

# ST. ROBERT BELLARMINE SCHOOL/SUMMER CAMP PROGRAM EMERGENCY CONTACT & EMERGENCY INFORMATION

Please print information (2 or more children use separate form)

Child's First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Birth date \_\_\_\_\_ age \_\_\_\_\_ Child Wear Glasses? Yes \_\_\_\_\_ No \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Parent's Cell Phone No. \_\_\_\_\_ Parent's Alternate Phone No. \_\_\_\_\_

## Emergency Contact:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Area Code \_\_\_\_\_ Cell/work No. \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Area Code \_\_\_\_\_ Cell/work No. \_\_\_\_\_

## Authorized Pickup:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Area Code \_\_\_\_\_ Phone No. \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Area Code \_\_\_\_\_ Phone No. \_\_\_\_\_

Medical Alert: Asthma/Allergies: Yes \_\_\_\_\_ No \_\_\_\_\_ Health Issues: Yes \_\_\_\_\_ No \_\_\_\_\_ Medication: Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes to any of the above  
specify: \_\_\_\_\_

Medical Group \_\_\_\_\_ Doctor's Name \_\_\_\_\_ Area Code \_\_\_\_\_ Phone No. \_\_\_\_\_

**"You must attach a copy of child's medical insurance card to this form"**

## \*WAIVER: MUST BE READ & SIGNED OR FORM WILL BE REJECTED!

In consideration of the foregoing, I my heirs, executors and administrators, waive and release any and all rights and claims for damages, demand, actions whatsoever in any manner as a result of my participation in the above program, including, but limited to any risks in participating in field trips & an any athletic event of any type. Should the need arise, I grant permission to Medical officials to authorize emergency treatment and to have full access to my child \_\_\_\_\_  
Medical records if need be. Further, I understand that my registration and weekly payment are nonrefundable.

Parent /Guardian Name (please Print) \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_