

Shooting Stars Out of School Care (OSC) REGISTRATION FORM

Commencement Date: _____

FAMILY INFORMATION

Child(ren)'s Full Name: _____

Physical Address: _____

Mailing Address: _____

City: _____ Postal Code: _____

Date of Birth: _____ Gender: _____
Year/Month/Day

	Parent/ Guardian	Parent/Guardian
Name		
Relationship		
Physical Address		
City		
Postal Code		
Home Number		
Work Number & Ext #		
Cell Number		
Email Address		

AUTHORIZATION TO PICK-UP AND DROP OFF

NAME OF PERSON (other than the parents) AUTHORIZED TO SIGN YOUR CHILD IN AND OUT OF OUR CARE. (Only the person designated will be allowed to pick-up your child unless prior permission is given by note or phone call. Person collecting your child will be required to produce picture identification)

	Designated Person #1	Designated Person #2
Name		
Relationship		
Home Number		
Work Number & Ext #		
Cell Number		

PEOPLE TO CONTACT IN CASE OF EMERGENCY

Please give the name and telephone number of a person who can be contacted during program hours in case of emergency when parents/guardians are not available.

	Emergency Contact
Name	
Physical Address	
Home Number	
Work Number & Ext #	
Cell Number	

HEALTH INFORMATION

Does your child have any physical, mental disabilities or medical conditions? Please specify. (ie:seizures, diabetes). _____

Allergies:

Food: _____ Reactions: _____

Drugs: _____ Reactions: _____

Environmental: _____ Reactions: _____

Medication:

What medication, if any, is taken on a regular basis? (Please list with directions) Will the program be required to administer medication during care hours?

Medication Name: _____

Directions for Administration: _____

Possible Side Effects: _____

ABSENT PARENTS

Is a formal custody order in place? _____ Details: _____

In the event that a custody order is in place, you may be required to provide a copy of your custody order.

	YES	YES, WITH PRIOR PERMISSION	NO
Does the absent parent have permission to visit their child at the programs?	_____	_____	_____

Does the absent parent have permission to pick up their child at the programs?	_____	_____	_____
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If the absent parent has permission to pick up their child, please provide the following information:

Name:	Relationship
Address:	City
Home Number:	Work Number

PARENTAL PERMISSION (Please Initial)

First Aid Permission: I give the Shooting Stars Out of School Care staff to administer First Aid if necessary.

YES _____ NO _____

Emergency Medical Permission: If emergency medical care is deemed necessary, I authorize the Shooting Stars Out of School Care staff, in the event that we are unable to contact you, to act on my behalf in granting permission for my child to receive emergency medical treatment.

YES _____ NO _____

Photographic Permission: I hereby give permission to have my child appear in any educational and/or media coverage approved by the Shooting Stars Out of School Care.

YES _____ NO _____

DECLARATION

I have read the above and have indicated my response as requested. All information provided in this registration form is true and complete. I will maintain current information with the program and any changes in place of residence, place of employment, home and/or work telephone numbers, persons having access to the children, emergency contact persons, etc., will be reported promptly.

Date: _____ Initial: _____

Shooting Stars Out of School Care not responsible for children's personal items that are damaged, lost or stolen.

Date: _____ Initial: _____

Parent Handbook

I have read the contents of the Parent Handbook Information and agree to comply with the regulations and policies of the Shooting Stars Out of School Care.

Date: _____ Initial: _____

Parents/Guardian Signature & Date

Witness Signature & Date

Office Use Only

Date of Latest Update: _____