

AFTERCARE REGISTRATION

Student Name(s) _____

Address _____

City _____ Zip _____ Phone _____

Email _____

Purpose: To enable parents/guardians to authorize the provision of emergency treatment for children who become ill or injured while attending the Aftercare Program, when parents/guardians cannot be reached.

Residential Parent or Guardian:

Mother's Name _____ Daytime Phone: (____) _____

Cell Phone (____) _____

Father's Name _____ Daytime Phone: (____) _____

Cell Phone (____) _____

Name of Relative or Childcare Provider who lives locally - to be notified in case parent/guardian cannot be reached. THIS MUST BE COMPLETED.

Name _____ Relationship _____

Daytime Phone: (____) _____

Name _____ Relationship _____

Daytime Phone: (____) _____

Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted: _____

** Registration Fee is \$25.00 per family.

** There will be a late charge of \$1.00/minute for late pickups after 6PM.