

C4K Emergency Information

Workforce & Continuing Education

Parents or Legal Guardians, please complete the following, print, sign and return to your

child's teacher the first day of class:

STUDENT'S NAME _____ GRADE _____ DATE OF BIRTH _____

STUDENT'S ADDRESS _____ CITY/STATE _____ ZIP CODE _____ PHONE NUMBER _____

PARENT/LEGAL GUARDIAN _____ RELATIONSHIP _____ PHONE DURING CLASS _____

ADDRESS IF DIFFERENT FROM STUDENT _____

CHILD'S DR. _____ ADDRESS _____ PHONE NUMBER _____

DR.'S HOSPITAL AFFILIATION _____ ADDRESS _____ PHONE NUMBER _____

MEDICAL INFORMATION: NONE CONVULSIVE DISORDERS DIABETES ALLERGIES* (I.E. DIET, STINGS) OTHER _____
**If checked, please clip at corner perforation*

DESCRIBE SYMPTOMS AND PRECAUTIONS _____

OTHER PERTINENT MEDICAL INFORMATION _____

I agree to indemnify and hold harmless Macomb Community College, its officers, agents and employees for any loss or injury my child _____ may sustain while participating in the C4K program. In case of emergency, I ask Macomb Community College to contact an adult listed above. If the College is unable to reach one of us, I authorize the College to secure emergency medical treatment for my child. My signature also indicates that I have read and understand the safety and program guidelines.

REQUIRED SIGNATURE _____ DATE _____

I give my consent for my child to be photographed or videotaped for promotional purposes. I do not expect compensation when Macomb takes promotional photos and videos of students in the learning environment.

SIGNATURE _____ DATE _____