East Lyme Public School Before/After School Care
Enrollment Form 2017-2018

Student: _____ Date of Birth: _____
(last) (first)

Address: _____School:_____
(street) (town) (zip code)

Home Phone: _____ Email: _____

Parent/Guardian: _____ Relation: _____
Employer: _____ Work Phone: _____
Cell Number: _____**Primary Contact Phone Number**: _____
(cell, work, home, other)

Parent/Guardian: _____ Relation: _____
Employer: _____ Work Phone:_____
Cell Number: _____**Primary Contact Phone Number**: _____
(cell, work, home, other)

Student Lives With: ___Both Parents ___Mother ___Father ___Other_____ (specify)

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In case of emergency, if the primary parent/guardian cannot be reached. Please call the following individuals:

1. _____ Phone: _____
2. _____ Phone: _____
3. _____ Phone: _____

Persons to whom my child may be released:

1. _____ Relation: _____Phone: _____
2. _____ Relation: _____Phone: _____
3. _____ Relation: _____Phone: _____

Parent/guardian initials: _____

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Schedule (please circle desired days; separate monthly calendars must be filled out and handed into the program facilitator with payment no later than the 25th of each month for child to receive care the following month**)**

If we have not received a calendar by the 1st of the month, each day your child attends our program, you will be charged the drop-in fee. Once a calendar is received for the month, you will be charged regular rate for all days signed up for thereafter.

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Medical Information and Special Conditions:
Does your child have any of the following:

Allergies: _____

Chronic Illness / Special conditions: _____

Additional Information: _____

Please initial:

___ My child will not be taking any medication **OR** ___ My child will be taking medication (i.e.: inhaler)

___ My child does not require an Epi-Pen. **OR** ___ My child does require an Epi-Pen.

Our program does not have access to the **emergency medication that you have provided to the school. If you would like our program facilitator to have emergency medication on hand in case of an emergency you must provide it in its original container with all appropriate paperwork filled out (*see program facilitator*).

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Parent Initials are required for each item below to indicate consent. If you do not give the program consent please make note:

1. Obtaining emergency medical care if needed: _____
2. Transportation in an ambulance if needed (parent/guardians would be contacted first): _____
3. Administration of minor first aid procedures (i.e.: ice, band aids etc): _____

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Parent's Signature:_____Date:_____

A $50.00 non-refundable deposit must accompany this form to secure a place in the Before/After-School Care Program.

Please make checks payable to E. L. BOE Special Account

For Office Use Only:

Check # _____ Received _____