LRES BEFORE SCHOOL PROGRAM
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