

BEFORE/AFTER CARE REGISTRATION

Please complete one form for each child.

Student's Name _____ Grade _____

Date of Birth _____

My child will use the program on the days circled below:

<u>AM Session</u>	Monday	Tuesday	Wednesday	Thursday	Friday	Every morning
<u>PM Session</u>	Monday	Tuesday	Wednesday	Thursday	Friday	Every afternoon

I, _____, authorize the following person(s) to pick up my child / children from After Care. *Parent /Guardian Name (PLEASE PRINT)*

Name	Phone Number	Relationship

****The Proctor on duty will ask the above named individual for identification. Please be sure the person picking up your child is aware of this.**

Person(s) to be contacted in the event of an emergency:

Name _____ Relationship to Child _____

Contact number _____

Name _____ Relationship to Child _____

Contact number _____

MEDICAL INFORMATION

Allergies: _____

Physical Limitations: _____

Other pertinent information: _____

Emergency Medical Release: If emergency care is deemed necessary and I cannot be contacted, I authorize the staff to act on my behalf in granting permission for my child to receive emergency treatment.

Parent / Guardian Signature: _____ **Date:** _____