

**ROSLYN SUMMER ACADEMIC PROGRAM
Registration/Emergency Contact Form**

Please Use One Registration Form for Each Child

Student's

Name: _____
Please Print

Address:

Street Town Zip Code

Current Grade in Spring 2009 (please circle one):

K 1 2 3 4 5 6 7 8

Date of Birth: ____/____/____
Mo. Day Year

Gender: ____ Female ____ Male

School Attended 9/08 – 6/09

- Heights School
 East Hills School
 Harbor Hill School
 Roslyn Middle School

Other _____
Private Schools: Did Roslyn provide transportation? _____

**Proof of Roslyn residency is required.
(Three (3) original documents must be presented to
Dr. Dan Brenner's Office at the Roslyn Administration
Building, 801-5010.)**

Registration is limited to 300 students.
A separate form is required for each child.
Emergency information must be completed on the back of
this form.

**Note: The Summer Academic Program is contingent
on the successful passage of the school budget on
May 19, 2009.**

**Return to:
Roslyn Summer Academic Program
Dr. Dan Brenner's Office
Roslyn Public Schools –Administration Building
P.O. Box 367
Roslyn, NY 11576-0367**

Summer Academic Program

Open to all students residing in the Roslyn School District
who have completed kindergarten through grade 8.
There is no fee.
Busing is provided.

**June 29 - July 24, 2009
8:30 a.m. – 12:30 p.m.**

**Field Trip Permission
Parent Signature Required**

I give my child permission to attend all field trips
sponsored by the Roslyn Summer Academic Program.

Please complete the emergency information on the
back of this form.

OVER PLEASE

ROSLYN SUMMER ACADEMIC PROGRAM 2009
Emergency Information/Emergency Contact

STUDENT'S NAME: _____ **GRADE COMPLETED JUNE 2009:** _____

Mother's/Parent's Name: _____ **Father's Name:** _____

Address: _____ **Address:** _____

Home Phone: _____ **Home Phone:** _____

Work Phone: _____ **Cell Phone/Beeper:** _____ **Work Phone:** _____ **Cell Phone/Beeper:** _____

Will this child have siblings in the program this year? **Yes** **No**

Name(s): _____ **Grade level completed in June 2009** _____

1. _____

2. _____

3. _____

EMERGENCY CONTACT – In the event you cannot be reached, please name two authorized individuals we may contact:

1. **Name:** _____ **Relationship:** _____ **Phone:** _____

2. **Name:** _____ **Relationship:** _____ **Phone:** _____

Significant Medical History: _____

ANY KNOWN ALLERGIES TO FOODS, POLLEN, INSECT BITES, ETC.: _____

MEDICATIONS: Doctor's prescription must accompany this form if any medications are to be dispensed throughout the day by our nurse. _____

If child has been diagnosed with asthma, please bring inhaler and doctor's orders to Nurse's Office.

FAMILY PHYSICIAN'S NAME: _____ **FAMILY DENTIST'S NAME:** _____

Address: _____ **Town:** _____ **Zip:** _____ **Address:** _____ **Town:** _____ **Zip:** _____

Phone No.: _____ **Phone No.:** _____

(OVER)