



CHILD INFORMATION FORM- WPC After School Enrichment Program 2025-2026

PARENT/GUARDIAN INFORMATION

Name: _____ Relationship to Child(ren): _____
Address: _____ Town: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Best # to Reach: _____ Billing Email Address: _____

Name: _____ Relationship to Child(ren): _____
Address: _____ Town: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Best # to Reach: _____ Email Address: _____

CHILD 1 School: _____ Grade: _____ Teacher/Team: _____

Name: _____ DOB: _____ Age: _____ M/F: _____

Eye Color: _____ Hair Color: _____ Weight: _____ Height: _____

Identifying Marks: _____

Please list any medical needs, dietary restrictions, allergies, etc. _____

Does your child require an EpiPen®? Yes _____ No _____ Inhaler? Yes _____ No _____

PLEASE NOTE: If your child has an EpiPen®, Inhaler or Benadryl you must supply them to the WPC site

Child's Physician: _____ Phone: _____

Child's Dentist: _____ Phone: _____

Movie Rating: I give my child permission to watch movies with the following ratings (check all that apply). G _____ PG _____ PG13 _____

Please attach a
current
photograph.

CHILD 2 School: _____ Grade: _____ Teacher/Team: _____

Name: _____ DOB: _____ Age: _____ M/F: _____

Eye Color: _____ Hair Color: _____ Weight: _____ Height: _____

Identifying Marks: _____

Please list any medical needs, dietary restrictions, allergies, etc. _____

Does your child require an EpiPen®? Yes _____ No _____ Inhaler? Yes _____ No _____

PLEASE NOTE: If your child has an EpiPen®, Inhaler or Benadryl you must supply them to the WPC site

Child's Physician: _____ Phone: _____

Child's Dentist: _____ Phone: _____

Movie Rating: I give my child permission to watch movies with the following ratings (check all that apply). G _____ PG _____ PG13 _____

Please attach a
current
photograph.

CHILD 3 School: _____ Grade: _____ Teacher/Team: _____

Name: _____ DOB: _____ Age: _____ M/F: _____

Eye Color: _____ Hair Color: _____ Weight: _____ Height: _____

Identifying Marks: _____

Please list any medical needs, dietary restrictions, allergies, etc. _____

Does your child require an EpiPen®? Yes _____ No _____ Inhaler? Yes _____ No _____

PLEASE NOTE: If your child has an EpiPen®, Inhaler or Benadryl you must supply them to the WPC site

Child's Physician: _____ Phone: _____

Child's Dentist: _____ Phone: _____

Movie Rating: I give my child permission to watch movies with the following ratings (check all that apply). G _____ PG _____ PG13 _____

Please attach a
current
photograph.

PLEASE COMPLETE BOTH SIDES

***ADDITIONAL PICK-UP CONSENT:** In the event that I cannot pick up my child(ren) for any reason, I authorize the WPC After School Enrichment Program and/or Westford Recreation to release my child(ren) to the following individuals:

*(Will NOT be used for "EMERGENCY CONTACTS")

Name: _____ Relationship to Child(ren): _____ Phone: _____

Name: _____ Relationship to Child(ren): _____ Phone: _____

Name: _____ Relationship to Child(ren): _____ Phone: _____

Name: _____ Relationship to Child(ren): _____ Phone: _____

***EMERGENCY CONTACTS:** If parent(s)/guardian(s) cannot be reached in the event of an emergency, please notify the following:

*(Will NOT be used for "ADDITIONAL PICK-UP CONSENT")

Name: _____ Relationship to Child(ren): _____

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

Name: _____ Relationship to Child(ren): _____

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

Name: _____ Relationship to Child(ren): _____

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

Hospital Preferred: _____ Health Insurance Carrier & Policy #: _____

CONSENT: I authorize WPC staff to give my child(ren) first aid when appropriate. If my child(ren) require further medical attention, 911 will be called and I will be notified immediately. I understand if I cannot be reached, one of the emergency contacts will be notified. If my child(ren) need to be taken to the nearest medical care facility or to my preferred hospital listed above by ambulance, one qualified staff person will accompany my child(ren) to the hospital. I also give permission to the attending physician to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child(ren) as indicated. I will accept responsibility for any expenses incurred in handling this emergency care.

Parent/Guardian Signature: _____ Date: _____

Release of Information

For the purpose of continuity of care, I hereby give permission for Westford Public Schools to release information to the WPC Director and my child(ren)'s Site Director(s) for my child(ren): _____, _____, and _____ . Information may be shared in written or verbal format.

Parent/Guardian Signature: _____ Date: _____

PUBLICITY/PHOTO RELEASE: I understand that my child(ren) may be photographed or videotaped by Westford Recreation or newspaper/television staff, should they feature our program and that my child's image may appear on Westford Recreation's website and/or publications.

I do _____ I do NOT _____ give permission for my child(ren) to be photographed/videotaped.

PARENT HANDBOOK ACKNOWLEDGEMENT

The Parent Handbook was created to outline the policies and procedures of the Westford Partnership for Children After School Enrichment Program. It is important that you understand and become familiar with them.

Your signature below indicates that you have read the 2025-2026 Parent Handbook, understand, and agree to abide by the policies of WPC.

Parent/Guardian Signature: _____ Date: _____

PLEASE COMPLETE BOTH SIDES