

Acton-Boxborough Community Education

Summer Day Program

Grade Sept 2017

MALE () FEMALE ()

NAME OF CHILD _____

LAST NAME FIRST NAME NICKNAME

Grade Sept 2016 _____

MALE () FEMALE ()

NAME OF CHILD _____

LAST NAME FIRST NAME NICKNAME

ADDRESS _____

STREET & TOWN ZIP

PHONE (HOME) _____ (EMERGENCY) _____

PARENT/FATHER NAME _____ PARENT/MOTHER NAME _____

CELL PHONE _____ CELL PHONE _____

BUSINESS PHONE _____ BUSINESS PHONE _____

CHILD'S PHYSICIAN _____ PHONE _____

Does your child have asthma or allergies? YES () NO () (IF YES, PLEASE EXPLAIN ON BACK)

Does your child take any medication? YES () NO () (IF YES, PLEASE EXPLAIN ON BACK)

Email address _____

PICK-UP AUTHORIZATION:

I authorize 1. _____
(Name) (Phone)

2. _____
(Name) (Phone)

To pick up my child at Summer Day Program. ***If there are any changes in these arrangements, I will let the staff know in advance with a written notice. Anyone picking up a child, including parents, will be required to show photo identification.*** Please note: If there are any special instructions or any persons who are **never** to be authorized to pick up your child, please also list.

First Aid and Emergency Medical Care Notice:

The staff of Summer Day Program may administer first aid to your child where appropriate. There is no nurse on duty at the program. In the event of a medical emergency, your child may be transported to the nearest medical facility for treatment. The staff will inform you, as soon as feasible, regarding your child's need for emergency medical treatment.

SWIMMING PERMISSION

_____ I am willing _____ I am not willing for my child to participate in a supervised open swim at the Acton-Boxborough Regional High School Pool. All children will walk to the pool or will be transported in bad weather by school bus. An activity will be provided for those not swimming. Lifeguards are on duty during the open swim.

PHOTOGRAPHIC PERMISSION

_____ I do _____ I do not consent and authorize Community Education to use and reproduce photographs taken of my child for advertising or publicity purposes.

WALKING RELEASE

I am ___ I am not ___ willing to allow my child to go on walks. Staff will supervise children on all walking trips within the school campus.

Signature of Parent or Guardian _____ Date

PLEASE FILL IN MEDICAL INFORMATION ON BACK SIDE OF THIS FORM. >>>>>>>>>>

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Summer Day Program

ABOUT MY CHILD

Child's Name: _____

Child's Name: _____

Child lives with: _____

Name & phone # of *local* person to notify if parents cannot be reached in an emergency:

MEDICAL/ALLERGY INFORMATION

- Allergies? (circle) Yes No

fruits ___ Milk/dairy ___ nuts ___ peanuts ___ bee stings

___ Chocolate ___ animals ___ mold/mildew ___ insect bites

Other (please specify)

- Please indicate severity of reaction to any above:

- My child uses the following for allergies:

___ Epipen ___ Inhaler ___ Other:

- My child has a history of: _____ Asthma ___ headaches ___ earaches ___ nosebleeds
Other (please specify)

- My child regularly takes the following medication

- My child will be taking the following medication while at the Summer Day Program (please read information in the letter accompanying this form)

- My child has a:

_____ Hearing impairment _____ vision impairment

Other

- Information that may help the Summer Day Program staff to better understand and assist your child in having an enjoyable experience:
