

PATCHOGUE-MEDFORD YOUTH & COMMUNITY SERVICES, INC.

WRAP (Winning Rewards through After-School Program)

I, _____, parent/guardian of
Parent/Guardian Name (Print)

_____ hereby give permission
Child's Name (Print)

for my son/daughter to participate in any activities associated with WRAP.

I have reviewed the attached list of possible activities and understand these are subject to change.

My child is in good physical health and is able to engage in full participation. I release WRAP and Patchogue-Medford School of any responsibility for any injury, which may result from such participation.

Parent/Guardian Signature: _____

Date: _____

PATCHOGUE-MEDFORD YOUTH & COMMUNITY SERVICES, INC.

83 East Main Street, Patchogue, NY 11772

Phone: (631) 758-4100

2003 WRAP (Winning Rewards through After-School Program) Application

(PLEASE PRINT CLEARLY)

CHILD'S FIRST NAME, LAST NAME AGE GRADE SCHOOL NAME

1. _____
2. _____
3. _____
4. _____

MOTHER / GUARDIAN'S FIRST & LAST NAME _____

ADDRESS _____ **APT #** _____ **TOWN** _____

HOME PHONE _____ **CELL PHONE** _____

EMPLOYER _____ **EMPLOYER'S PHONE** _____

FATHER / GUARDIAN'S FIRST & LAST NAME _____

ADDRESS _____ **APT #** _____ **TOWN** _____

HOME PHONE _____ **CELL PHONE** _____

EMPLOYER _____ **EMPLOYER'S PHONE** _____

The following person must be available to pick-up the child in case the parent/guardian is unable to be reached:

EMERGENCY CONTACT:

Name _____ **Relationship to Child** _____

Street Address _____ **Town** _____ **Phone** _____

OTHER AUTHORIZED PICK-UP

Other than the "Emergency Contact" person listed, list TWO other individuals authorized by you to pick-up your child(ren)

1. Name _____ Relationship to Child _____
Street Address _____ Town _____ Phone _____
2. Name _____ Relationship to Child _____
Street Address _____ Town _____ Phone _____

HEALTH /EMERGENCY INFORMATION

1. Physician to call in an emergency _____ Phone _____

Health History (Please check each item that applies)

- | | |
|--------------------------|------------------------------------|
| _____ Excessive Bleeding | _____ Mononucleosis / Epstein Barr |
| _____ Hypertension | _____ Ear Infections |
| _____ Diabetes | _____ Heart Defect/Disease |

Allergies

- | | |
|-----------------------------|--------------------|
| _____ Asthma | _____ Insect Bites |
| _____ Hay Fever | _____ Penicillin |
| _____ Poison Ivy | _____ Other Drugs |
| _____ Other (Specify) _____ | |

2. Food allergies/Special Diet: _____

3. Is child routinely taking medication? _____ If Yes, please specify _____

4. Is there anything else we need to know about your child? _____

My child is in good health and I hereby give permission for my child to participate in the Patchogue-Medford Youth and Community Services WRAP after school program. In signing this application, I hereby certify that the above information is correct. In case of medical emergency, I understand that every effort will be made to contact parent or guardian. In the event that I cannot be reached, I hereby give permission for the WRAP Staff to give consent for necessary medical treatment and hospitalization for my child, _____

(Print Child's Name)

I do _____ / do not _____ give permission for Patchogue-Medford Youth and Community Services to use my child's photograph for press releases, news stories, agency newsletters, agency website and/or any other publicity materials:

Parent / Guardian Signature _____ Date _____