Enrollment Form

Parent Password

Primary Parent/Guardian Information

Last Name	First Name		Relationship to child
Address	City	State	Zip Code
Email	Home Number		Cell Number
Employer Name	Work Number		Ext

Secondary Parent/Guardian Information

Last Name	First Name		Relationship to child
Address	City	State	Zip Code
Email	Home Number		Cell Number
Employer Name	Work Number		Ext

Emergency Contacts / Pick up list **Mandatory**

Name	Phone Number	Relationship to child
Name	Phone Number	Relationship to child

Additional Contacts/Pick up list

Name	Phone Number	Relationship to child
Name	Phone Number	Relationship to child
Name	Phone Number	Relationship to child

Enrollment Form

Child(ren) Information

Child's Name	Gender	Male	Female	Date of Birth
		☐	☐	

Child's School	Child's Grade	Child's Teacher	Date to Start Care

Medical Information

Name of Physician	Address	Phone Number

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

I DO give consent ☐ I DO NOT give consent ☐

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 below.

Abilene Regional Medical Center (325) 695 – 9900 ☐ (OR) Hendrick Medical Center (325) 670 - 2000 ☐

Disabilities and Special Needs

Allergy	Severity	Treatment

Additional Notes

Media Permission Slip

☐ I DO give permission for my child to be photographed or filmed by the media

☐ I DO NOT give permission for my child to be photographed or filmed by the media

☐ I DO give permission for my child to be photographed or filmed for Alliance internal publication

☐ I DO NOT give permission for my child to be photographed or filmed for Alliance internal publication

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.

Please select all activities that are important to your child's After-School Care experience

☐ Homework	☐ Additional Learning	☐ Friends	☐ Snack	☐ Art and Drama
☐ Sports	☐ Structured Play	☐ Inside Games	☐ Outside Play	☐ Mentoring

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For grant purposes only, we are asking that you provide this information.
This will, in no way, affect your child's eligibility to be in Alliance After-School Care.

Yearly Household Income

- ☐ Less than $19,000
- ☐ $20,000 - $29,000
- ☐ $30,000 - $39,000
- ☐ $40,000 - $49,000
- ☐ More than $50,000

How many living in your household

☐

Reason for After-School Care

- ☐ Parent(s) working during 3:00pm-6:00pm
- ☐ Parent(s) in School during 3:00pm-6:00pm
- ☐ Desire child(ren) to have more activity
- ☐ Child(ren) requested to participate in ASC program
- ☐ Other _____

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.

_____ _____

Parent/Guardian Signature Date