

# Williamsburg Academy Aftercare Registration

## 2025-2026

Student's Name: \_\_\_\_\_ SS# \_\_\_\_\_ Entering Grade: \_\_\_\_\_

Address: \_\_\_\_\_

Father: \_\_\_\_\_ Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Mother: \_\_\_\_\_ Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Please list individuals who have permission to pick up your child/children.

\_\_\_\_\_

Please give any extra information that you feel would help us to provide the best possible atmosphere for your child/children. \_\_\_\_\_

\_\_\_\_\_

Insurance Verification Name of Health/Accident Insurance Provider: \_\_\_\_\_

Policy # \_\_\_\_\_ Expiration Date \_\_\_\_\_

Family Physician \_\_\_\_\_ Office Phone # \_\_\_\_\_

Emergency Information and Medical Treatment Consent I, \_\_\_\_\_, the parent or guardian of \_\_\_\_\_ recognize that as a result of participation in student activities, medical treatment on an emergency basis may be necessary. I further recognize that school personnel may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then existing circumstance. Please make the following notations on my son/daughter's records:

Allergies to medication: \_\_\_\_\_

Medications for long-term illness: (Indicate illness and medication)

\_\_\_\_\_

Relevant Medical Information (e.g., contact lens wearer, history of family diabetes, epilepsy, heart murmur)

\_\_\_\_\_

It is the parents' responsibility to keep all insurance and medical information current throughout the entire school year.

May Tylenol be given at school? Yes \_\_\_\_\_ No \_\_\_\_\_ May Motrin be given at school? Yes \_\_\_\_\_ No \_\_\_\_\_

I plan on using daycare \_\_\_\_\_ full time \_\_\_\_\_ several days a week \_\_\_\_\_ drop in occasionally-

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