MEDICAL FORM

Please fill in this form as accurately as possible. It is essential for program staff to evaluate individual and group health needs as part of program planning, and for use during emergencies. Your coordinator may follow-up by phone or email should we need more information. Information provided will remain confidential.

General Information

Name: ___________________________________ Gender: ______ Age: ______ Date of Birth __________

Height: ________ Weight: _______ Hair Color: __________ Eye Color: __________

Primary Emergency Contact: ________________________________ Relationship: ____________________

Home: (_____________) Work: (________________) Mobile: (________________)

Secondary Emergency Contact: _____________________________ Relationship: ____________________

Home: (_____________) Work: (________________) Mobile: (________________)

Medical History

Date of last tetanus immunization:___________________ Date of most recent physical: _________________

Physician's name:_______________________________ Physician's number:_________________________

Please answer the following medical history questions. If answering Yes, please explain in more detail.
Do you currently have or have a history with the following conditions ***(circle response)*:**

Respiratory problems, Asthma YES NO ______________________________________
Diabetes YES NO ______________________________________
Gastrointestinal problems YES NO ______________________________________
Cardiac problems, Hypertension YES NO ______________________________________
Neurological problems, Seizures YES NO ______________________________________
Vision or Eye problems YES NO ______________________________________
Hearing problems YES NO ______________________________________
Bone, Joint, Muscle Problems YES NO ______________________________________
Other YES NO ______________________________________

Allergies
Include allergies to food, insect bites and stings, medicines, animals and environment (dust, pollen, etc.)
Select ☐ NO ALLERGIES – if none **Special Dietary Needs: ____________________________**

Allergy	Reaction	Medication Required

If medication is required for any condition, a medication authorization form must be completed.

Medical Insurance

Please provide a copy of student's medical insurance card.

Company Name: _____________________________ Subscriber's Name: _____________________
Company Address: ___________________________ Policy Number: ________________________
Contact Phone Number: _______________________ Group Number: ________________________

The information provided here is a complete and accurate statement of any medical conditions that may affect my child's participation in this program. I realize that failure to disclose information could result in serious harm to my child and other participants. I agree to inform the coordinator should there be any changes to my child's health status. I understand the program may require vigorous activity that is both physically and mentally demanding and release camp staff and NCSS from any liability associated with their participation.

Student Signature______________________________**Date**_________________________.

Parent/Guardian Signature______________________**Date**_________________________.

MEDICATION AUTHORIZATION FORM

If medication can be given at home or during school hours by nurse, please do so. However, if medication must be given during the ASAP, this form must be completed.

Student's Name: ____

Teacher: ______________________________ Grade: ____________________

I hereby request that the Newton County School System After School Academic Program (ASAP), through the Site Coordinator administer of medication to my child according to the instructions contained on this statement below. I understand that:

- Medications must be in the original labeled container (no baggies, foil, etc.).
- Parent/guardian must provide specific instructions, as well as the medication and related equipment to the Site Coordinator.
- It will be the responsibility of the parent/guardian to inform the school of any changes. New medication or new doses will not be given unless a new form is completed.
- All medication will be taken directly to the Site Coordinator's office by the parent.
- Unused medication will be disposed of unless picked up within one week after medication is discontinued.

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Name of Medication(s): ____

Dosage and Time to be Given: ____

Stop Medication On: ____

Physician's Name: ____________________ Physician's Phone: ____________________

I release the Newton County Board of Education and any ASAP employee from any liability involved with administering this medication.

______________________________ ____________________

Parent/Guardian Signature **Date**

Home phone: ______________ Work Phone: ______________ Cell: ______________

Must be signed also by a physician for all prescription medications given longer than two weeks.

Condition/Illness Requiring Medication: ____

Possible Side Effects (if any): ____

______________________________ ____________________

Physician's Signature **Date**