PACES

Phoenix After-School Care Enrichment Services

HEALTH AND EMERGENCY INFORMATION

CHILD'S NAME_____BIRTH DATE_____

ADDRESS_____

HOME PHONE_____

DOCTOR'S NAME_____PHONE_____

Does the child have any physical problems, mental health disorders, or developmental disabilities, which would limit the child's participation in the program and activities?
YES_____NO_____SPECIFY:_____
_____
_____

Does the child have any allergies? (food, medications, insects, etc.)
YES_____NO_____SPECIFY:_____
_____
_____

Are there any special procedures that are required in caring for the child?
YES_____NO_____SPECIFY:_____
_____
_____

IN CASE OF EMERGENCY, THE FOLLOWING CONTACTS WILL BE CALLED IN ORDER:

MOTHER'S NAME_____
HOME#_____CELL#_____OTHER_____

DAD'S NAME_____
HOME#_____CELL#_____OTHER_____

ADDITIONAL EMERGENCY CONTACT:_____
HOME#_____CELL#_____OTHER_____

I,_____give my permission for PACES to seek medical attention for my child,_____, in the event of emergency if I cannot be reached, and to hold harmless and release PACES from all liability. I further agree to keep PACES informed of any changes in telephone numbers, etc, where I can be reached. PACES will use Med Center High Point, 2630 Willard Dairy Rd. (884-3777) for any medical emergencies.

Parent's signature:_____Date:_____