BEFORE 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

Children are enrolling for a: _____ 1 day _____ 2 day _____ 3 day _____4 day _____5 day program.
Weekly charges per child will be: $4/wk $8/wk $12/wk $16/wk $20/wk

If not 5 days (Monday-Friday), please check the days of the week your child(ren) will be attending the program.

DAYS ATTENDING	DAY
	MONDAY
	TUESDAY
	WEDNESDAY
	THURSDAY
	FRIDAY

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

PARENT/GUARDIAN SIGNATURE__________________________________ DATE______________

ADDRESS____

EMAIL____

PHONE NUMBER (home)___________________________ (work)______________________________

BROADALBIN-PERTH CENTRAL SCHOOL DISTRICT

BEFORE 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 Before 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 #