



Good Shepherd School

Preschool & K-8

AFTERCARE REGISTRATION 2024-2025

75 Shepherd Way

Frankfort, KY 40601

Child's Name: _____ Birthdate: _____

Grade: _____ Teacher: _____

Address: _____ City/ Zip: _____

Person/s with whom the child lives: _____

| | Mother: | Father: |
|---------------|---------|---------|
| Name: | | |
| Home Address: | | |
| Employer #: | | |
| Work phone #: | | |
| Cell phone #: | | |

Child's Physician: _____ Phone: _____

Insurance Information: Insurance Carrier: _____

Policy #: _____ Group #: _____

Preferred Hospital: _____ Phone: _____

Parent Signature: _____
Date: _____

Parent Signature: _____ Date: _____

individuals to contact in the case of an emergency:

Phone#: _____
Phone#: _____

Does your child have any food allergies? No Yes _____

Does your child have any dietary restrictions? No Yes _____

Does your child receive any special services? No Yes _____

Is there any medical history GSS should be aware of? (surgeries, illnesses, ect...)

No Yes _____

My child has permission to be released to the following individuals in addition to the emergency contact persons listed above.

Relationship: _____
Relationship: _____
Relationship: _____

My child's schedule for attendance is as follows: (Please check all that apply)

M____ T____ W____ Th____ Fri____

I authorize Good Shepherd School and its representatives to get emergency medical treatment for my child if necessary.

Parent Signature: _____ Date: _____

Permissions and Acknowledgements:

Good Shepherd Preschool Academy ☐ HAS ☐ **DOES NOT HAVE** my permission to publish on the school website and social media channels or release to the media my child/ren's name or photos/ videos/ recordings of my child/ren for school-related purposes.

My child/ren's name and photos may be published in the school yearbook. ☐ YES ☐ NO

Parent Signature: _____

Date: _____