

**CAYUGA HEIGHTS  
SCHOOL AGE PROGRAM  
607-257-0368  
OCCASIONAL CARE FORM**

*\* Note: Occasional Care will not be billed - the money is due the day your child attends. Please send in a check with your child or bring it in prior to the day you need care.*

**CHILD'S NAME** \_\_\_\_\_ **Sex** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_ **Grade** \_\_\_\_\_

**Parent/Guardian**                      **Home Address**                      **Home Phone**

1. \_\_\_\_\_

2. \_\_\_\_\_

**Parent/Guardian**                      **Work Address**                      **Work Phone**                      **Cellular/Pager**

1. \_\_\_\_\_

2. \_\_\_\_\_

***Emergency Contact Persons\* (other than parent)***

**\*DO NOT LEAVE BLANK**

1. \_\_\_\_\_ **Phone** \_\_\_\_\_

2. \_\_\_\_\_ **Phone** \_\_\_\_\_

\*\*\*\*\*

**Doctor:** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Dentist:** \_\_\_\_\_ **Phone** \_\_\_\_\_

\*\*\*\*\*

**CHILDCARE NEEDS**      **Circle the days & write the dates you desire care.**

**AFTER SCHOOL CARE:** M TU W TH F \_\_\_\_\_

**RATES:**

After School Care    \$12.00

Full Day Care        \$30.00

## Cayuga Heights School Age Program Medical Information

I understand that parents will be contacted immediately in case of sickness or accident. I authorize the Cayuga Heights School Age Program to seek medical attention as necessary. I further understand that I am financially responsible and that my insurance company will be billed first.

I give permission for the attending physician to give emergency treatment including anesthesia, injections and X-rays as necessary on arrival, only if my child's own physician is unavailable at that time to oversee medical treatment of my child.

I verify that my Physician has examined my child and determined that he/she is physically fit and all immunizations are up to date.

Please list any allergies or medical conditions for your child \_\_\_\_\_

\_\_\_\_\_

Physician

phone number

\_\_\_\_\_

\_\_\_\_\_

Dentist

phone number

\_\_\_\_\_

\_\_\_\_\_

If your child needs to have medication at camp please let Bruno or Lindy know in order to get the proper paperwork.

### PERMISSION STATEMENT

I give permission for \_\_\_\_\_ to attend and participate in the following activities:  
(child's name)

-Walking field trips----- Yes / No

-Bus field trips----- Yes /No

-My child has permission to have their picture taken at camp----- Yes/No

- I give CHSAP permission to use photo's of my child.-----Yes/No

**Parent/Guardian**

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_