REGISTRATION/EMERGENCY FORM – EXTENDED DAY PROGRAM (EDP)

Students to be enrolled in program:

Name: _____ Grade: _____

Name: _____ Grade: _____

Name: _____ Grade: _____

Parents' Name:_____ Home Phone_____

Home Address:_____ City:_____ Zip:_____

Mother's Work Phone: _____ Cell Phone: _____ Email: _____

Father's Work Phone: _____ Cell Phone: _____Email: _____

Please Check One:

_____ EDP Part Time: (Dismissal-4:30pm every day)

_____ EDP Full Time: (Dismissal-6:00pm every day)

Changes to your EDP Billing Plan cannot be made mid-month. If you would like to change billing plans, an EDP Billing Change Request Form must be completed and turned into the office by the 15th of the month. Please note that any changes will not be effective until the 1st of the following month.

In the event of apparent serious illness or accident, when I cannot be reached, I wish one of the following to be notified by telephone. They are authorized to act in my absence:

Name: _____ Phone: _____

Name: _____ Phone: _____

If one of the above cannot be reached, I wish my child to be taken to the nearest hospital:
_____NO _____YES - If time permits, I wish my child to be taken to the following hospital:
_____

Please notify the doctor listed below:
Name: _____ Phone: _____

Please list any information about your child that you feel we should be aware of: _____
_____

Please list other persons who have permission to sign out and pick up your child:

Name:_____Phone:_____

Name:_____Phone:_____

Note: No child will be released to a person not on this list unless a parent sends a written note to the EDP staff.

Signature: _____ **Date**: _____