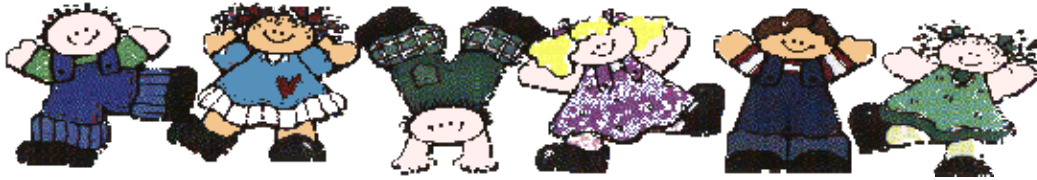


# ARKANSAS BAPTIST SCHOOL SYSTEM



## EXTENDED CARE

### Child's Personal Data Sheet and Registration Form

TO REGISTER YOUR CHILD FOR EXTENDED CARE FOR THE \_\_\_\_\_ SCHOOL YEAR

- Complete and return this form. We are aware that much of this information is on your school enrollment form; however, Department of Human Services requires that we have this information (including your child's shot record for K3 and K4) in our files in the Extended Care office.
- Complete and return the Extended Care Payment Plans document.
- Attach a \$50 registration fee. The registration fee is non-refundable. In the event classes are filled and space is not available for your child, the registration fee will be returned to you.

#### 1. Student Information

Child's name \_\_\_\_\_ DOB \_\_\_\_\_

School year \_\_\_\_\_ Grade your child is entering \_\_\_\_\_ Home telephone \_\_\_\_\_

Person responsible for paying account \_\_\_\_\_

E-mail address \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Billing Address (if different from above) \_\_\_\_\_

Father's name \_\_\_\_\_

Father's employment \_\_\_\_\_

Father's work phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Pager \_\_\_\_\_

Mother's name \_\_\_\_\_

Mother's employment \_\_\_\_\_

Mother's work phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Pager \_\_\_\_\_

#### 2. Enrollment (See Payment Plan document for description of fees)

Check which sessions: I (7:00 to 7:45 a.m.) \_\_\_ II (11:45-3:00 p.m.) \_\_\_ III (3:00 to 6:00 p.m.) \_\_\_ Drop-in \_\_\_

#### 3. Emergency Contact Information

Name of parent or guardian with whom child resides \_\_\_\_\_

Name of person to call if parents cannot be reached \_\_\_\_\_

Phone \_\_\_\_\_ Relationship \_\_\_\_\_ Address \_\_\_\_\_

Is this person authorized to take your child from center? \_\_\_\_\_

List any other adults, their relationship, address, and phone number who may take your child from center:

1. \_\_\_\_\_  
\_\_\_\_\_

**4. Medical Information**

Child's physician \_\_\_\_\_ Telephone \_\_\_\_\_  
Address \_\_\_\_\_

Child's dentist \_\_\_\_\_ Telephone \_\_\_\_\_  
Address \_\_\_\_\_

Hospital \_\_\_\_\_ Telephone \_\_\_\_\_

Consent for emergency medical care:

*I do hereby request and give consent of the Director of Arkansas Baptist Extended Care or her duly appointed representative for my child to receive such medical or surgical aid as may be deemed necessary and expedient by a duly licensed or recognized physician or surgeon in case of an emergency when the parents cannot be reached. Consent is also given for the Director or her duly appointed representative to transport my child for emergency medical treatment if the parents cannot be reached.*

*I hereby give the Director of Arkansas Baptist Extended Care or her appointed representative permission to give my child Tylenol if needed. I understand I will be notified that Tylenol is needed and will be administered.*

\_\_\_\_\_  
Parent Signature Date

**5. Immunizations** - Please attach a copy of your child's shot record for K3 and K4 students.

**6. Please list special concerns or allergies**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**7. Discipline and Accountability Policies**

*Christian discipline is love. We expect the following characteristics in our students: cheerful obedience, cooperation with others, courtesy and respect for others, truthfulness and honesty, and respect for property that belongs to others. When these characteristics are missing, the following actions will be taken: removing the child from the group, loss of privileges, parents called, parent/teacher conference, and the final step would be permanent expulsion. Our goal is to help children prepare for future success in school by extending their self-control.*

*At any time, the children of Extended Care can be subject to interviews from the center's Licensing Specialist, DCFS Special Investigative, and law enforcement for investigative purposes and/or for determining compliance with licensing requirements. I understand that I can report any licensing violations to the Director or DCFS.*

***I have read and understand all Extended Care policies and procedures. I will support the Extended Care Director and the staff in the application of these policies.***

\_\_\_\_\_  
Signature Date



**RETURN TO THE ELEMENTARY EXTENDED CARE OFFICE**  
62 Pleasant Valley Drive  
Little Rock, AR 72212  
501-227-7070 ext.386 FAX: 501-227-0060



**Office Use Only**  
Shot Records \_\_\_\_\_  
Registration Fee received \_\_\_\_\_  
Financial Agreement received \_\_\_\_\_