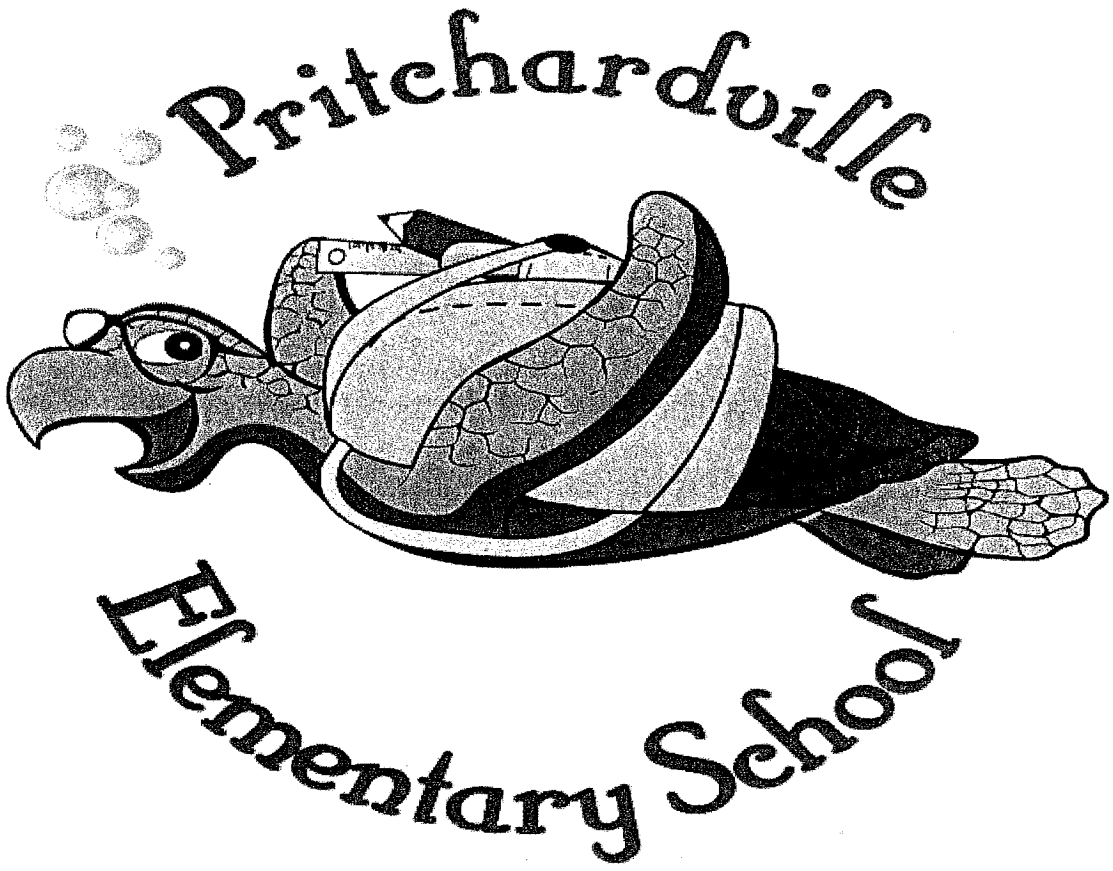

Contact Information for Afterschool Care

Name: Lameka Capers

Phone Number: 843-707-0574

Email: Lameka.capers@beaufort.k12.sc.us

After-School Program 2017-2018

$55 per week Aug-May

After-School: 3:00-6:00pm / / Late pick-up fees may apply

Participant Name_____ / _____ / _____
(Birth given first name) (Birth given middle name (Birth given last name)

Address:_____ City: _____ Zip: _____

Date of Birth: ____ /____ / ____ E-mail: _____ Gender: Male/Female

Name of Parents/Guardians: _____ Home Phone: _____

Mom's Cell: _____ Dad's Cell:_____ Mom's Work: _____ Dad's Work: _____

Best Person to Contact: _____ Mom Cell _____ Dad Cell _____ Home _____Other _____

Other than parent:

1st Emergency Contact Name: _____ Relationship: _____ Phone #:_____

2nd Emergency Contact Name: _____ Relationship: _____ Phone #:_____

ADDITIONAL PEOPLE AUTHORIZED FOR PICK UP

Name: _____ Contact Number: _____ Work Phone: _____ Relationship: _____

Name: _____ Contact Number: _____ Work Phone: _____ Relationship: _____

Name: _____ Contact Number: _____ Work Phone: _____ Relationship: _____

Name: _____ Contact Number: _____ Work Phone: _____ Relationship: _____

AFTER CARE PROGRAM MEDICAL RELEASE

I, the undersigned parent/guardian of _____ do hereby give my child permission to participate in the _____ After School Care Program activities. I am aware of the nature and extent of the program and do hereby unconditionally release and agree to hold harmless Beaufort County School District, its agents and employees, from any and all claims of any kind or nature which may arise in connection with this program. I also give the staff of _____ After School Care Program permission to seek medical attention for my child in my absence.

In case of emergency: Parents or someone who would be responsible:

_____ _____

Name Phone # Name Phone #

Please list any allergies/medical problems, including those problems requiring maintenance medication, (i.e. Diabetic, Asthma, Seizure Disorder)

Medical Diagnosis	Medication	Dosage	Frequency

The purpose of the above information is to ensure medical personnel has details of any medical problem which may interfere with or alter treatment.

_____ _____

Signature of Parent or Guardian Date

PAYMENT GUIDELINES

- I understand that payment is due on Monday of each week payable to Beaufort County School District, in the form of cash, check or the On-Line Payment option on the Pritchardville Elementary School website. On-line payment via credit card is preferred.
- I understand that a late fee of $25.00 per child will be applied to my payment if I do not pay by the close of business on Monday of each week.
- I understand that if payment is not received by the close of business on Monday of each week my child will not be allowed to attend the after-school program until payment has been made. (Space may not be available in the program once removed)
- I understand that failure to pick up my children on time may result in late fees. In the case of extreme tardiness with inability to reach a point of contact, local law enforcement authorities may be contacted as provided for in the SC code of laws.

_____

Parent/Guardian

Date: _____