1958 N. Road Street
Elizabeth City, NC 27909

(252) 335-5812 office
(252) 334-9663 fax

AFTER CARE-STUDENT APPLICATION

Student name: _____ **Date:** _____

Grade currently enrolled in (circle one): Teacher: _____

PS (5 yrs. old) K 1 2 3 4 5 6 7 8 9 10 11 12

Student's Last Name: _____ First: _____Middle:_____

Address: _____ City: _____

State: _____ Zip: _____

Birth date: ____/____/____ Birth Place: _____ Age: _____ Sex: M / F

Choose one: _____ Father _____ Stepfather _____Guardian

Name: _____ Living with child: _____Yes _____No

Home Address: _____ _____Deceased _____Divorced

_____ Home Phone: _____

Employer: _____ Work Phone: _____

Occupation: _____ Cell Phone: _____

Email: _____

Choose one: _____ Mother _____ Stepmother _____Guardian

Name: _____ Living with child: _____Yes _____No

Home Address: _____ _____Deceased _____Divorced

_____ Home Phone: _____

Employer: _____ Work Phone: _____

Occupation: _____ Cell Phone: _____

Email: _____

If the child is not living with both legal parents, please attach a copy of the legal document pertaining to custody.

Authorized Pick Up (Please specify any person, other than parent(s), that is authorized to pick up your child):

Name Address Phone Relationship DL#

_____

_____

EMERGENCY AND MEDICAL INFORMATION

Students Full Legal Name: _____ Date: _____

Date of Birth: _____

Does your child have any known allergies or other health conditions? _____Yes _____No

If yes, please describe:

_____

_____

_____

_____

Does your child have any physical handicaps or other conditions that might affect his or her school work, including physical education? _____Yes _____No

If yes, please describe:

_____

_____

_____

_____

Does your child have any evidence of hearing or vision difficulties? _____Yes _____No

If yes, please describe:

_____

_____

_____

_____

Does your child take any prescription medications? _____Yes _____No

If yes, please name the medications:

_____

Will these be administered during school hours? _____Yes _____No

Family Doctor: _____ Phone: _____

Preferred Hospital: _____

Health Insurance Company: _____

Action Plan and Permission to Administer Medication Form Filled out? _____Yes _____No

Please note that if your child has medication they require to take during school hours you will need to fill out the Permission to Administer Medication form. All medication has to be turned into staff to be locked up for health and safety reasons.
If your child needs to carry and/or leave an epi-pen or inhaler in the classroom an action plan will need to be filled out as well.

Parent/Guardian Signature: _____ Date: _____