After School Care Program

Registration Form

Child's Name: _____

Address: _____

Parent Name: _____

Contact Number: _____

Child's Birthday: _____

Grade: _____

MEDICAL INFORMATION

My Child has the following medical conditions:

_____

_____

_____

Pediatrician's Name: _____

Contact Number: _____

☐ I will make a full payment in the amount of $1,300 (elementary) $650 (middle) by July 22, 2022.

☐ Please set-up payments through my FACTS account.

Parent Signature: _____ Date: _____

WAOLANI JUDD NAZERENE SCHOOL

Child's Name: _____

Emergency Contact

Name:		Relationship:	
Home Phone:		Mobile Phone:	
Address:			
Name:		Relationship:	
Home Phone:		Mobile Phone:	
Address:			
Name:		Name:	
Home Phone:		Home Phone:	
Address:			

Authorized Pick-up List

Name:		Relationship:	
Home Phone:		Mobile Phone:	
Address:			
Name:		Relationship:	
Home Phone:		Mobile Phone:	
Address:			
Name:		Name:	
Home Phone:		Mobile Phone:	
Address:			
Name:		Name:	
Home Phone:		Mobile Phone:	
Address:			