Corpus Christi After School Program Registration Form

Family Name: _____

Child Name	M/F	DOB	Circle Status Type and Days
_____	M/F	/ /	Full or Part M T W TH F
_____	M/F	/ /	Full or Part M T W TH F
_____	M/F	/ /	Full or Part M T W TH F
_____	M/F	/ /	Full or Part M T W TH F

***Please be sure days of the week are circled for your child's weekly schedule. Note: Full-time offers a better rate if you child utilizes after school for more than 9 hours a week. Otherwise, please select part-time. Please refer to the after school handbook for additional information.**

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.

Please email this form by August 24. 2020 to ccasp@corpuschristischoolct.org

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: _____