

TOWN OF PORTER RECREATION

CHILD'S Name _____ (in Sept.)
GRADE _____ AGE _____

Mother's Name _____ Work Phone _____ Cell Phone _____

Father's Name _____ Work Phone _____ Cell Phone _____

HOME ADDRESS _____ Home Phone _____

BIRTH DATE ____/____/____

Town of residence (circle one) PORTER LEWISTON WILSON CAMBRIA OTHER

School attending _____

Medical information

Child's Doctor _____ phone _____

List all current health problems _____

List all medications taken regularly _____

List all food and other allergies _____

Emergency contact - in case parent(s) are not available

1.)Name _____ address _____

phone _____ relationship to child _____

2.)Name _____ address _____

phone _____ relationship to child _____

In an emergency situation concerning my child _____ (i.e. accident or sudden medical problem), I authorize the Town of Porter Recreation staff/volunteers to be my agent in obtaining emergency medical care. The 911 emergency team and emergency department staff of Mt. St. Mary's Hospital will be utilized.

Date _____ Parent/Guardian Signature _____