



Foxborough Regional Charter School
After School Academic Enrichment Program
Grades 5-12

Please complete all registration information. Staff will refer to this registration information provided by the parent/guardian regarding authorized persons to pick up/transport and emergency contacts.

Registration Information

Student's Name: _____ Age: _____ Grade: _____

Address: _____

Town/State/Zip: _____

Home Telephone: _____

Parent/Guardian Name: _____

Work Telephone: (Mother) _____ (Father) _____

Cell Phone: (Mother) _____ (Father) _____

Additional Information

Allergies/Special Diet: _____

Chronic health conditions: _____

Special limitations or concerns: _____

Days attending: _____

I certify that documentation of physical examination and immunizations in accordance with public school health requirements and lead poisoning screening in accordance with public health requirements is on file at the school.

I authorize staff who are trained in the basics of first aid and CPR to give my child medical treatment when appropriate.

I understand that every effort will be made to correct me in case of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to arrange transportation to the nearest medical facility and to secure necessary medical treatment for my child.

**Only emergency Epi-pens can be administered in the after school programs. Please speak to staff if you have any concerns.

Parent/Guardian Signature: _____ Date: _____

After School Academic Enrichment Program
Grades 6-12

Other emergency contacts who will be responsible for picking up my child

1. Name: _____

Relationship: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

2. Name: _____

Relationship: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

3. Name: _____

Relationship: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

4. Name: _____

Relationship: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____