

Student Information Form

*** (must be received by Kids Zone staff before or on the first day of the program) ***

Child's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home phone: _____ Date of birth: ____/____/____

Does your child have a sibling currently enrolled in a Kids Zone Program? YES/NO

What Track is your child on? _____

Name of School: _____

Parent/Guardian Information

Parent/Guardian's Name: _____ *contact first*

Parent/Guardian's home address (if different): _____

Parent/Guardian's cell: _____ Parent/Guardian's work phone: _____

Parent/Guardian's work name: _____

Parent/Guardian's work address: _____

Parent/Guardian's signature: _____

Parent/Guardian's Name: _____ *contact first*

Parent/Guardian's home address (if different): _____

Parent/Guardian's cell: _____ Parent/Guardian's work phone: _____

Parent/Guardian's work name: _____

Parent/Guardian's work address: _____

Parent/Guardian's signature: _____

Health History

Child's Name: _____

Home phone: _____ Date of birth: ____/____/____

Child's Physician: _____ Phone: _____

Child's Dentist: _____ Phone: _____

Mother/guardian's name

Occupation: _____ Work address: _____

Work phone _____ Cell phone: _____

Father/guardian's name

Occupation: _____ Work address: _____

Work phone _____ Cell phone _____

Does your child have any special medical conditions (diabetes, seizures, asthma, etc)?

Does your child have any allergies? (Please include both food and medication allergies).

I hereby authorize Kids Zone staff or emergency first responders to act for me according to their best judgment in any emergency requiring medical or dental attention.

Parent's signature

Date

Authorization to Pick Up

I grant permission for the following individuals to pick up my child from the Kids Zone Program.

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

Work phone: _____ *is this person an emergency contact? YES / NO*

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

Work phone: _____ *Is this person an emergency contact? YES / NO*

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

Work phone: _____ *Is this person an emergency contact? YES / NO*

NOTE: Only people listed on this sheet will be authorized to pick up your child. Additional sheets may be attached if necessary. Only authorized adults (listed on pick-up authorization form), over the age of 18 and with proper photo identification, will be allowed to pick up a program participant.

Parent's signature

Date

Emergency Contact

(Note: your emergency contact should live within 25 miles of the school your child attends class at. If your child requires an inhaler or special medication, and it is difficult for you to make yourself available, your emergency contact is the person you will leave these items with).

Emergency Contact #1

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

Work phone: _____

Emergency Contact #2

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

Work phone: _____

Emergency Contact #3

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

Work phone: _____

*Kids Zone staff will always try to contact a parent first. In the case that contact cannot be made staff will contact the emergency contact.

Acknowledgement of Receipt and Kids Zone Parent Agreement

I have read a copy of the JCSD Parks and Recreation Kids Zone Parent Handbook. By signing below, I attest that I have read these policies, procedures, suggestions, and other important information and agree to follow them.

Furthermore, I understand that it is my responsibility to explain the rules and policies to my child(ren) enrolled in the Kids Zone Program so that they are aware of their importance. I also understand that it is my responsibility to complete the JCSD Medical Treatment Form, if necessary for my child.

Participant Name – printed

Date

Parent Name – printed

Parent's Signature