

BSCS EXTENDED DAY ENROLLMENT APPLICATION

CHILDS NAME: _____ GRADE: _____

MAILING ADDRESS: _____

HOME PHONE: _____ DATE OF BIRTH: _____

MOTHERS NAME: _____ FATHERS NAME: _____

CELL PHONE: _____ CELL PHONE: _____

WORK PHONE: _____ WORK PHONE: _____

E-MAIL: _____ E-MAIL: _____

CHILD'S PHYSICIAN: _____ PHONE: _____

ALLERGIES: _____

MEDICATIONS: _____

NAME AND PHONE # OF AT LEAST TWO OTHER PEOPLE TO CONTACT IF PARENTS CANNOT BE REACHED:

1): _____ PHONE: _____ RELATION: _____

2): _____ PHONE: _____ RELATION: _____

PERSON WHO MAY PICK UP YOUR CHLD OTHER THAN PARENTS (Must bring in a Photo ID)

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

IN CASE OF AN EMERGENCY, I GIVE MY PERMISSION FOR MY CHILD _____ TO BE TAKEN TO THE HOSPITAL OR TO A PHYSICIAN FOR TREATMENT.

PARENTS SIGNATURE: _____

POLICY AGREEMENT:

IN USING THE BSCS EXTENDED DAY PROGRAM, I AGREE TO ABIDE BY THE POLICIES OF THE BSCS EXTENDED DAY PROGRAM AS SET FORTH IN THE BSCS SCHOOL MANUAL, TO INCLUDE PAYMENT SCHEDULE AND FEE'S, HEALTH/MEDICATIONS, AND DICIPLINE CONCERNS.

PARENT'S SIGNATURE: _____ DATE: _____