PARAMOUNT CARE FOUNDATION
Afterschool Program
Mandatory Health Form

2023-2024

Grade:_____

School_____

Name of Student _____Date of Birth _____
Address _____Age _____
City_____State _____Zip _____
Phone # (_____)_____-_____Sex ___ Height_____Weight_____

Emergency Contact Person:
Parent/Guardian Name _____
Address (if different from student) _____
City _____State_____Zip _____
Phone #(Home)(_____) _____-_____ (Work) (_____) _____-_____
Cell Phone # (_____) _____-_____
E-mail_____

Alternate Contact Person" (Use someone near the primary contact)
Name _____
Address_____
City_____State_____Zip_____

Phone #(Home)(_____) _____-_____ (Work) (_____) _____-_____

If you have medical insurance, your carrier will be billed for medical charges in the case of illness or injury while your child is at the activity.

Do you have health insurance? _____ Yes _____ No
Name of insurance company _____
Policy # _____ Group #_____
In whose name is the insurance? _____
Family Doctor _____
City_____Phone# (_____) _____-_____

If your child should require medical attention for injuries received or illnesses contracted prior to activity, please send us the necessary information to give him/her proper medical care during his/her time with the After school Program.

Health History
Any pre-existing or present medical conditions: _____
_____
_____
Name and dosage of any medications that must be taken _____
_____

Any allergies? _____
to Medications? _____
_____Hay fever ____ _Heart Condition _____Diabetes _____Insect Stings
____Epilepsy/Nervous Disorders ____Asthma ____Frequent stomach upsets
____Physical Handicap ____Any major Illnesses during the past year? _____

If any of the above are checked, please give details (i.e., include normal treatment of allergic reactions) _____
_____

Date of last Tetanus shot _____ contact Lenses? _____
Any swimming restrictions? _____No _____Yes What? _____
Any activity restrictions? _____No _____Yes What? _____

Parent Medical and Liability Release Statement:
*I understand that in the event medical intervention is needed, every attempt will be made to contact immediately the persons listed on this form. In the event I cannot be reached in an emergency during the activity dates shown on this form, I hereby give my permission to the physician or dentist selected by the activity leader to hospitalize, to secure medical treatment and/or order an injection, anesthesia, or surgery for my child as deemed necessary.
*I understand all reasonable safety precautions will be take at all times by Paramount Care Foundation/Emmanuel Reformed Church, and its agents during the events and activities. I understand the possibility of unforeseen hazards and know the inherent possibility of risk. I agree not to hold Paramount Care Foundation or Emmanuel Reformed Church, its leaders, employees, and volunteer staff liable for damages, losses, diseases, or injuries incurred by the subject of this form.

Parent/Guardian Signature_____Date _____

I give permission to take and publish pictures from my child to use in PCF advertising materials. _____Initials

This form shall be in effect from August 2023 to May 2024, unless revoked sooner in writing.