Emergency Information Form

Name of Child: _____

Home Phone: _____

Mother's Name: _____ Mother's Cell: _____

Father's Name: _____ Father's Cell: _____

ASAP! Summer Camp is a nut free program.

In the event that we cannot be reached, ASAP! staff have my permission to contact either of the people listed below for the care and transportation of my child:

_____

Name Address Phone

_____

Name Address Phone

Physician:_____ Phone:_____

Known Sensitivities:_____

Asthma/Allergies (Please Circle):

Bee Sting Nuts Asthma Other

Medication:_____

Other Disorders (Please Circle):

Seizures Diabetes Other

Medication:_____

I hereby give permission to ASAP! (After School Arts Program, Inc.) staff to take my child to the physician or to a hospital if an accident or serious illness occurs during the program and I cannot be located.

Furthermore, if I cannot be reached, I hereby appoint the staff of ASAP! to act in my/our behalf to administer first aid treatment (please see the ASAP! Medication Policy).

Date:_____ Signature of Parent/Guardian:_____