Registration Fee Paid ($25) ____

Check # _____ Cash _____

Date _____

BEFORE/AFTER SCHOOL CARE
REGISTRATION FORM
2016-2017

Family Name	Address	Phone Number
	City, State, Zip	

Children In Program	Grade	Room

Emergency Contact Information

Name	Phone Number	Relationship to Child

The following people are authorized to pick up my child/children:

Name	Phone Number	Relationship to Child

Does your child/ren have any allergies? _____ yes _____ no

If yes, please explain. _____

Is your child/ren on medication that needs to be given after school? _____ yes _____ no

If yes, please send in the doctor's instructions with the medication.

Is there anything that we should know about your child/ren?

_____

_____