Forms Required for ALL Students

- Department of Social Services Registration with signed Health Agreement
- Child Release Authorization (pick-up)
- Medication Administration Policy
- Medication Authorization Form
- Authorization of Release School Records
- Authorization to Provide Transportation
- Child's Proof of ID
- Copy of Immunization
- Copy of Physical done within last 12 months
- Parent Handbook

Henrico PAL Child Release Authorization Form

I, ______________________________, give my authorization for the individual(s) below to pick up my child, ________________________________, from the Henrico PAL program in my absence.

Name:	Contact #:	Relationship to Child:

Parent Signature____________________________ Date_____________________

***Appropriate paperwork such as custody papers shall be attached if a parent is not allowed to pick up child. Section 22.1-4.3 of the Code of Virginia states that unless a court order has been issued to the contrary the noncustodial parent of a student enrolled in a public school or day program center must be included, upon the request of such noncustodial parent, as an emergency contact for events occurring during school or day program activities.

Henrico Police Athletic League

Administration of Medication

All Henrico PAL programs, including those at: Baker, Chamberlayne, Dumbarton, Harvie, Pinchbeck, Skipwith, and Ward have made the following decision regarding the administration of medication:

I (or my staff) will administer **only sunscreen, liquid Benadryl, EpiPen (epinephrine), and/or asthma inhalers**. Any other medication needs must be discussed with Henrico PAL and require an additional **Medical Management Plan** to be signed by parents, physicians, and Henrico PAL.

The program will administer prescription medication by all routes covered in the EMAT course (liquid Benadryl, inhaler, and EpiPen to give epinephrine), as well as sunscreen.

The program will administer only the listed medications above in accordance with VDSS child day program regulations pertaining to the administration of medication in a child day program. Only a provider who has completed the appropriate training or has appropriate licensure and is listed as a medication administrator in the *Program's Decision Regarding Medication Plan* will be permitted to administer medication in the program, except for sunscreen.

I (or my staff) will have permission to apply for any over-the-counter sunscreen in accordance with VDSS regulations. Any over-the-counter sunscreen will be applied in accordance with the package directions for use. If the parent's instructions do not match the package directions, I (or my staff) will get health care provider instructions before applying the sunscreen. All over the counter sunscreen will be kept in its original labeled container. All child-specific sunscreen will be labeled with the child's first and last names. Sunscreen will be kept in a clean area that is inaccessible to children. Sunscreen will be stored in a lock box inaccessible to children.

All leftover or expired sunscreen will be given back to the child's parent for disposal. Sunscreen not picked up by the parent will be disposed of in a garbage container that is not accessible to children. All over-the-counter sunscreen administered to a child during program hours will be documented on a child-specific log. All observable side effects will be documented. Parents will be notified of any observed side effects by the end of the day. Parent notification will be immediate if the side effects are severe. If necessary, emergency medical services will be called. Parents will be notified of all "as needed" over-the-counter sunscreen applied to their child and

told what symptoms were observed that required the application. The program will only apply over-the-counter sunscreen which parents supply for their child.

I understand that as a provider it is my obligation to protect the children in my care from injury. Part of this obligation includes the application of sunscreen according to parent permission.

Authorized Staff to Administer Medication:

I understand that any individual listed in this section as a medication administrator is approved to administer medication using the following routes: liquid Benadryl by mouth, asthma inhaler, and EpiPen to give epinephrine.

I understand that to be approved to administer medication, other than over-the-counter sunscreen, all individuals listed in my *Program's Decision Regarding Medication* plan must have valid:

- Emergency Medication Administration Training (EMAT) certificate.
- CPR certificate which covers all ages of children my program is approved to care for as listed on my registration/license.
- First aid certificate which covers all ages of children my program is approved to care for as listed on my registration/license.

I understand that the individuals listed in my *Program's Decision Regarding Medication* plan as medical administrators may only administer medication when the medication labels, inserts, instructions, and all related materials written in the language indicated on the EMAT certificate.

Medication Administrators:

All staff listed as medication administrators will have EMAT, first aid, and CPR certificates that cover the ages of the children in care and are at least 18 years of age. Documentation of age-appropriate first aid and CPR certificates will be kept on site and are available on request.

Forms and Documentation Related to Medication Administration:

Medication Consent Form: My program will accept permission and instructions to administer medication on the Henrico PAL medication consent form. All medication administered to a child during program hours will be documented on the VDSS form *Log of Medication Administration*.

Application of over-the-counter sunscreen during program hours will be documented on the VDSS form *Log of Medication Administration.*

Each medication log will be attached to the child's corresponding medication consent form.

All observable side effects will be documented on the child's medication log. Parents will be notified on any observable side effects by the end of the day. Parent notification will be immediate if the side effects are severe. If necessary, emergency medical services will be called. I (or my staff) will document whenever medication is not given as scheduled. The date, time, and reason for this will be documented. Parents will be notified as soon as possible. If the failure to give medication as scheduled is a medication error, I (or my staff) will follow all policies and procedures related to medication errors. All medication consents and medication logs will be kept in a secure cabinet in the Medication logbook.

Handling Storage and Disposal of Medication:

All medication must be properly labeled with the child's first and last name and be accompanied by the necessary parent permission and, when applicable, health care provider instructions in accordance with VDSS regulations before it will be accepted from the parent or parent representative. All medication must be kept in its original labeled container. Medication must be kept in a locked place using a safe locking method that prevents access by children. Medication will be stored in a lock box inaccessible to children. All medications with a pharmacy label identifying the contents as a controlled substance are regulated by the Federal Drug Enforcement Agency. These medications will be stored in a locked area with limited access.

The controlled substances will be stored in a lock box and access will be given only trained staff members with EMAT certification.

I (or my staff) will check for expired medications monthly. All leftover or expired medication will be given back to the child's parent for disposal. Medication not picked up by the parent within one month will be flushed down the toilet or disposed of in a garbage container that is not accessible to children.

Medication Errors:

If a medication error occurs in my program, I will notify the child's parent immediately. I will maintain confidentiality of all children's records. I will encourage the child's parents to contact the child's health care provider if an error occurs. I will complete the VDSS form *Medication Error Report Form* to report all medication errors that occur in my program. If more than one child is involved in the error, I will complete a *Medication Error Report* for each child involved.

Confidentiality Statement:

Information about any child in my program is confidential and will not be given to anyone except Henrico PAL designees or other person authorized by law unless the child's parent gives written permission.

Information about any child in my program will be given to the local department of social services whether the child receives a day care subsidy or if the child has been named in a report of suspected child abuse or maltreatment or as otherwise allowed by law.

ADA Statement for Programs:

My program will comply with the provisions of the Americans with Disabilities Act. If any child enrolled in my program now or in the future is identified as having a disability covered under the Americans with Disabilities Act, I will assess the ability of the program to meet the needs of the child. If my program can meet the needs of the child without making a fundamental alteration to the program, I will not exclude the child from my program.

Provider Statement:

I understand that it is my responsibility to follow my *Program's Decision Regarding Medication* plan and all health and infection control regulations applicable to child day programs.

I will verify and document the credentials for all new staff certified to administer medication before the staff is allowed to administer medication to any child in the child day program.

The *Program's Decision Regarding Medication* plan will be made available to parents at enrollment, whenever changes are made and upon request.

The parent of each enrolled child must sign below. The provider must maintain a copy of this form in each child's individual record.

Provider's Name (please print): Charles Anderson, Jazmine Bruce, Cara Hayes, and James Atkins	Facility Name: Baker, Chamberlayne, Dumbarton, Harvie, Pinchbeck, Skipwith, and Ward
Parent's Name (please print):	**Name(s) of Child or Children:**
Parent or Guardian Signature:	**Date:**

Medication Authorization Form

Section A: To be completed by parent/guardian - Instructions: Section A must be completed by the parent/guardian for ALL medication authorizations.

Medication authorization for: ____ (Child's name)

Henrico Police Athletic League certified staff have my permission to administer the following medication:

Medication name: ____

Dosage and times to be administered: ____

Special instructions (if any): ____

____

This authorization is effective from: ______________ until: ________________

Parent's or Guardian's Signature: ________________________________ Date: ____________

Section B: to be completed by child's physician - Section B must be completed for any long-term medication authorizations (those lasting longer than 10 working days).

I, ___________________________________ (Name of Physician) certify that it is medically necessary for the medication(s) listed below to be administered to: ______________________________________ for a duration that exceeds 10 work days. (Child's name)

Medication(s): ____

Dosage and times to be administered: ____

Special instructions (if any): ____

____

This authorization is effective from: _____________________ until: _______________________

(Start date) (End date)

Physician's Signature: _______________________________________ Date: ______________

Physician's Phone: ____________________________

AUTHORIZATION OF RELEASE SCHOOL RECORDS

I authorize Henrico County Public Schools (HCPS) to release and exchange confidential school records with Henrico Police Athletic League (Henrico PAL) related to the following student:

____

(Student name) *(Student Date of Birth)*

For purposes of this release, school records shall include, but are not limited to, personally identifiable "education records," as defined by the Family Educational Rights and Privacy Act ("FERPA"), 20 U.S.C. § 1232g(a)(4) and 34 C.F.R. § 99.3, "scholastic record," as defined by Va. Code Ann. § 22.1-289, and other oral and written exchanges of information relating to the Student's education at Henrico County Public Schools.

This release covers the following information:

- ✓ Student demographics
- ✓ Student sensitive demographics
- ✓ School information
- ✓ School grades
- ✓ Student Attendance
- ✓ Student discipline
- ✓ Student schedule
- ✓ Student SOL test results

I understand that Henrico Police Athletic League and his/her staff will regard any information released to them as confidential and privileged any information to be used for the purpose of supporting student academic achievement through Henrico PAL programming.

I intend for this General Release to be in compliance with FERPA and its implementing regulations at 34 C.F.R. § 99.30 and Va. Code Ann. § 22.1-287(2).

A copy of this Authorization shall be as valid as the original. This authorization is effective immediately and expires one year from the date below.

Date: ________________________________

Signature: ________________________________

Print full name: ________________________________

Relationship to minor: __________________________________

If applicable, the most recent custody order must be on file with the school.

Phone number: _____________________________________

AUTHORIZATION FOR HENRICO PAL TRANSPORTATION

I authorize Henrico Police Athletic League to pick up my child from their day school and transport them to the Henrico PAL After School Site.

Child's name: ____

Child's home school: ____

Henrico PAL After School Location (circle one):

- Baker
- Dumbarton
- Harvie
- Pinchbeck

Henrico PAL vehicles are white with the Henrico PAL logo and have the appropriate seat belts and regular inspections. All drivers are vetted, properly licensed and insured, and meet state requirements.

Please contact info@henricopal.org should have any questions or concerns.

PARENT ACKNOWLEDGEMENT

I acknowledge and affirm that I have read the entire Henrico Police Athletic League 2025-2026 Parent Handbook and will comply with its contents.

Parent Signature: ____

Print Name: ____

Print Child's Name: ____

Site Location: ____

Date: ________________________________

Please submit signed acknowledgment form to site manager or Henrico PAL administration office located at:

Henrico Police Athletic League
2401 Hartman Street, Building B
Richmond, VA 23223