

**EMERGENCY CONTACT/ PARENTAL CONSENT FORM  
TROJAN LEARNING CENTER AFTER SCHOOL PROGRAM**

CHILD'S NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_

SCHOOL: \_\_\_\_\_ GRADE: \_\_\_\_\_

CHILD'S ADDRESS \_\_\_\_\_ ZIP CODE \_\_\_\_\_

MOTHER'S NAME/LEGAL GUARDIAN \_\_\_\_\_

ADDRESS \_\_\_\_\_ ZIP CODE \_\_\_\_\_

PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

FATHER'S NAME/LEGAL GUARDIAN \_\_\_\_\_

ADDRESS \_\_\_\_\_ ZIP CODE \_\_\_\_\_

PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

**EMERGENCY CONTACT PERSON(S) NAME & PHONE**

1. NAME \_\_\_\_\_ PHONE: \_\_\_\_\_

2. NAME \_\_\_\_\_ PHONE: \_\_\_\_\_

**LIST NAMES TO WHOM CHILD MAY BE RELEASED**

1. NAME \_\_\_\_\_ PHONE \_\_\_\_\_

2. NAME \_\_\_\_\_ PHONE \_\_\_\_\_

NAME OF CHILD'S PHYSICIAN/MEDICAL CARE PROVIDER \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

SPECIAL DISABILITIES (IF ANY) \_\_\_\_\_

ALLERGIES (INCLUDING MEDICATION REACTION) \_\_\_\_\_

MEDICAL OR DIETARY INFORMATION NECESSARY IN AN EMERGENCY SITUATION \_\_\_\_\_

MEDICATION, SPECIAL CONDITIONS \_\_\_\_\_

ADDITIONAL INFORMATION ON SPECIAL NEEDS OF CHILD \_\_\_\_\_

HEALTH INSURANCE COVERAGE & POLICY NUMBER (REQUIRED) \_\_\_\_\_

**CIRCLE ONE FOR PARENTAL CONSENT:**

**PARENT SIGNATURE REQUIRED BELOW**

OBTAINING EMERGENCY MEDICAL CARE: YES / NO      PHOTO CONSENT: YES / NO

ADMIN. OF MINOR FIRST AID PROCEDURES: YES / NO      AGREE TO DISCIPLINE POLICY: YES / NO

WALKS AND FIELD TRIPS: YES / NO

TRANSPORTATION BY THE FACILITY : YES / NO

SWIMMING AND WADING: YES / NO

**PARTICIPATION IN SPECIAL EVENTS WILL BE DETERMINED BY BEHAVIOR AND ATTENDANCE.**

SIGNATURE OF PARENT OR GUARDIAN \_\_\_\_\_

**\*PLEASE NOTIFY FACILITY WHEN ANY CHANGES ARE MADE**

**ALL INFORMATION MUST BE COMPLETED FOR ELIGIBILITY**

