Old Homosassa Learning Center's After School Program

Registration Form

Student's Name ____ Date of Birth ______________

Address ____

Parent/Guardian Name_______________________________________ Contact # _________________

Parent/Guardian Name_______________________________________ Contact # _________________

Emergency Contacts

Name ____ Contact # _________________

Name: ____ Contact # _________________

Student will be picked up by ____________________________ Relation ________________ #____________

Student will be picked up by ____________________________ Relation ________________ #____________

Student will be picked up by ____________________________ Relation ________________ #____________

Student will be picked up by ____________________________ Relation ________________ #____________

Student will not be allowed to leave with someone NOT listed above unless prior arrangements are made by parent/guardian

Student is allowed to walk home ☐Yes ☐No

<u>Is your child being treated for any of the following?</u>

Diabetes ☐Yes ☐No Hemophilia or bleeding disorder ☐Yes ☐No

Asthma ☐Yes ☐No Epilepsy or Seizures ☐Yes ☐No

<u>Is your child taking medication?</u> ☐Yes ☐No

If yes:

Prescription Medication: ____

Non-prescription Medication: ____

All medication must be in original pharmacy container/bottle and labeled with appropriate medication label and times for administration must be noted.

<u>Does your child have allergies?</u> ☐Yes ☐No If yes, specify: ________________________

PARENT/GUARDIAN SIGNATURE ____ **DATE** ______________