

OXFORD PUBLIC SCHOOLS

AFTER SCHOOL DAYCARE

CLARA BARTON / CHAFFEE / MIDDLE SCHOOL

Child's Name: _____ Grade: _____ Room#: _____

Date of Birth: _____ Telephone#: _____

Street Address: _____

Father's Name: _____ Telephone#: _____

Father's Place of Employment: _____ Telephone#: _____

Mother's Name: _____ Telephone#: _____

Mother's Place of Employment: _____ Telephone#: _____

Child's Health Insurance: _____ Insurance #: _____

Child's Physician: _____ Telephone#: _____

Responsible Person(s) to call when parent cannot be reached:

Name: _____ Telephone#: _____

Name: _____ Telephone#: _____

Please indicate if your child has had any physical conditions or injuries that we should be aware of:

In case of emergency, which hospital would you prefer your child to be transported to: _____

I authorize my child to be released to the following person (s): (APPROPRIATE IDENTIFICATION WILL BE REQUIRED)

Name: _____ Name: _____

Name: _____ Name: _____

Name: _____ Name: _____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____