Last Name _____

Pitman Panther Club
Pitman School District
420 Hudson Avenue
Pitman, NJ 08071
(856) 589-2145

2018-2019 School Year Emergency Contact Form

Child's Name: _____ Grade: ____ Teacher: _____ School: _____ Birth Date: _____

Child's Address: _____

Primary Email Address: _____

Sibling (include ages) of Above Named Student:

1. _____ 2. _____

3. _____ 4. _____

Mother's Name: _____ Father's Name: _____

Mother's Address: _____ Father's Address: _____

_____ _____

Mother's Home Phone: _____ Father's Home Phone: _____

Mother's Cell Phone: _____ Father's Work Phone: _____

Mother's Work Phone: _____ Father's Cell Phone: _____

Mother's Email: _____ Father's Email: _____

Emergency Contact Name (*Not Parent*): _____ Relationship: _____

Emergency Contact Phone: _____ Cell: _____ Work: _____

The following adults are given permission to pick up my child/children from Panther Club Program:

1. Name: _____ Address: _____ Phone: _____
2. Name: _____ Address: _____ Phone: _____
3. Name: _____ Address: _____ Phone: _____

Please List any person(s) NOT permitted to pick-up your child/children:

1. Name: _____ Relationship: _____
2. Name: _____ Relationship: _____

____ Check here if: **I DO NOT** grant my permission for photographs or videos of my child, or any of his/her work to be submitted to newspapers or TV stations for publication or posted on the Pitman School District website.

OVER→

MEDICAL INFORMATION

***Any medical conditions must be disclosed at the time of registration. We may not be able to accept your child due to state regulations; only a registered nurse can administer medications. Panther Club does not employ a nurse outside of normal school hours.**

CHECK IF THE STUDENT HAS ANY OF THE FOLLOWING CONDITIONS:

____ Heart Condition: Restrictions ____ yes ____ no ____ Seizure Disorder

____ Asthma: On medication ____ yes ____ no ____ Diabetes

____ Adverse Drug Reaction ____ Severe Allergies (including food or bee stings)

____ Hearing Problems: ____ Ear tubes ____ aids ____ Braces

____ ADHD: On Medication ____ yes ____ no ____ Vision problems: Glasses ____ Contacts ____

____ Other: _____ ____ Fractures ____ year

Please explain any of the above questions if they are checked:

_____

_____

My child is on the following medication: _____

Recent surgery, illnesses, or injuries and date(s): _____

_____

Family Physician: _____

Family Dentist: _____

Does your child have health insurance? Yes ____ No ____

If yes, name of insurance company: _____

In case of an **EMERGENCY** and your child has to be taken to the nearest hospital, your preference is: _____. I give my son/daughter permission to receive emergency hospital treatment, if necessary.

I hereby give permission to release information regarding my child's health condition(s) to essential school personnel and those authorized on the emergency card who assume temporary care of my child in order to best meet the medical and health needs of my child in the school setting.

_____ _____

Signature of Parent/Guardian Date