

Morning and After School Care Registration TK3 – 5th Grade

- Morning Care Only

After School Care Only

Morning and After School Care

AFTER SCHOOL



Child's Name: _____ Grade: _____

Child's Name: _____ Grade: _____

Child's Name: _____ Grade: _____

Home Address: _____

Father's Name: _____

Father's Cell Phone: _____

Father's Work Phone: _____

Mother's Name: _____

Mother's Cell Phone: _____

Mother's Work Phone: _____

Is Your Child Under Medical Care or Taking Any Medications? ___ Yes ___ No

If Yes Please Provide Details: _____

Please Check Any of the Following Conditions That Apply to Your Child:

- | | |
|---------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Inhaler |
| <input type="checkbox"/> Bee Sting Allergy | <input type="checkbox"/> Insulin |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Peanut Allergy |
| <input type="checkbox"/> Epi-pen Use | <input type="checkbox"/> Seizers |
| <input type="checkbox"/> Food Allergy _____ | <input type="checkbox"/> Vision |
| <input type="checkbox"/> Hearing | |

Person(s) Authorized to Pick Up Your Child; Must Be Written on Emergency Card and Show Picture Identification.

1. _____	_____	_____
Name	Relationship	Telephone
2. _____	_____	_____
Name	Relationship	Telephone
3. _____	_____	_____
Name	Relationship	Telephone

Parent Signature: _____ Date: _____