



School

Enrollment Date

AFTER CARE STUDENT REGISTRATION FORM
2019-2020 SCHOOL YEAR

Please print legibly and complete all information

STUDENT'S NAME AS IT APPEARS ON THE BIRTH CERTIFICATE

Last Name _____ First Name _____ Middle Name _____ Suffix _____

Grade _____ Male _____ Female _____

Student's Physical Address _____
Street City State Zip Code

Student's Mailing Address _____
(If different from physical address) Street City State Zip Code

Date of Birth _____ Social Security Number (Last Four) _____

PARENT/LEGAL GUARDIAN INFORMATION

Parent/Guardian 1:

Last Name _____ First Name _____

Relationship to Student: _____ Is the person a legal guardian? ___ Yes ___ No

Does this person live in the same household as the student? ___ Yes ___ No

Mailing Address _____
Street City State Zip Code

Home Phone # _____ Cell Phone # _____

Employer: _____ Work Phone # _____

Email Address _____

Parent/Guardian 2:

Last Name _____ First Name _____

Relationship to Student: _____ Is the person a legal guardian? ___ Yes ___ No

Does this person live in the same household as the student? ___ Yes ___ No

Mailing Address _____
Street City State Zip Code

Home Phone # _____ Cell Phone # _____

Employer: _____ Work Phone # _____

Email Address _____

Emergency Contact/Health Information (other than parents):

Emergency Contact 1:

Last Name _____ First Name _____ Relationship to Student _____

Physical Address _____
(No PO Boxes) Street City State Zip Code

Home Phone # _____ Cell Phone # _____ Work # _____

Emergency Contact 2:

Last Name _____ First Name _____ Relationship to Student _____

Physical Address _____
(No PO Boxes) Street City State Zip Code

Home Phone # _____ Cell Phone # _____ Work # _____

Names of Person(s) that are permitted to sign your child out and/or pick up your child:

(Person Must Show ID)

Last Name _____ First Name _____ Relationship to Student _____

Last Name _____ First Name _____ Relationship to Student _____

Last Name _____ First Name _____ Relationship to Student _____

Last Name _____ First Name _____ Relationship to Student _____

Medical Information:

Physician: _____ Phone _____

Does the student have any medical programs, take medications or have a special diet, etc?

List any allergies this student may have?

All information above is correct to the best of my knowledge. Additionally, I understand that it is my responsibility to inform the school IMMEDIATELY of any changes.

Signature of Parent/Legal Guardian

Relationship to Student

Date

FOR OFFICE USE ONLY:

Student Name: _____

Grade: _____

Application Fee Received: _____

Receipt Number: _____

Signed Contract Received: _____

____ PR

____ ABC

____ 1st Child \$50.00

____ Rate Per Child

____ Additional Child \$40.00

Teacher Name: _____