SCS STUDENT (K-6) EXTENDED CARE
ENROLLMENT APPLICATION

Child's Information

Name_____ Birthdate_____ M_____ F_____

Address_____ Town_____ State_____ Zip_____

Home Phone_____ Grade Level _____

Father: _____ Mother: _____

Work Phone: _____ Work Phone:_____

Cell Phone: _____ Cell Phone: _____

Email _____ Email _____

Emergency Contacts (relative/friend whom we can call if you cannot be reached)

Name	Phone	Relationship

Extended Care

Please select the program options for which you are enrolling your child.

	Monday	Tuesday	Wednesday	Thursday	Friday
Hours Needed *(Please enter start and end times.)*					

☐ Please check if you are selecting the monthly option. Start Date: _____

Medical Information

Doctor: _____ Telephone: _____

Dentist:_____ Telephone: _____

I certify that the information I have provided in this application is truthful, accurate and complete. In case of accident or injury, I authorize any and all emergency medical, dental, and/or hospital necessary for the proper health and well-being of my child.

Parent/Guardian_____ Date_____