

Registration Fee Paid (\$25) _____
Check # _____ Cash _____
Date _____

BEFORE/AFTER SCHOOL CARE
REGISTRATION FORM
2019-2020

Family Name Address Phone Number

City, State, Zip

<u>Children In Program</u>	<u>Grade</u>	<u>Room</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Emergency Contact Information

<u>Name</u>	<u>Phone Number</u>	<u>Relationship to Child</u>
_____	_____	_____
_____	_____	_____

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

<u>Name</u>	<u>Phone Number</u>	<u>Relationship to Child</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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?

