Washougal School District / Community Education Student Information Form

Office Use Only: **SPACE** School _____ Start Date _____ Mon: AM_____ PM_____ Tues: AM_____ PM_____ Wed: AM_____ PM_____ Thurs: AM_____ PM_____ Fri: AM_____ PM_____	Office Use Only: **SPACE** Comments:

Child's Name _____School_____ Grade _____ Date of Birth_____

Mother Info: Name _____Phone #1 _____#2 _____

Address: _____ Email: _____

Father Info: Name _____ Phone #1 _____#2_____

Address: _____ Email:_____

Name(s) of other persons authorized to pick up your child:

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone _____

Does your child have any allergies to food, etc? _____

_____

Does your child have any physical limitations?_____

If your child needs prescribed medication, arrangements must be made with the Program Coordinator at 360-954-3895.

MEDICAL RELEASE: I give permission for staff to seek emergency medical treatment for my child.

Name of Child's Physician _____ Phone Number _____

Address _____

Emergency Contact Person (if you cannot be reached)_____

Phone #1 _____ Phone #2 _____

Adddress_____

Please state any other information you feel will help us work with your child_____

_____

I understand that the Washougal Community Education Program does not provide insurance to its participants. I certify that my child is physically and mentally able to participate in this program. I, intending to be legally bound, waive and release all rights and claims for damages that I may accrue against any and all sponsors of this program.

Signature_____ **Date**_____