



AFTERCARE APPLICATION FORM

Student Information:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Teacher's Name: _____ Grade: _____ Date of Birth: _____

Mother's Name: _____ Home Phone: _____

Cell: _____ Work Phone: _____ Email: _____

Father's Name: _____ Home Phone: _____

Cell: _____ Work Phone: _____ Email: _____

Is there a separation, divorce, or custody concern, with which our staff should be aware of? Yes No

Is any person prohibited from picking up the child by court order? Yes No

If yes, attach a copy of the court order and an explanation.

Prohibited Person's Name: _____ Relationship: _____

Contact and Permission for Pick Up:

The following persons are authorized to pick up my child from the program and/or be reached in case of emergency.

Name: _____ Relationship: _____ Phone# _____

Name: _____ Relationship: _____ Phone# _____

Name: _____ Relationship: _____ Phone# _____

*******Indicate the day/days of the week your child will attend*******

Monday	
Tuesday	
Wednesday	
Thursday	
Friday	

Health Care Needs:

For any child with health care needs such as allergies, asthma, or other chronic conditions that require specialized health services, a medical action plan shall be attached to the application. The medical action plan must be completed by the child's parent or health care provider. Is there a Medical action plan attached? Yes No

List any allergies and the symptoms and type of response required for allergic reaction:

List any health care needs or concerns, symptoms of and type of response for these health care needs or concerns:

List any particular fear or unique behavior characteristics the child has:

List any types of medication taken for health care needs: _____

Share any other information that has a direct bearing on assuring safe medical treatment for your child: _____

Emergency Medical Care Information:

Name of health care professional: _____ Phone: _____

Hospital preference: _____ Phone: _____

I, as the parent/guardian, authorize the school to obtain medical attention for my child in an emergency.

Signature of Parent/Legal Guardian _____ **Date:** _____

I, as the operator, do agree to provide transportation to appropriate medical resources in the event of an emergency situation, other children in the facility will be supervised by a responsible adult. I will not administer any drug or medication without specific instructions from the physician or the child's parent, guardian, or full-time custodial.

Signature of Administrator: _____ **Date:** _____

I (we) give permission for photos and/or video obtained, as a result of participation, to be utilized for further use of the Carolina Achieve Aftercare Program.

Signature of Parent/Legal Guardian: _____ **Date:** _____