



a Nila M. Lowey 21st Century Community Learning Centers (21st CCLC) Program

## L.E.A.P. REGISTRATION FORM

COMPLETE **ALL** THE FORM AND PLEASE PRINT **CLEARLY**

CHILD'S NAME \_\_\_\_\_ D.O.B. \_\_\_\_\_ Grade: \_\_\_\_\_  
Last First M.

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

FATHER'S NAME \_\_\_\_\_ DAYTIME PHONE \_\_\_\_\_

CELL PHONE \_\_\_\_\_ EMAIL \_\_\_\_\_

MOTHER'S NAME \_\_\_\_\_ DAYTIME PHONE \_\_\_\_\_

CELL PHONE \_\_\_\_\_ EMAIL \_\_\_\_\_

ALLERGIES \_\_\_\_\_

PHYSICAL DISABILITIES/RESTRICTIONS \_\_\_\_\_

Please list at least two neighbors or relatives who will assume temporary care of your child if you cannot be reached.

1. NAME \_\_\_\_\_ PHONE \_\_\_\_\_

2. NAME \_\_\_\_\_ PHONE \_\_\_\_\_

FAMILY PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

HOSPITAL OF CHOICE \_\_\_\_\_ PHONE \_\_\_\_\_

NAME OF HEALTH INSURANCE \_\_\_\_\_

INSURANCE GROUP OR ID # \_\_\_\_\_

In case of accident or serious illness, I request Raymond School District to contact me. If RSD or its authorized representative is unable to reach me, I hereby authorize RSD to call the physician indicated and to follow his/her instructions. If it is impossible to contact this physician, RSD may make whatever arrangements necessary.

\*DATE STUDENT WILL START PROGRAM: \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF PARENT/LEGAL GUARDIAN

\_\_\_\_\_  
DATE