SIOUX CENTER CHRISTIAN SCHOOL

Aftercare Program Registration

Child Information:

Full Name _____ Nick/Preferred Name _____

Date of Birth ____/____/____ Anticipated Start Date _____

Address _____ City _____ Zip _____

Any Food Allergies/Intolerances _____

Medication Allergies _____

Other Allergies _____

Medical Conditions (attention disorders, epilepsy, diabetes, physical limitations, etc.)_____

_____

Additional information you would like us to know about your child _____

_____

Immunizations: The program requires a current copy of immunizations to be kept on file. I give permission for this program to obtain a copy from the County Health Office or obtain a copy SCCS has on file.

Parent initials _____

Family Information:

1) Parent/Guardian Name _____

Address (if different from child) _____ City_____ Zip_____

Mobile phone _____Text: yes no Home phone _____

Place of employment _____ Work phone _____

e-mail that you check on a regular basis _____

2) Parent/Guardian Name _____

Address (if different from child) _____ City_____ Zip_____

Mobile phone _____Text: yes no Home phone _____

Place of employment _____ Work phone _____

e-mail that you check on a regular basis _____

3) Siblings: Name Age Grade Can they "pick up" above child?

_____

_____

_____

_____

CHILD'S NAME _____

Child Safety Information:
Please list people who are going to pick your child up from the program on a regular basis. Please note that a verified phone call or text to program staff will suffice if a different individual not listed will be picking your child up for the day. _____
_____
_____

Is your child allowed to walk or ride bike to and from the program unaccompanied? _____yes no _____
Please note that the program will not provide this supervision. If children are transporting themselves to and from the program (by bike, for example), the program will not take responsibility for any injury the child suffers while not in our care.

Is there anyone that is restricted from seeing or picking up above child? Please list and explain _____
_____
_____

Emergency Contacts:
Please list at least two emergency contacts (other than parent/guardian)
Name Relationship to child Contact number:
_____
_____
_____
_____

Child's Primary Doctor_____ Phone _____
Child's Primary Dentist _____ Phone _____
Other Medical professionals who may need to be contacted in an emergency
_____ Phone_____

I attest that the information I have provided on this form is accurate and up to date to the best of my knowledge. In the event of an emergency, I give my permission to the program staff to have my child treated by medical personnel. The staff member in charge shall make reasonable attempts to contact me prior to and during emergency medical treatment. I will not hold any program staff or staff of Sioux Center Christian School liable in the case of accident and/or injury.

Signed Name _____ Date_____

Printed Name _____

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Registration received on _____(date) by _____(staff)

Reviewed on the following dates for information and accuracy:
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