



MIDTOWN EXTENDED DAY REGISTRATION



STUDENT'S NAME _____ AGE _____ GRADE _____
Last First

STUDENT'S NAME _____ AGE _____ GRADE _____
Last First

STUDENT'S NAME _____ AGE _____ GRADE _____
Last First

ADDRESS _____

MOTHER _____ HOME PHONE _____

CELL PHONE _____ WORK PHONE _____

PLACE OF EMPLOYMENT _____

DRIVER LICENSE # _____

EMAIL
ADDRESS _____

FATHER _____ HOME PHONE _____

CELL PHONE _____ WORK PHONE _____

PLACE OF EMPLOYMENT _____

DRIVER LICENSE # _____

EMAIL
ADDRESS _____

PERSON(S) AUTHORIZED TO PICK CHILD UP WITHOUT A NOTE OR PHONE CALL
FROM THE PARENTS

APPROXIMATE PICK UP TIME _____

EMERGENCY CONTACTS:

NAME

HOME PHONE

WORK PHONE

1. _____
2. _____
3. _____

MEDICAL INFORMATION (Allergies, Nosebleeds, etc.)

NAME OF INSURANCE COMPANY: _____

POLICY NUMBER: _____

IN THE EVENT OF AN EMERGENCY REQUIRING IMMEDIATE MEDICAL ATTENTION, THE STAFF OF THE WEST MADISON EXPANDED DAY PROGRAM HAS AUTHORIZATION TO SECURE THE NECESSARY MEDICAL TREATMENT.

PHYSICIAN _____ PHONE _____

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I HAVE READ AND UNDERSTAND ALL THE RULES GOVERNING THE EXPANDED DAY PROGRAM AND WILL ABIDE BY THEM.

Signature of Parent/Guardian

Date

A \$55.00 NON-REFUNDABLE REGISTRATION FEE MUST ACCOMPANY THIS APPLICATION

FOR OFFICE USE ONLY:

Registration date: _____ Fee: Cash _____ Check# _____
Received by: _____ Date: _____