

After School Registration Form

Childs' Name _____ Age _____

Date of Birth (D/M/Y) _____

Address _____

Mother's Name _____

Phone (H) _____ (W) _____

Father's Name _____

Phone (H) _____ (W) _____

Legal Guardian (if different than above) _____

Phone (H) _____ (W) _____

E-mail _____

Child lives with ___ Mother ___ Father ___ Both ___

Other (explain) _____

Authorized individual to pick up Child if other then parent or legal Guardian

Alternate Contact in case of Emergency:

1. Name _____

Phone (H) _____ (W) _____

Relationship to Child _____

MEDICAL INFORMATION

Please check if your child has any of the following conditions:

___ Asthma ___ Physical Disability ___ ADHD

___ Diabetes ___ Tourette Syndrome ___ ADD

___ Epilepsy ___ Allergies ___ Emotional Disability

Please list any important details (medications, precautions, etc.)

Physician(s) _____

Medicare # _____ Expiry Date _____

ALLERGY ALERT: Please list your child's Allergies
