

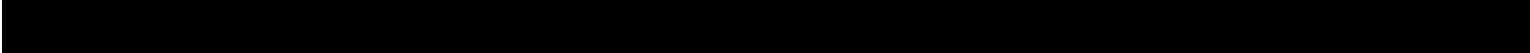


After Care Registration Form

OFFICE USE:	
Sibling:	Yes or No
Program Code:	_____
Form Complete	_____
Registration Fee Received	_____
Initial Payment Received	_____

CHILD'S NAME (Last name, First name)	CHILD'S AGE	DATE OF BIRTH	HOME PHONE NO.
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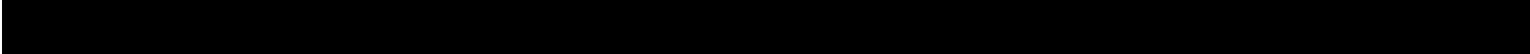
CHILD'S ADDRESS	CITY	STATE	ZIP
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PARENT/GUARDIAN'S NAME (Last name, First name)	DATE OF BIRTH	HOME PHONE	CELL PHONE
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HOME ADDRESS	CITY, STATE, ZIP	E-MAIL ADDRESS
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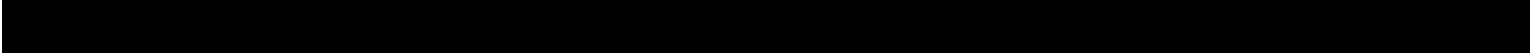
DRIVER'S LICENSE #	PLACE OF EMPLOYMENT	WORK PHONE NO.
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PARENT/GUARDIAN'S NAME (Last name, First name)	DATE OF BIRTH	HOME PHONE	CELL PHONE
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HOME ADDRESS	CITY, STATE, ZIP	E-MAIL ADDRESS
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DRIVER'S LICENSE #	PLACE OF EMPLOYMENT	WORK PHONE NO.
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EMERGENCY CONTACT IF PARENTS CANNOT BE REACHED	RELATIONSHIP	PHONE NO.
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EMERGENCY CONTACT HOME ADDRESS	CITY	STATE	ZIP
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AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION: In the event that I cannot be reached, I give consent for necessary emergency treatment for my child.
 ____ Yes ____ No

I AUTHORIZE SOMERSET ACADEMY BETHANY TO RELEASE MY CHILD TO THE ADDITIONAL FOLLOWING PEOPLE:

NAME	RELATIONSHIP	PHONE NO.

Parent's Acknowledgements: This is to acknowledge that Somerset Academy Bethany (SAB) has provided me with access to the online Parent Guide/Handbook or provided me with a copy of the Parent Guide/Handbook. I agree to read and adhere to the information included.

Parent Initials:

Date: _____

Are there any court orders affecting custody of this child?	CUSTODY/ COURT ORDERS ____ Yes ____ No <i>(If yes, you MUST provide a copy of these orders)</i>
Are there any restraining orders? ____ Yes ____ No	Who has Primary custody of this child? _____
Child may be released to: () FATHER () MOTHER () OTHER/NOTES: _____	



Health History:

Health History
Please list any **DIETARY** or **PHYSICAL** restrictions:

Please list any known **ALLERGIES**:

Treatment to be given when in contact with stated **ALLERGIES**:

Please check all the following that apply to your child's **HEALTH HISTORY**:
 ADD ADHD EXISTING ILLNESS
 DIABETES TAKES DAILY MEDICATION
 ASTHMA OTHER: Please explain: _____

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:
In the event of an emergency, I authorize SAB staff and administration to contact emergency services.
Please list your student's primary physician information below and preferred hospital:
NAME OF LICENSED PHYSICIAN: _____
ADDRESS: _____

PHONE NUMBER: _____
NAME OF HOSPITAL OR CLINIC: _____
ADDRESS: _____

PHONE NUMBER: _____
I give consent for necessary emergency treatment when my child is in the care of this physician and/or hospital/clinic.
Parent Signature: _____ Date: _____

I HAVE READ THIS RELEASE:

Parent or Guardian's Signature if Participant is legally a minor

Printed Name

Parent's E-Mail Address

Date: ____/____/____

