

Child Enrollment Information Form

This form shall be completed prior to the child's first day and updated annually as needed.

Child's LAST Name: _____ Child's FIRST Name: _____

Child's Date of Birth: _____ First Day of Program: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Number: _____ Cell Phone: _____

Parent/Guardian Name: _____ **Relationship to child:** _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Number: _____ Cell Phone: _____

Email Address: _____

Name of Work/School Name: _____ Work Number: _____

Work Address: _____ City: _____

Please indicate if this name should be released if a parent/guardian, of a child attending AlphaBEST, request contact information for other parents/guardians. Yes No

If answered yes, please indicate which number(s) above to include on the list Work Cell Home

Where can you be reached while your child is in this program? _____

Parent/Guardian Name: _____ **Relationship to child:** _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Number: _____ Cell Phone: _____

Email Address: _____

Name of Work/School Name: _____ Work Number: _____

Work Address: _____ City: _____

Please indicate if this name should be released if a parent/guardian, of a child attending AlphaBEST, request contact information for other parents/guardians. Yes No

If answered yes, please indicate which number(s) above to include on the list Work Cell Home

Where can you be reached while your child is in this program? _____

Emergency Contacts

Child's Name: _____

Parent's cannot be listed as emergency contacts. List the name of at least one person who can be contacted in the event of an emergency or illness if you cannot be reached. Any person listed should be able to assist in contacting you. At least one person listed must be within one hour of the center/school, able to take responsibility for the child in case the parent/guardian cannot be contacted and should be at least 18 years of age.

Contact #1

Name: _____
Address: _____ City: _____ State: _____
Home Number _____ Cell Number _____
Relationship to child _____

Contact #2

Name: _____
Address: _____ City: _____ State: _____
Home Number _____ Cell Number _____
Relationship to child _____

Name of Child's Physician or Clinic: _____

Street Address: _____

City: _____ State: _____ Telephone Number _____



First Aid & Emergency Authorization Form

Child's Name: _____

I authorize AlphaBEST staff who are trained in the basics of First Aid/CPR to give my child First Aid/CPR when appropriate.

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child to the nearest medical care facility and to secure medical treatment for my child.

Signature: _____ Date: _____

Permission to Transport

<p>Program Name: _____</p> <p>Has permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.</p> <p>Parents Signature: _____</p> <p>Date: _____</p>	<p style="text-align: center;">OR</p> <p style="text-align: center;">Do not Sign Both</p>	<p>Program Name: _____</p> <p>Does not have permission to secure emergency transportation for my child in the event of an illness or injury which requires emergency treatment. The emergency transportation service will determine the facility to which my child will be transported.</p> <p>Parents Signature: _____</p> <p>Date: _____</p>
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Allergies, Special Health or Medical Conditions, and Food Supplements Form

Please fill in this section as accurately as possible. If your child has a current health or medical condition requiring staff to perform child specific care, such as: to monitor a condition, provide treatment, care, or to give medication please make sure you indicate that below.

Child's Name: _____ Date: _____

1. Does your child have any food, medication or environmental allergies? (check all that apply)

No

Yes – check all that apply Food Medication Environmental

2. Does your Child's allergy/allergies require staff to monitor your child for symptoms, act if a reaction occurs, or give emergency medication to your child? (check one)

No

Yes

3. Does your child have a special health or medical condition?

No

Yes

4. Is your child currently using any medication, food supplement or medical food (such as electrolyte solution)? (check one)

No

Yes

If yes to the following question above, does this medication, food supplement, or medical food need to be administered at the program/school?

No

Yes

5. Does your child have any dietary restrictions, including those for medical, religious or cultural reasons?

No

Yes

If you answered yes to any of the following questions above, please briefly describe the type of allergy, special health or medical condition:

List any history of hospitalization, outpatient surgery, or previous health concerns that would be needed to assist the staff or medical personnel in an emergency situation.

List any additional information about your child that would be useful for staff to know, such as fears, eating sleeping habits, or special routines. This information should not be medical or health related, as that information should be included above.

This form is to be initialed and dated, at least annually, after it has been reviewed by the parent/guardian. This is to indicate all information has stayed the same or changes have been noted. If significant changes are needed, please complete a new form.

Parent/ guardian Initials: _____ Date Reviewed _____ Administrator Initials: _____ Date reviewed: _____

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Authorization to Pick Up a Child From AlphaBEST (Before and After School Program)

Name of Child _____

I hereby inform AlphaBEST that the people listed below are authorized to pick up the above-named child at any time. Accordingly, AlphaBEST is hereby instructed to release my child into the care of the following people whenever they come to the before and after school program.

AUTHORIZED PICK-UP PERSON:

Name:	Relationship to Child:	Phone Number:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

I understand that:

- Parents/guardians must inform AlphaBEST (call, leave a note at drop off) of the name of the person who is picking up their child on any day when they themselves are not.
- The "Authorized Pick-Up Person" **must be at least 18 years old** and may be asked to provide a photo ID to the staff.
- This authorization shall remain in force until edited or rescinded in writing by the signers of this authorization.

Authorized by: (Print Name)

Parent/Guardian Signature:

Date:
