

<b>Registration Form for Summer School District Early Learning Programs</b>		Little Phins Little Eagles <i>CIRCLE ONE</i> Tiny Sparts Panther Cubs	
Child's Name Last First Middle		Name Used	Birthdate
Street Address		City Zip Code	
Child's Parent/Guardian Name	10 Digit Telephone Number	10 Digit Telephone Number (Work)	
Street Address		City Zip Code	
Work Address (or where you can be reached while child is in care) City Zip Code			
Child's Parent/Guardian Name	10 Digit Telephone Number	10 Digit Telephone Number (Work)	
Street Address		City Zip Code	
Work Address (or where you can be reached while child is in care) City Zip Code			
<b>OTHER PEOPLE TO NOTIFY IN CASE OF EMERGENCY</b>			
Name	Address	10 Digit Telephone Number	
Relationship:			Work: Home:
Relationship:			Work: Home:
Relationship:			Work: Home:
Relationship:			Work: Home:
<b>OTHER THAN YOU, WHO HAS PERMISSION TO PICK UP YOUR CHILD?</b>			
Name	Address	10 Digit Telephone Number	
			Work: Home:
			Work: Home:
			Work: Home:
<b>WHO DOES NOT HAVE PERMISSION TO PICK UP YOUR CHILD?</b>			
Name	Reason		

**CHILD'S HEALTH INFORMATION**

Date of Child's Last Physical Examination:	Child's Health Care Provider's Name	10 Digit Telephone Number
Street Address		City Zip Code
Special Health Problems	Allergies, Including Drug Reactions	
Regular Medications	Other Pertinent Data	
Child's Dentist's Name	10 Digit Telephone Number	
Street Address		City Zip Code

**CHILD'S MEDICAL INSURANCE COVERAGE**

Insurance Company Name	Member/Policy Number
Policy Holder Name	Employer Name
Insurance Company Name	Member/Policy Number
Policy Holder Name	Employer Name

**CONSENT TO MEDICAL CARE AND TREATMENT OF MINOR CHILDREN**

I hereby give permission that my child, \_\_\_\_\_,  
may be given emergency treatment by a qualified child care provider at  
\_\_\_\_\_,  
Name and/or Address

When I cannot be contacted, I authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital or aid car attendant when deemed necessary or advisable by the physician or aid car attendant to safeguard my child's health. I waive my right of informed consent to such treatment.

I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

I certify (or declare) under penalty of perjury under the laws of the State of Washington that the foregoing is true and correct.

Parent/Guardian Signature Date

Parent/Guardian Signature	Date	Parent/Guardian Signature	Date
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