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

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)

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

Food Allergies: ____

- Bee Sting
- Trees, Grass, Pollen
- Animals ________________
- 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)

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

Food Allergies: ____

- Bee Sting
- Trees, Grass, Pollen
- Animals ________________
- 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)

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

Food Allergies: ____

- Bee Sting
- Trees, Grass, Pollen
- Animals ________________
- 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)

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

Food Allergies: ____

- Bee Sting
- Trees, Grass, Pollen
- Animals ________________
- 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)

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

Food Allergies: ____

- Bee Sting
- Trees, Grass, Pollen
- Animals ________________
- Other: __________________

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