Registration Form

Child's Name _____ Grade Entering _____

Father's Name _____ Work Phone _____

Mother's Name _____ Work Phone _____

Child lives with: _____

In case of accident or serious illness, I request the school to contact me. If it is impossible to contact me, the school may make whatever arrangements deemed necessary.

Parent's Signature _____ ***Date*** _____

We must have on file the names and phone numbers of the individuals permitted to pick up your child from After-School. If someone comes to pick up your child and we do not have his/her name in our file, we cannot allow your child to leave with that person.

NAME	PHONE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

For added security, if you desire, list a password in the blank provided. The After-School program will keep a copy of the security password on file.

_____

Please list any person(s) **NOT** allowed to pick up your child. (Please note: In the case of a divorce or separation, a copy of a form by the court must be on file.)

_____ _____

Please indicate below how you want to be charged for Aftercare: (If no indication is made, students will be charged the daily rate.)

____ **MONTHLY** - $222.00 per month (September through May)

____ **HOURLY** - $ 6.00 first hour - a charge of $1.25 for each additional 15 minutes

Medical History/Emergency Form

Student's Name _____ Birth Date _____

Do other children attend our Program? YES NO

If so, please list names _____

Physician _____ Office Phone _____

Dentist _____ Office Phone _____

Hospital preference in case doctor or parent cannot be reached _____

Persons who could care for your children in case parent cannot be reached:

Name _____ Home Phone _____

Name _____ Home Phone _____

Explain **IN DETAIL** any health considerations: _____

_____

_____

Medications _____

Allergies _____

Date of last:
Physical Exam _____ Eye Exam _____ Hearing Test _____

Initial the medications that you give permission to the After-School Program staff to administer to your child:

___ Benadryl Cream
___ Caladryl
___ Solarcaine (sunburn)
___ Antibiotic Ointment

I give the After-School Program staff permission to administer the medications initialed above.

Parent's Signature _____ ***Date*** _____