CATOOSA COUNTY PUBLIC SCHOOL

REQUEST FOR ENROLLMENT IN AFTER SCHOOL PROGRAM

Student Names (s) _____

Home Address: _____

_____

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The After School Program is a voluntary, self-sustaining program that provides care for students during after school hours. The safe and caring environment is intended to meet the needs of students who would otherwise be home alone after school. Although it is not a basic element of the general education program, it provides an opportunity for students to engage in after school activities.

Due to the fact that no particular supervision would necessarily be provided by certified personnel, this program may not be appropriate for all students.

I agree to be responsible for all costs associated with the individualized needs of my child during their participation in the After School Program.

As parent/guardian, I understand the purpose of the After School Program and understand that at times it may not be appropriate for my child to attend and agree to remove him/her from the program at that time.

Parent/Guardian Signature: _____

Date: _____

Star Care
After School Program
Registration Form

Child's Name:_____

Additional Children: _____

Best Phone Number to Reach Parent: _____

Address: _____

City: _____ ST: _____ Zip: _____

PARENT/GUARDIAN INFORMATION

Guardian's Name: _____ Cell Phone: _____

Relationship to student (Father/Mother, etc.) _____

Name of Employer:_____

Work Phone: _____ Other Emergency #: _____

Authorized to pick children up from Star Care YES or NO

Guardian's Name: _____ Cell Phone: _____

Relationship to student (Father/Mother, etc.) _____

Name of Employer:_____

Work Phone: _____ Other Emergency #: _____

Authorized to pick children up from Star Care YES or NO

I hereby authorize the release of my child(ren) from The Star Care After School Program to ONLY the following individuals. I understand that a phone call for student release to any other individual will not be accepted. **I also authorize Star Care, in case of an emergency, to contact these individuals in the event the parent/guardian cannot be reached.**

Name:_____ Phone:_____

Name:_____ Phone:_____

Name:_____ Phone:_____

Name:_____ Phone:_____

MEDICAL INFORMATION

Is your child allergic to bee stings? Yes No Does your child have asthma? Yes No

Please list any food allergies/restrictions:

_____

_____

Please list any medication that your child takes daily:

_____

_____

Please list any additional medical information that you feel we should know (include any special instructions regarding diet/allergies, etc.)

_____

_____

_____

_____

MEDICATION (INCLUDING OVER-THE-COUNTER) **WILL NOT** BE ADMINISTERED WITHOUT A DOCTOR'S NOTE.

All of the above information given is true to the best of my knowledge. I have also read the Parent Handbook and agree to abide by the conditions set forth in the handbook. **I acknowledge that I understand the charges for this program are paid weekly and are due in full every Friday. I understand that failure to adhere to the payment schedule will result in my child not being able to participate in this after school care program.**

Parent/Guardian Signature: _____Date: _____

OFFICE USE ONLY

$5.00 Star Care Enrollment Fee Paid: CASH CHECK #_____

DATE PD:_____