

SOUTHPORT CHRISTIAN SCHOOL

AFTERSCHOOL CARE REGISTRATION FORM

2017-2018 SCHOOL YEAR

\$25 Registration Fee due at time of Registration.

STUDENT INFORMATION

Student's Name: _____

Date of Birth: _____ Age: _____ Grade: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email address: _____

FAMILY INFORMATION

Father's name: _____

Work Phone: _____ Cell Phone: _____ Home Phone: _____

Place of Employment: _____

-Mother's Name: _____

Work Phone: _____ Cell Phone: _____ Home Phone: _____

Place of Employment: _____

Emergency Contact Name and Number if parents cannot be reached:

Names and contact numbers of persons allowed to pick up your child from ASC:

MEDICAL INFORMATION

Name of Family Doctor: _____

Phone Number: _____

Does your child use regular medication? _____ If yes, please list on the line below

Does your Child have any allergies or physical needs that will require special attention?

If yes, please explain : _____

Parent's/Legal Guardian's Signature: _____ Date: _____