



EVANGEL CLASSICAL  
CHRISTIAN SCHOOL  
SOLI DEO GLORIA

# Evangel Classical Christian School

## After-Hours Care

### Registration Form

### **(Please complete a Registration Form for each child)**

After-Hours Care is a service provided to assist working parents who need care for children after school hours. AHC is dependent on the availability of adequate staffing.

Please return this **completed** form and Registration Fee to the school office **by August 1.**

**After-Hours Care will be available each school day from 1:00 p.m. – 6:00 p.m.**

**Cost: \$25.00 Registration and \$5.00/hour per child. Drop-in rate: \$7.00/hour**

Child's Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Father/Guardian's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

Phone Numbers: (home) \_\_\_\_\_ (Father's work) \_\_\_\_\_  
(Father's cell) \_\_\_\_\_ (Mother's work) \_\_\_\_\_ (Mother's Cell) \_\_\_\_\_

Parents' Email addresses:

\_\_\_\_\_

Emergency Contacts:

(other than parents)	Name	Phone

### **Please circle only the days and list the hours your child will need After-Hours Care:**

Days Needed:	Hours needed:
Monday	_____
Tuesday	_____
Wednesday	_____
Thursday	_____
Friday	_____
Drop In Only	

Parent's Signature: \_\_\_\_\_

Parents will be billed the first week of each month for the previous month's hours and payment will be due on the 15<sup>th</sup> of each month. Late fees of \$25 per month per family will be charged for payments made after the 15<sup>th</sup>. Any student not picked up by 6:00 p.m. will be charged \$5.00 per every 15 minutes late.

**Over →**

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_ Insurance \_\_\_\_\_

In the event my child needs medical attention and Evangel Classical Christian School is unable to reach me, I authorize the person named as emergency contacts to speak and act on my behalf for my child's welfare. I have advised these persons of any special medical needs my child may require. I further release the staff of Evangel Classical Christian School and Evangel Church, PCA from any liabilities in connection with the administering of first aid and other necessary medical attention required by my child. In the event of any emergency, when neither I nor my authorized contacts can be reached, the Evangel Classical Christian School authorities are hereby authorized to use their best judgment in obtaining medical attention/treatment for my child.

•Does your child have a significant medical condition(s)? Yes  No  If yes, please provide pertinent information:

\_\_\_\_\_

•Does your child take any medications on a routine basis? Yes  No  If so, please note medication, dosage, frequency and reason for the medication. \_\_\_\_\_

•Does your child have allergies to any of the following?

Ants: Yes  No

Bee Stings Yes  No

Latex: Yes  No

Medications Yes  No  \_\_\_\_\_  
(list)

Food: Yes  No  \_\_\_\_\_  
(list)

If yes, please briefly describe their typical reaction and treatment, if treatment will need to be provided at school, parents will need to follow the medication policy outlined in the ECCS Student Handbook.

\_\_\_\_\_

Parent's Signature \_\_\_\_\_

Date \_\_\_\_\_

Thank you for entrusting your child into our care!

ECCS