Beaver Cross After School Youth Program

Contact Information

Youth's Name _____ Nickname _____

Date of Birth ____/____/_____ Gender _____ Grade _____ Home Phone _____

Address _____

_____

Mother's Name _____ Mobile Phone (_____)_____

Employment _____ Work Phone (_____)_____

Father's Name _____ Mobile Phone (_____)_____

Employment _____ Work Phone (_____)_____

Family Status ❑ Married ❑ Separated ❑ Divorced ❑ Single

Email _____ Home Church _____

Would you like to receive the Beaver Cross Newsletter? ❑ Yes ❑ No

By checking this box ❑ I have read, understood, and agree to the policies laid out by Beaver Cross including, and not limited to: payments, scheduling, and parent responsibilities._____ (initials)

Medical Information

Alternate Emergency Contact _____ Relationship _____

Phone (_____)_____ Other (_____)_____

Do you have family medical insurance? ❑ Yes ❑ No Take medicine on a routine basis ❑ Yes ❑ No

List medication(s) and reason _____

Known Allergies ❑ Yes ❑ No

List Allergies _____

The person herein has permission to engage in all scheduled activities except as noted by me. In the event of an emergency, I hereby give permission to the medical personnel selected by Beaver Cross staff to hospitalize, secure proper treatment for, and to order injections and/or surgery for my above named child. This application has my approval. Photographs in which my child appears may be used for promotional purposes.

Signature of parent or guardian _____Date _____

Registration Information

Days Attending ❑ MON ❑ TUE ❑ WED ❑ THUR ❑ FRI

Pick-up Time ❑ 4:00 ❑ 4:30 ❑ 5:00 ❑ 5:30 ❑ Other _____

Special needs _____

Authorized for pick-up _____