

**Student Information: 2024 – 2025**

Student's Last Name	First	Grade	Date of Birth	Allergies	List any medication taken on a regular basis
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1.
2.
3.

If in a medical emergency, we are unable to contact you, do we have permission to transport your child to the hospital? (please initial one) Yes \_\_\_\_\_ No \_\_\_\_\_

Do we have your permission for the hospital and physician on call to treat your child? (Please initial one) Yes \_\_\_\_\_ No \_\_\_\_\_

Family Physician - \_\_\_\_\_

List all medical or physical problems your child has (ex. Epilepsy): \_\_\_\_\_

Student's Address	City	Zip	Home Phone
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Email address of individual responsible for weekly payment: \_\_\_\_\_

Mother's Last Name	First	Work Phone	Cell Phone	Home Phone	4 Digit ID Code
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Father's Last Name	First	Work Phone	Cell Phone	Home Phone	4 Digit ID Code
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Child Resides With:                      Both Parents   ☐                      Mother   ☐                      Father   ☐

**Please list anyone who has your permission to pick up your child/children from after care:**

Last Name	First	Work Phone	Cell Phone	Home Phone	4 Digit ID Code
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1.
2.
3.
4.

Will your child attend aftercare?                      Daily \_\_\_\_\_                      Sometimes \_\_\_\_\_