

COLCHESTER YOUTH SERVICES REGISTRATION

127 NORWICH AVENUE, COLCHESTER CT 06415 (860)537-7255

Today's Date

Name: _____ Grade: _____ Age: _____

Date of Birth: _____ Parent's Name: _____

Program:

Address: _____

Home Phone: _____ Work Phone: _____

Cell phone or other number where parents can be reached: _____

My child has: *(if no medical issues, please write NONE)*

The following behavioral/social/psychological issues: *(such as ADHD, depression, bi-polar, autism, etc.)* _____

And takes the following medications for those conditions: _____

The following medical needs or concerns: *(such as asthma, epilepsy, diabetes, etc.)* _____

And takes the following medications for those conditions: _____

Allergies (please include foods, RX, bees, etc): _____

And takes the following medications: _____

IN CASE OF EMERGENCY:

We make every effort to provide a safe and secure environment for your child during all events. Should there be an emergency, we will contact the parent listed on this form. Parents should also provide another contact (not living at the same address) who is authorized by the parent to act on his/her behalf should the parent not be available.

I understand that in the event that medical treatment is required, every effort will be made to contact me. However, if I cannot be reached, I give permission to the staff to secure the services of a licensed physician to provide the necessary care for my child's well being. I also give permission to the physician selected to hospitalize or secure other medical treatment, as needed. Additionally, I give permission to the Town of Colchester employees/designees to render First Aid, should the need arise.

If I cannot be reached, please contact (name) _____ (phone) _____

In addition, I permit the taking of photographs of my child during activities for publication and use by the Colchester Youth Services Bureau for promotional purposes unless otherwise stated.

Signed: _____ Date: _____
(Parent or Guardian)