

SAS EXTENDED CARE REGISTRATION

Check the program for which you are registering:

Check# _____ 2010-2011

Amt. _____

_____ Full Time

_____ Mornings Only

_____ Afternoon Only

STUDENT NAME _____ GRADE _____ (Grade entering 2010-2011)

STUDENT NAME _____ GRADE _____

STUDENT NAME _____ GRADE _____

HOMEADDRESS _____ City _____

Zip _____ Phone# _____ Person responsible for payments _____

FATHER'S NAME _____ HOME# _____

Address (if different from above) _____

EMPLOYMENT _____ PHONE# _____

FATHERS CELL # _____ e-mail address _____

MOTHER'S NAME _____ HOME # _____

Address (if different from above) _____

EMPLOYMENT _____ PHONE# _____

MOTHER'S CELL# _____ e-mail address _____

STEP-PARENT NAME _____ EMPLOYMENT _____

“ “ WORK# _____ CELL # _____ e-mail address _____

Emergency numbers/other persons authorized to pick up your child:

NAME _____ PHONE# _____ CELL# _____

NAME _____ PHONE# _____ CELL# _____

NAME _____ PHONE# _____ CELL# _____

NAME _____ PHONE# _____ CELL# _____

PHYSICAL HANDICAPS

NAME _____ VISION ___ ASTHMA ___ OTHER _____

Food/ALLERGIES _____ LIST _____

NAME _____ VISION ___ ASTHMA ___ OTHER _____

Food/ALLERGIES _____ LIST _____

*****PLEASE PRINT INFORMATION ONLY*****