REGISTRATION

Fall Session of Story Port 2018

CHILD'S NAME _____

PARENT(S)/GUARDIAN(S) _____

ADDRESS, CITY _____

PHONE NUMBER _____
HM/WK/CELL (circle one)

PRESENT AGE _____ GRADE _____SCHOOL ATTENDING _____

ATTENDANCE RECORD:

9/10	9/17	9/24	10/1	10/8	10/15	10/22	10/29	11/12	11/19	11/26	12/3	12/10

LIST ANY **ALLERGIES OR MEDICAL CONDITIONS** THAT YOUR CHILD HAS:

_____

DOES YOUR CHILD NEED MEDICATION WITH THEM FOR THIS CONDITION? _____

IF SO, WHAT IS THE NAME AND DOSAGE OF THE MEDICATION(S)?

_____

IS YOUR CHILD ALLOWED TO LEAVE WITH ANYONE OTHER THAN YOU? **YES NO (Circle one)**

IF YES, PLEASE PROVIDE THE NAME(S) OF THE PERSON(S)

_____

PLEASE READ AND UNDERSTAND THE FOLLOWING CONSENT STATEMENT:

- **THE PORT LIBRARY, ITS EMPLOYEES AND VOLUNTEERS ARE NOT TO BE HELD RESPONSIBLE FOR ACCIDENTS OR INCIDENTS WHICH MAY OCCUR TO THE PARTICIPANTS DURING LIBRARY PROGRAM EVENTS.**
- **I GIVE PERMISSION FOR THE USE OF PHOTOGRAPHS OR VIDEO WHICH MAY BE TAKEN DURING STORY PORT.**
- **I UNDERSTAND TREATS MAY OCCASIONALLY BE PROVIDED AND MY CHILD MAY PARTAKE OF THESE UNLESS I OTHERWISE ADVISE IN WRITING.**

X_____ _____.
EMERGENCY CONTACT NAME: **TELEPHONE**

X_____ _____
PARENT'S SIGNATURE **DATE**