AFTER SCHOOL APPLICATION FORM

Section 1
Student's Legal Name:

_____
FIRST MIDDLE LAST

Date of Birth: ___ ___ / ___ ___ / ___ ___ ___ ___
DAY MONTH YEAR

Home Address:

_____
Street City

Gender: O Male O Female

Section 2
Mother's Name:

_____
FIRST MIDDLE LAST

Mother's Home Phone: _____

Mother's Mobile Phone: _____

Place of Employment: _____

Occupation: _____

Business Phone: _____

EMAIL: _____@_____._____

Section 3

Father's Name:

_____

FIRST MIDDLE LAST

Father's Home Phone: _____

Father's Mobile Phone: _____

Place of Employment: _____

Occupation: _____

Business Phone: _____

EMAIL: _____@_____._____

Student lives with: O Mother O Father O Both O Other

Person who has legal custody of child is _____

Section 4

Emergency Contact:

_____

FIRST MIDDLE LAST

Home Phone: _____

Mobile Phone: _____

Place of Employment: _____

Occupation: _____

Business Phone: _____

EMAIL: _____@_____._____

Section 5

Proposed Start Date: _____

Christmas/ Easter/ Summer Term & Year

Proposed Location: _____

Section 6

Language (s) spoken at home: _____

Section 7

Indicate any medical problems by placing a circle around the appropriate condition:

Asthma Respiratory ailments Chest problems
Heart problems Migraine/ headaches Bladder problems Gastric problems
Sting allergy Nut allergy Lactose intolerance Hay fever
Vision impairment Hearing impairment Mobility ailment Diabetes Sickle Cell
Epilepsy Kidney complaints Skin complaints

'Other' health complaints/problems:

_____
_____

'Other' description and any additional medical data:

_____
_____

Description of steps to be taken in the event of a medical emergency:

_____
_____
_____

Please note that any medication to be administered during school hours must be accompanied with a signed note, outlining dosage instructions, time to be administered, etc. These forms are available at the front desk.

Special Dietary Needs: _____

Paediatrician's Name: _____

Paediatrician's Telephone Number: _____

Paediatrician's Cell Phone Number: _____

Section 8

Additional Information

Has your child ever been a recipient of a special services program? PLEASE CHECK ALL THAT APPLY (If so please bring a copy of your child's evaluation).

O Visual or Hearing Treatment

O Physical Therapy

O Speech Therapy

O Behaviour Therapy

O Other (please describe)

_____

_____

_____

Section 9

School (s)/ Programme (s) attending: _____

_____

PARTICIPATION WAIVER:

As with any activity I understand that there may be risk of injury or harm. I agree to be responsible for any medical expenses incurred by my child(ren) while participating in sessions. I agree to hold the staff and volunteers of Fundaciones Limited, and their families, harmless from, and indemnify them for, any damage or loss arising as a result of my child(ren)'s participation in activities.

Parent/ Guardian Name: _____

Parent/ Guardian Signature: _____

Date: ___/ ___/ ___