CALOOSA MIDDLE SCHOOL **BEFORE/AFTER SCHOOL** PROGRAM APPLICATION

Child's Last Name _____First _____ M.I. _____

Home Address _____City/State _____Zip _____

Home Phone _____ Birthday _____ Age _____ Sex: F___ M___

Grade _____ Child Lives With: Both Parents _____ Mother _____ Father _____

Child's Doctor _____Doctor's Phone # _____

Medical Info _____Disabilities _____

Allergies _____

Father's Name _____Work Phone _____ Cell_____

Mother's Name _____Work Phone _____Cell_____

If Parents Can Not be Reached Call _____Phone _____

OTHER PERSON AUTHORIZED TO REMOVE THE CHILD FROM THE FACILITIES, IN CASE OF ILLNESS, ACCIDENT OR EMERGENCY, IF FOR SOME REASON THE PARENT CANNOT BE REACHED, IF NONE, INDICATE "NONE"

Name_____ Phone_____ Relationship_____

Name_____ Phone_____ Relationship_____

It is understood and agreed by the undersigned that CMS is not liable for damage/loss of property or injury, unless such damage/loss of property or injury is the result of the negligence of an employee of the organization.

I grant CMS permission to authorize and obtain emergency medical care in case of illness or injury when neither parent/guardian is available to grant permission for medical treatment.

Enrollment in the Before/After School Program requires a $10.00 non-refundable fee. Please return cash/check with this application to enroll your child. Students are not permitted on campus before 7:00am.

PAYMENT: Payment for the program is due on a weekly basis. We are not able to extend credit to any parent. If payment is more than two weeks delinquent, we reserve the right to dismiss your child/children from the program. Please pay promptly.

A penalty of $1.00 will be assessed for every minute a child is left after 6:00 pm. More than **three** late pick-ups may result in your child/children being removed from the program**.** _____
Parent Initials

Parent/Guardian Signature _____Date _____