

**\*MAC WILL BE CLOSED May 27<sup>th</sup> and 28<sup>th</sup> , July 1<sup>st</sup> - 5<sup>th</sup> and August 2<sup>nd</sup>,5<sup>th</sup> , 6<sup>th</sup>**

**Franklin Special School District MAC Program  
2024 Summer MAC Registration Form**

**REGISTRATION DEADLINE: Friday, May 10th**

**MATERIALS FEE ATTACHED  
DATE PAYMENT RECEIVED:**

**RECEIVED BY:**

**\$35.00 Non-refundable materials fee charge per child. Please do not include payments with the materials fee.**

**CHILDREN TO BE ENROLLED:**

**LAST NAME, FIRST NAME      T-SHIRT SIZE      SCHOOL      GRADE ('23-'24)      DATE OF BIRTH**  
(Indicate Adult or Youth)

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

**Have children been enrolled in MAC previously? If so, where? \_\_\_\_\_**

**Ethnicity (choose one) \_\_\_\_\_ Hispanic      \_\_\_\_\_ Not Hispanic, Latino or Spanish origin**

**Race(Choose all that apply) \_\_\_\_\_ American Indian/Alaskan Native      \_\_\_\_\_ Asian      \_\_\_\_\_ White**

**\_\_\_\_\_ Pacific Islander/Native Hawaiian      \_\_\_\_\_ Black/African American**

**PARENT INFORMATION:**

**PRIMARY PARENT/GUARDIAN: \_\_\_\_\_**

**EMAIL: \_\_\_\_\_**

**HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_**

**ADDRESS: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_**

**EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_**

**SECONDARY PARENT/GUARDIAN: \_\_\_\_\_**

**EMAIL: \_\_\_\_\_**

**HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_**

**ADDRESS: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_**

**EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_**

**FOR CHILD'S SAFETY,**

**LIST ALL PERSONS INCLUDING PARENTS TO WHOM CHILD MAY BE RELEASED:  
(DO NOT LEAVE BLANK)**

<b>NAME</b>	<b>PHONE</b>	<b>NAME</b>	<b>PHONE</b>
_____	_____	_____	_____
_____	_____	_____	_____

**LIST ALL PERSONS TO WHOM CHILD MAY NOT BE RELEASED:  
(Parent must provide legal documentation to  
support this request if person listed is a parent of the child.)**

\_\_\_\_\_  
\_\_\_\_\_

**EMERGENCY INFORMATION**

Name of person, other than parent, authorized to act for the parent in an emergency: **DO NOT LEAVE BLANK**

NAME: \_\_\_\_\_ RELATION: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

NAME OF CHILD'S PHYSICIAN: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

Child's Health is: Excellent: \_\_\_\_\_ Good: \_\_\_\_\_ Fair: \_\_\_\_\_ Poor: \_\_\_\_\_

Please describe any medical diagnosis including allergies: Does your child have an IEP? Yes \_\_\_ No \_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICATION**

Please list all prescription medication that your child takes on a daily basis. We would like to be aware of any medicines your child takes to provide this information to medical personnel in case of an emergency. Please refer to the Parent Manual for details on dispensing of medication while in MAC.

NAME OF MEDICATION	DAILY DOSAGE	REASON PRESCRIBED
_____	_____	_____
_____	_____	_____
_____	_____	_____

In the event of an emergency, I hereby give permission to MAC staff to secure proper medical treatment for my child if I cannot be reached, I hereby give permission for emergency personnel selected by MAC staff to order x-rays, routine tests and treatment for the health of my child. I also give permission to emergency personnel selected by MAC staff to hospitalize, secure proper treatment for, and to order injection and/or surgery of my child.

\_\_\_\_\_  
Printed Name of Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date