

Siskiyou County Office of Education – SAFE After-School Program

Siskiyou Afterschool For Everyone

**2019-2020 Student Registration Form**

School: \_\_\_\_\_ District: \_\_\_\_\_

Student's Legal First Name: \_\_\_\_\_ Student's Legal Last Name: \_\_\_\_\_

Name Student Goes By If Different from Legal First Or Last Name: \_\_\_\_\_

Teacher: \_\_\_\_\_ Grade as of August 2019: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Student's Home Address: \_\_\_\_\_  
Street address or P.O.Box # City Zip Code

Student is homeless  Yes  No

Student is in foster care  Yes  No

Mother/Guardian's First Name: \_\_\_\_\_ Father/Guardian's First Name: \_\_\_\_\_

Mother/Guardian's Last Name: \_\_\_\_\_ Father/Guardian's Last Name: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Home Phone Number: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Place of Employment: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Parent(s) Email Address: \_\_\_\_\_

**My child will depart from the program by:**

Unsupervised Walk (if school district policy allows.) My child has my permission to sign (him/her) self out each day at \_\_\_\_\_ p.m.  School District Bus or Van  Parent Pick-Up

Other (describe) \_\_\_\_\_

**I give permission for my child to be released from the program to:**

The adults listed as **Emergency Contacts** on this registration form.

**NO ONE** except the Parent/Guardians listed on this registration form.

**Emergency Numbers and Persons Authorized to Pick Up Student** other than parents listed above: (Students will not be allowed to leave with any persons not listed below.) Please complete all information (Photo ID may be required.) In case of an emergency, and when parents/guardians cannot be contacted, the following people will also serve as emergency contacts.

	Full Name (Please Print Clearly)	Phone Number(s)	Relationship to Student
1			
2			
3			
4			

**Release for Emergency Medical Care**

Does your family carry medical insurance?  Yes  No

If yes, what is the name of your insurance carrier? \_\_\_\_\_ Policy # \_\_\_\_\_

Name of Family Physician \_\_\_\_\_ Phone Number \_\_\_\_\_

Student's medical conditions \_\_\_\_\_

Medications \_\_\_\_\_

List child's allergies (food, insects, pollen, etc.) \_\_\_\_\_

Does your child carry an epi-pen?  Yes  No

**Signature of parent or guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_