



# Before and After Care Program Family Registration 2024-2025

## Please Print

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_  
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Guardian 1: \_\_\_\_\_ Guardian 2: \_\_\_\_\_  
 Address: \_\_\_\_\_ Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

**In the event of an emergency or illness, the following persons may be notified if I am unable to be reached. They also have permission to release my child(ren) from Aftercare.**

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

### Medical Contacts, In Case of Emergency

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Other: \_\_\_\_\_ Phone: \_\_\_\_\_

### I Grant Permission to Provide First Aid & Transportation to Emergency Care Facilities:

Signature of Parent/Guardian \_\_\_\_\_ Date: \_\_\_\_\_

### Child's Health Information

Child's Medical/Health Needs: \_\_\_\_\_  
 Child's Allergies/Treatments: \_\_\_\_\_  
 Child's Dietary Needs/Restrictions: \_\_\_\_\_

**Child's Medication(s): A Medication Form Must Be Completed For Each Medication Administered While in Program.**

### Please check all that apply

My child(ren) will attend: \_\_\_\_\_ Before Care \_\_\_\_\_ Daily \_\_\_\_\_ 2-3 times per week \_\_\_\_\_ As needed  
 \_\_\_\_\_ After Care \_\_\_\_\_ Daily \_\_\_\_\_ 2-3 times per week \_\_\_\_\_ As needed