Donald W. Reynolds Boys and Girls Club-School Kids Connection

Childs Name_____ Age ____ Date of Birth _____

Address_____ Zip _____ Grade _____

School _____ Parents _____ Home Phone _____

Mother's Employer _____ Work #_____ Mobile # _____

Work Hours: _____

Father's Employer _____ Work #_____ Mobile # _____

Work Hours: _____

Medical Information *State Licensing requires this information*

Family Dr._____ Phone #_____ Address_____

SpecialNeeds/Medications/Allergies_____

Sign-Out Information

I authorize the below mentioned individuals the right to pick up my child from the School Kids Connection Program and so hereby remove all responsibility from SKC after the below mentioned individuals have signed out.

Name Address & Telephone # Relation to Child

1._____

2._____

3._____

Parent Signature _____ Date _____

Consent for Emergency Medical Care

I _____ (parent/guardian) of _____ (child) do hereby request and give consent to the Donald W. Reynolds Boys and Girls Club, SKC program director, or a duly appointed representative, for my child to receive medical or surgical aid as may be deemed necessary and expedient by a duly licensed physician or surgeon in case of an emergency when the parent/guardian cannot be reached.

_____ _____ _____

Parent/Guardian Signature Witness Date

I have received and read a SKC policy manual _____

Parent/Guardian Signature

Please feel free to supply additional information about your child _____