Home Beneath Our Feet
After School Program Application

Applicant Information

Students Name: _____ Date: _____

Address: _____

Street Address *Apartment/Unit #*

_____

City *State* *ZIP Code*

Phone:

_____ Date of Birth: _____

School: _____ Grade: _____

Male or Female? M ☐ F ☐ Nickname _____

Applicant Information

Name of Person applying for Student: _____

Relationship to Student: _____ Employer: _____

Address: _____

Cell Phone: _____ E-mail: _____

In case of an emergency, notify: (List contact information for hours during Day Care - for example work address and phone if at work)

Parent/Guardian _____ DOB_____

Address_____

Day Phone_____ Cell Phone_____

Parent/Guardian _____ DOB_____

Address_____

Day Phone _____ Cell Phone _____

Physician or Medical Svc _____ Address _____

Names of individuals authorized to pick up child who are NOT listed above:

Name _____ Address_____ Phone: _____

Name _____ Address_____ Phone: _____

Health Information

The following information must be filled in by the parent/guardian. The intent of this information is to provide staff the background to provide appropriate care. Provide complete information so that we can be aware of your child's needs.

Allergies Describe reaction and management of the reaction

- Medications (e.g., penicillin)
- Food (e.g., eggs, dairy)

• Other (e.g., insect stings, hay fever) _____ _____

_____ _____

Insurance

_____ _____

Is participant covered by family medical/hospital insurance? ☐ Yes ☐ No

Carrier/plan name _____

Name of insured_____ Relationship to child_____

insurance ID # _____ Group # _____ Carrier Address_____

Any activities that child cannot participate in or needs one-on-one assistance? ☐ Yes ☐ No If yes, please explain

_____

_____

_____

Any additional information about the child's behavior and physical, emotional or mental health the staff should be aware of?

_____

_____

_____

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I, _____, give permission for _____to
(Mother, Father, Guardian) (Health care provider)

discuss my child's medical information, diagnosis and treatment, including medications with a representative of the Home Beneath Our Feet's Summer Growth program.

Signature of parent or guardian_____Date_____

Health Care Provider's phone_____Fax_____

Publicity Photographs

May we use your child in publicity photographs? ☐ Yes ☐ No

Disclaimer and Signature

I certify that my answers are true and complete to the best of my knowledge.

Signature: _____ Date: _____