Palisades Park Board of Education
After Care Program Registration 2017-2018

Child 1

Name: First_____ Last_____

Birthdate: _____ Age _____ Grade _____

School: _____Teacher: _____

Medical Conditions/Allergies: _____

_____

Doctor's Name _____ Phone _____

Epi-Pen: yes no Inhaler: yes no Other device: _____

Days per week: M T W TH F Monthly Fee: _____

Child 2

Name: First_____ Last_____

Birthdate: _____ Age _____ Grade _____

School: _____Teacher: _____

Medical Conditions/Allergies: _____

_____

Doctor's Name _____ Phone _____

Epi-Pen: yes no Inhaler: yes no Other device: _____

Days per week: M T W TH F Monthly Fee: _____

Child 3

Name: First_____ Last_____

Birthdate: _____ Age _____ Grade _____

School: _____Teacher: _____

Medical Conditions/Allergies: _____

_____

Doctor's Name _____ Phone _____

Epi-Pen: yes no Inhaler: yes no Other device: _____

Days per week: M T W TH F Monthly Fee: _____

Palisades Park Board of Education
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Home address: _____

Home Phone: _____

Parent/Guardian Information

Parent/Guardian Name: _____

Address: _____

Cellphone: _____ Home Phone: _____

Email: _____

Place of Employment: _____

Work Phone: _____

Parent/Guardian Name: _____

Address: _____

Cellphone: _____ Home Phone: _____

Email: _____

Place of Employment: _____

Work Phone: _____

Emergency Contact Information

(Including medical emergencies if parent/guardian not available)

Emergency Contact Name: _____

Relationship: _____

Contact Phone #: _____

Emergency Contact Name: _____

Relationship: _____

Contact Phone #: _____

Please indicate what hospital you would prefer should it be necessary to call the ambulance. _____