AFTER SCHOOL PROGRAM ENROLLMENT FORM

STARTING DATE:

Total number of children who will attend program _________.
(Please list **all** children attending)

CHILD'S NAME	AGE	GRADE	TEACHER/SCHOOL

Children are enrolling for a: _____ 1 day _____ 2 day _____ 3 day _____4 day _____5 day program.

Program:	1 day	2 days	3 days	4 days	5 days
Fee/PK-6	$12.00	$22.00	$30.00	$38.00	$45.00
Add. Child	$10.80	$19.80	$27.00	$34.20	$40.50

Please check the days of the week and list the pick-up time each day your child(ren) will attend the After School Program.

DAYS ATTENDING	DAY	PICK UP TIME
	MONDAY	
	TUESDAY	
	WEDNESDAY	
	THURSDAY	
	FRIDAY	

IF SOMEONE OTHER THAN THE PARENT/GUARDIAN WILL BE PICKING UP YOUR CHILD(REN), PLEASE LIST THEIR NAMES AND RELATIONSHIPS BELOW. WITHOUT THIS INFORMATION WE WILL NOT BE ABLE TO RELEASE YOUR CHILD.

NAME ________________________________ RELATIONSHIP_______________ PHONE_____________

NAME ________________________________ RELATIONSHIP_______________ PHONE_____________

Your signature below indicates you have agreed to the After School Program regulations and procedures –

PARENT/GUARDIAN SIGNATURE_____________________________________ DATE_______________

ADDRESS____

EMAIL ____

PHONE NUMBER (home)_____________________________ (work)________________________________

BROADALBIN-PERTH CENTRAL SCHOOL DISTRICT

AFTER SCHOOL PROGRAM EMERGENCY CARD

STUDENT'S LAST NAME FIRST NAME SEX

DATE OF BIRTH GRADE TEACHER

FATHER'S NAME (FIRST/LAST) HOME ADDRESS/BOX # PHONE #

FATHER'S PLACE OF EMPLOYMENT ADDRESS PHONE#

MOTHER'S NAME (FIRST/LAST) HOME ADDRESS/BOX # PHONE#

MOTHER'S PLACE OF EMPLOYMENT ADDRESS PHONE #

HEALTH PROBLEMS OR ALLERGIES ____

____

In the event emergency treatment is needed, I authorize the After School Program staff to transport my child ______________________________ to ____________________ hospital for necessary treatment.

____ _______________________

Signature of Parent/Guardian Date

____ _______________________

Child's Physician Telephone #

____ _______________________

Child's Dentist Telephone #

List three friends or relatives who will assume temporary care of your child if you cannot be reached. **Do Not** list anyone who works and cannot be reached.

NAME ADDRESS PHONE #

NAME ADDRESS PHONE #

NAME ADDRESS PHONE #