one)

**STUDENT(S) INFORMATION:**

Student name: \_\_\_\_\_

List of medications or special needs: \_\_\_\_\_

Student name: \_\_\_\_\_

List of medications or special needs: \_\_\_\_\_

If my student(s) is in need of prescription medications, I will provide the Saint Sophia **After School** with a medical release form signed by the doctor, and his/her medicine in a correctly labeled prescription bottle for the after school staff to give to the student(s) before the after school program begins. If emergency medical attention is necessary, I understand that the Saint Sophia staff will call 911 and then IMMEDIATELY contact the parent/guardian. Once 911 has been called, the paramedics will decide on the appropriate action and medical care facility. I will be responsible for any/all medical costs.

**I understand and will abide by the medical policies as outlined in the Parent Handbook.**

Parent/guardian signature: \_\_\_\_\_

Print name: \_\_\_\_\_

Date: \_\_\_\_\_