# 2024-2025 Registration Form
# Aldersgate After-School Program

**School Attending: (Please Check)**

**___Easley**
**___Excelsior**
**___E. K. Powe**
**___Eno Valley**
**___Holt**
**___Little River**
**_____ Carrington**
**_____ School of Creative Studies**
**_____ Other**

**Attendance:**

**____ Full Time**
**____ Part Time**
**_____Part time days**

**Student's Name: _____**
**(Last) (First) (Middle) (Nickname)**

**Address: _____**
**(Street) (City) (State) (Zip)**

**Birth Date: _____ Age: _____ Grade: _____**

**Parent Email Address: _____**

**Parent 1 Name: _____Home Phone: _____ Cell # _____**

**Address: _____**
**(if different) (Street) (City) (State) (Zip)**

**Parent 1 Employer: _____ Work Phone: _____**

**Parent 2 Name: _____ Home Phone: _____ Cell # _____**

**Address: _____**
**(if different) (Street) (City) (State) (Zip)**

**Parent 2 Employer: _____ Work Phone: _____**

**List the names of persons who are permitted to pick up your child from the After-School Program:**

**_____ _____**
**_____ _____**
**_____ _____**

**Does your child have any known allergies such as food, medications, plants or animals? Yes No If yes, please explain. _____**
**_____**

**Does your child require medication to be administered during after-school hours? Yes No**
****If yes, please complete a Medication Administration Form.**

**Does your child have any medical condition that we should be aware of while at the after-school? (I.e. asthma, allergies, etc.) Yes No**
**If yes, please explain. _____**

**Is there anything your child cannot eat? Yes No**
**If yes, please list. _____**

**How much of your child's homework should he/she do during homework time? All Some None**

**Does your child have particular fears or anxieties of which we should be aware? Yes No If yes, please explain. _____**
**_____**

**Emergency Care Information:**

**Child's Doctor: _____ Phone: _____**

**Child's Dentist: _____ Phone: _____**

**Hospital Preference: _____**

**If neither parent can be reached, whom should we contact in case of an emergency situation?**

**_____**
**(Name) (Relationship) (Phone Number)**

**_____**
**(Name) (Relationship) (Phone Number)**

***Parent Statement:***
***I agree that the Director may authorize the physician of her choice to provide emergency care in the event that neither I, nor the family physician can be contacted immediately. I have also, received and read the Parent Handbook and I understand the information outlined in the handbook.***

**_____ _____ _____ _____**
**(Parent Signature) (Date) (Parent Signature) (Date)**