RAP Emergency Information Form 2024-2025

| Personal Information | Please print and use blue or black ink. |   Please fill out all sections. |  |
| --- | --- | --- | --- |
| Child/ren’s Name (Last) |  ***(First)*** | ***School and Grade*** | ***Birthdate*** |
| 1. |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |
| *Parent/Guardian Information*  | ***(Last)*** | ***(First)*** | ***Address*** | ***Phone #*** |
| Mother/Guardian Name |  |  |  |
| Work Address and Phone # |  |  |  |  |
| Father/Guardian Name |  |  |  |
| Work Address and Phone # |  |  |  |
| *Mother/Guardian email* | ***Father/Guardian email*** |

The following people have permission to pick up my child. The child will not be allowed to leave with anyone, not on this list.

|  |
| --- |
|  *Name (Last) (First) (Address) (Phone #)* |
| 1. |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |
| 4. |  |  |  |  |
| *Child’s Medical Information* |
| *Doctor’s name* |  |
| *Address* |  |
| *City* |  | ***Phone #*** |
| IN CASE OF EMERGENCY FOR MEDICAL TREATMENT: My child will be transported to  |
| Hospital |  |
| Medical Insurance |  |
| Insurance # |  |
| Additional Information: IEP’s, Behavioral Plans, etc.  |  |
| Allergies, Medical Limitations or Medications,  |  |
|  |
|  |
| In case of accident or emergency, I authorize a Ripon After-School Program staff member to take my child to the above-named physician or to the nearest hospital for any emergency treatment and action deemed necessary for the safety of the child, at my expense. Permission for Medical Treatment procedures varies among medical personnel and facilities with regards to provision for the child in the absence of the parent. A parent should have verified the procedure in advance.  |
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| Parent’s Signature Date |