

Corpus Christi After School Program Registration Form

Family Name: _____

Child Name	M/F	DOB	Check Full Time or Circle Days
_____	M/F	/ /	___ M T W Th F
_____	M/F	/ /	___ M T W Th F
_____	M/F	/ /	___ M T W Th F
_____	M/F	/ /	___ M T W Th F

Family Contact Information

Parent's/Guardian's Name: _____

Address: _____
Street Town Zip Code

Email #1 : _____

Email #2 : _____

Email #3 : _____

Father

First & Last name: _____

Place of employment: _____

Business phone number: _____

Cell Phone number: _____

Mother

First & Last name: _____

Place of employment: _____

Business phone number: _____

Cell Phone number: _____

Pick-up & Emergency Contact

First & Last Name

Phone Number

Relationship to Child

Any medical concerns or allergies: _____

NOTE: With the exception of emergency medication the After School Director and/or staff are not authorized to administer any over the counter or prescription medication during after school hours.

I have read the After School Program Policy Handbook and I have discussed it with my child/children. I understand my obligation to cooperate in enforcing the rules and regulations stated in this handbook and in having my child/children abide by these rules.

Signature of Parent/Guardian _____

Date: _____