



Applicants must be entering a Fall 2019 Kindergarten Program

Please <u>print</u> clearly, and fully complete the application.

Child's Name:						Male	
-	First Nan	ne Last N	ame		Nickname	Female	
Date of	Will a	tend Kindergarten at	:				
Birth:/							
Home Address: _							
:	Street	То	wn	State	ZIP Code		
Parent's			Careg	iver's			
Name: First	: Name	Last Name	Na	ime:	First Name	Last Name	
Daytime Phone		Cell Phone	 E-ma	ail Addre			
Session 1 Ju		e rank (1-4) all pos :00am to 11:30am)			-	00pm)	
Session 3 Ju	ne 10 - 14 (9	00am to 11:30am	Session 4	June 10	– 14 (12:30pm to 3:0	00 pm)	
		Regist	ration Chec	klist			
	***	Incomplete For	ms will NOT I	be Pro	cessed***		
I have enclosed a	check for the t	help support the costs of otal amount of \$ (VISA, American Express,	•				
Card number:			Expirati	on date:_			
Authorized Signature	e		NO A	PPLICAT	TIONS/REFUNDS AFT	ER MAY 20, 2019	
		ding to my preference.					
I have completed	both sides of th	e application and signed t ance. (Do not send a chec	he back.				

Questions? Please contact 203-869-8444 or - safetytown.GNY@redcross.org

Send Application and Payment Payable to: Metro New York North Chapter--American Red Cross, 99 Indian Field Rd., Greenwich, CT 06830

Child's Name:	First Name	Last Name						
EMERGENCY CONTACT INFORMATION								
Emergency_								
Contact #1	Name	Phone Number	Relationship					
Emergency_								
Contact #2	Name	Phone Number	Relationship					
 I, the undersigned parent/guardian, give my child permission to participate in all activities at Safety Town 2019 sponsored by the MNYN Chapter of the American Red Cross. I understand that first aid trained personnel will be on site at all times for minor injuries. In case of a medical emergency, all reasonable efforts will be made to contact designated individuals before the administration of treatment, each of whom is authorized to provide required consent. Notwithstanding the foregoing, I understand that in certain situations Safety Town staff may need to first: Contact local EMS, and if they deem advanced treatment necessary, I agree that my child may be transported at my expense. Administer pre-designated Epi-pen and/or other allergic reaction treatment. If the contacts listed cannot be reached, I hereby give my permission to Safety Town personnel to take any emergency measures that they deem necessary for the care and protection of my child. Such emergency measures may include, without limitation, medical treatment/attention as determined by local EMS unit or disaster evacuation procedures. I give to the American Red Cross, its designees, agents and assigns unlimited permission to use, publish and republish 								
in any form identificatio	or media informatior	n about me and my likeness (photographic consent and agree, individually and as pare	or otherwise) voice, with or without					
Restrictions/Allergies								
Modification	ns for my child:							
My child is a	llergic to:							
Epi-pens, medication and instructions/indications must be provided in a clearly labeled bag.								
Other medic	cal conditions:							
Pediatrician	·							
	Name		Phone					

Incomplete Forms will NOT be processed

Parent's

Signature___

Parent's Name:

(Print) _____