

2018-2019 Registration Form
Aldersgate After-School Program

School Attending: (Please Check)

- Easley**
- Excelsior**
- Carrington**
- Eno Valley**
- Sandy Ridge**
- School of Creative Studies**

Attendance:

- Full Time**
- Part Time**

Student's Name: _____
(Last) (First) (Middle) (Nickname)

Address: _____
(Street) (City) (State) (Zip)

Birth Date: _____ **Age:** _____ **Grade:** _____

Parent Email Address: _____

Mother's Name: _____ **Home Phone:** _____ **Cell #** _____

Address: _____
(Street) (City) (State) (Zip)

Mother's Employer: _____ **Work Phone:** _____

Father's Name: _____ **Home Phone:** _____ **Cell #** _____

Address: _____
(Street) (City) (State) (Zip)

Father's Employer: _____ **Work Phone:** _____



List the names of persons who are permitted to pick up your child from the After-School Program:

_____	_____
_____	_____
_____	_____

Does your child have any known allergies such as food, medications, plants or animals? Yes No If yes, please explain. _____

Does your child require medication to be administered during after-school hours? Yes No

****If yes, please complete a Medication Administration Form.**

Does your child have any medical condition that we should be aware of while at the after-school? (I.e. asthma, allergies, etc.) Yes No
If yes, please explain. _____

Is there anything your child cannot eat? Yes No
If yes, please list. _____

How much of your child's homework should he/she do during homework time? All Some None

Does your child have particular fears or anxieties of which we should be aware? Yes No If yes, please explain. _____

Emergency Care Information:

Child's Doctor: _____ Phone: _____

Office Address: _____

Child's Dentist: _____ Phone: _____

Office Address: _____

Hospital Preference: _____

If neither parent can be reached, whom should we contact in case of an emergency situation?

(Name) (Relationship) (Phone Number)

(Name) (Relationship) (Phone Number)

Parent Statement:

I agree that the Director may authorize the physician of her choice to provide emergency care in the event that neither I, nor the family physician can be contacted immediately. I have also, received and read the Parent Handbook and I understand the information outlined in the handbook.

(Parent Signature)

(Date)

(Parent Signature)

(Date)