AFTER CARE PROGRAM REGISTRATION FORM

Name of child: _____

Date of Birth: _____ Age: _____ Male Female

Child's grade _____ Teacher's name: _____

Circle days After School Care is needed: M T W Th F

occasional/will vary

Approximate departure time of child: _____

Does your child have any allergies? Yes No

If so please specify: _____

_____

Name of your physician: _____

Address: _____ Phone #: _____

Emergency Contact: Emergency Contact:

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone #: _____ Phone #: _____

I agree that in the case of an accident or an injury, emergency medical care may be given in the event that I or the person(s) designated above cannot be reached. Emergency transportation will be provided by an ambulance.

_____ _____

Parent or Guardian Signature Date

A $10.00 NON-REFUNDABLE REGISTRATION FEE MUST ACCOMPANY THIS FORM.