

NEW LENOX COMMUNITY PARK DISTRICT
Spencer Campus ACES Before & After School Program
Participant Information Form

Child's Last Name: _____ First Name: _____

Birth Date: _____ Grade: _____

Address: _____ City: _____

Home Phone Number: _____

Mothers Name: _____ Work Phone Number: _____

Cell Phone Number: _____

Fathers Name: _____ Work Phone Number: _____

Cell Phone Number: _____

Name/Phone Number of a **LOCAL** (In Town) neighbor/relative to call in an emergency when a parent cannot be reached _____.

I understand that in the event of an emergency, every effort will be made by the **New Lenox Community Park District** to reach a parent first, however, if the day care provider determines that 911 must be called, it is the policy of the New Lenox Fire Department to transport to Silver Cross Hospital. List any allergies/health problems your child may have; or home/custody situations (i.e. stepparent, single parent, etc.) that day care provider should be aware of.

FOR MEDICAL PURPOSES:

Doctors Name: _____

Address/Phone Number: _____

IN CASE OF INJURY;

Medical Group Name: _____

Group and Identification Number: _____

Parent Signature: _____ Date: _____

****SPENCER CAMPUS ACES****

Your child will not be released to anyone who is not on this list, without prior **written** confirmation from you.

1. _____

Name Relationship

2. _____

Name Relationship

Date: _____

Child's weight _____ lbs.