Wellington 21st Century After School Programs (WASP) 2014/2015 ENROLLMENT FORM—ELEMENTARY

USD 353—WASP + 605 North A Street + Wellington, KS 67152 + (620) 326-4320

Date	School: □ Eisenhower	□ Kennedy [□Lincoln □ Wa	shington	Grade	
	Primary Day Teacher					
<u>Student Information</u> :						
Name						
Firs	t	MI	L	ast		
Address		<u> </u>		~ * \		
Home Phone:		(City, State, Zip Code) Cell Phone:				
Date of Birth		<u>Gender</u> : □	Male 🗖 Female	Foster Care	∶□Yes □ No	
Race: □ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian or Other Pacific Islander □ White		Ethnicity: Hispanic/Latino Not Hispanic/Latino				
Parent/Guardian Names						
Main Contact name and phon	e # during Program hours 3:30	—5:30 pm				
Please indicate days of attenda	ance: □Monday—Friday	or ⊡Mor	n □Tues □	∃Wed □Thu	urs □Fri	
Health Conditions: Please list any allergies (food,	drug, seasonal, etc.) that your	child may have	e:			
Please list any medical condit	ions your child may have:					
Please list any medications that	at need to be administered duri	ng program hou	urs of 3:30 to 5:30)pm:		
Please attach a physician's writte	en order for any medications that r	need to be admin	istered during prog	ram hours.		
Name & Office Phone Numbe	r of your child's physician:					
Authorizations:						
	nt that photographs or videos of the state o					

 \Box Yes \Box No I hereby consent that my child may attend activities out of and away from the school building with the After School Program. Transportation will be via school vehicle or walking—no personal vehicles will be used except in extreme emergencies. I understand that information will be given to me regarding any scheduled field trips or special activities on an individual activity basis.

□Yes	□No	I hereby g	ive permission for r	ny child to	walk from the After School Program at	pm to:
		🗖 home	□my work place	\Box Other		

Name and Address

 \Box Daily \Box Only when I authorize

Parent/Guardian Information for:

Please list each child you are enrolling in the Elementary After School Program

Father/Guardian Name:	Responsible party for payment: □Yes □No
Street Address:	
Home Phone:	
Employer:	
Home email:	
Work email:	
Please send emails regarding invoices and statements to m Please send emails regarding special notices of school/pro Social Security #	<i>ny:</i> □ Home email □ Work email <i>ogram closings, special events, etc., to my:</i> □ Home email □ Work email Custodial Parent/Guardian □Yes □No
Mother/Guardian Name:	Responsible party for payment: □Yes □No City, State, Zip
Home Phone:	
Employer:	
Home email:	
Work email:	
	<i>ny:</i> □ Home email □ Work email <i>ogram closings, special events, etc., to my:</i> □ Home email □ Work email Custodial Parent/Guardian □Yes □No

□ Providing supervision on a field trip or outing

□ Providing snacks one evening

□ Volunteering to assist with homework or reading with students:

□ Once a month □Once a quarter □Once during the school year Please specify day of week you'd prefer_____

Transportation

All students must be picked up (if not authorized to walk) by 5:30 pm.

Emergency Contact and Child Release Information:

Please list below the people you authorize to pick up your child from the After School Program. Also, specify the people you authorize as an Emergency Contact — those you trust to pick up and care for your child during an emergency situation, if we are unable to reach you.

Name	Relationship to Student	Phone #	Authorized Emergency Contact	
			□Yes	□ No
			🗆 Yes	□ No
			🗆 Yes	□ No
			🗆 Yes	□ No
			🗆 Yes	□ No

Parent Handbook Agreement:

This certifies that I have read the Elementary Program Handbook and fully understand the policies stated therein.

Signature of Parent/Guardian

Date ____