

**VOORHEES CER**  
**SCHOOL AGE CARE**  
**REGISTRATION FORM**  
2011-2012  
**Please Print Clearly**

NAME: \_\_\_\_\_  
Last First

SCHOOL: \_\_\_\_\_ GRADE: \_\_\_\_\_ TEACHER: \_\_\_\_\_

Address: \_\_\_\_\_

Town: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Father's name: \_\_\_\_\_  
Last First work # cell #

Mother's name: \_\_\_\_\_  
Last First work # cell #

E-mail address for billing purposes: \_\_\_\_\_  
Primary Secondary

Check one: \_\_\_\_\_ Please e-mail bills \_\_\_\_\_ Mail bill home \_\_\_\_\_ E-mail and mail bill home

Child's medical concerns or allergies: (be specific)

\_\_\_\_\_

Emergency contacts other than parents:

\_\_\_\_\_

\_\_\_\_\_

Persons authorized to pick up child (other than above mentioned). \_\_\_\_\_

\_\_\_\_\_

Persons NOT authorized to pick up child \_\_\_\_\_

Indicate times attending: Morning drop off = \_\_\_\_\_ M T W Th F (circle days needed)  
Afternoon pick up = \_\_\_\_\_ M T W Th F (circle days needed)

Date beginning childcare: \_\_\_\_\_

**Registration fee of \$25 is required for each child at time of registration.**  
**Voorhees CER SAC Program 1000 Holly Oak Dr. Voorhees, NJ 08043**

## HEALTH INFORMATION

Child's Name \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Asthma Diabetes, Epilepsy/Seizures, Heart Condition

Allergic to: Aspirin, Penicillin Sulfa, Bee Stings, Latex, Food Allergies Name of Foods:

Other: \_\_\_\_\_

\_\_\_\_\_

Does your child have any medical conditions that our staff should be made aware of: **Yes** **No**

**Explain:** \_\_\_\_\_

**Is an Epinephrine Auto Injector kept in school** **Yes** **No**

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

Name of medication(s): \_\_\_\_\_

Does your child have health insurance? **Yes** **No**

If yes, name of insurance company: \_\_\_\_\_

*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)