

## 2017-2018 After School Program REGISTRATION

**Part I: STUDENT INFORMATION:** *(PLEASE PRINT CLEARLY & COMPLETE ALL REQUESTED INFORMATION)*

Name of Child: \_\_\_\_\_  
Last First

Permanent Address:

\_\_\_\_\_  
Number and Street City State /Zip

Home Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Grade \_\_\_\_\_  
Month Day Year

Days Attending \_\_\_\_\_

**Part II: FAMILY DATA:** (Please complete all information)

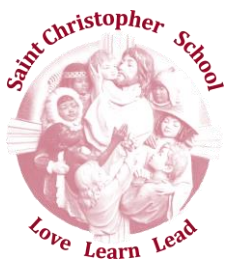
<b>Mother's / Guardian's Name</b>	<b>Father's / Guardian's Name</b>
<b>Street Address:</b>	<b>Street Address:</b>
<b>City/State/Zip Code:</b>	<b>City/State/Zip Code:</b>
<b>Home Phone:</b>	<b>Home Phone:</b>
<b>Cell Phone:</b>	<b>Cell Phone:</b>
<b>Email:</b>	<b>Email:</b>
<b>Work Phone:</b>	<b>Work Phone:</b>
<b>Occupation:</b>	<b>Occupation:</b>
<b>Employer:</b>	<b>Employer:</b>

**Part III: EMERGENCY CONTACT**

Name \_\_\_\_\_

Address \_\_\_\_\_  
Number and Street City State /Zip

Phone \_\_\_\_\_  
Home Cell Work



**Part IV: MEDICAL INFORMATION**

Physician \_\_\_\_\_

Address \_\_\_\_\_  
Number and Street City State /Zip

Phone \_\_\_\_\_

Allergies \_\_\_\_\_

Other Medical Conditions \_\_\_\_\_

Insurance Company \_\_\_\_\_  
Name Policy #

**Other than parent / legal guardian, who will have permission to pick up your child from the After School Program?**

*The After School Program staff is unable to release any child/children to someone other than a parent or guardian without written permission. Please complete the following items to indicate those individuals who have permission to pick up your child/children from the After School Program.*

1. \_\_\_\_\_  
(Name and relation to the child)

Phone: \_\_\_\_\_

2. \_\_\_\_\_  
(Name and relation to the child)

Phone: \_\_\_\_\_

3. \_\_\_\_\_  
(Name and relation to the child)

Phone: \_\_\_\_\_

*If there is a change in permission for any individual, I will inform the ASP staff in writing.*

**Parent / Legal Guardian Signature** \_\_\_\_\_

**Date** \_\_\_\_\_