SCHOHARIE
CHRISTIAN AFTER SCHOOL PROGRAM
REGISTRATION 2017-2018

Student's Name _____ M F

Age_____ Birthday_____ Grade Entering ___

School_____

Church_____

How did you hear about us? _____

Parent/Guardian Information

Name of parent(s)/guardian with whom student resides:

_____

Home Phone_____ Cell Phone_____

Work Phone _____

E-mail address_____

Mailing Address_____

City_____ State_____ Zip_____

Emergency Contact (if parent/guardian unavailable):

_____

Home Phone_____ Cell Phone_____

Work Phone_____

All children attending the program must be able to use the bathroom independently.

Is your child fully potty trained? Y N

Mail Registration forms to:
Schoharie Christian After School Program
PO Box 340
Schoharie, NY 12157

Make checks payable to: Schoharie Christian After-School Program

Questions? Call: *518*-295-8931
e-mail: supc09@yahoo.com

MEDICAL RECORD

The medical record, including all immunization dates, must be filled out completely before your registration can be processed. **Please fill in all blanks**, even if the problem doesn't apply to your child (NA). It is recommended that each student receive a medical examination within 12 months of beginning the program to determine fitness to engage in strenuous activities. A copy of your child's school medical records is adequate.

HEALTH INSURANCE

None_____ Your Company_____

Group # _____ Identification #_____

IMMUNIZATIONS

Dates must be listed or separate form attached

Dose	Date Admin.	Dose	Date Admin.
DPT 1		MMR 1st	
2		2nd	
3			
DT 4		IPV or 1st	
5		OPV 2nd	
Tetanus (td)		3rd	
Latest			

Meningitis if given_____
Hepatitis B 1st_____ 2nd_____ 3rd_____
Hib 1st_____ 2nd_____ 3rd_____
Varicella (Chicken Pox)_____

MEDICAL HISTORY (Mark "n/a" if none)

Food Allergies (list) _____
Medication Allergies (list) _____
Insect Allergies (list) _____
ADHD_____
Physical Limitations_____
Asthma-1st Attack_____ Uses inhaler: yes no
If inhaler needed: (circle one) child keeps nurse should hold
Learning Disabilities_____
Fainting_____
Special Diet_____
Serious Operation_____ Date_____ Type_____
Current Medications_____
Other_____
With any "yes" to above, enclose a separate statement regarding the child's present condition and medical history.
If female, has she been told about menstruation? Y N
Has she started menstruation? Y N

RELEASE INFORMATION

My signature below certifies and gives permission that:

1. All information given is correct.
2. Photos of my child can be used in program publicity.
3. My child's medical records can be released in case of illness/ injury.
4. In the event I cannot be reached, I give permission to the Physician selected by the Program Director to hospitalize, select treatment for, order medications, anesthetize, and/or perform surgery on the child named above.

_____ _____
Parent/Guardian Signature Date