



**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

**\*\*YOU MUST PROVIDE A WEEKLY OR MONTHLY SCHEDULE FOR YOUR CHILD/CHILDREN TO BOTH THE CLASSROOM TEACHER AND AFTER CARE\*\***

Approximate departure time of child: \_\_\_\_\_

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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.**

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Parent or Guardian Signature

Date

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