# SAINT PAUL BEFORE-CARE & AFTER-CARE PROGRAMS

## EMERGENCY FORM

CHILD'S NAME: ______________________________________________________________

Address ______________________________________________________________

Phone ____________________________ Birth Date ___________________ Grade _________

Parent(s) Email address(es)______________________________________________

Father's/Guardian's name ________________________________ Cell phone ___________________________
Place of employment ____________________________________ Home phone __________________________
Business address ______________________________________Work phone __________________________

Mother's/Guardian's name _______________________________ Cell phone ____________________________
Place of employment ____________________________________ Home phone __________________________
Business address ______________________________________ Work phone __________________________

***Individuals listed below are authorized to pick up my child from the extended day program:***

| **Name/Relationship to Child**: | **Contact Numbers (during program hours):** |
|---|---|
| ______________________________________ | ______________________________________ |
| ______________________________________ | ______________________________________ |
| ______________________________________ | ______________________________________ |

Child lives with: Both parents ____ Mother____ Father____ Other___________________________

Child's Doctor ___________________________________________________ Phone _____________________________

Other children in family (names & ages) ________________________________________________

______________________________________________________________________________

Does your child have any of the following (yes or no) - if yes, explain below.

Speech problems _____ Heart problems _____ Allergies _____

Physical restrictions _____ Vision problems _____ Hearing problems ____

Allergy to medication _____ Special fears _____ Asthma _____

Has your child had: Mumps _____ Rubella _____ Measles_____ Chicken Pox_____

Frequent colds_____ Frequent earaches_____

______________________________________________________________________________

______________________________________________________________________________

Parent/Guardian signature ________________________________________________ Date ______________________

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## SAINT PAUL BEFORE-CARE & AFTER-CARE PROGRAMS

### AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FOR MINOR CHILD

I ________________________________ and ________________________________
(mother or legal guardian) (father or legal guardian)

of ________________________________________ Town of ________________________
(street address)

County of Hartford, State of Connecticut, and of ________________________________________

________________________________________________________________________
(other address if applicable)

are (am) the parent(s) and or legal guardian(s) of ________________________________
(child's name)

of ________________________________________________________________________
(street address)

Town of ________________________________, County of Hartford and State of Connecticut,

who attends the Saint Paul Before Care/After Care Program, 461 Alling Street, Kensington, CT 06037.

I (We) hereby give my (our) consent to the Director of said program or any authorized official of said school, in the event all reasonable attempts to contact me (us) at ____________ or ____________
(phone number) (phone number)

for the administration of any treatment deemed necessary by Dr. ________________ phone #:__________
(preferred physician)

or Dr. __________________ phone #:___________ or in the event the appropriate practitioner is
(preferred dentist)

is not available, by another licensed physician or dentist; and the transfer of the named child to

________________________________ or any other hospital reasonably accessible.
(preferred hospital)

**Parent/Guardian Signatures:** **Date:**

________________________________________ ________________________

________________________________________ ________________________