R.I.S.E FAMILY REGISTRATION FORM - STOUGHTON

Parent/Guardian Information

Registration Date:_____

PLEASE WRITE CLEARLY & LEGIBLE

Mother / Guardian

First Name: _____ M.I.___ Last Name: _____

Address: _____

Occupation: _____ Date of Birth (MM/DD/YYYY): _____

Cell Phone: ( ) _____Other Phone: ( ) _____

Instagram: _____ Facebook:_____

Email: _____

[ ] Custodial Parent (If married, mark both parents)

Marital Status:[ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed [ ] Other_____

Contact: [ ] Text [ ] Email [ ] Call

Father / Guardian

First Name: _____ M.I.___ Last Name: _____

Address: _____

Occupation: _____ Date of Birth (MM/DD/YYYY): _____

Cell Phone: ( ) _____Other Phone: ( ) _____

Instagram: _____ Facebook:_____

Email: _____

[ ] Custodial Parent (If married, mark both parents)

Marital Status:[ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed [ ] Other_____

Contact: [ ] Text [ ] Email [ ] Call

List Children's Names Whom You Are Registering:

_____

_____

_____

_____

_____

_____

Child Information

1st Child

First Name: _____ M.I.___ Last Name: _____

Name child prefers to be called: _____ Grade/Class:_____

School: _____Date of Birth (MM/DD/YYYY):_____

List any existing medical conditions, medication and/or special attention your child may require?

_____

Does your child take any medication: [Y] [N]

Will your child need to be administered any medication during the program? [Y] [N]

If so list:_____

This information will help us provide the best care for your child during the program and will help in the event of emergency. Please provide accurate and thorough information. (Check all that apply)

- o Asthma
  Does your child carry an inhaler? [Y] [N]
- o ADD/ ADHD
- o Heart Defect / Disease
- o Diabetes
- o Hypertension
- o Epilepsy
- o Other: _____

Food Allergies: _____

- o Bee Sting
- o Trees, Grass, Pollen
- o Animals _____
- o Other: _____

Does your child carry an Epipen? [Y] [N]

LIABILITY WAVER By signing this document, I agree to the following terms:

In case of illness or accident, Jubilee Staff/ R.I.S.E. Volunteers are authorized to secure emergency medical treatment at my expense. Jubilee reserves the right to dismiss (to parent or guardian) any participant who does not show respect for the facility, including, but not limited to: property, equipment, policies, other members and volunteers. Participants who are dismissed will not be given a refund of dues paid. Jubilee Christian Church does not assume responsibility for personal property.

Please check the appropriate box:

I give Jubilee Christian Church / R.I.S.E Girls Program permission to use photographs and videos of participant(s) for advertising purposes. [YES] [NO]

_____ Date: _____

Name of Parent/Guardian (Please Print)

_____

Signature of Parent/ Guardian:

Emergency Contacts & Authorized Pickup Persons:

1st Contact/Pick Up

Name: _____ Phone: _____

Relationship to the Child: _____ [ ] Able to pick up all children in the family

2nd Contact/Pick Up

Name: _____ Phone: _____

Relationship to the Child: _____ [ ] Able to pick up all children in the family

Payment Information:

[ ] $5 / Weekly [ ] $20 / Full 6 Week Session

Late Fee Agreement:

Late Fee Agreement ensures you will pick up your child on time. Dismissal time will always be given to you with RISE Day details. There will be a $10 fee charged to me every 15 minutes.

Example: 30 minutes late - $20 will be charged to your card once you pick up your child unless you pay the fee in cash. You will receive a receipt. All proceeds go to the R.I.S.E Girls Program.

By signing this document, I agree to the following terms:

If I am late to pick up my child(ren) there will be a $10 fee charged to me every 15 minutes.

Signature: _____

Name on Card: _____

Card # _____EXP: _____ CVV:_____

Additional Comments & Information:

Is there is any other information that that would be helpful to our management and teaching staff?

_____

_____

Signature:

Parent's Signature: _____ Date: _____

Thank You!

2nd Child

First Name: _____ M.I.___ Last Name: _____

Name child prefers to be called: _____ Grade/Class:_____

School: _____Date of Birth (MM/DD/YYYY):_____

List any existing medical conditions, medication and/or special attention your child may require?

_____

Does your child take any medication: [Y] [N]

Will your child need to be administered any medication during the program? [Y] [N]

If so list:_____

This information will help us provide the best care for your child during the program and will help in the event of emergency. Please provide accurate and thorough information. (Check all that apply)

- o Asthma
  Does your child carry an inhaler? [Y] [N]
- o ADD/ ADHD
- o Heart Defect / Disease
- o Diabetes
- o Hypertension
- o Epilepsy
- o Other: _____

Food Allergies: _____

- o Bee Sting
- o Trees, Grass, Pollen
- o Animals _____
- o Other: _____

Does your child carry an Epipen? [Y] [N]

3rd Child

First Name: _____ M.I.___ Last Name: _____

Name child prefers to be called: _____ Grade/Class:_____

School: _____Date of Birth (MM/DD/YYYY):_____

List any existing medical conditions, medication and/or special attention your child may require?

_____

Does your child take any medication: [Y] [N]

Will your child need to be administered any medication during the program? [Y] [N]

If so list:_____

This information will help us provide the best care for your child during the program and will help in the event of emergency. Please provide accurate and thorough information. (Check all that apply)

- o Asthma
  Does your child carry an inhaler? [Y] [N]
- o ADD/ ADHD
- o Heart Defect / Disease
- o Diabetes
- o Hypertension
- o Epilepsy
- o Other: _____

Food Allergies: _____

- o Bee Sting
- o Trees, Grass, Pollen
- o Animals _____
- o Other: _____

Does your child carry an Epipen? [Y] [N]

4th Child

First Name: _____ M.I.___ Last Name: _____

Name child prefers to be called: _____ Grade/Class:_____

School: _____Date of Birth (MM/DD/YYYY):_____

List any existing medical conditions, medication and/or special attention your child may require?

_____

Does your child take any medication: [Y] [N]

Will your child need to be administered any medication during the program? [Y] [N]

If so list:_____

This information will help us provide the best care for your child during the program and will help in the event of emergency. Please provide accurate and thorough information. (Check all that apply)

- o Asthma
  Does your child carry an inhaler? [Y] [N]
- o ADD/ ADHD
- o Heart Defect / Disease
- o Diabetes
- o Hypertension
- o Epilepsy
- o Other: _____

Food Allergies: _____

- o Bee Sting
- o Trees, Grass, Pollen
- o Animals _____
- o Other: _____

Does your child carry an Epipen? [Y] [N]

5th Child

First Name: _____ M.I.___ Last Name: _____

Name child prefers to be called: _____ Grade/Class:_____

School: _____Date of Birth (MM/DD/YYYY):_____

List any existing medical conditions, medication and/or special attention your child may require?

_____

Does your child take any medication: [Y] [N]

Will your child need to be administered any medication during the program? [Y] [N]

If so list:_____

This information will help us provide the best care for your child during the program and will help in the event of emergency. Please provide accurate and thorough information. (Check all that apply)

- o Asthma
  Does your child carry an inhaler? [Y] [N]
- o ADD/ ADHD
- o Heart Defect / Disease
- o Diabetes
- o Hypertension
- o Epilepsy
- o Other: _____

Food Allergies: _____

- o Bee Sting
- o Trees, Grass, Pollen
- o Animals _____
- o Other: _____

Does your child carry an Epipen? [Y] [N]