

# WCPSS After School Program Student Registration

School Year: \_\_\_\_\_  
Student Start Date: \_\_\_\_\_

There is a \$15.00 registration fee per applicant. Please make check payable to the school. Put your child's name on the check.

Student ID (required) \_\_\_\_\_  
Student First Name \_\_\_\_\_  
Student Last Name \_\_\_\_\_

Name Student is to be called \_\_\_\_\_  
Homeroom Teacher \_\_\_\_\_ Grade Level \_\_\_\_\_ Track \_\_\_\_\_  
Date of Birth \_\_\_\_\_

Home Address:

Street \_\_\_\_\_  
City \_\_\_\_\_  
Zip \_\_\_\_\_

**Primary Parent/Guardian** First Name \_\_\_\_\_  
Last Name \_\_\_\_\_

Address is the same as child: yes ☐ no ☐

If different:

Street \_\_\_\_\_  
City \_\_\_\_\_  
Zip \_\_\_\_\_

Please include all applicable phone numbers, and check one for primary contact:

Home Phone ☐ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Day Phone ☐ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Cell Phone ☐ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Primary email to send receipts \_\_\_\_\_ @ \_\_\_\_\_

Place of employment \_\_\_\_\_

**Secondary Parent/Guardian** First Name \_\_\_\_\_  
Last Name \_\_\_\_\_

Address is the same as child: yes ☐ no ☐

If different:

Street \_\_\_\_\_  
City \_\_\_\_\_  
Zip \_\_\_\_\_

Please include all applicable phone numbers, and check one for secondary contact:

Home Phone ☐ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Day Phone ☐ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Cell Phone ☐ (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Check those that apply:  
Monday-Friday

Program  
**Daily Rate Program**

All Mondays  
All Tuesdays  
All Wednesdays  
All Thursdays  
All Fridays

**Early Release Only**

Secondary email \_\_\_\_\_ @ \_\_\_\_\_

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

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

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

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

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

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.).

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

My signature indicates that I have received, read and understand the information outlined in:

- the *After School Fee Schedule and Payment Schedule*
- the *After School Parent Information*, and
- the *Behavior Management Procedures*

\_\_\_\_\_  
Parent/Legal Guardian Signature

Date: \_\_\_\_\_

Distribution: Original signed registration kept in program files; Copy of signed registration given to parent