SOUTHGATE ACADEMY
850 West Valencia Road Tucson, AZ 85706
T 520.741.7900 F 520.741.7901 www.southgateaz.org

Southgate Summer Program 2019

June 3rd to July 19th

Monday – Friday

Holiday - No Summer Program: July 4th – 5th

Welcome to the Southgate Summer Program! Our Program provides a safe, secure environment for the students of Southgate and the surrounding community. Our program will serve breakfast and lunch, and do fun physical activities at no cost to you.

Required for Registration:

The Summer Program Registration Form (one per family)

The Completed Emergency Information Form (one per student)

Hours of Operation:

Breakfast	8:30am – 9:30am
Activity Time	9:30am – 12:00pm
Lunch	12:00pm – 1:00pm

All students must be picked up no later than 1:00 pm.

*Any student picked up later than 30 minutes could result in a permanent suspension from the program.

Southgate Summer Program Registration Form 2019

Student Name:_____ Grade:_____

Student Name:_____ Grade:_____

Student Name:_____ Grade:_____

Student Name:_____ Grade:_____

Parent/Guardian #1

First Name:_____ Last Name:_____

Home Phone:_____ Cell Phone:_____

Address:_____

_____

Parent/Guardian #2

First Name:_____ Last Name:_____

Home Phone:_____ Cell Phone:_____

Address:_____

_____

Emergency Information Summer 2019

Child's Name:	Date Enrolled:	Updated:
Home Address(#, Street, City, State, Zip Code):		
Home Phone:	Date of Birth:	Sex: ☐ Male ☐ Female

Mother or Guardian Name:	Home Address(#, Street, City, State, Zip Code):
Cell Phone (optional):	Contact Telephone Number:

Father or Guardian Name:	Home Address (#, Street, City, State, Zip Code):
Cell Phone (optional):	Contact Telephone Number:

I authorize the following individuals to collect my child from the facility in case of emergency or if I cannot be contacted:

Name:	Contact Telephone Number:
Name:	Contact Telephone Number:
Name:	Contact Telephone Number:
Name:	Contact Telephone Number:

If Medical care is necessary, Call:

Health Care Provider*	Name:	Contact Telephone Number:

*A Health Care Provider is a physician, physician assistant or registered nurse practitioner.

I hereby give authority to any hospital or doctor to render immediate aid as might be required at the time for his/her health and safety. It is understood by me that the expense of this service will be accepted by me.

In case of injury or sudden illness, I request that this individual be called first:

Does your child have insurance coverage? ☐ No ☐ Yes Name of Insurance Company:

The following individual(s) may NOT remove my child from the facility:

Name(s):

Custody papers have been provided and are on file at the facility: ☐ Yes ☐ No

Medical Information

Is child allergic to food or other substances? ☐ No ☐ Yes If yes, describe symptoms, name foods or substances to be avoided, and the procedure to follow if reaction occurs:
Is child usually susceptible to infections and if so, what precautions need to be taken? ☐ No ☐ Yes If yes, list precautions:
Is Child subject to convulsions and what should be our procedure if one occurs? ☐ No ☐ Yes If yes, specify procedure:
Is there any physical condition that we should be aware of and what precautions should be taken (heart trouble, foot problem, hearing impairment, hernia, etc.)? ☐ No ☐ Yes If yes, list precautions:
Additional Comments:
Other special instructions:

This Emergency Information is accurate and complete, provided by:

_____ _____ ____/____/_____
Parent's Name (printed) Signed Name Date

(All information on this card will be used for emergencies only, and will not be seen by any other agencies.)