



CLUB ORION AFTER SCHOOL Health Record/Medical Release Form

This form must be completed and returned **before** attendance in order for the student to be permitted to participate in after school.

Part A– To be filled out by parent **before** presenting to student’s physician. **Part B** – To be filled out by student’s physician.

Part A PERSONAL INFORMATION

Child’s Last Name _____ First Name _____ Nickname _____
DOB _____ Gender _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
Parent #1 Name _____ Parent #1 e-mail _____ Parent #1 cell _____ work _____
Parent #2 Name _____ Parent #2 e-mail _____ Parent #2 cell _____ work _____
Health Insurance Carrier _____ Policy Number _____ Plan Number _____
Is physician authorization needed? _____ *Please attach copy of insurance card.

In case of emergency, please notify

If neither parent nor guardian is available in an emergency, please contact:

1. _____ Daytime Phone Numbers _____

HEALTH HISTORY (If applicable please check approximate dates that student first experienced allergies or health conditions)

Allergies

Hay Fever _____ Poison Ivy _____ Insect Stings _____ Penicillin _____ Other Drugs _____

Food Allergies (please list) _____

Health

Rheumatic Fever _____ Ear Infections _____ Seizures _____ Diabetes _____ Asthma _____

Concussion _____ Other Health Conditions _____

Social Emotional

Please check any that apply to your child

Curious ___ Social ___ Happy ___ Anxious ___ Fearful ___ Depressed ___ Non-compliant ___ Dramatic ___ Distractible ___
Aggressive ___ Distracted ___ Passive ___ Perfectionist ___ Active ___ Immature ___ Honest ___ Confidant ___ Intuitive ___
Irritable ___ Follower ___ Calm ___ Unusual ___ Shy ___ Charming ___ Impulsive ___ Well-liked ___ Leader ___ Dreamer ___
Confused ___ Helpful ___ Oppositional ___ Witty ___ Kind ___ Intuitive ___ Shy ___ Overbearing ___ Creative ___ Inattentive ___

Please list any medical diagnosis your child has and who gave it _____

Please list any illnesses your child has had in the past 3 years (contagious/non-contagious) _____

Please list any operations or serious injuries (include dates): _____

Has your child been hospitalized within the past 3 years? _____

Does your child have any chronic or recurring illness? _____

Is there anything else in child’s health history that after school staff should know? _____

List any activities from which the child should be restricted. _____

List any specific activities that you would like to be encouraged. _____

List any medical appliance (glasses, contact lenses, orthodonture, etc.) that the child wears. _____

Does your child have any sensory issues that we should be aware of? _____

Elaborate on dietary restrictions (intolerances, special diets)? _____

Please list and explain and social, emotional, cognitive or physical struggles your child has as well as how they are managed

List any medication your child will be taking during after school _____

Please list all medications and times of day they are taken. _____

IF MEDICATION IS REQUIRED, IT MUST COME IN THE ORIGINAL CONTAINER WITH USAGE/DOSAGE/ INSTRUCTIONS CLEARLY PRINTED ON LABEL. A DOCTOR’S NOTE AND PARENT’S NOTE MUST ALSO BE SENT.

Please hand deliver or mail completed form to:
The Orion School
458 Ponce de Leon Avenue
Atlanta, GA 30308



CLUB ORION AFTER SCHOOL

CONSENT FOR MEDICAL TREATMENT

I do hereby authorize that all of the above information is correct and that my child is fully able to participate in all Club Orion After School activities without need of individual or specialized attention or medical regimen. I agree to notify The Orion School of any changes in my child's physical or mental health between the dates of enrollment and the start of the school as well as during school. I hereby consent and authorize the administration of all medical treatments advisable or necessary under the judgment of the teachers, emergency room physicians or any other clinical physicians with the understanding that I will be notified as soon as possible.

If emergency treatment is necessary, I give permission for my child to be brought to the nearest emergency room by ambulance or helicopter for treatment. I authorize staff to release all records necessary for insurance purposes so that my insurance company can be billed for the visit, lab tests and/or x-rays if necessary. If time and circumstances permit, I would prefer my child be taken to his regular hospital.

_____ (Name, Address and Phone Number of Hospital)

I will provide all necessary medications and supplies needed by my child. However, if my child requires any additional prescription medications, I give the medical staff permission to obtain these and bill upon my notification.

Name _____
Signature _____

Relationship _____
Date _____ Phone _____

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CLUB ORION AFTER SCHOOL

Part B to be completed by student's physician:

Name of Student _____ Name of Physician _____

IMMUNIZATION INFORMATION

Date of most recent Tetanus Shot _____

Other immunizations up to date? Yes No, explain

***Immunization Form #3231 must be submitted prior to child's attendance.**

MEDICAL EXAMINATION

Examination must be performed no more than 12 months prior to arrival at school Lab if indicated: _____

CODE: S = Satisfactory
X = Not Satisfactory (explanation required)
O = Not examined

General Appearance _____ Height _____ Weight _____ Blood Pressure _____
ENT _____ Neck _____ Spine _____
Extremities _____ Heart _____ Lungs _____ Skin _____
Abdomen _____ Genitalia _____

Neurological Findings: _____

Allergies (please specify): _____

Please describe any abnormal findings: _____

RECOMMENDATION AND RESTRICTIONS DURING AFTER SCHOOL

Special Diet _____
Special Medicine Needed _____ Is Parent Sending Medicine? _____
Strenuous Activity _____
General Appraisal _____

DOCTOR'S RELEASE

I have examined the person herein described and reviewed his/her health history. It is my opinion that he/she is physically able to engage in all of The Orion School After School Enrichment Program activities, except as noted above.

Examining Physician (Primary Care Provider) Signature _____

Name (please print) _____

Telephone _____

Address _____ Zip Code _____

Date of Examination _____

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