

Quinton Township School District
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SACC REGISTRATION FORM

Child's Name Age Date of Birth Sex Grade

Parent(s) or Guardian(s) with whom the child resides:

Name Address Zip Home Phone

Work Phone Work hours and location Cell Phone

Name Address Zip Home Phone

Work Phone Work hours and location Cell Phone

E-mail address: _____

Person responsible for payment if different from above:

Name Address Zip Home Phone

Person(s) authorized to pick up your child(ren). Any changes in this list must be received from you in writing. Note: These will be used for emergency numbers, any additions please place on the reverse side.

Name Address Zip Home Phone

Name Address Zip Home Phone

Name Address Zip Home Phone

Child(ren)'s Physician:

Name Address Zip Phone

Does your child(ren) have any allergies/medical problems? _____

Special information – food/activities your child(ren) should avoid: _____

Would you like your child(ren) to do homework here? _____

In case of a medical emergency, the SACC program always tries to contact the parent. However, in the event the parent/emergency contact cannot be reached, and the emergency is such, that immediate hospital, or doctor treatment is necessary, we do need your signature on this form.

I give permission for my child _____ to be treated at a hospital or physician's office, in case of injury or illness.

Parent Signature Date