

COUNTRY KNOLLS

A 50.00 deposit will be required for our program for insurance fees.
Check# _____
Amount \$ _____
Date _____

BEFORE /AFTER CARE APPLICATION

School Year Attending 20__/20__ Date: _____
Before school _____ After School _____ Drop off time: _____
School District _____ Fulmar _____ Austin _____ Lakeview Pick up time: _____

STUDENT INFORMATION

First Name _____ Last Name _____
Date of Birth _____ Age _____ Gender _____
Address _____
City _____ State _____ Zip _____
Home Phone Number _____ E-mail _____

PARENT'S INFORMATION

Father's Name _____ Mother's Name _____
Employer _____ Employer _____
Position _____ Position _____
Work # _____ Work # _____
Cell# _____ Cell # _____
Emergency Contact # _____ Name & Relationship _____
Emergency Contact # _____ Name & Relationship _____

MEDICAL INFORMATION

Student's Physician _____ Physician's # _____
Any Physical Impairments or Allergies we should know about: _____

Agree to terms and conditions of before/aftercare.

Parent Signature