SCLS AFTER SCHOOL PROGRAM 2018 - 2019

If Parent and Student are in agreement with the After School Program as outlined in handbook, please print and sign your name below and complete the needed information for our files.

Name of Student(s): Grade (s): Days Attending Date Beginning Program

Parent/Guardian Name (please Print) Parent/Guardian Signature

Parent/Guardian Name (please Print) Parent/Guardian Signature

BEST Phone Number(s) to contact Parent/Guardian between 3:30 and 5:30 pm:

Name Phone Number

Name Phone Number

Name Phone Number

EMERGENCY contact if Parent/Guardian is not reached:

Name Relation to Student Phone Number

Name Relation to Student Phone Number

Medical Information - Please complete form on opposite side

Medical Information:

Does your child have any health conditions? No_____ Yes_____

If yes, then please check and explain: Asthma___ Diabetes___ Deafness___ Wears Glasses___
Blood Disorder___ Convulsive Seizures___ Arthritis___ Kidney/Bladder___ ADHD___
Heart___ Bee Sting Allergy___ Seasonal Allergies___ Dietary Restrictions___
Food Allergies___ Other___(Please list)_____
_____
_____

Does your child require daily medication? No___ Yes___

Does your child have an epi-pen or inhaler? No___ Yes___

Physical Handicap (Describe)_____

Hospital Preference if necessary in an emergency_____