

THE WAKEFIELD RECREATION DEPT.

SUMMER FUN PROGRAM

THIS FORM MUST BE COMPLETED FOR EACH CHILD PRIOR TO PROGRAM START

INFORMATION SHEET

Child's Name: _____

Attending Week of: _____

Days Attending: Mon Tue Wed Thur Fri

(Please circle)

Days Attending AM Care: Mon Tue Wed Thur Fri

(Please circle)

Days Attending PM Care: Mon Tue Wed Thur Fri

(Please circle)

Parent/Guardian Name(s) _____

Phone Number: _____

Emergency Contact/Phone: _____

Name of Child's Doctor/Health Clinic: _____

Doctor/Health Clinic Phone No.: _____

Person(s) to be called should a parent/guardian not be reached:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Important information about your child (allergies, physical limitations, etc): _____

(if your child requires an epi-pen or inhaler, he/she is required to bring it to the program)

Friend Request (Not Guaranteed): _____

MY CHILD WILL BE PICKED UP BY: _____
