

**WATERTOWN COMMUNITY EDUCATION  
VACATION ADVENTURE  
REGISTRATION INFORMATION**

**CHILD'S NAME** \_\_\_\_\_

My child will attend:            TUES\_\_\_ WED\_\_\_ THURS\_\_\_ FRI\_\_\_

GRADE\_\_\_\_\_ SCHOOL \_\_\_\_\_ TEACHER \_\_\_\_\_

**BEST PHONE NUMBER TO USE TO REACH YOU:** \_\_\_\_\_

**PARENT NAME** \_\_\_\_\_ **CELL PHONE** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_ **HOME PHONE** \_\_\_\_\_

**EMPLOYER** \_\_\_\_\_ **PHONE** \_\_\_\_\_

**E-MAIL ADDRESS** \_\_\_\_\_

**PARENT NAME** \_\_\_\_\_ **CELL PHONE** \_\_\_\_\_

**EMPLOYER** \_\_\_\_\_ **PHONE** \_\_\_\_\_

INDIVIDUALS WITH PERMISSION TO PICK  
UP YOUR CHILD:

IS THERE ANYONE **NOT**  
**ALLOWED** TO PICK UP YOUR  
CHILD?

NAME \_\_\_\_\_

Emergency contacts other than Parent/Guardian (in order to be contacted) Use back if additional space is needed

Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_ Phone \_\_\_\_\_

**EMERGENCY MEDICAL AUTHORIZATION**

In the event of serious injury or illness involving my child while attending the Vacation Program, and I, or others listed, as the emergency contacts cannot be reached, I authorize the staff to take the above named child to the nearest hospital for treatment. I do hereby grant permission for said medical staff to administer appropriate treatment to ensure the health and well being of my child.

Child's Physician's Name \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

**Child's Allergies/Medical Concerns:**      **Medications: WCE WILL NOT ADMINISTER ANY MEDS**

**Does your child receive support services during the school day, if so, please specify:**

**Additional Information you want us to know about your child:**

Health Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

**I agree to inform the site coordinator of any changes in medical concerns or medications.**

**I give my permission for the release of medical and IEP information to WCE.**

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_