



**OFFICE USE ONLY!**  
 Payment Date \_\_\_\_\_  
 Payment Method \_\_\_\_\_

**KidzQuest  
 Before/After School  
 Registration Form  
 2010/2011**

School \_\_\_\_\_  
 Before School Registration  
 Fee \$10  
 Before School (\$3/day 1<sup>st</sup>  
 child, \$2/day each  
 additional child)  
 After School Registration  
 Fee \$15  
 After School (\$12/day 1<sup>st</sup>  
 child, \$7/day 2<sup>nd</sup> child,  
 \$5/day each additional  
 child)

Start Date \_\_\_\_\_  
 Parents who do not fill in a  
 start date **MUST** call (540-  
 967-4420) 24 hours before  
 your child attends.

Days Attending:  
 M T W Th F

Child's Name Last	First	Middle	Teacher/Grade	Birth Date	Sex
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Street Address	City	Zip Code
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Child's Parent/Guardian Name	Email Address
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Home Phone	Cell Phone	Work Phone
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Street Address	City	Zip Code
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Child's Parent/Guardian Name	Email Address
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Home Phone	Cell Phone	Work Phone
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Street Address	City	Zip Code
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**OTHER PEOPLE TO NOTIFY IN CASE OF EMERGENCY**

Name	Relationship	10 Digit Telephone Number
		Work/Cell: Home:
		Work/Cell: Home:
		<b>*Please circle best contact number*</b>

**OTHER THAN YOU, WHO HAS PERMISSION TO PICK UP YOUR CHILD?**

Name	Address	10 Digit Telephone Number
		Work/Cell: Home:
		Work/Cell: Home:
		<b>*Please circle best contact number*</b>

**WHO DOES NOT HAVE PERMISSION TO PICK UP YOUR CHILD?**

Name	Reason(*appropriate paperwork must be attached if parent is not allowed to pick up child, ie: custody papers)

**Child's Name**

<b>CHILD'S HEALTH INFORMATION</b>			
Date of Child's Last Physical Examination:	Child's Health Care Provider's Name	10 Digit Telephone Number	
Street Address		City	Zip Code
Special Health Problems		Allergies, Including Drug Reactions	
Regular Medications		Other Pertinent Data	
Child's Dentist's Name		10 Digit Telephone Number	
Street Address		City	Zip Code
<b>CHILD'S MEDICAL INSURANCE COVERAGE</b>			
Insurance Company Name		Member/Policy Number	
Policy Holder Name		Employer Name	
Insurance Company Name		Member/Policy Number	
Policy Holder Name		Employer Name	
<b>CONSENT TO MEDICAL CARE AND TREATMENT OF MINOR CHILDREN</b>			
<p>I hereby give permission that my child, _____,</p> <p>may be given emergency treatment by a qualified child care provider at</p> <p>_____</p> <p align="center">Name and/or Address</p> <p>When I cannot be contacted, I authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician, health care provider, hospital or aid car attendant when deemed necessary or advisable by the physician or aid car attendant to safeguard my child's health. I waive my right of informed consent to such treatment.</p> <p>I also give my permission for my child to be transported by ambulance or aid car to an emergency center for treatment.</p> <p>I certify (or declare) under penalty of perjury under the laws of the Commonwealth of Virginia that the foregoing is true and correct.</p>			
Parent/Guardian Signature	Date	Parent/Guardian Signature	Date