Franklin Special School District MAC Program
Registration 2014-2015

REGISTRATION FEE ATTACHED
DATE PAYMENT RECEIVED: **RECEIVED BY:**

CHILDREN TO BE ENROLLED:

LAST NAME, FIRST NAME	SCHOOL CHILD ATTENDS	GRADE	DATE OF BIRTH

1.____

2. ____

3. ____

4. ____

Have children been enrolled in MAC previously? If so, where? ____

Ethnicity (choose one) _____ Hispanic _______ Not Hispanic, Latino or Spanish origin

Race(Choose all that apply) _____American Indian/Alaskan Native ______Asian ______White

______Pacific Islander/Native Hawaiian _______Black/African American

PARENT INFORMATION:

NAME OF MOTHER:___________________________**HOME:** ___________**CELL PHONE:**__________________

ADDRESS:____ **ZIP CODE:**_____________

EMPLOYER: ____**WORK PHONE:**________________

EMPLOYER ADDRESS: ____ **ZIP CODE:**_____________

MOTHER'S EMAIL ADDRESS:____

NAME OF FATHER:_____________________________**HOME:**_____________**CELL PHONE:**_______________

ADDRESS:____ **ZIP CODE:**____________

EMPLOYER: ____**WORK PHONE:**_______________

EMPLOYER ADDRESS: ____ **ZIP CODE:**_____________

FATHER'S EMAIL ADDRESS:____

FOR CHILD'S SAFETY, LIST ALL PERSONS TO WHOM CHILD MAY BE RELEASED:

(DO NOT LEAVE BLANK)

NAME	PHONE#	NAME	PHONE#

LIST ALL PERSONS TO WHOM CHILD <u>MAY NOT</u> BE RELEASED:
(Parent must provide legal documentation to support this request if person listed is a parent of the child.)

_______________________________ _______________________________

_______________________________ _______________________________

EMERGENCY INFORMATION

Name of person, other than parent, authorized to act for the parent in an emergency: DO NOT LEAVE BLANK

NAME: ______________________ **HOME:** __________ **CELL PHONE:** _________

ADDRESS: _______________________________ **ZIP CODE:** ___________

EMPLOYER: _______________________________ **WORK PHONE:** ____________

EMPLOYER ADDRESS: _______________________________ **ZIP CODE:** __________

NAME OF CHILD'S PHYSICIAN: ______________________ **PHONE NUMBER:** __________

PHYSICIAN'S ADDRESS: _______________________________ **ZIP CODE:** ___________

Child's Health is: Excellent: ___________ **Good:** ___________ **Fair:** ___________ **Poor:** __________

Please describe any medical conditions including allergies

____

____

____

MEDICATION

Please list all prescription medication that your child takes on a daily basis. We would like to be aware of any medicines your child takes to provide this information to medical personnel in case of an emergency. Please refer to the Parent Manual for details on dispensing of medication while in MAC.

NAME OF MEDICATION	DAILY DOSAGE	REASON PRESCRIBED

In the event of an emergency, I hereby give permission to MAC staff to secure proper medical treatment for my child if I cannot be reached, I hereby give permission for emergency personnel selected by MAC staff to order x-rays, routine tests and treatment for the health of my child. I also give permission to emergency personnel selected by MAC staff to hospitalize, secure proper treatment for, and to order injection and/or surgery of my child.

_______________________________ _______________

Signature of Parent/Legal Guardian **Date**