

**WCPSS Before and After School Programs  
Before School Program Student Application**

School Year \_\_\_\_\_

There is a \$15.00 registration fee per applicant. Please make check payable to the school.

Student NC Wise Number: \_\_\_\_\_

School Name: \_\_\_\_\_

Student's Full Name: \_\_\_\_\_

Name the Child Is To Be Called: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Home Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Student's NCWise Number: \_\_\_\_\_

Monthly Fee: \_\_\_\_\_ Track# \_\_\_\_\_

Grade: \_\_\_\_\_ Homeroom Teacher's Name: \_\_\_\_\_

Parent's/Guardian's Name: \_\_\_\_\_

Parent's Guardian's Email Address: \_\_\_\_\_

Father's/Guardian's Place of Employment: \_\_\_\_\_

Phone: \_\_\_\_\_

Mother's/Guardian's Place of Employment: \_\_\_\_\_

Phone: \_\_\_\_\_

In case of emergency, notify the following person(s) if parents/guardians cannot be reached:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

- Check those that apply:
- Monday-Friday Program
  - PLT Days-Staff Only

**Daily Rate Program**

- All Mondays
- All Tuesdays
- All Wednesdays
- All Thursdays
- All Fridays

Names of Individuals to Whom the Program Staff May Release the Child as Authorized by the Person Who Signs the Application:

\_\_\_\_\_  
\_\_\_\_\_

Student's Physician \_\_\_\_\_ Phone \_\_\_\_\_

Student's Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Hospital Preference: first choice \_\_\_\_\_ second choice \_\_\_\_\_

**Before School Program Student Application continued...**

Does your student have allergies or chronic illnesses? If yes what are they?

\_\_\_\_\_

Does your student take medications and/or have a medical plan on file with the school? If yes, please explain.

\_\_\_\_\_

Please give any other information that you would like the Before School Program staff to know about your student (special interests, fears, behaviors, custody arrangements, etc.).

\_\_\_\_\_

\_\_\_\_\_

In case of emergency, I authorize the Before School Program staff to obtain medical attention for my student in the event that I cannot be contacted immediately.

My signature indicates that I have read and understand the procedures for the Before-School Program.

\_\_\_\_\_  
Parent Signature Date: \_\_\_\_\_