Ginter Park United Methodist After-School Program

1010 W. Laburnum Ave
Richmond, VA 23227
804-262-8651/Fax: 804-553-3132
E-mail: afterschool@ginterparkumc.org
Web: www.ginterparkumc.org/after-school

Medical Information

Please print clearly. When complete, please sign in the space indicated on the back of this form.

Parent/Guardian name, Mr/Mrs/Ms _____ Emergency phone #:_____

Home address: _____
House/apt. # Street City Zip

1st Child:

Name: _____ Age: _____ Date of birth: _____

GPUMC ASP requires all immunizations to be up to date. Are all immunizations up to date? Yes ___ No ___

Can you provide immunization records? Yes _____ No _____

Doctor's name: _____ Phone: _____

Dentist's name: _____ Phone: _____

Allergies or pre-existing conditions: _____

_____

Medications: _____

_____

Do meds need to be administered during their time with us after school? Yes ____ No ____

Instructions: _____

_____

Preferred Hospital: _____ Location: _____

Insurance provider: _____Policy number: _____

Name of policy holder: _____ Relationship to child: _____

Back-up emergency contact, in the event you cannot be reached:

Name: Mr/Mrs/Ms _____ Phone: _____

Alternate phone numbers: _____ _____ _____

Relationship to the child: _____

Please read and sign below

1. I certify and affirm these statements are true and complete.
2. **I give permission for my child to be treated by medical staff in the event of an emergency.**
3. I understand minor scrapes & bumps will be attended to by the GPUMC ASP staff, an incident report will be made. For further details, see the After School Program Policy Manual.

_____ _____ _____

Signature of Parent/Guardian Please print name Date

GPUMC ASP Medical Information

Please print clearly. When complete, please sign in the space indicated on the back of this form.

Guardian name, Mr/Mrs/Ms:_____ Emergency phone #: _____

Home address: _____

House/apt. # Street City Zip

2nd Child:

Name: _____ Age: _____ Date of birth: _____

GPUMC ASP requires all immunizations to be up to date. Are all immunizations up to date? Yes ___ No ___

Can you provide immunization records? Yes _____ No _____

Doctor's name: _____ Phone: _____

Dentist's name: _____ Phone: _____

Allergies or pre-existing conditions: _____

_____

Medications: _____

_____

Do meds need to be administered during their time with us after school? Yes ____ No ____

Instructions: _____

_____

Preferred Hospital: _____ Location: _____

Insurance provider: _____Policy number: _____

Name of policy holder: _____ Relationship to child: _____

Back-up emergency contact, in the event you cannot be reached:

Name Mr/Mrs/Ms: _____ Phone: _____

Alternate phone numbers: _____ _____ _____

Relationship to the child: _____

Please read and sign below

1. I certify and affirm these statements are true and complete.
2. **I give permission for my child to be treated by medical staff in the event of an emergency.**
3. I understand minor scrapes & bumps will be attended to by the GPUMC ASP staff, an incident report will be made. For further details, see the After School Policy Manual.

_____ _____ _____

Signature Please print name Date

GPUMC ASP Medical Information

Please print clearly. When complete, please sign in the space indicated on the back of this form.

Guardian name, Mr/Mrs/Ms:_____ Emergency phone #: _____

Home address: _____

House/apt. # Street City Zip

3rd Child:

Name: _____ Age: _____ Date of birth: _____

GPUMC ASP requires all immunizations to be up to date. Are all immunizations up to date? Yes ___ No ___

Can you provide immunization records? Yes _____ No _____

Doctor's name: _____ Phone: _____

Dentist's name: _____ Phone: _____

Allergies or pre-existing conditions: _____

_____

Medications: _____

_____

Do meds need to be administered during their time with us after school? Yes ____ No ____

Instructions: _____

_____

Preferred Hospital: _____ Location: _____

Insurance provider: _____Policy number: _____

Name of policy holder: _____ Relationship to child: _____

Back-up emergency contact, in the event you cannot be reached:

Name, Mr/Mrs/Ms: _____ Phone: _____

Alternate phone numbers: _____ _____ _____

Relationship to the child: _____

Please read and sign below

1. I certify and affirm these statements are true and complete.
2. **I give permission for my child to be treated by medical staff in the event of an emergency.**
3. I understand minor scrapes & bumps will be attended to by the GPUMC ASP staff, an incident report will be made. For further details, see the After School Program Policy Manual.

_____ _____ _____

Signature Please print name Date