



EXTENDED DAY REGISTRATION FORM

PLEASE PRINT

Grade: _____ Student Last Name: _____ Student First Name: _____

Days per week: ☐ Monday; ☐ Tuesday; ☐ Wednesday; ☐ Thursday; ☐ Friday

Address:

Home Number: _____ Email: _____

Mother's Cell Number: _____

Father's Cell Number: _____

Person(s) responsible for picking the child up and relationship to child:

| Name | Relationship |
|------|--------------|
|------|--------------|

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In the event that you cannot be reached at the above number, please give another name, Relationship to child and phone number.

| | |
|--------------|---------------------|
| Name _____ | Relationship: _____ |
| Cell # _____ | |

| | |
|--------------|---------------------|
| Name _____ | Relationship: _____ |
| Cell # _____ | |

WE WILL NOT RELEASE YOUR CHILD TO ANYONE WHOSE NAME DOES NOT APPEAR ON THIS FORM.

Does your child have allergies? _____ If so, please list:

If an emergency should arise and a parent or guardian cannot be contacted, please complete the following:

Name of family doctor: _____ Phone number: _____ Hospital: _____

Parental signature(s) _____

**Preferred Billing: E-Mail Only _____; Paper Only _____; Email & Paper _____