WONEWOC-CENTER
2025 SUMMER SCHOOL

Please fill out this form and return it with the registration form.

EMERGENCY INFORMATION

Student's Name:_____ Date of Birth: _____

Address: _____

Phone:_____

List TWO persons to contact in case of emergency (please print):

Parent/guardian's name:_____ Home Phone:_____

Address:_____ Work Phone:_____

Second person's name:_____ Home Phone:_____

Address:_____ Work Phone:_____

Relationship to student:_____

Medical Information:

Physician's Name:_____ Phone:_____

Are you Allergic to any drugs?_____ If so, what? _____

Do you have any other allergies? (i.e., bee sting, dust)_____

Do you suffer from _____asthma, _____ diabetes, or _____ epilepsy? (check any that apply)

Are you on any medication?_____ If so, what? _____

Do you wear contacts? _____

In case I cannot be reached I authorize the teacher/coach(es) of summer school to call the physician named above. In case of extreme emergency the teacher/coach(es) will transport your child to the nearest medical facility for immediate attention. Please list any other instructions: (if needed, write on back)

Signature:_____ Date: _____