Lakeland Extended Activities Program (LEAP)
Registration 2017-2018

REGISTRATION FEE ATTACHED
DATE PAYMENT RECEIVED: _____ RECEIVED BY: _____

STUDENT ENROLLMENT INFORMATION

LAST NAME, FIRST NAME **GRADE** **DATE OF BIRTH** **Registering: AM/PM/Both**

1. _____
2. _____
3. _____
4. _____

Ethnicity (choose one): _____ Hispanic _____ Not Hispanic, Latino or Spanish origin

Race (choose all that apply): _____ American Indian/Alaskan Native _____ Asian _____ Whit

_____ Pacific Islander/Native Hawaiian _____ Black/African American

PARENT INFORMATION

NAME OF MOTHER:_____HOME:_____CELL PHONE:_____

ADDRESS:_____ ZIP CODE:_____

EMPLOYER:_____ WORK PHONE:_____

EMPLOYER ADDRESS:_____ ZIP CODE:_____

MOTHER'S EMAIL ADDRESS:_____

NAME OF FATHER:_____HOME:_____CELL PHONE:_____

ADDRESS:_____ ZIP CODE:_____

EMPLOYER:_____ WORK PHONE:_____

EMPLOYER ADDRESS:_____ ZIP CODE:_____

FATHER'S EMAIL ADDRESS:_____

FOR CHILD'S SAFETY, LIST ALL PERSONS TO WHOM CHILD MAY BE RELEASED:
(DO NOT LEAVE BLANK)

NAME:_____PHONE#_____

NAME:_____PHONE#_____

NAME:_____PHONE#_____

NAME:_____PHONE#_____

LIST ALL PERSONS TO WHOM CHILD MAY NOT BE RELEASED: (Parent must provide legal documentation to support this request if person listed is a parent of the child.)

NAME:_____PHONE#_____

NAME:_____PHONE#_____

NAME:_____PHONE#_____

NAME:_____PHONE#_____

EMERGENCY INFORMATION

Name of person, other than parent, authorized to act for the parent in an emergency: DO NOT LEAVE BLANK

NAME:_____ PHONE:_____ CELL PHONE:_____

ADDRESS:_____ ZIP CODE:_____

EMPLOYER:_____ WORK PHONE:_____

EMPLOYER ADDRESS:_____ZIP CODE:_____

NAME OF CHILD'S PHYSICIAN:_____ PHONE NUMBER:_____

PHYSICIAN'S ADDRESS:_____ ZIP CODE:_____

Child's Health is: Excellent: _____ Good: _____ Fair: _____ Poor: _____

Please describe any medical conditions including allergies:

MEDICATION

Please list all prescription medication that your child takes on a daily basis. We would like to be aware of any medicines your child takes to provide this information to medical personnel in case of an emergency. Please refer to the Parent Handbook for details on dispensing of medication while in LEAP.

NAME OF MEDICATION	DAILY DOSAGE	REASON PRESCRIBED

In the event of an emergency, I hereby give permission to LEAP staff to secure proper medical treatment for my child if I cannot be reached, I hereby give permission for emergency personnel selected by LEAP staff to order x-rays, routine tests and treatment for the health of my child. I also give permission to emergency personnel selected by LEAP staff to hospitalize, secure proper treatment for, and to order injection and/or surgery of my child.

Signature of Parent/Legal Guardian:_____ Date:_____