ELEMENTARY SCHOOL
BEFORE & AFTER SCHOOL PROGRAM
REGISTRATION FORM

- ❑ **Yes**, please register my child(ren) for **2011-2012** Before & After School Program. I have attached a registration fee payment of **$25.00** per child to this COMPLETED form.
- ❑ **No**, I do not wish to register my child(ren) at this time. I understand by selecting this option, my child(ren) will not be able to participate in HYP's before and/or after school programs. If I opt to register them at a later date, I understand that the Registration Fee at that time will be **$30.00** per child.

Please complete the entire form, sign it and return it to the Horizon Youth Programs or School office.

Last Name _____ **First Name**_____ **Grade**_____

Address_____

City_____ **State** _____ **Zip** _____ **Phone** ( )_____

☐ **Male** ☐ **Female** **Birth date** _____/_____/_____

Parent/Guardian _____ **Relationship** _____

Phone ( ) _____ **Work Phone** ( ) _____

Parent/Guardian _____ **Relationship** _____

Phone ( ) _____ **Work Phone** ( ) _____

If not available, please notify in emergency:

Name _____ **Relationship** _____

Work Phone ( ) _____ **Alternate** ( ) _____

Persons Authorized For Pick Up

Physical Conditions:

❑ Allergies ❑ Asthma ❑ Epilepsy ❑ Diabetes ❑ Heart Condition ❑ Other_____

Medical Concerns/ Limitations:

Diet Restrictions _____ **Allergies** _____

Special Needs _____ **Activity Restrictions** _____

PERMISSION/CONSENT FORM

I hereby waive all claims which I might have against Horizon Christian Fellowship, their agents and employees, for injury, accident, illness or death occurring during or by any reason of the above described activity. (I)(We)(Parents)(Guardians) of the above named child do hereby authorize HCF as agents for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by and is rendered under the general or specific supervision of any physician or surgeon licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given in advance to provide authority and power on part of the afore stated agents to give a specific consent to any and all such diagnosis, treatment or hospital care which the afore said physician in the exercise of his best judgment may deem advisable. This authorization is given pursuant to the provisions of section 25.8 of the Civil Code of California.

☐ ***I understand and comply with the HYP registration, payment and refund policy.***

_____ _____

Signature of parent or guardian ***Date***