2022-2023 Registration Form
Aldersgate After-School Program

School Attending: (Please Check)
- **___Easley**
- **___Excelsior**
- **___Carrington**
- **___Eno Valley**
- **___Sandy Ridge**
- **_________________________**

Attendance:

____ Full Time
____ Part Time
_____part time days

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

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

Birth Date: _________________ Age: ________ Grade: _______

Parent Email Address: ____

Parent 1 Name: ______________Home Phone: ___________ Cell # ___________

Address: ____
(if different) (Street) (City) (State) (Zip)

Parent 1 Employer: ______________________ Work Phone: _______________

Parent 2 Name: _____________ Home Phone: ___________ Cell # ____________

Address: ____
(if different) (Street) (City) (State) (Zip)

Parent 2 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: ___________________

Child's Dentist: ___________________________ Phone: ____________________

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)