

American Red Cross Safety City Registration Confirmation
PLEASE RETURN THIS FORM ASAP TO P. O. BOX 4337, NEWARK, OH 43058-4337

Date _____ Location _____ Session (time): 8:30-11:30am
Paid _____

Child's Full Name _____	Nickname _____	Age _____	Boy _____	Girl _____	T-Shirt Size: Small: 6-8 Medium: 10-12 Large: 14-16
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Full Street Address _____	City _____	State _____	Zip _____
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Email _____

Parent/Guardians Name(s) _____	Phone _____	Phone _____
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In Case of Emergency Contact:	Phone	Relation
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1. _____

2. _____

Medical Information: (allergies, handicapping conditions, treatment information, etc.)

Child's Doctor _____ Phone _____

Child's Dentist _____ Phone _____

I give my permission for emergency medical treatment in the event that I cannot be reached. I also give my permission for my child to participate in all activities, including walking and bus field trips, as described in the enclosed Safety City Parent Brochure. **(please read & sign photo consent form)**

Date _____	Signature of Parent/Guardian _____
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