



### Health and Emergency Contact Form

This form must be completed for each child and received by the Prairie State College (PSC) Matteson Area Center. You may email the packet back to [psceducation@prairiestate.edu](mailto:psceducation@prairiestate.edu). Visit [prairiestate.edu/kids](http://prairiestate.edu/kids) to print additional forms.

#### Contact Information

Child's Full Name: \_\_\_\_\_

Child's Date of Birth: \_\_\_\_\_ Grade in fall: \_\_\_\_\_ Gender:  M  F

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_

My child is registered for the following weeks:

- June 17  June 24  July 1  July 8  July 15  July 22  All six weeks

**Mother/Guardian Name:** \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_

**Father/Guardian Name:** \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_

**In an emergency contact: Parent(s) as listed above first, then contact individual(s) below:**

**Name:** \_\_\_\_\_ **Relation to Child:** \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**Name:** \_\_\_\_\_ **Relation to Child:** \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**Name(s) of Additional Authorized Adult(s) picking up the student: that are not listed above.**

Name	Relationship	Phone

**Immunization/Health Information**

1) Participant's Physician's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Child's Full Name: \_\_\_\_\_

**Immunization/Health Information (continued)**

2) Please tell us about any allergies; mark all that apply:

- |   |  |
|---|--|
| <input type="checkbox"/> None that I know about   | <b>Is this a life threatening allergy?</b>               |
| <input type="checkbox"/> Bee sting  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Peanuts/other nuts   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Other: _____   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> My child carries an EpiPen (please make sure they are labeled)   |  |
| <input type="checkbox"/> My child carries and inhaler (please make sure they are labeled) |  |

3) Please list any medications, dietary restrictions or special needs your child may have so we can ensure a safe environment. Any medication the child may need will have to be authorized by a doctor's note and all medication will have to have the name printed on the container.

None

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4) Is there anything else we should be aware of to ensure your child's success in the program?

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I have read and understand the above procedures. I certify the above information to be true and correct to the best of my knowledge and I take responsibility form child's compliance with the appropriate student behavior. I understand that disruptive and inappropriate behavior may result in dismissal.

Please printout and sign before scanning or mailing.

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

