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

REGISTRATION/
EMERGENCY INFORMATION
2025-2026

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

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

Name	Address	Zip	Home Phone
Work Phone	Work hours/location		Cell Phone
Name	Address	Zip	Home Phone
Work Phone	Work hours/location		Cell Phone

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
Name	Address	Zip	Phone
Name	Address	Zip	Phone

Student's Physician:

_____

Name Address Zip Phone

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

Hospital Preference _____