Quinton Township School District
8 Robinson Street, PO Box 365
Quinton, NJ 08072
Phone: 856-935-2379 * FAX: 856-935-1978

Gwen Herman
Principal
gherman@quintonschool.info

Stewart G. Potter Jr.
Superintendent
spotter@quintonschool.info

Karen Mathews
Business Administrator
kmathews@quintonschool.info

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?_______________

Anticipated start date: ____

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