R. B. Hunt Extended Day Program
2021-2022

Registration Form

- ☐ Before Care $100
- ☐ After Care $260
- ☐ Before and After $340
- ☐ Daily $20 M T W TH F

Annual Non-refundable Registration Fee
$50 before May 31, 2021
$75 after May 31, 2021

I qualify for:

☐ Free/Reduce Lunch ☐ SJCSD Employee – (location) ____________________

(Must provide yearly documentation for Free and Reduce Rate by Sept. 1)

Child's name: ____________________________ ____________________________
Last First

Male____ Female_____ Birthdate____________ Grade 2021-2022 ____________

Sibling's name: ____________________________ ____________________________
Last First

Male____ Female_____ Birthdate____________ Grade 2021-2022 ____________

RESPONSIBLE PARTY FOR PAYMENT:

NAME: ______________________________ Email: ______________________________

Mother's name: ____________________________ ____________________________
Last First

Father's name: ____________________________ ____________________________
Last First

Primary Resident Address: ____

I have received a copy and understand the rules and payment schedule for R. B. Hunt Elementary School Extended Day Program 2021-2022.

____
Signature

MUST BE FILLED OUT COMPLETELY AND ON FILE IN EXT DAY OFFICE

R.B. Hunt Elementary Extended Day Program

STUDENT EMERGENCY AND HEALTH INFORMATION

2021-2022

Student Last Name: ___________________________________ **First Name:** ____

Birth date: ________________________ Grade: __________ Teacher: ____

Address: ____City:____________________________________Zip:____________________

Legal Guardian(s): ☐ Both Parents ☐ Mother ☐ Father ☐ Other: ____________________ (Appropriate legal custody documentation must be on file)

Name__________________________________ **Relationship**___________________ **Home #**___________________________________

Cell #______________________________________**EMAIL**____

Name__________________________________ **Relationship**___________________ **Home #**___________________________________

Cell #______________________________________**EMAIL**____

MUST BE FILLED OUT-Persons who will care for student in case neither parent can be reached (Only people listed may pick up your child):

Name__________________________________ **Relationship**___________________ **Home #**_______________ **Cell #**______________

Name__________________________________ **Relationship**___________________ **Home #**_______________ **Cell #**______________

Name__________________________________ **Relationship**___________________ **Home #**_______________ **Cell #**______________

Please check if student has a current problem with any of the following: ***Please note any medication student is taking.***

☐ **ADD/ADHD Medication**__________ **When Given**__________ ☐ **Allergies Specify**_________________ **Medication**________________________

☐ **Asthma Medication**_____________ **When Given**__________ ☐ **Diabetes** ☐ **Heart Condition Describe:** ____________________________

☐ **Seizures - Type**____________________________________ **Medication:**____

☐ **Any other condition:**

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DOCTOR'S NAME___________________________ **PHONE** _______________________ ☐ ***Check if you add additional information to add to form***

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Parent/Guardian Statement: I accept responsibility for notifying the school of any changes of home address or phone number or any change in health status of my child. In the event of serious illness or accident and the school cannot contact me, I give permission to have my child moved via ambulance or other conveyance to a hospital for immediate attention, and I assume responsibility for payments of same. In case of an accident or illness when immediate treatment is not needed, but when my child is unable to remain in school, I request to be contacted by the school. If I am unable to be reached, I request that one of the persons listed below be contacted to care for my child until I can be reached. These persons have permission to transport my child. I consent that appropriate information from my child's educational records will be shared with District health care partners as needed to provide and evaluate health services and that information from my child's medical treatment records created by health care personnel at school may be shared with school officials who have a legitimate need for access.

Signature of Parent or Guardian____ Date__________________.