Emergency Contact Form
Please turn this into the instructor on the first day.

Please complete this form if your child has any medical, physical or emotional matters of which CPAC staff and instructors should be informed. After that, please be aware of your teen’s daily health and do not bring them to the workshop with any of the known symptoms of COVID-19. Thank you.

Child’s Name:__________________________________________________________

Parent/Guardian Name:____________________________________________________

Cell Phone: ____________________ Evening Phone: ____________________________

Alternate Contact Name: ____________________ Phone:________________________

EMERGENCY Contact Name: ____________________ Phone:_______________________

Primary Care Physician: _________________________________________________

Primary Care Physician Phone Number:_______________________________________

Does your child have any allergies (food and/or medication)? YES \ NO

If YES, please list all allergies:

________________________________________________________________________

________________________________________________________________________

CPAC welcomes youth of all abilities. We will work with each family in the best interest of the child(ren) in our program, on a case-by-case basis, to determine if CPAC is able to meet the needs of the child. Parent communication and support is essential in deciding if CPAC can meet the needs of the child.

IMPORTANT: Please comment on any other medical, physical or emotional issues that CPAC staff and instructors should know:

________________________________________________________________________

________________________________________________________________________