For Office Use Only

Date Entered___________
Start Date_____________
Restrictions____________

FOR OFFICE USE ONLY
Registration Paid

Cash______ Check #_______
Rec #______ Amt. Pd.______

BARTOW COUNTY AFTER SCHOOL PROGRAM
STUDENT APPLICATION FORM

(Return to the school office)

____ _____________ ☐ Male ☐ Female
Child's Name Grade

____
Address City State Zip

___________________________________ ____
Home Phone e-mail address

____
Mother/Guardian Name Home# Cell#

____
Father/Guardian Name Home# Cell#

<u>IN CASE OF EMERGENCY CONTACT:</u>

Name:____

Phone: Home_________________________________Work____________________Cell____________________

Name: ____

Phone: Home_________________________________Work____________________Cell____________________

The following people are the only persons that are allowed to pick up my child from the After School Program (other than parent/guardian). ID must be provided upon pick up.

____
Name Relationship Phone#

____
Name Relationship Phone#

My Child will be enrolled for: _______Full Week ________Drop In ______ Certain day of the Week:_______________

Bartow County After-School Program
Student Application Form
(page 2)

If your child has special requirements such as allergies, diet, medical, etc. proper documentation must be on file. Please list any additional medical information the ASP staff should know about your child.

____

____

____

____

____

Additional people who are allowed to pick up my child:

Name____ **Relationship**______________________ **Phone#**_________________

Name____ **Relationship**______________________ **Phone#**_________________

Name____ **Relationship**______________________ **Phone#**_________________

Name____ **Relationship**______________________ **Phone#**_________________

I have been provided with the After-School Parent Handbook and have, read, understand, and agree to abide by all regulations and procedures. I also agree to assume liability for all accidents and injuries occurred during After-School Program. In the event of an emergency, I authorize the person(s) in charge to seek immediate medical attention for my child.

____

Parent/Guardian Signature.

Bartow County Board of Education Health Record

Student Name: ____Today's Date:_____________

Answers to the following questions are for our records and will be released on a need to know basis only.

Is your child now under the care of a physician? _________If yes, explain______________________________

Physician's Name_____________________________________Telephone#_____________________________

Is your child in good health? Yes___________ No____________

Does your child have, or has he/she had any of the following diseases or problems?

ANEMIA__________CHICKEN POX__________DIABETES__________EYE PROBLEMS___________

CYSTIC FIBROSIS__________SEIZURES__________TYPE___________________________________

AGE OF ONSET__________PRESCRIBED MEDICATIONS____________________________________

DATE OF LAST SEIZURE____

ASTHMA__________PRESCBRIBED MEDICATION____

AGE OF ONSET___________

Please note any special medical problems____

Has your child ever been diagnosed with ADD/ADHD? ______________________________________

Prescribed Medication____

Is your child enrolled in some type of special needs program? ________________________________

Is your child taking any other medications? Yes__________ No__________ If yes, give name of

Medication____

List food and any other allergies your child has____

Insurance Carrier____**Group#**_________

Policy Holder's Name____**Employer**__________________

Family Physician____**Telephone #**______________

Directions to home:____

____

Please list relatives or friends who will assume temporary care of your child in the event that you cannot be reached. (It is important that we have these numbers. Sick children cannot be left at school.) NO STUDENT WILL BE ALLOWED TO LEAVE SCHOOL WITH A PERSON NOT LISTED. BE SURE TO LIST ALL PERSONS WHO YOU WISH TO BE ABLE TO PICK UP YOUR CHILD.

____

NAME	RELATIONSHIP TO STUDENT	TELEPHONE

____

NAME	RELATIONSHIP TO STUDENT	TELEPHONE

____

NAME	RELATIONSHIP TO STUDENT	TELEPHONE

IN THE EVENT THAT I CANNOT BE REACHED, I GIVE PERMISSION FOR THE SCHOOL REPRESENTATIVE TO TRANSPORT MY CHILD TO THE NEAREST MEDICAL FACILITY, OR FAMILY DOCTOR AND I DO AUTHORIZE EMERGENCY TREATMENT, I WILL ASSUME FULL RESPONSIBILITY FOR CHARGES RELATED TO THIS ILLNESS OR ACCIDENT.

SIGNATURE OF PARENT OR GUARDIAN____

SIGNATURE OF PARENT OR GUARDIAN____

Student Name___________________________________ **Teacher**________________________________

Birthday____ **SS#**____________________________________

Student's Address:____

Student lives with: Both Parents_____ **Mother**_____ **Father**_____ **Guardian**_____

Father's Name _____________________ **Home Phone#** ____________________**Cell#**____________________

Employer__________________________ **Phone #**_________________________ **Ext.**____________________

Mothers' Name_____________________ **Phone #**_________________________**Cell#**____________________

Employer__________________________ **Phone #**_________________________ **Cell#**____________________

Guardian's Name ___________________ **Phone #**_________________________ **Cell#**____________________

Employer __________________________ **Phone#** ________________________ **Ext.**_____________________