A.W. Spalding Aftercare

2018-19

Aftercare: **Mon-Thurs:** *3:00 – 6:00pm* **Friday:** *2:30 – 4:00*

- $140 monthly rate
- $20 drop in rate
- $1.00 Per Minute Late Fee

Child's Name: _____ Date of Enrollment: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____/_____/_____ Grade: _____

Emergency Information

Mother's Name: _____ Address: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Father's Name: _____ Address: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Person(s) Responsible for Child: _____

Physician: _____ Phone: _____ Address: _____

Additional person who may be called in an EMERGENCY

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Names of person(s) authorized to take child from facility:

_____ Relationship: _____
_____ Relationship: _____
_____ Relationship: _____
_____ Relationship: _____
_____ Relationship: _____
_____ Relationship: _____

Child's Health Checklist

1. Is your child taking any medication? If so, what? _____
2. Does your child have any allergies? If so, what? _____
3. Does your child have any medical problem(s) that would interfere with physical activity? If so, explain:

_____

Consent for Medical Treatment

As the parent, agency representative of legal guardian, I hereby give consent for (facility name) _____to provide all emergency dental or medical care prescribed by a duly licensed physician (M.D.) or dentist (D.D.S.) for(child's name) _____. This care may be given under whatever condition(s) are necessary to preserve the life, limb, or well being of my dependent.

Date: _____/_____/_____ Parent/Guardian Signature: _____