

# REGISTRATION FORM

BEACON AFTER SCHOOL PROGRAM  
Middle School Monday - Friday  
Elementary School Monday - Friday  
3:00 – 5:30 PM

<b>FOR OFFICE USE ONLY</b>
DATE COMPLETE _____
DATE CHILD ACCEPTED AND PAID _____
Cash _____ Check # _____ Receipt # _____

**NOTICE:** All BEACON Students Must Be Picked Up by 5:30 PM. Students may begin attending BEACON when payment and registration are complete.

## REGISTRATION FEE: \$ 20.00 per semester

Grade: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Birth Date: \_\_\_\_\_ Race: \_\_\_\_\_

NAME: \_\_\_\_\_ Other Name/s this Child Uses: \_\_\_\_\_

## FAMILY CONTACT INFORMATION:

Name: _____	Name: _____
Relationship to Child: _____	Relationship to Child: _____
Email Address: _____	Email Address: _____
Home Phone: _____	Home Phone: _____
Cell Phone: _____	Cell Phone: _____
Employer: _____	Employer: _____
Work Phone: _____	Work Phone: _____

Homework/tutoring is an essential part of BEACON. In accordance with the after-school grant all students must participate in homework time each day. I support the goals of BEACON and will abide by the rules and policies that have been established and will encourage my child to do likewise. I understand a late fee of \$1.00 per minute will be assessed beginning at 5:30 PM and running until the time my child is picked up from the Director (or the police if they have taken custody of him/her.) I have received and read the School Handbook.

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## AUTHORIZATION FOR MEDICAL CARE OF MINOR

I, the undersigned parent, legal guardian, or person having legal custody of this child do hereby authorize the Eufaula Public Schools to:

- I. Contact the following physician in case of emergency:

Physician's Name : \_\_\_\_\_ Phone: \_\_\_\_\_

Address \_\_\_\_\_

- II. Administer prescription medication that has been prescribed for my child when I send it to school. Over the counter medications such as Tylenol may also be given to the child if I have provided it. I understand that all medications must be in the original bottle with the instructions for the dosage on

it. Medication will only be given to the child whose name is on the bottle. All medications must be submitted to the office. YES \_\_\_\_\_ NO \_\_\_\_\_

III. In the case of an emergency, notify the alternate contact persons listed below if I cannot be notified quickly. They have the authority to consent to emergency transportation, x-ray, medical, surgical or dental diagnosis or treatment as deemed necessary upon the advice of a physician, surgeon, or dentist licensed under the laws of the State of Oklahoma. In the event that neither parent nor alternate persons can be reached, I authorize the Eufaula Public Schools to give these consents.

YES \_\_\_\_\_ NO \_\_\_\_\_

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**In case of emergency, if parent/guardian cannot be reached, please notify (in order of preference):**

NAME: \_\_\_\_\_ TELEPHONE NUMBER: \_\_\_\_\_

NAME: \_\_\_\_\_ TELEPHONE NUMBER: \_\_\_\_\_

NAME: \_\_\_\_\_ TELEPHONE NUMBER: \_\_\_\_\_

**HEALTH RECORDS:** Please check below any health concerns that apply to your child:

Asthma \_\_\_ Epilepsy \_\_\_ Diabetes \_\_\_ Allergic to bee stings \_\_\_ Frequent nose bleeds \_\_\_

Food allergies (Please list) \_\_\_\_\_

Plant or mold allergies (Please list) \_\_\_\_\_

Please list the medications your child takes on a regular basis: \_\_\_\_\_

**PERMISSION FORM - FIELD TRIPS**

BEACON students are often taken on field trips in the Eufaula area. They may be bused to the Eufaula Memorial Library, to another school site, to a park or local business.

Yes, this student may attend local field trips    No, this student may not attend local field trips

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**CAUTION:** A COURT ORDER PROHIBITS THE PERSON (OR PEOPLE) LISTED BELOW FROM PICKING UP MY CHILD: \*(Official documentation must be provided to BEACON Coordinator)

**RELEASE OF STUDENT**

People picking up children must be at least 18 years of age and will be required to produce a Photo ID unless they are personally known to the school official releasing the student. The following persons have my permission to pick up my child from the BEACON Program. DO NOT LIST SOMEONE THAT IS UNDER 18 Yrs OF AGE

Name: _____	Name: _____
Relationship to Student: _____	Relationship to Student: _____
Phone Number: _____	Phone Number: _____