BAYONNE BOARD OF EDUCATION

AFTER SCHOOL CHILD CARE PROGRAM

REGISTRATION 2024-2025

ABBREVIATED SESSION

STUDENT'S NAME:_____ AGE:_____ DATE OF BIRTH_____

HOME ADDRESS:_____ SCHOOL:_____ Grade_____HR#_____

PARENT #1 NAME:_____ PARENT #2 NAME:_____

PARENT #1 CELL:_____ PARENT #2 CELL:_____

PARENT #1 EMAIL:_____ PARENT #2 EMAIL:_____

PARENT #1 HOME PHONE:_____ PARENT #2 HOME PHONE:_____

PARENT #1 WORK PHONE:_____ PARENT #2 WORK HONE:_____

NAME & ADDRESS WORK:_____ NAME & ADDRESS WORK:_____

EMERGENCY CONTACT INFORMATION

In case of an emergency, it may be necessary to contact parents during BSCC/ASCC hours. Please furnish us with the following information. I will not hold the Bayonne Board of Education personnel responsible in the event of an accident or injury as a result of his/her participation. I understand that in an emergency I will be contacted immediately. If I am not available I hereby designate:

NOTE: EMERGENCY CONTACTS MUST BE SOMEONE OTHER THAN PARENTS!

Name	Relationship to Student	Home Phone	Work Phone	Cell Phone
Name	Relationship to Student	Home Phone	Work Phone	Cell Phone

NAMES OF PERSONS, OTHER THAN PARENTS, TO WHOM STUDENT MAY BE RELEASED:

_____

EMERGENCY MEDICAL RELEASE

If neither of us is available, I hereby authorize the Bayonne Board of Education take whatever measures that are deemed necessary. I also give permission for my child to be given emergency treatment at a local hospital.

PARENT/GUARDIAN SIGNATURE:_____

Doctor's Name & Phone:_____

Medical Insurance Company (if none, state "none"):_____

Policy Number:_____

If your child has any special needs, allergies, or uses any medications, please list them. Please inform the BSCC/ASCC Teacher.

*ALLERGIES:*_____

*MEDICATIONS:*_____

*SPECIAL NEEDS:*_____