

HEALTHIER TOMORROWS PEDIATRIC WEIGHT MANAGEMENT PROGRAM

Emergency Contact Form

Please Print

Child's Full Name: _____ Birth Date: _____ Age: _____ Gender: _____

Address: _____ Town: _____ Zip: _____

Phone: _____ Cell: _____ Grade completed in June: _____

Mother's Name: _____ Phone (H): _____ (W): _____ email: _____

Father's Name: _____ Phone (H): _____ (W): _____ email: _____

EMERGENCY/AUTHORIZED TO PICK UP (other than parent)

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Parents and/or authorized persons picking up child must present photo ID at drop off and pick up. _____ Initial

Parent and/or authorized persons must sign-in and sign-out child at registration desk. _____ Initial

Parents must provide legal documentation of unauthorized persons picking up child. _____ Initial

Permission:

I, _____, give permission for my child, _____, to participate in all program activities. I understand that I must have a complete medical form and required blood work signed by a physician on file at the Dolan Family Health Center before the first day my child begins the program. I have read and will adhere to the policies outlined above.

Parent's Signature: _____ Date: _____