MANNINGTON TOWNSHIP SCHOOL AGE CHILD CARE
MANNINGTON TOWNSHIP SCHOOL
495 ROUTE 45
MANNINGTON, NEW JERSEY 08079

REGISTRATION FORM

Child's Name Age Date of Birth Sex Grade

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____

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