# After School Application

**Child's First Name:**_____**Last Name:**_____

**Date of Birth:** ____/____/____ **Teacher:**_____**Grade:** **Room #:**_____

**Parents or Guardian's Name(s):** _____

**Email**_____

**Address:** _____**Home Phone #:** _____

**Mother's Work Phone #**_____**Father's Work Phone#:** _____

**Mother's Cell#** _____**Father's Cell Phone#:**_____

***Person(s) authorized to pick up your child / Emergency Contacts:*** **(Person must show picture I.D.)**

Name:_____ Relationship: _____ Phone#:_____
Name:_____ Relationship: _____ Phone#:_____
Name:_____ Relationship: _____ Phone#:_____
Name:_____ Relationship: _____ Phone#:_____

**Is your child under medical care or taking any medication(s)? □ Yes □ No**
**If yes, please check all of the following conditions that your child has and indicate if medication needs to be dispensed during the after school program?**

□ Bee Sting Allergy Epi-pen □ Yes □ No □ Other Allergies: _____
□ Asthma Inhaler □ Yes □ No □ Special Needs / Disability:_____
□ Diabetes Insulin □ Yes □ No □ Other:_____
□ Vision / Hearing Glasses □ Yes □ No

**Family Health Care:** Physician's Name:_____ Phone #:_____
Address:_____ Medi-Cal: □Yes □ No
Health Insurance# _____

**Parent or Guardian Signature:**_____ **Date:**_____

***For Office Use Only***
Enroll Date:_____ Initials: _____

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