CAVS AFTER CLASS

2024-2025 AFTER SCHOOL CARE ENROLLMENT

Application Date: _____ **Grade for 2024-2025 School Year:** _____

Name of Student: _____ DOB: _____ ○ Male ○ Female
Last First Middle

Preferred Name: _____ With Whom Does The Student Reside?: _____

Home Address: _____
City State Zip Code

Father/Guardian: _____	Mother/Guardian: _____
Address: _____	Address: _____
_____	_____
Cell Phone: _____	Cell Phone: _____
Employer: _____	Employer: _____
Work Phone: _____	Work Phone: _____
Email Address: _____	Email Address: _____

Physician Name: _____ Phone Number: _____

Dentist Name: _____ Phone Number: _____

Does your child have any of the following?:

☐ allergies ☐ Epi-pen ☐ daily medication ☐ pre-existing medical condition ☐ dietary restrictions

Please explain: _____

___ (Initials) I authorize Calvary Baptist Early Academy to secure medical treatment for my child in the event of an emergency.

Does your child have any specific or special needs for after school care? _____

_____

Emergency Contact (other than parent):

Name: _____ Phone: _____ Relationship: _____

My child has permission to be released to the following individuals in addition to emergency contact persons listed aove.

(These individuals may be asked to show proof of identity)

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

_____ _____

Parent/Guardian Signature Date