

**WATERTOWN COMMUNITY EDUCATION  
VACATION ADVENTURE  
REGISTRATION INFORMATION**

CHILD'S NAME \_\_\_\_\_ PROGRAM \_\_\_\_\_

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

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

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

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

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

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

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

**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:**

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

**Date of last DT immunization:**

**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 \_\_\_\_\_