ACPC Enrollment Form

This form also serves as a medical consent and must be presented upon admission for treatment.

This form allows parents and guardians to authorize the provision of emergency treatment for below named child who becomes ill or injured while under program authority when parents or guardians cannot be reached.
In the event reasonable attempts to contact have been unsuccessful, I hereby give consent for the administration of any treatment deemed necessary by the doctor or dentist listed below, or if unavailable, another licensed physician or dentist.
I agree to pay all costs and fees as secured or authorized under this consent.

CHILD'S NAME:	**BIRTH DATE:**	**GENDER:**
CHILD'S ADDRESS:		
PARENT(S)/GUARDIAN(S) WITH WHOM THE CHILD RESIDES		
1. PARENT/GUARDIAN NAME	ADDRESS (if different)	
PLACE OF EMPLOYMENT	OCCUPATION	
WORK NUMBER	CELL NUMBER	HOME NUMBER
		EMAIL
2. PARENT/GUARDIAN NAME	ADDRESS (if different)	
PLACE OF EMPLOYMENT	OCCUPATION	
WORK NUMBER	CELL NUMBER	HOME NUMBER
		EMAIL
EMERGENCY CONTACT PERSON(S) AND/OR PERSON(S) AUTHORIZED TO PICK UP CHILD (at least one local)		
1. NAME	RELATIONSHIP TO CHILD	
HOME NUMBER	CELL NUMBER	WORK NUMBER
2. NAME	RELATIONSHIP TO CHILD	
HOME NUMBER	CELL NUMBER	WORK NUMBER
3. NAME	RELATIONSHIP TO CHILD	
HOME NUMBER	CELL NUMBER	WORK NUMBER

ACPC has an open door policy for parents unless there is a court order which prohibits a parent from visiting or taking a child from the center. Provide us with a copy of that order if it pertains to your situation.

This form allows parents and guardians to authorize the provision of emergency treatment for the child named on this form who becomes ill or injured while under program authority when parents or guardians cannot be reached. In the event reasonable attempts to contact have been unsuccessful, I hereby give consent for the administration of any treatment deemed necessary by the doctor or dentist listed below, or if unavailable, another licensed physician or dentist. I agree to pay all costs and fees as secured or authorized under this consent.

PHYSICIAN NAME	**DENTIST NAME**
PHONE NUMBER	PHONE NUMBER
ADDRESS	ADDRESS
HOSPITAL: Mary Greeley Medical Center	
KNOWN ALLERGIES	
INSURANCE COMPANY	POLICY HOLDER ID

By signing this form, you are authorizing ACPC staff to secure any necessary emergency medical, dental, and/or surgical treatment for my child and agree to pay all associated costs and fees.

DAILY SCHEDULE (7:00am-6:00pm)
Check Days Attending: ☐M ☐T ☐W ☐TH ☐F
Arrival Time_____ **Departure Time**_____

ACPC Enrollment Form

This form also serves as a medical consent and must be presented upon admission for treatment.

This form allows parents and guardians to authorize the provision of emergency treatment for below named child who becomes ill or injured while under program authority when parents or guardians cannot be reached.
In the event reasonable attempts to contact have been unsuccessful, I hereby give consent for the administration of any treatment deemed necessary by the doctor or dentist listed below, or if unavailable, another licensed physician or dentist.
I agree to pay all costs and fees as secured or authorized under this consent.

EMAIL ADDRESS FOR ACPC BILLING CORRESPONDENCE
Email Address:

SIGNATURE OF PARENT OR GUARDIAN	DATE
UPDATE	**DATE**