APEX REGIONAL PROGRAM

Authorization to Pick Up

CHILD Last Name: _____ First Name: _____ Goes By: _____ M☐ F☐

Age: ___ Birth Date: _____ Lives with: ☐ Mother ☐ Father ☐ Both Other: _____

GUARDIAN 1 NAME _____ Relation to child: _____

Cell Phone: _____ Home Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

Employer: _____ Work Phone: _____

Employer Address: _____ City: _____ State: ___ Zip: _____

GUARDIAN 2 NAME _____ Relation to child: _____ Cell Phone:

_____ Home Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

Employer: _____ Work Phone: _____

Employer Address: _____ City: _____ State: ___ Zip: _____

OTHER PERSONS (authorized to pick-up and/or care for your child if parents cannot be reached in an emergency)
Name: _____ Relation to Child: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Name: _____ Relation to Child: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Name: _____ Relation to Child: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

In the event our child becomes ill or sustains injury while in the care of Apex Children's Center and the center is unable to reach us, we give our permission to those in charge to take whatever steps are necessary. Consent is given to any licensed physician or dentist to perform such emergency procedures deemed necessary to treat the emergency.

Parent/Guardian's Signature: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

School Transportation

Transportation Director Name: _____ Phone: _____

Driver Name: _____ Phone: _____

Driver Name: _____ Phone: _____