

Medical Information:

Physician or Pediatrician _____ Telephone#: _____

Address: _____ City / State / Zip: _____

- Is your child taking any medication? Yes No If yes, explain _____
- Does your child have any allergies? Yes No If yes, explain _____
- Does your child have any physical disabilities? : Yes No If yes, explain _____
- Does child wear glasses or contacts? Yes No If yes, Specify _____
- Are there any restricted activities? Yes No If yes, Specify _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Person # 1

Name: _____ Relationship _____

Address: _____ City / State / Zip: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact Person # 2

Name: _____ Relationship _____

Address: _____ City / State / Zip: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact Person # 3

Name: _____ Relationship _____

Address: _____ City / State / Zip: _____

Home Phone: _____ Cell Phone: _____

Waiver

I give permission to Nida-UI-Islam to obtain any medical care necessary for the welfare of my child/children through a qualified person, physician or hospital in case of any injury or sickness during school hours. I give permission to my child to participate in all indoor and outdoor school activities held in conjunction with the After School Program and within the premises of the Nida-UI-Islam Islamic Center. I hereby waive all rights claims against NIDA-UL-ISLAM, its management, Essentials-After School Program teachers and volunteers.

Parent/Guardian signature: _____

Print Name: _____ Date: _____

For Office Use Only

Accepted by: _____ Date: _____

Signature: _____ Date: _____