



**Health and Emergency Contact Form**

This form must be completed for each child and received by WDCE staff. You may FAX the completed form to (708) 709-7883 or email to wdce@prairiestate.edu. Visit prairiestate.edu/kids to print additional forms.

**Contact Information**

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

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

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

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

My child is registered for the following sessions:

- Session I (6/20 - 6/24)     Session II (7/18 - 7/22)

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

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

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

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

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

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

**Name(s) of Additional Authorized Adult(s) picking up the student:**  Same as above plus:

Name	Relationship	Phone

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

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

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

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

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

**Immunization/Health Information**

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