

AFTERCARE-MONTHLY USE-LCS STUDENTS
DO NOT FILL OUT IF DOING DROP-IN
APPLICATION FOR ADMISSION

Please submit application in black or blue ink.
 Fill out application completely.
 Incomplete applications will not be accepted.



2331 NE 26th Ave
 Pompano Beach, FL 33062
 954-941-7501

TODAY'S DATE _____

CHILD'S NAME _____ (first) _____ (last) SEX ____ NICKNAME _____

ADDRESS _____ (street) PHONE _____

 (city) (state) (zip code) DATE OF BIRTH _____

<u>NAME</u>	<u>HOME ADDRESS (IF DIFFERENT)</u>	<u>CELL PHONE</u>
MOTHER _____	_____	_____
FATHER _____	_____	_____
GUARDIAN _____	_____	_____
DAD'S EMAIL _____	MOM'S EMAIL _____	

IN THE EVENT OF A TRUE EMERGENCY, 911 WILL BE CONTACTED AND EMERGENCY PROCEDURES FOLLOWED

OTHER PERSONS TO BE NOTIFIED IN CASE OF ILLNESS OR ACCIDENT and ARE PERMITTED TO REMOVE CHILD:

<u>NAME</u>	<u>ADDRESS</u>	<u>CELL PHONE</u>
_____	_____	_____
_____	_____	_____

ALLERGIES _____ FOOD PROBLEMS _____

ANY PHYSICAL PROBLEMS WE SHOULD BE AWARE OF? _____

MARITAL STATUS OF PARENTS: (circle one) MARRIED DIVORCED SEPARATED WIDOWED

****IF DIVORCED, please describe custody and visitation agreement for the child. If custody is limited, you must provide custody papers.

*IS MOTHER PERMITTED TO REMOVE CHILD? YES NO - - * IS FATHER PERMITTED TO REMOVE CHILD? YES NO
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I UNDERSTAND THAT MY FACTS ACCOUNT WILL BE CHARGED FOR MY CHILD USING THE **MONTHLY** AFTERCARE PROGRAM.

PARENT SIGNATURE _____

PARENT NAME(PRINT) _____