



Graystone Academy  
**AFTER SCHOOL PROGRAM**  
2008-09

**Application and Agreement**

*Return completed form to the ASP Program Director Prior to Start Date*

**\*Please Print**

**Date of Enrollment:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Start date:** \_\_\_\_\_ **Enrollment Fee Paid:** \_\_\_\_\_

**Program:**  After School

**I. Child Data:**

**Name:** \_\_\_\_\_ **D.O.B/age:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Home Address:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**With whom does the child live?** \_\_\_\_\_

**II. Parent/Guardian Data:**

**1. Mother/Legal Guardian:** \_\_\_\_\_

**Home Address:**  Same as Above ~ If not please note below:  
\_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Pager:** \_\_\_\_\_

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

**Business Address:** \_\_\_\_\_

Business Phone: \_\_\_\_\_ Cellular Phone: \_\_\_\_\_

2. **Father/Legal Guardian:** \_\_\_\_\_

Home Address:  Same as Above ~ If not please note below:

\_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_ Pager: \_\_\_\_\_

Employer: \_\_\_\_\_

Business Address: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Cellular Phone: \_\_\_\_\_

3. **Step Parent/Legal Guardian:** \_\_\_\_\_

Home Address:  Same as Above ~ If not please note below:

\_\_\_\_\_  
\_\_\_\_\_

Home Phone: \_\_\_\_\_ Pager: \_\_\_\_\_

Employer: \_\_\_\_\_

Business Address: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Cellular Phone: \_\_\_\_\_

III. **Other Information:**

1. In the event of a medical emergency, every effort will be made to notify parents/guardians. If it is necessary, children will be transported to the closest medical facility by emergency vehicle while the charter school staff continues in an attempt to notify parents.

2. Special emergency instructions to be followed: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Primary Insurance Carrier: \_\_\_\_\_  
Name of Insured: \_\_\_\_\_  
Policy or Group Number: \_\_\_\_\_

4. Medical Alert: \_\_\_\_\_  
Medications to avoid: \_\_\_\_\_  
Allergies: \_\_\_\_\_  
Foods to avoid: \_\_\_\_\_

5. Pediatrician's Name: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Alternate: \_\_\_\_\_

7. Dentist's Name: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Alternate: \_\_\_\_\_

8. Adult persons (18 years and older) whom you authorize the center to contact in the event of a medical emergency in which the child's parent, guardian, physician (if appropriate) is unavailable. **Must be local contacts.**

A. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Relationship: \_\_\_\_\_

B. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Relationship: \_\_\_\_\_

**\*Is the center authorized to release your child to above named persons? Please mark one: Yes:  No:**

9. Children are not allowed to enter or leave the facility without being escorted by a parent, or adult person authorized by parents or center personnel. ***Under no circumstances will the ASP program release a child to anyone not identified below or not otherwise known to center staff without specific authorization from the parent or legal guardian enrolling the child. The enrolling parent must provide legal documentation if the child is not to be released to the other parent.***

10. Individuals, other than parent, to whom the center is authorized to release the child: (Parents/Guardians must notify contact to provide picture ID to center staff and be at least 18 years of age)

A. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Relationship: \_\_\_\_\_

B. Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Relationship: \_\_\_\_\_

11. The following person(s) are forbidden by court order to pick up my child unless I have granted specific written authorization. **Please attach legal documentation.**

Name: \_\_\_\_\_

Remarks: \_\_\_\_\_

12. I (do)  (do not)  give permission for my child to be photographed or videotaped and the photographs/videotape to be publicly displayed.

13. Child's brothers and sisters:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

14. Specify any dietary restrictions if any: \_\_\_\_\_

15. Please describe any additional information that would help us get to know your child's special needs: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

16. I have received a copy of the following and will complete and return any form requiring my signature before my child enrolls:

- Program Policies for Parents
- Acknowledgement of Receipt of Policies
- Application and Agreement
- Medical Information/Authorization
- Certificate of Health/Immunization
- Illness Policy
- Emergency Contact/Permission Card

I have read and understand the above material and I agree to abide by the policies and procedures as described:

Signature: \_\_\_\_\_

Parent/Legal Guardian

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Reviewed and Accepted by: \_\_\_\_\_

Program Director

Start Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_