To be completed by ASP staff: Registration paid: _____ CCPS employee: _____ Date: _____	**Email Address:** _____

After School Program Enrollment Form 2026-2027 School Year

Child's name:_____ Grade:_____
Address:_____ Teacher:_____
City:_____ Zip:_____ Home #:_____

Name (s) of Parents/Legal Guardians:_____

Guardian #1 Name:_____ Relationship to student:_____
Work #_____ Cell #_____

Guardian #2 Name:_____ Relationship to student:_____
Work # _____ Cell #_____
Does either parent/guardian work for Catoosa County Public Schools? Y/N
If so, where?_____

Please check if there are custody issues: ____. If yes, please list any names NOT allowed to pick up a student from ASP_____

Required: In case of emergency, the following may be contacted, in the order listed, if the parents/guardians cannot be reached. The following persons have permission to pick my child up from ASP:

Name:_____ ***relationship***_____***Phone***_____
Name:_____ ***relationship***_____***Phone***_____
Name:_____ ***relationship***_____***Phone***_____
Name:_____ ***relationship***_____***Phone***_____
Is your child allergic to bee stings? _____ Food Items:_____
Please list any food restrictions:_____
Does your child have asthma? Y/N Inhaler used:_____
*Please list any medications your child is currently taking_____
_____
*Medications (including over-the-counter) will not be administered without a doctor's note.
Please list any other medical information we should know:_____

Names of siblings enrolled in ASP

1. _____ Grade: _____ Teacher:_____
2. _____ Grade:_____ Teacher:_____

My child's enrollment status will be: _____ full time (4-5 day/week) _____ Part time (1-3 days/week) IN THE EVENT OF ANY EMERGENCY, I AUTHORIZE PERMISSION FOR WOODSTATION ASP TO SEEK IMMEDIATE MEDICAL ATTENTION FOR MY CHILD.

Parent/Guardian signature_____ date_____