

Duniway After School Care Program, Inc.
7700 SE Reed College Place, Room 5
Portland, OR 97202
(503)774-9963
www.duniwayasc.com

INFORMATION AND AUTHORIZATION FORM

CHILD'S Name _____ **Birthdate** _____ **Sex** _____
Nickname _____ **Child's Age at Entry** _____ **Today's Date** _____

PARENT/Guardian Name _____ **Phone Number #1** _____
Home Address _____ **City** _____ **Zip** _____
Place of Employment _____ **Occupation** _____
Relationship to Child _____ **Phone #2** _____ **Phone #3** _____
Email Address _____ **Additional Contact Info** _____

PARENT/Guardian Name _____ **Phone Number #1** _____
Home Address _____ **City** _____ **Zip** _____
Place of Employment _____ **Occupation** _____
Relationship to Child _____ **Phone #2** _____ **Phone #3** _____
Email Address _____ **Additional Contact Info** _____

SIBLINGS of Child

Name _____ **Birthdate** _____ **Sex** _____
Name _____ **Birthdate** _____ **Sex** _____

OTHERS Living in the Home

Name _____ **Relationship to Child** _____
Name _____ **Relationship to Child** _____

EMERGENCY Contact Person: (If we are unable to reach parents, this person must be in the Portland area, and must have permission to pick up the child without additional authorization)

Name _____ **Relationship to Child** _____
Phone Number #1 _____ **Phone Number #2** _____

ADDITIONAL ADULTS Authorized to pick child up without prior authorization:

Name _____ **Phone** _____ **Relationship to Child** _____
Name _____ **Phone** _____ **Relationship to Child** _____
Name _____ **Phone** _____ **Relationship to Child** _____

PLEASE FILL OUT AND REVIEW BOTH SIDES

EMERGENCY INFORMATION

CHILD'S NAME _____ BIRTHDATE _____

List all known or suspected food allergies _____

List all known or suspected allergies related to medications _____

Date of last tetanus shot _____ Has your child had chicken pox? _____

Does your child take any medications on a regular basis? (Please list medications and describe condition.)

Are there health considerations or treatment restrictions that should be noted here? _____

Are there injuries, medical conditions, or problems that warrant restricting the child's activity? _____

If yes, please explain _____

Child's Physician _____ Phone _____

Child's Dentist _____ Phone _____

Hospital Preference (if any) _____

Insurance Co. _____ Policy ID/Group Number _____

Subscriber's Name _____

Yes No In an emergency DAS has my permission to call an ambulance or a taxi and take my child to any available physician or hospital at my expense.

Yes No In an emergency, DAS has my permission to obtain medical treatment for my child.

Yes No DAS has my permission to give medication under Parent or Physician direction.

Yes No My child may be taken on field trips and walks under proper supervision.

Yes No My child may have his/her photograph taken for news or publicity purposes.

EMERGENCY MEDICAL TREATMENT AUTHORIZATION

As parent/guardian of _____, (Birthdate _____), I hereby authorize Duniway Afterschool Care, Inc. located at 7700 SE Reed College Place, Portland, Oregon, 97202 (Phone number 503.774.9963) consent to emergency medical or urgent medical or surgical treatment of above named child when a parent or legal guardian cannot be reasonably located when the child is brought in for treatment. This authorization will be effective as of _____ and will expire in one year.

Special Notes or Comments: _____

Parent/Guardian Signature Date