

PUGET SOUND SKILLS CENTER 18010-8TH AVENUE SOUTH BURIEN, WA 98148 (206)631-7300
ACTIVITY PARTICIPATION/EMERGENCY FORM

STUDENT NAME _____ SOCIAL SECURITY # _____
 PSSC PROGRAM _____ SESSION (CIRCLE) 1ST 2ND DATE _____
 GRADE _____ SEX (CIRCLE) M F BIRTHDATE _____ HOME PHONE (_____) _____ - _____
 STREET ADDRESS _____ UNIT # _____ CITY _____ ZIP _____
 FEMALE PARENT/GUARDIAN _____

DATE _____ **WHOM YOU ARE LIVING** _____ **RELATIONSHIP TO YOU** _____
 WORK PHONE # (_____) _____ - _____ E-MAIL ADDRESS _____
 MALE PARENT/GUARDIAN
 SIGNATURE OF MALE PARENT/GUARDIAN _____ DATE _____
 WITH WHOM YOU ARE LIVING _____ **RELATIONSHIP TO YOU** _____

WORK PHONE # (_____) _____ - _____ E-MAIL ADDRESS _____

IF DIVORCED, WHICH PARENT HAS AUTHORITY TO MAKE SCHOOL/CHILD DECISIONS? (CIRCLE) **MOTHER**
 FATHER BOTH

ARE THERE ANY RESTRAINING ORDERS AGAINST: (CIRCLE) MOTHER? FATHER? OTHER _____?
 (LEGAL DOCUMENTS MUST BE FILED WITH THE PSSC OFFICE.)

IN CASE OF AN EMERGENCY, EARLY CLOSURE (I.E. SNOW), OR IF THE STUDENT MUST BE RELEASED DURING SCHOOL TIME, AND I AM UNABLE TO BE REACHED, I AUTHORIZE THE FOLLOWING PERSON(S) (LOCAL) TO BE NOTIFIED TO PICK UP MY STUDENT AT SCHOOL (THIS MIGHT INCLUDE ROOMMATES, SIBLINGS, NONCUSTODIAL PARENT, ETC.)

NAME & RELATIONSHIP _____ HOME PHONE _____ WORK PHONE _____
 STREET ADDRESS _____ (_____) _____ - _____ (CITY) _____ - _____ ZIP _____
 STREET ADDRESS _____ (_____) _____ - _____ (CITY) _____ - _____ ZIP _____

HEALTH PROBLEMS (EXAMPLES: DIABETES, BEE STING ALLERGY, ASTHMA, HEART PROBLEMS, SEIZURES, VISION, HEARING, ETC.)

A MEDICAL AUTHORIZATION FORM IS REQUIRED TO BE ON FILE FOR MEDICATIONS TO BE GIVEN BY THE SCHOOL. PLEASE LIST ALL MEDICATION YOUR CHILD IS CURRENTLY TAKING: _____

DOCTOR _____ PHONE (_____) _____ - _____

DENTIST _____ PHONE (_____) _____ - _____

PARENT/GUARDIAN

ALTHOUGH THE RECOMMENDATIONS OF PARENTS WILL BE RESPECTED AS FAR AS POSSIBLE, I UNDERSTAND THAT THE FINAL DISPOSITION OF AN EMERGENCY, THE JUDGEMENT OF THE SCHOOL AUTHORITIES WILL PREVAIL.

EACH ACTIVITY AT PSSC HAS ITS VESTIGES OF DANGER AND REGARDLESS OF THE SUPERVISION THAT IS PROVIDED, A STUDENT MAY BE INJURED. AS THE PARENT/GUARDIAN OF THE CHILD WHOSE NAME AND BIRTHDATE ARE LISTED, I/WE CONSENT TO HIS/HER PARTICIPATION IN THE PUGET SOUND SKILLS CENTER PROGRAMS.

1) THE UNDERSIGNED GIVES PERMISSION TO THE PUGET SOUND SKILLS CENTER OR ANY MEDICAL DOCTOR ON MY BEHALF TO TAKE MEASURES THEY DEEM NECESSARY IN THE EVENT OF SICKNESS OR INJURY DURING A FIELD TRIP, OFFICIAL SCHOOL RELATED EVENT OR DURING CLASS TIME AT PUGET SOUND SKILLS CENTER.

2) I AGREE TO PAY FOR ANY MEDICAL EXPENSES FOR MY SON/DAUGHTER WHOSE NAME APPEARS ON THIS FORM.

3) I WILL PLACE AN "X" IN THE "MEDICAL ALERT" BOX IF I WISH TO NOTIFY ANY MEDICAL PERSONNEL THAT SPECIAL MEDICAL CONDITIONS EXIST.



SIGNATURE OF FEMALE PARENT/GUARDIAN _____