SCHOOL DAY OFF PROGRAM CHILD INFORMATION FORM

PLEASE FILL OUT ONE FORM PER CHILD AND BRING IT ON THE FIRST DAY OF THE PROGRAM. HAND FORM TO THE PROGRAM DIRECTOR. YOUR CHILD WILL NOT BE ABLE TO ATTEND THE PROGRAM UNLESS THIS FORM IS COMPLETELY FILLED OUT AND TURNED IN.

Child's Name_____ ____/____/_____
(Last) (First) (Birthdate)

Parent's Name_____ Cell Phone ( ) _____-_____

Parent's Name_____ Cell Phone ( ) _____-_____

PLEASE ANSWER THE FOLLOWING QUESTIONS.

□ Please check this box if your child has any special needs (physical, behavioral, cognitive, processing, social/ emotional or communication.) If yes, please describe below.

_____

_____

Does your child have any medical conditions or health concerns? Yes▣ No ▣Please describe: _____

_____

Does your child have any allergies? Yes □ No □ Please list and describe any possible reactions to exposure: _____

_____

Does your child take any medication? Yes□ No □ Please list: _____

EMERGENCY CONTACTS/<u>ADULTS</u> AUTHORIZED TO PICK UP YOUR CHILD (At least one other than parents above.)

Name_____ Phone ( ) _____-_____

Name_____ Phone ( ) _____-_____

Parent Signature Date

_____ _____