SALADO INDEPENDENT SCHOOL DISTRICT

STUDENT REGISTRATION FOR AFTER SCHOOL CARE

Student Name: ____
First Middle Last

______________ Sex: Male / Female Date of birth: ____/____/____
Grade

Mother's Name: ______________________________ Father's Name: ______________________

______________________________ ______________________
cell phone number cell phone number

Physical Address (where child sleeps at night):____

Parent's email: ______________________________ ______________________
home phone number

If parents cannot be reached contact:

____
Name Relation phone number

____
Name Relation phone number

Siblings: ____________________, ____________________, ____________________

List any MEDICAL CONDITIONS we should be aware of: ______________________________________
____

List any FOOD ALLERGIES: ____

IN CASE OF EMERGENCY, ILLNESS OR ACCIDENT TO THE STUDENT NAMED ABOVE, THE SCHOOL IS AUTHORIZED TO TRANSPORT OR ARRAGE TRANSPORTATION OF THE CHILD TO A PHYSICIAN/HOSPITAL FOR TREATMENT.

SISD PERSONNEL WILL RELEASE YOUR CHILD ONLY TO THE PERSON(S) LISTED ABOVE.
IF THERE ARE ANY CUSTODY OF LEGAL ISSUES, THE PARENT/GUARDIAN MUST NOTIFY THE SCHOOL PRIOR TO AFTER SCHOOL CARE.

____
Parent/Guardian Signature Date

STUDENT WILL ATTEND: (____) MONTHLY (_____) DROP IN APPROXIMATE TIME OF PICK UP: _________

CHILD OF SISD EMPLOYEE: Y / N ELIGIBLE FOR FREE/REDUCED LUNCH PROGRAM: Y / N

____ Registration Fee received ____ Information required received

____ 1st Payment received: Cash $__________ Check#__________ Received by:______________