

EMERGENCY INFORMATION

Child's Name: _____ Date of Birth: _____

Child's Address: _____ Phone: _____

EMERGENCY CONTACT PERSON(S)

1. _____
(Name, Address, Phone #, Relationship to child)

2. _____
(Name, Address, Phone #, Relationship to child)

PEDIATRICIAN OR SOURCE OF HEALTH CARE

1. _____
(Doctor's Name, Address, Phone)

MEDICAL EMERGENCY TREATMENT

I hereby give CHAMPIONS permission to administer first aid and/or CPR to my child _____, and/or take my child to a hospital for medical treatment when I cannot be reached or when delay would be dangerous to my child's health.

Parent Signature: _____ Date: _____

INSURANCE INFORMATION (OPTIONAL)

Company Name: _____ Policy: _____

Participating Hospital: _____ Special Instructions: _____

THIS DOCUMENT AFFECTS YOUR LEGAL RIGHTS. YOU MUST READ IT CAREFULLY AND THOROUGHLY UNDERSTAND ITS RAMIFICATIONS BEFORE SIGNING WHICH WILL BE EVIDENCED AND ACKNOWLEDGED BY YOUR SIGNATURE. DO NOT SIGN IT OTHERWISE. SIGNATURE: _____

TRANSPORTATION PLAN AND AUTHORIZATION

Child's Name: _____ My child will **ARRIVE** at the program by (check those that apply):

Unsupervised walk from (grades 1-8) _____ Other (describe _____)

My child will **DEPART** from the program by (check those that apply):

_____ Parent pick up

_____ Unsupervised walk from classroom to parent waiting at front desk

_____ Other (describe _____)

I give permission for my child to be released from the program at the end of the day as stated above and/or I give my permission to the following people to receive my child at the end of the day (If no one is authorized, please indicate below by writing "NO ONE").

1. Name _____ Relationship _____

Address _____ Phone: _____

2. Name _____ Relationship _____

Address _____ Phone: _____

Any other transportation requests must be stated in writing and maintained in the child's file of the above plan must be implemented. This permission is valid for one program from the date of signature.

Parent/Guardian Signature _____ Date: _____