2025-2026 Registration Form

Aldersgate After-School Program

School Attending: (Please Check)

- ___Easley
- ___Excelsior
- ___E. K. Powe
- ___Eno Valley
- ___Holt
- ___Little River
- _____ Carrington
- _____ School of Creative Studies
- _____ Other

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)