



**Please complete each blank. Write N/A if item is not applicable.**

Please list three authorized persons to take child from the program in the event of an emergency.

1.) Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

2.) Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

3.) Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

List of Person(s) **NOT** permitted to pick up this child:

Name: \_\_\_\_\_ Restraint papers or divorce decree attached? Yes No

Name: \_\_\_\_\_ Restraint papers or divorce decree attached? Yes No

**Transportation/ activity plan to allow a child to leave the program for specific activities (Girl/ Boy Scouts, sports, clubs, etc.) Please complete the following information if you plan for your child to participate.**

1.) Destination/ activity: \_\_\_\_\_

Estimated time departure: \_\_\_\_\_ Estimated time of return: \_\_\_\_\_

Time Period for which this agreement is valid: \_\_\_\_\_

Authorized person to take child fro program: \_\_\_\_\_

2.) Destination/ activity: \_\_\_\_\_

Estimated time departure: \_\_\_\_\_ Estimated time of return: \_\_\_\_\_

Time Period for which this agreement is valid: \_\_\_\_\_

Authorized person to take child fro program: \_\_\_\_\_

**Parent/ Guardian Signature**

**Date**

Please complete each blank. Write N/A if item is not applicable.

Medical Information

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Other Health Care Provider: \_\_\_\_\_ Phone: \_\_\_\_\_

Permission to provide first aid and transportation to an emergency care facility if needed? Yes No

If you do NOT want your child transported to an emergency care facility or provided first aid describe procedures to follow: \_\_\_\_\_

Medical / Health Needs: \_\_\_\_\_

Allergies and Treatment: \_\_\_\_\_

Diet Restrictions: \_\_\_\_\_

Medications: \_\_\_\_\_

\*A medication form must be completed for each medication administered while in attendance at the program.

Parent/ Gaurdian Signature

Date

Please complete each blank. Write N/A if item is not applicable.

## SACC Emergency Contact Form

Students Full Name: \_\_\_\_\_

Emergency contact telephone numbers

*Please circle which phone number should be used 1<sup>st</sup>, 2<sup>nd</sup>, and 3<sup>rd</sup> in case of an emergency*

**Father's daytime phone numbers:**

Name: \_\_\_\_\_

Work Number: (1 2 3 ) \_\_\_\_\_

Home Number: (1 2 3 ) \_\_\_\_\_

Cell Number: (1 2 3 ) \_\_\_\_\_

**Mother's daytime phone numbers:**

Name: \_\_\_\_\_

Work Number: (1 2 3 ) \_\_\_\_\_

Home Number: (1 2 3 ) \_\_\_\_\_

Cell Number: (1 2 3 ) \_\_\_\_\_

Babysitters Name: \_\_\_\_\_ Number: \_\_\_\_\_

Carpoolers Name: \_\_\_\_\_ Number: \_\_\_\_\_

Other daytime contact (relative or Neighbor)

1.) Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Number: \_\_\_\_\_

2.) Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Number: \_\_\_\_\_