

VOORHEES CER BEFORE & AFTER CHILD CARE

SCHOOL YEAR REGISTRATION FORM

(Please print all information.)

Name: _____ School: _____ Grade: _____ Teacher: _____
(Last) (First)

Name: _____ School: _____ Grade: _____ Teacher: _____
(Last) (First)

Home Address: _____ Phone: _____

Mother's Name: _____

Address (If different from student's): _____ Phone: _____

Employer: _____ Work Phone: _____

Cell: _____

Father's Name: _____

Address (If different from student's): _____ Phone: _____

Employer: _____ Work Phone: _____

Cell: _____

Emergency Name: _____ Relationship: _____

Address: _____ Phone: _____

Emergency Name: _____ Relationship: _____

Address: _____ Phone: _____

Persons **AUTHORIZED** to pick up child(ren): _____

Persons **NOT AUTHORIZED** to pick up child(ren): _____

Times Attending: Morning dropoff: _____ AM M T W TH F (Circle days needed)

Afternoon pick up: _____ PM M T W TH F (Circle days needed)

Actual Date Beginning Child Care: _____

\$20 Registration fee is required for each child at the time of registration: Check #: _____ Amount: _____

Send Registration Form and check to" Voorhees CER, Voorhees Middle School, Holly Oak Drive, Voorhees, NJ 08043

HEALTH INFORMATION

Family Physician: _____

Address: _____ Phone: _____

Check if any of these conditions should be known to the appropriate school personnel and other healthcare providers:

Asthma Diabetes Epilepsy/Seizures Heart Condition

Other: _____

Allergic to: Bee Stings Latex Food Allergies Name of Foods: _____

Aspirin Penicillin Sulfa

Other: _____

***Epinephrine Auto Injector kept in school**

Does your child take medication on a regular basis? Yes No

Name of medication(s): _____

Does your child have health insurance?

Yes If yes, name of insurance company: _____

No NJ Family Care provides free or low cost health insurance for uninsured children and certain low income parents.

For more information, call 800-701-0710 or visit www.njfamilycare.org to apply online.

You may release my name and address to NJ Family Care to contact me about health insurance.

Signature: _____ Printed Name: _____ Date: _____

Written consent required pursuant to 20 USC 1232g (b) (1) and 34 CFR 99.30 (b).

I understand that the above relevant information regarding my child's health may be shared with appropriate school personnel and other health care providers as necessary.

(Parent or Guardian Signature)

(Date)

In case of emergency, I give permission to have my child treated at the nearest hospital.

(Parent or Guardian Signature)

(Date)

Security Card/Fob Order Form

Please complete this form and return it to the CER office or to your site supervisor as soon as possible. Once this system is activated, you must have a fob for access into the school at non-school hours.

You will be charged \$10 per fob. If only one parent will be picking up/dropping off the child, then only one fob needs to be ordered.

Child's Name: _____

School: _____

First Parent Name: _____

Second Parent Name (if applicable): _____

Name(s) of Any Other Persons Needing a Fob:
