



Creation Station at the WPC After-School Enrichment Program

CHILD INFORMATION FORM

PARENT/GUARDIAN INFORMATION

Name: _____ Relationship to Child(ren): _____
Address: _____ Town: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Best # to Reach: _____ Email Address: _____

Name: _____ Relationship to Child(ren): _____
Address: _____ Town: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Best # to Reach: _____ Email Address: _____

CHILD School: _____ Grade: _____ Teacher/Team: _____
Name: _____ DOB: _____ Age: _____ M/F: _____
Eye Color: _____ Hair Color: _____ Weight: _____ Height: _____
Identifying Marks: _____
Please list any medical needs, dietary restrictions, allergies, etc. _____
Does your child carry an EpiPen®? Yes _____ No _____
***PLEASE NOTE:** If your child carries an EpiPen® one must be supplied to the WPC site*
Child's Physician: _____ Phone: _____
Child's Dentist: _____ Phone: _____

Please attach a
current
photograph
of
your child.

PUBLICITY/PHOTO RELEASE: I understand that my child(ren) may be photographed or videotaped by Westford Recreation or newspaper/television staff, should they feature our program and that my child's image may appear on Westford Recreation's website and/or publications.

I do _____ I do NOT _____ give permission for my child(ren) to be photographed/videotaped.

EMERGENCY CONTACTS: IF PARENT(S)/GUARDIAN(S) CANNOT BE REACHED.

Name: _____ Relationship to Child(ren): _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Name: _____ Relationship to Child(ren): _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Name: _____ Relationship to Child(ren): _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Hospital Preferred: _____ **Health Insurance Carrier & Policy #:** _____

CONSENT: I authorize WPC staff to give my child(ren) first aid when appropriate. If my child(ren) require(s) further medical attention, 911 will be called and I will be notified immediately. I understand if I cannot be reached, one of the emergency contacts will be notified. If my child(ren) need(s) to be taken to the nearest medical care facility or to my preferred hospital listed above by ambulance, one qualified staff person will accompany my child(ren) to the hospital. I also give permission to the attending physician to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child(ren) as indicated. I will accept responsibility for any expenses incurred in handling this emergency care.

Parent/Guardian Signature: _____ **Date:** _____