



Swampscott

2018-19 MEDICAL FORM

Extended Day

Before and Afterschool Program

Student's Full Name/s _____ Grade/s _____

Circle one or more: Clarke Hadley Stanley SMS DOB/s _____

Family Physician _____ Telephone _____

Circle one of the following Morning Program Afternoon Program Both

My student/s has/have no known allergies.

Name _____ has the following allergy: Allergy _____ Reaction _____

Name _____ has the following allergy: Allergy _____ Reaction _____

Name _____ has the following allergy: Allergy _____ Reaction _____

My student/s _____ has/have no known allergies, and I give permission for my student/s to eat snack given by the staff at the Extended Day Program. I will alert the staff immediately if allergies develop.

My student/s _____ has /have allergies and I will supply snack for my child to have while attending the Extended Day Program.

My student has other non-food allergies/health limitations

Is there any other information about your student's learning, health, or social development that you wish for Extended Day to know about? If so explain below:

Example: Has anxiety. Needs to have directions repeated. Runs off when upset.

Name/s _____ is/are receiving services for an Education School Plan (check applicable)

IEP 504 Accommodation Plan

I give permission for the (circle one) Clarke Hadley Stanley SMS School to share important information from this plan with Extended Day Staff.

I do not give permission to share important information from this plan with Extended Day Staff.

AUTHORIZATION AND CONSENT

I authorize staff members at Extended Day who are trained in the basics of First Aid/ CPR to give my student/s First Aid/CPR when appropriate. I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my student/s. If the Director of Extended Day and/or Site Coordinator is unable to reach me, I hereby authorize the Director of Extended Day and/or Site Coordinator to call 911 and if necessary transport my child to the nearest medical facility.

Parent /Guardian Signature _____ Date _____

Printed Name _____