LATCHKEY STUDENT FORMS

Child's Last Name	Child's First Name	Middle Name	Grade (22-23 School Year)

Date of Birth	Home Address	School Child Attends

Parent/Guardian Name	Place of Employment/Work Phone	Work Hours
Parent/Guardian Name	Place of Employment/Work Phone	Work Hours

If there will be other people dropping off and picking student up, please list below

Full Name	Relationship	Phone Number(s)

Schedule Information:

_____ Full Time (AM and PM) _____ Part Time (AM ONLY) _____ Part Time (PM ONLY)

_____ Drop In ONLY

_____ Cancellation days/scheduled days off

On the cancellation days/scheduled days off, your child MUST be pre-registered to attend.

Estimated morning drop off time: _____

Estimated afternoon pick up time: _____

→

About your child:

Does your student have any special needs, conditions, medications, or allergies?

_____

Tell us about some of the things that your child enjoys outside of school:

_____

_____

Does your child have trouble with: Loud Noises _____ Bright Lights _____

Group Play Activities _____ Change of Routine _____

What coping skills does your child use when he/she is anxious, angry or upset?

_____

_____

Are there any special circumstances at home or at school currently occurring or about to occur in your child's life that you would like to share with the Latchkey staff?

_____

_____

Parent Checklist:

- ☐ I have read and agree with Latchkey Program parent/student handbook.
- ☐ I have attached the 'Medications On-Site' ***if applicable***.
- ☐ I have read the Tuition Payment guidelines and agree to make the necessary payments every Monday for the current week.
- ☐ I have received a copy of the 2022-2023 Latchkey Calendar (back of handbook).
- ■ *I DO / I DO NOT* ***(circle one)*** give permission to have my child appear in any media coverage approved by the Sidney City Schools Latchkey Program.

Print Parent/Guardian Name: _____

Signature of Parent/Guardian: _____ Date: _____

ADMINISTRATION OF MEDICATION DURING LATCHKEY HOURS

Providing medical care to children is the responsibility of the parent/guardian and should be assumed by the Latchkey staff. We would prefer that children receive medication before and/or after Latchkey hours. If it is absolutely necessary that medication be given during Latchkey hours, the following procedures will apply:

1. For legal purposes, a written permission form for dispensing medication must be obtained from the child's parent/guardian and from his/her physician. The administration of any medication (prescription or over-the-counter) without the order of the physician and the permission of the parent/guardian could be interpreted as practicing medicine and is prohibited by law.

2. The statement should include the child's name, name of medication, dosage, time it should be given, possible side effects, if any, and length of time the child will be taking the medication. This information is needed for each new medication or dosage change. No medication will be given unless this information and permission is provided. This is a STATE LAW, in accordance with the Ohio Revised Code 3313-713. Medical Form must be completed.

3. Except in cases of emergency, parents/guardians shall give the first dose of any newly prescribed medication so that they may personally observe the child's reaction.

4. The parent/guardian must bring the medication to the Latchkey site lead, with the original container clearly marked giving the name of the child, name of medication, dosage directions, physician's name, and prescription number. The parent/guardian must supply the Latchkey site with the exact dosage.

5. If the medication has been discontinued, any remaining medication must be picked up by the parent/guardian immediately after discontinuation.

Latchkey Program Medication Permit

(In accordance with OHIO REVISED CODE 3313.713)

Use this form if it is necessary for student to receive medication during the Latchkey hours

TO BE COMPLETED BY PARENT/GUARDIAN

Name of Child_____ Birth Date_____

Child's Address_____ School_____

I request Latchkey personnel to administer the medication as instructed and agree to (1) deliver the medication to the school in the original container and (2) notify the Latchkey program if I change physicians or if the medication is changed/eliminated. I understand it is the child's responsibility to report on time for this medication. I agree to hold Latchkey personnel and the Board of Education free from all responsibility for results of such medication.

Parent/Guardian Signature _____ Date _____

Telephone during Latchkey hours _____

TO BE COMPLETED BY PHYSICIAN

Medication _____ Date of Authorization _____

Dosage _____

Times to be given _____ Start Date _____ End Date _____

Adverse reactions to be reported _____

_____

Physician emergency telephone _____

Special Administration Instructions _____

Storage Instructions _____

Prescribing Physician (print) _____ Signature _____

Physician's Address _____

TO BE COMPLETED BY LATCHKEY PERSONNEL

The following Latchkey personnel have read this form and are authorized to administer the medication as outlined:

Signature _____ Date_____

Signature _____ Date_____

Signature _____ Date_____