

SUNRISE/SUNSET

Emergency/ Medical Information

(Note: This form MUST be completed and returned with your full registration package, first month's payment for registration and registration fee for your registration to be processed. A one-week minimum processing time is required for the start of the child's program. Children may not start the program until the full registration process is completed. For any applications received after August 25th, parents will be notified as to the date the child may begin the program.)

Student's Name _____ Gr. _____ School _____

Address _____

Street

Town

Zip

Mother's Name _____ Home phone # _____ Cell # _____

Place of Employment _____ Bus. Phone # _____ Work email _____

Father's Name _____ Home phone # _____ Cell # _____

Place of Employment _____ Bus. Phone # _____ Work email _____

IN CASE OF ILLNESS, PLEASE LIST NAMES AND TELEPHONE NUMBERS TO BE CALLED IN AN EMERGENCY IF PARENT CANNOT BE REACHED.

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

TO BE COMPLETED BY PARENT/GUARDIAN:

1. Does this child have any physical conditions of which we should be aware? _____
2. Does this child require any special attention or routines that would be helpful to take into consideration during the program times of the day? _____
3. Medical/Orthopedic/Emotional Conditions _____
4. Allergies _____
5. Does your child have a life-threatening allergy that might require the use of epinephrine? Yes No
6. Medications taken daily _____
(Please note: Medications cannot be administered by program staff. Please make arrangements to have any required medications administered either before or after program.)
7. Please note any other special concerns or information about which we should know. _____

8. Date of last physical examination _____

In the event of an emergency and I cannot be reached, I give my permission for my son/daughter to be given immediate medical care at a hospital or other medical/dental facility.

Doctor's Name _____ Phone # _____

Parent/Guardian Signature _____ Date _____