EXPANDED DAY REGISTRATION

_____FULL TIME
_____PART TIME (3 day minimum) ____Mon. ____Tues. ____Wed. ____Thurs. ____Fri.

STUDENT'S NAME _____ AGE_____ GRADE_____
Last First

STUDENT'S NAME _____ AGE_____ GRADE_____
Last First

STUDENT'S NAME _____ AGE_____ GRADE_____
Last First

ADDRESS _____

MOTHER _____ HOME PHONE _____

CELL PHONE_____ WORK PHONE _____

PLACE OF EMPLOYMENT_____

DRIVER LICENSE #_____

EMAIL
ADDRESS_____

FATHER _____ HOME PHONE _____

CELL PHONE_____ WORK PHONE _____

PLACE OF EMPLOYMENT _____

DRIVER LICENSE #_____

EMAIL
ADDRESS_____

PERSON(S) AUTHORIZED TO PICK CHILD UP WITHOUT A NOTE OR PHONE CALL FROM THE PARENTS

_____

_____

_____

APPROXIMATE PICK UP TIME _____

EMERGENCY CONTACTS:

NAME **HOME PHONE**
WORK PHONE

1. _____

2. _____

3. _____

MEDICAL INFORMATION (Allergies, Nosebleeds,etc.)

_____

_____

IN THE EVENT OF AN EMERGENCY REQUIRING IMMEDIATE MEDICAL ATTENTION, THE STAFF OF THE WEST MADISON EXPANDED DAY PROGRAM HAS AUTHORIZATION TO SECURE THE NECESSARY MEDICAL TREATMENT.

PHYSICIAN _____ PHONE _____

I HAVE READ AND UNDERSTAND ALL THE RULES GOVERNING THE EXPANDED DAY PROGRAM AND WILL ABIDE BY THEM.

Signature of Parent/Guardian Date

A $50.00 NON-REFUNDABLE REGISTRATION FEE MUST ACCOMPANY THIS APPLICATION

FOR OFFICE USE ONLY:

Registration date: _____ Fee: Cash _____ Check# _____

Received by: _____ Date: _____