

CHRIST THE KING AFTER CARE PROGRAM
REGISTRATION FORM

THIS COMPLETE FORM MUST BE ACCOMPANIED BY A \$5.00 REGISTRATION FEE FOR EACH CHILD.
(THE FEE IS NON-REFUNDABLE.) RETURN THIS FORM AND FEES TO THE SCHOOL OFFICE.

MOTHER'S NAME _____

ADDRESS (INCLUDE ZIP CODE) _____

HOME PHONE _____ WORK PHONE _____
(In the event these phone numbers change, contact office immediately)

FATHER'S NAME _____

ADDRESS (INCLUDE ZIP CODE) _____

HOME PHONE _____ WORK PHONE _____
(In the event these phone numbers change, contact office immediately)

Please identify persons to be contacted in an emergency if neither parent can be reached.

1. NAME _____

ADDRESS (include zip code) _____

HOME PHONE _____ WORK PHONE _____

2. NAME _____

ADDRESS (include zip code) _____

HOME PHONE _____ WORK PHONE _____
(In the event these phone numbers change, contact office immediately)

CHILDREN ENROLLING IN THE AFTER CARE PROGRAM (first and last name)

NAME _____ circle one: FULL TIME PART TIME

If part time, circle days of care each week: M T W TH F:

Allergies _____

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I HAVE READ AND WILL COMPLY WITH ALL THE RULES OF THE AFTER CARE PROGRAM

PARENT'S SIGNATURE