Lopatcong Township School District After-Care Program

Emergency Form

PART I

The After-Care staff will take responsible measures to supervise your child's daily activities. However, emergencies may necessitate contact with you at work. Please provide us with the necessary information. If any changes occur please provide us with the changes.

Child's Name_____ Male____ Female____ Age____

Address_____ Phone_____

_____ Date of Birth _____

Grade_____ Teacher _____

Father or Guardian's Name_____

Business Phone #_____ Cell Phone #_____

Mother or Guardian's Name _____

Business Phone #_____ Cell Phone #_____

Email address: _____

Emergency Information:

LOCAL PERSONS OVER THE AGE OF 18 TO BE CONTACTED IN AN EMERGENCY IF PARENTS CANNOT BE REACHED.

Name_____Phone_____ Cell Phone_____

Name_____Phone_____ Cell Phone_____

Signature of Parent/Guardian _____ **Date**_____

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PART II

Child's Name _____

Please describe any medical information that might be useful to the staff in dealing with your children.

List any know allergies:

Food_____

_____

Drug_____

_____

Beverages_____

_____

Insects_____

_____

Outdoor Vegetation_____

_____

List all medications that your child uses on a regular basis: _____

_____

_____

List any other health/medical issues you would like us to be aware of: _____

_____

_____

Signature of Parent/Guardian _____ **Date**_____

NOTE: A Nurse is NOT available during After-Care hours. Medications will NOT be administered by the After-Care staff. However a child may self-medicate (inhaler/EpiPen only if a release form is signed by the child's doctor. Staff members may store the medications if requested and as necessary.

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PART III

Child's Name _____

Does your child have any physical conditions that may limit participation in activities?

_____No _____Yes Explain_____

_____

_____

Please describe your child's preferences with respect to activities (artistic, athletic, creative, board games, etc.) _____

_____

_____

_____

List any information (special needs) that may be pertinent in caring for your child:

_____

_____

_____

DOCTOR TO BE NOTIFYIED IN CASE OF EMERGENCY

Name_____ Phone # _____

Address_____

Insurance Company_____ Policy # _____

Hospital Preference _____

Signature of Parent/Guardian _____ **Date**_____