



# 2011-2012 E.T. KidZone Participant EMERGENCY INFORMATION

Each child is required to have this form on file prior to starting the E.T. KidZone Program.

Child's Name (last) \_\_\_\_\_ (first) \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Circle CHILD'S SCHOOL:	BRIARGATE	DEER PATH	THREE OAKS	PRESCHOOL	JUNIOR HIGH							
<u>E.T KidZone (at school location)</u>												
Circle DAYS ATTENDING:	<u>Mornings: (7:00-8:45)</u>	M	T	W	Th	F	<u>Afternoons: (3:30-6:00)</u>	M	T	W	Th	F
<u>KINDERGARTEN E.T KidZone (at Cary Park Community Center)</u>												
Circle DAYS ATTENDING:	<u>Mornings: (7:00-12:30)</u>	M	T	W	Th	F	<u>Afternoons: (11:35-6:00)</u>	M	T	W	Th	F

Mother/Guardian Name \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_

Father/Guardian Name \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_

Home Address \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ E-Mail \_\_\_\_\_

Which parents/legal guardians listed above may we contact if a need arises?  Mother  Father  Both

Which parents/legal guardians listed above are authorized for pick-up?  Mother  Father  Both

*In the event a parent/legal guardian cannot be reached and a completed 'Release of Child' form has not been submitted to site staff, I authorize the following individuals to be contacted to pick up my child. One contact must be a Cary resident.*

Name Relationship Phone Number

1) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

2) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Medical History:** \*If your child needs medications or special accommodations during the program please contact Erica Hedlund at 847.639.6100 ext 117.

Allergies \_\_\_\_\_

\*Current Medications \_\_\_\_\_

\*Does your child need any special accommodations in order to be successful in this program?  
\_\_\_\_\_

Family Physician Name and Phone Number \_\_\_\_\_

**Consent For Treatment:**

THIS CONSENT WILL BE VALID FOR THE 2011-2012 SCHOOL YEAR OR UNTIL RESCINDED IN WRITING BY THE PARENT OR GUARDIAN. IN A MEDICAL EMERGENCY, I GIVE PARENTAL/LEGAL GUARDIAN CONSENT FOR THE CARY PARK DISTRICT TO TAKE MY CHILD LISTED ABOVE TO THE NEAREST HOSPITAL OR MEDICAL CLINIC TO RECEIVE NECESSARY MEDICAL ATTENTION, IF THE CARY PARK DISTRICT IS UNABLE TO CONTACT A PARENT OR LEGAL GUARDIAN.

Signature of parent/legal guardian \_\_\_\_\_ Relationship \_\_\_\_\_

Office Use Only: SITE DIRECTOR REVIEW \_\_\_\_\_ (Initials and Date)