



**BAYONNE BOARD OF EDUCATION**  
**AFTER SCHOOL CHILD CARE PROGRAM**  
**REGISTRATION 2022-2023**

**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

**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: \_\_\_\_\_