

ALLOWAY SCHOOL AGE CHILD CARE
ALLOWAY TOWNSHIP SCHOOL
43 CEDAR STREET
PO BOX 327
ALLOWAY, NEW JERSEY 08001

**REGISTRATION/
EMERGENCY INFORMATION
2023-2024**

Student's Name	Age	Date of Birth	Sex	Grade
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Parent(s) or Guardian(s) w/whom the student resides:

Name	Address	Zip	Home Phone
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Work Phone	Work hours/location	Cell Phone
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Name	Address	Zip	Home Phone
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Work Phone	Work hours/location	Cell Phone
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E-mail address: _____

Person(s) authorized to pick up your student. Any changes in this list must be received from you in writing.

Note: These will be used for emergency numbers; any additions please place on the reverse side.

Name	Address	Zip	Phone
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Name	Address	Zip	Phone
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Name	Address	Zip	Phone
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Student's Physician:

Name	Address	Zip	Phone
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Does your student have any allergies/medical problems? _____

Special information – food/activities your student should avoid: _____

Would you like your student to do homework here? _____

In case of a medical emergency, the SACC program always tries to contact the parent. However, in the event the parent/emergency contact cannot be reached, and the emergency is such, that immediate hospital, or doctor treatment is necessary, we do need your signature on this form.

I give permission for my child _____ to be treated at a hospital or physician's office, in case of injury or illness.

Parent Signature	Date
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Hospital Preference _____