AFTER SCHOOL PROGRAM Registration Form

Please return form with $100 registration fee.

STUDENT INFORMATION

Child's Name: ____ Age: __________

Child's Address: ____ Male____ Female____

PARENT/GUARDIAN INFORMATION

1. Name: _______________________________________ Home Phone: _______________________

Address: ______________________________________Cell Phone: _________________________

____Email: ______________________________

Employer ______________________________________Work Phone ________________________

2. Name: ____Home Phone: ______________________

Address ____Cell Phone: ________________________

____Email: ____________________________

Employer: _______________________________________Work Phone: _______________________

PERSONS (16+) AUTHORIZED TO PICK UP CHILD

1.Name: _______________________________ Phone: __________________

2.Name: _______________________________ Phone: __________________

3.Name: _______________________________ Phone: __________________

ESTIMATED TIMEOF PICKUP: ______________________________________

INFORMATION ABOUT YOUR CHILD

List any allergies, restrictions, special needs, medication or NA for not applicable.

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EMERGENCY CARE INFORMATION

Child's Doctor's Name: __________________________ Phone: ________________

Address: ____________________________________Hospital Preference: ________

If parent/guardian cannot be reached call:

Name: ____________________________ Phone: _________________ Relationship______________

I give permission for the After-School Director or personnel designated for the responsibility in charge to give immediate medical treatment if parent cannot be reached. This is done with the understanding that every attempt will have been made to contact the parents, the child's physician and persons listed for emergency contact.

Parent/Guardian Signature: _____________________________________ Date: __________________