EarthTrek Extreme After School Program Enrollment Form (page 1/2)

School Year_____**Site Location**_____

Child Information

Child's Name:

Last:_____**First:**_____**Middle:**_____

Home Address:_____

City:_____**State:**_____**Zip:**_____

Phone Number: _____**Sex: Male**_____**Female**_____

Birthdate:_____**Age:**_____**Grade Level:**_____

School:_____

Please list any special restrictions or health information we should know about your child. These will include any special medical needs, allergies (food, insect bites, animals, medications, etc.), dietary restrictions, any health conditions, special accommodations, or one on one care. Are there any factors involving your child's health and/or development Amazing Adventures in Education should be aware of?

_____

_____

_____

_____

Primary Parent/Guardian

Last:_____**First:**_____

Home Address:_____

City:_____**State:**_____**Zip:**_____

Driver's License #:_____**State:**_____

Employer:_____

Employer Address:_____

Hours of work:_____**Email:**_____

Phone-*Home:* _____ ***Work:*** _____ ***Cell:***_____

Relationship to child:_____

Contact this person in case of emergency (y/n):_____

EarthTrek Extreme After School Program
Enrollment Form (page 2/2)

Secondary Primary Parent/Guardian

Name:____

Home Address:____

City:________________________State:________Zip:________________

Driver's License #:________________________State:________

Employer:____

Employer Address:____

Hours of work:______________Email:________________________________

Phone-*Home:* ________________ *Work:* ________________ *Cell:*________________

Relationship to child:____

Contact this person in case of emergency (y/n):______This person may pickup(y/n):__________

Authorized Release and Emergency Contacts (List three):

Name:____

Relationship to child:____

Home Address:____

City:________________________State:________Zip:________________

Phone-*Home:* ________________ *Work:* ________________ *Cell:*________________

Name:____

Relationship to child:____

Home Address:____

City:________________________State:________Zip:________________

Phone-*Home:* ________________ *Work:* ________________ *Cell:*________________

Name:____

Relationship to child:____

Home Address:____

City:________________________State:________Zip:________________

Phone-*Home:* ________________ *Work:* ________________ *Cell:*________________

Medical Information:

Child's Name:____

Physician's Name:________________________Phone:________________________

Physician's Address:____

Preferred Hospital or Clinic:____

Dentist's Name: ________________________Phone:________________________

Address:____

Insurance Provider:________________________Policy Number:________________________

Parent's Signature:________________________Date:________________________