ENROLLMENT FORM

Today's Date	Date to Start Care	Parent Password
School Name		

Primary Parent/Guardian Name	Relationship to child	Cell Phone	Home Phone
Primary Parent's Address, City, State, Zip			
Place of Employment		Business Phone	
E-mail			
Child's Address, City, State, Zip (IF DIFFERENT FROM PRIMARY PARENT)			
Secondary Parent/Guardian Name	Relationship to child	Cell Phone	Home Phone
Address, City, State, Zip (IF DIFFERENT)		Place of Employment	
E-mail		Business Phone	

Child's Name	Gender ☐ male ☐ female	Date of Birth
Child's Grade and Teacher		
Child's Name	Gender ☐ male ☐ female	Date of Birth
Child's Grade and Teacher		
Child's Name	Gender ☐ male ☐ female	Date of Birth
Child's Grade and Teacher		
Child's Name	Gender ☐ male ☐ female	Date of Birth
Child's Grade and Teacher		

It is mandatory to name two people in case of an EMERGENCY if a parent cannot be reached.

Name	Telephone	Relationship
Name	Telephone	Relationship

In addition to those listed above, I authorize the following people to pick up my child: Not Applicable ☐

Name	Telephone	Relationship
Name	Telephone	Relationship

Authorization for Emergency Medical Attention

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the facility director or person in charge to call an ambulance to transport my child to the hospital circled below. (THIS IS REQUIRED).

☐ Abilene Regional Medical Center 6250 Hwy 83-84 (325) 695-9900	☐ Either	☐ Hendrick Medical Center 1242 North 19th (325) 670-2000

I give consent for necessary emergency treatment when my child is in the care of the above listed physician and/or hospital/clinic.

____ Parent/Guardian Signature

__________________________ Date

A copy of my child's immunization record and hearing & vision screening is at:

____________________ School Name

______________________________ School Address

____________________ School Phone Number

Name of Physician	Address	Telephone No.
Name of Physician	Address	Telephone No.

List any of your child's special problems or needs such as:
Allergies, existing illness, previous serious illness, injuries, any disabilities, any hospitalization during the past 12 months, any medication prescribed for long-term use, and/or any other information of which staff should be aware of:

____

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____

Please rank from 1-10 (10 most important), importance of After-School activities:

Snack ____	Art & Drama _____	Sports _____	Structured Play _____	Additional Learning _____
Rest ____	Homework _____	Free Play _____	Games Inside _____	Friends _____

For grant purposes only, we are asking that you provide your child's ethnic background, Household income and reason after-school care is needed. This will, in no way, affect your child's eligibility to be in Alliance After-School Care.

How many living in your household: ☐

Reason for After-School Care:

- ☐ Parent working 3-6:00
- ☐ Parent in school 3-6:00
- ☐ Child(ren) asked to participate in program
- ☐ Desire child(ren) to have more activity
- ☐ Other ________________________

Yearly Household Income: ☐

Race:

- ☐ Hispanic/Latino
- ☐ Non-Hispanic/Latino

Ethnicity:

- ☐ African American
- ☐ Asian/Pacific Islander American
- ☐ White
- ☐ Native American
- ☐ Multi-Racial
- ☐ Other

ACKNOWLEDGEMENTS

I have read and understand the Alliance After-School Care policies
as stated in the Parent Handbook.
I attest that the information I provided on the Enrollment Form is correct and accurate.
I also understand that it is my responsibility to contact the Alliance for Women & Children should any of the information change and/or if I choose to un-enroll my child during the school year.

____________________________________ Parent/Guardian Signature

______________________ Date

MEDIA PERMISSION SLIP FORM

School Name	Parent Password
Child's Name	Parent's Name

Due to the unique nature of our program, the local media might be interested in filming or photographing the children in Alliance After-School Care. As a result, your child could be in the newspaper or on television.
Your PERMISSION IS REQUIRED in order for your child to participate.

☐ I DO: ...give permission for my child(ren) to be photographed or filmed by the media

☐ I DO NOT: while in Alliance After-School Care.

By selecting one of the choices above, I understand that I have given or not given written permission for my child's involvement with media within the care of the ALLIANCE FOR WOMEN & CHILDREN.

I also acknowledge by my signature below that it is my responsibility to notify the ALLIANCE AFTER-SCHOOL CARE PROGRAM in writing, should any information change.

____ __________________________
Please PRINT Parent/Guardian Name **Relationship to Child**

____ __________________
Parent/Guardian Signature **Date**