After Care Registration Form

DROP IN

OFFICE USE:

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

CHILD'S NAME (Last name, First name)	TEACHER	HOME PHONE NO.	
CHILD'S ADDRESS	CITY	STATE	ZIP

PARENT/GUARDIAN'S NAME (Last name, First name)	DATE OF BIRTH	HOME PHONE	CELL PHONE
HOME ADDRESS	CITY, STATE, ZIP	E-MAIL ADDRESS	
DRIVER'S LICENSE #	PLACE OF EMPLOYMENT	WORK PHONE NO.	

PARENT/GUARDIAN'S NAME (Last name, First name)	DATE OF BIRTH	HOME PHONE	CELL PHONE
HOME ADDRESS	CITY, STATE, ZIP	E-MAIL ADDRESS	
DRIVER'S LICENSE #	PLACE OF EMPLOYMENT	WORK PHONE NO.	

EMERGENCY CONTACT IF PARENTS CANNOT BE REACHED	RELATIONSHIP	PHONE NO.	
EMERGENCY CONTACT HOME ADDRESS	CITY	STATE	ZIP

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

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: _____

CUSTODY/ COURT ORDERS _____ Yes _____ No

Are there any court orders affecting custody of this child? *(If yes, you MUST provide a copy of these orders)*

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 THE ABOVE MEDICAL RELEASE:

_____
Parent or Guardian's Signature

_____ Date: _____/_____/_____
Printed Name

_____
Parent or Guardian's E-Mail Address