# After School Care Program Registration Form - Horizons K-8

Child's Name:_________________________________ Date of Enrollment:___/___/___

Home Address:_______________________________________________________________

Home Phone:______________________ Sex: M / F D.O.B.:____/____/____ Age:_____

Parent/Guardian's Name:_____________________________________________________

Address(if different):_______________________________________________________

Home #:(___)___-______ Cell #:(___)___-______ Email:__________________________

Place of Employment:________________________________________________________

Address of Employment:_______________________________Work #:(___)___-______

Parent/Guardian's Name:_____________________________________________________

Address(if different):_______________________________________________________

Home #:(___)___-______ Cell #:(___)___-______ Email:__________________________

Place of Employment:________________________________________________________

Address of Employment:_______________________________Work #:(___)___-______

Other Family Members:_______________________________________________________

Special instructions: _________________________________________________________

**Person(s) authorized to pick up your child (Must show valid photo ID if requested)**

Name:_________________________ Phone #:(______)______-_______ License/ID#:______________

Address:_____________________________________________________________________________

Name:_________________________ Phone #:(______)______-_______ License/ID#:______________

Address:_____________________________________________________________________________

Special Instructions for Pick-Up: ______________________________________________________

Information Updated: ___/___/___ Initials of Parent/Guardian: _____

**Emergency Contacts**

1. Name:____________________________________________ Relationship:______________________

   Phone #:(______)_______-_______ Home #:(______)_______-_______

   Address:____________________________________________________________________________

2. Name:_____________________________________ Relationship:______________________________

   Phone #:(______)_______-_______ Home #:(______)_______-_______

   Address:_____________________________________________________________________________

3. Name of Child's Doctor:_____________________________ Phone #:(______)_______-_______

   Address:_____________________________________________________________________________

4. Name of Child's Dentist:_____________________________ Phone #:(______)_______-_______

   Address:_____________________________________________________________________________

5. Insurance Policy/Number: __________________________________________________________

6. Hospital Preference:_________________________________ Phone #:(______)_______-_______

   Address:_____________________________________________________________________________

**<u>Medical Information</u>**

**Health History – Check all that apply. Describe if necessary.**

Chronic Medical Conditions:________________________________________________________________

- Visual Impairments
- Hearing Impairments
- Ear Infections
- Flu/Flu Shot
- Asthma
- Nosebleeds
- Measles
- Mumps
- Diabetes
- Heart Disease/Defect
- Convulsion/Seizures
- Chicken Pox

**Allergies (check all that apply)**

- Hay Fever
- Plant Poisoning
- Insect Stings
- Penicillin
- Other Drugs
- Animals

Foods: ________________________

Other/Special Instructions:

________________________________

Operations/Serious Injuries (dates): ____________________________________________________________

Does he/she take any Medications? : ___________________________________________________________

Information Updated: ___/___/___ Initials of Parent/Guardian: _____

If applicable, please describe any health limitations relevant to your child:
______________________________________________________________________________

If applicable, please check any activities you would like your child opted out of. A separate activity will be provided in a different location. If you do not check any, your child will be allowed to participate to the extent of program offerings.

- Music
- Technology skills (Computer Lab)
- Arts and Crafts
- Cooking
- Story Time
- Indoor Activities
- Outdoor Activities
- Other: ____________________

_____(INITIAL) **Authorization for Leaving School Premises**

I/We hereby give permission to the staff of Horizons K-8 School and After School Care program to leave school premises for all program purposes including, but not limited to field trips on foot or in a vehicle, and to provide off-campus supervision and possible transportation in emergency situations.

_____(INITIAL) **Authorization for Emergency Medical Care**

I/We hereby give permission to the staff of Horizons K-8 School and After School Care program to call on my/our child's behalf for any doctor or emergency medical services. I/We give permission for the doctor, hospital, or medical services to provide emergency medical or surgical care for my/our child. It is understood that the child care provider will make a conscientious effort to communicate with any parents, guardians and emergency contacts listed on the registration document before any action will be taken, time allowing. If the child care providers is unable to reach any of the contacts listed, treatment will not be delayed. I/we will accept the possibility and expense of emergency transportation, medical or surgical treatment.

**Movie Viewing Permission**

It is possible that Movies and/or TV shows may be watched during this program. Please Choose one or more of the following for your child.

______(INITIAL) My child may watch **G** (General Audience) movies/television.
(Examples: WALL-E, March of the Penguins, The Muppet Movie)

______ (INITIAL) My child may watch **PG** (Parental Guidance Suggested) movies/television.
(Example: Brave, Ice Age, Jumanji)

______ (INITIAL) My child may **NOT** watch movies/television during the After School Care Program. An alternate activity will be provided in a separate area.

I HAVE READ, UNDERSTAND, AND AGREE TO FOLLOW THE POLICIES AND PROCEDURES OF THE HORIZONS K-8 SCHOOL AFTER SCHOOL CARE PROGRAM.

__________________________Parent/Guardian Signature(s)  Date:

Information Updated: ___/___/___ Initials of Parent/Guardian: _____