CLOVER SCHOOL DISTRICT

Before and After School Activity Medical Form

Completion of this form is required to ensure medical concerns are addressed. Medications should be administered only when necessary in accordance with school policy during this time. Parents/Guardians are responsible for supplying medication and any other needed information for the safety of their child. Failure to complete form prior to starting this program will be viewed as refusal to consent for participation.

Student Name____ DOB_______________

Name of Before or After School Activity (For example…Athletic team, Club Name)

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Please check all that apply: [ ] Diabetes [ ] Severe Allergies with Epi-pen for______________

[ ] Asthma [ ] Seizure Disorder [ ] Bleeding Disorder [ ] Catheter/Colostomy [ ] ADHD

[ ] Feeding Tube [ ] Heat Related Problems [ ] Previous Concussion [ ] Heart Problems

[ ] Emotional/Behavioral issues [ ] Other: ____

List any medication needed for health condition above___________________________________

Where will medication be located during this time ______________________________________

Physician's Name____ Phone _______________

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I give my child ___________________________________permission to participate in the above named before/after school activity. I understand a school nurse is not present before/after school hours. I release Clover School District, its employees or agents, from any claims or suits related to my child's health condition and participation in the above mentioned activity. I understand emergency medications and the location of this medication should be communicated by the parent/guardian and student to those activity sponsors responsible for the student.

Parent/Guardian Signature______________________________________ Date_________________

Emergency Contact Number ____________________________

Coach/Teacher/Team ____ Date __________________

Activity sponsor keep form and contact nurse for further medical instructions.