After School Program Registration Form: 2024-2025

Start Date:_____ End Date:_____

Child's Name	Age	Grade	Sex	Date of Birth

Circle the days of attendance **M T W Th F**

School your child is attending: _____

Email Address _____

Parent/Guardian Name _____ Home Phone _____

Home Address _____ Cell Phone _____

Place of Work _____ Work Phone _____

Work Schedule _____

Parent/Guardian Name _____ Home Phone _____

Home Address _____ Cell Phone _____

Place of Work _____ Work Phone _____

Work Schedule _____

Marital Status: ____Married ____Separated ____Divorced ____Remarried ____Parent Deceased ____Single

Custody Arrangements? _____

Is anyone restricted from seeing the child (ren)? Is so, please list. _____

Other members in the household (including adults & children)

Name	Relationship to child

CONTINUE ON NEXT PAGE ⇨

Method of Payment: **Please CIRCLE one of the following: MEMBER or NON-MEMBER**

_____ Pay in Full Semester: Fall (Sept, Oct, Nov, Dec) Member: $640 Non-Member: $740
Spring (Jan, Feb, Mar, Apr, May) Member: $800 Non-Member: $925

_____ Pay in Full Annual: September-May (Full school year) Member: $1,440 Non- Member: $1,665

_____ Bank Draft: Community Center will debit payment on the 2nd or 15th of each month. **(Attach a voided check)**
Member: $160 per month Non-Member: $185 per month

Withdraw/Refund Policy: Program withdrawal requires an advanced two-week notice. Bank Draft cancellations must be received by the 25th of the current month to stop the monthly billing for the next month. If a child is removed, due to conduct issues, there will be no refunds given for the current month. Refunds will be prorated based on the payment method that is selected from the above options.

Authorized Persons for EMERGENCY CONTACT/Authorized to SIGN children out.

These people will be notified in case of emergency or illness when parents/guardian cannot be reached. Community Center will allow children to be checked out by the following people. **(PLEASE PROVIDE 2 NAMES)**

Name	Relationship to Child	Contact Phone #'s
_____	_____	_____
_____	_____	_____
_____	_____	_____

Child/ Family Physician:

Doctor's Name:_____ Clinic: _____

Emergency Medical Release

If emergency medical care is deemed necessary and I cannot be contacted, I authorize the staff to act in my behalf in granting permission for my child to receive emergency treatment.

Is there any health problems/allergies that would restrict your child's participation in any activities? _____

_____

If yes, explain: _____

_____

Parent/Guardian Signature _____ Date _____

PHOTOGRAPHIC PERMISSION: I DO I DO NOT (circle one) give permission to have my child appear in any media coverage approved by the Community Center ASP. I understand that the instructor, in conjunction with the Coordinator, has been given the authority by the Community Center Board of Directors to determine appropriate requests.

Is there any additional information you would like to share about our child? (Favorite food or color, special interests, etc.)

_____

I/We attest that the information listed on this application is as accurate and complete as possible.

_____ _____

Parent Signature Date