# AFTER SCHOOL ENRICHMENT PROGRAM REGISTRATION FORM

Please check the appropriate box ☐ **FULL TIME** (4 or 5 days per week) OR ☐ **PART TIME**

| I want to register the following child(ren): First and Last Name | Grade 2017/2018 | DOB |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Parent's Name_____

Address:_____
*Street* *City* *Zip*

Mother's Phone: Home#_____Work#_____Cell#_____

Father's Phone: Home#_____Work#_____Cell#_____

Emergency Contact (People authorized to pickup child – *other than parents*)

| Name | Home Phone | Work Phone |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Please list any allergies, disabilities, restrictions or special needs that your child may have:

_____

Doctor's Name: _____Phone#_____
Dentist Name:_____Phone#_____
Insurance Company and Policy Number:_____
Hospital Preference:_____

**I agree that the staff may authorize a physician to provide emergency care in the event that I cannot be contacted.**

Signature: _____Date:_____

Please submit one registration form per family and the **$50.00** family registration fee
Make check payable to Asheville Catholic School