



Child Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

Parent Name \_\_\_\_\_ Address \_\_\_\_\_

Cell# \_\_\_\_\_ Work# \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

**EMERGENCY CONTACT:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Cell# \_\_\_\_\_ Work# \_\_\_\_\_ Home# \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Insurance ID# \_\_\_\_\_

Children may only be picked up by their guardian. Please list any additional persons authorized to pick up your child. PLEASE NOTE: They must have I.D.

\_\_\_\_\_ Relationship \_\_\_\_\_

\_\_\_\_\_ Relationship \_\_\_\_\_

Is your child allergic to any medication and/or foods? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please list \_\_\_\_\_

Does your child require any special accommodations? If so, please describe (please include any medications your child is taking)

\_\_\_\_\_

I understand and agree to abide by the operation rules as set by Kixs 4 Kidz. I further agree to hold Kixs 4 Kidz, its members, its officers, its staff and other participants, free and harmless from any and all liability whatsoever arising from my child's participation in this activity. My signature authorizes Kixs 4 Kidz to use a photograph or similar likeness or image of myself or the child named on this form in any future advertisement or promotion of Kixs 4 Kidz. Further, my signature authorizes my child to be treated by the first available medical facility and physician should the need arise and my signature authorizes emergency contact listed above to pick up my child from the program and make decisions regarding my child if I am not available.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_