**Registration Form 1**

|  |  |
| --- | --- |
| **Today’s Date:** | **First Date of Attendance:** |
| Student’s Last Name (use student’s legal name) | First Middle |
|  |  |
| Birth Date: Age: | Sex: |
| What School/Grade Does Your Child Attend? | Teacher: |
| Street Address: (where child resides everyday) | City: State: Zip Code: |
|  |  |
| Home Phone: | Cell Phone: |
| Best Time to Call: | Best Time to Call: |
|  |  |

Father’s Last/First Name Mother’s Last/First Name Guardian’s Last/First Name

(Please complete information on all the following that apply to your family status)

Father’s Employer: Employer’s Phone No.:

Best Time To Call:

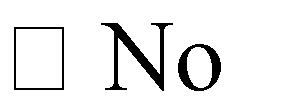
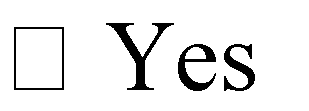
Mother’s Employer: Employer’s Phone No.:

Best Time To Call:

Guardian’s Employer: Employer’s Phone No.:

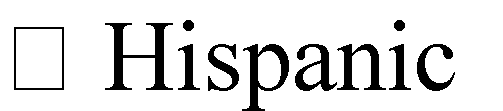
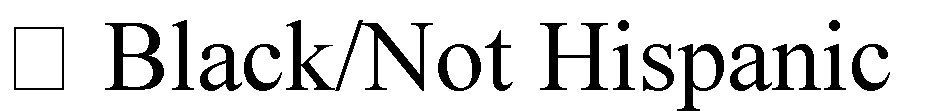
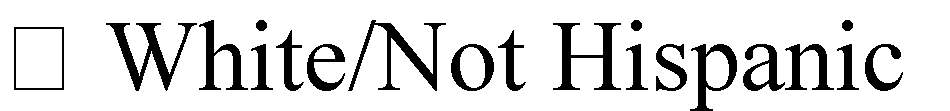
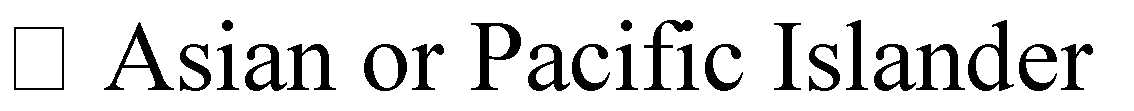
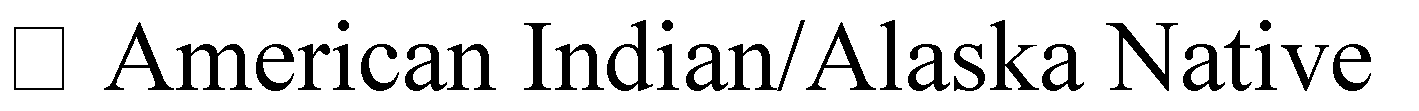
Best Time to Call:

**Is there a legal document to keep on file regarding child custody or parent rights?**



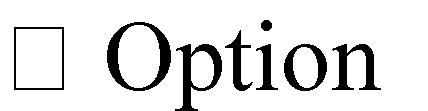
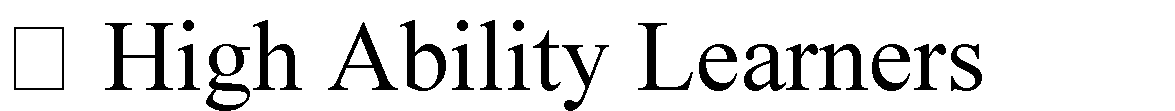
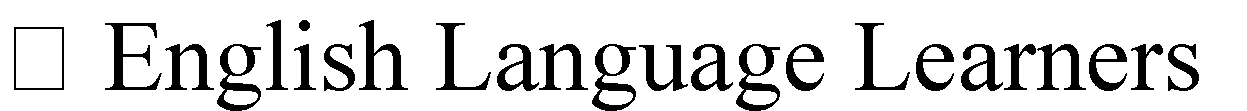
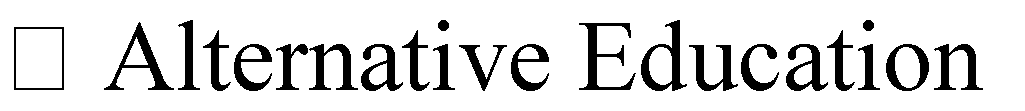
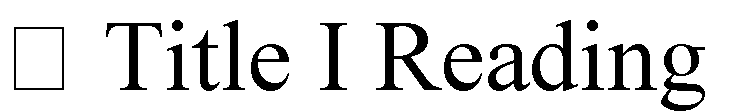
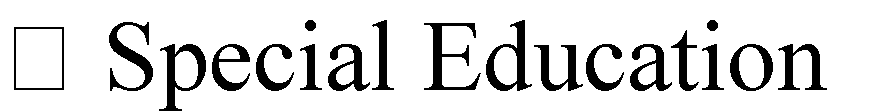
(If “yes”, please provide a copy of document)

**Ethnicity (Check area that best describes your child. Required for State/Federal Forms):**



Comments:

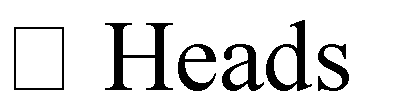
**Programs in which this student has participated in the past:**



-

In (F

rom another District)



tart



None

**Emergency Information (REQUIRED) Please list two emergency contacts other than parent/guardian:**

Name: Relationship to Child: Phone No.

Name: Relationship to Child: Phone No.

In addition to emergency contacts, please specify individuals who are authorized to check out your child from

program:

**MEDICAL INFORMATION (REQUIRED):**

Please list any medical conditions including illnesses, conditions affecting health, allergies to foods or medications, any special accommodations needed and any medications your child regularly takes:

Special accommodations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child require medication during after school hours? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If it is necessary to give your child medications, do you give permission to the staff to give medications in line with [Program Name] policy and procedures? □ Yes □ No: Please initial: \_\_\_\_\_\_\_\_

What will your child do at the end of the day?

□ walk or bike at \_\_\_\_\_ p.m. to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ location.

□ be picked up at \_\_\_\_\_p.m.

**OTHER**

I give permission for my child to be enrolled in programs and activities, on and off school campus.

I give permission to use photographs, writings, artwork, etc. for promotional purposes.

I give staff permission to transport my child to program activities and for medical care purposes.

I give permission for staff to give and receive necessary information about my child with [Program Name], partners, and evaluators to assist with providing the best program experience for my child.

If my child walks home from the program, I understand that [Program Name] is no longer responsible for the care of my child after they are signed out of the program.

YES NO

YES NO

YES NO

YES NO

YES NO

**I have received, read, and understand the policies of the parent handbook.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

PARENT SIGNATURE DATE

The hours of operation for normally scheduled school days will be Monday through Friday,

[time to time]. Afternoon snack is provided during the afterschool program.

The hours of operation for full district in-service days will be [time to time].

During full days, morning snack, lunch, and an afternoon snack will be provided.