



# BEFORE & AFTER SCHOOL REGISTRATION FORM

Please print clearly - one child per registration

I wish to register for:  Before School  After School  Before & After School  Monday Only

School: \_\_\_\_\_ School Year: \_\_\_\_\_

My Child receives:  Full Lunch  Reduced Lunch  Free Lunch

(Sioux City Sites: Current determination letter from School Food Service Dept. must be provided to receive financial assistance. If child does not qualify for financial assistance based on lunch status, income guidelines may be used. Ask for form).

Child's Name: \_\_\_\_\_  
(First) (Nick Name) (Last Name)

Grade \_\_\_\_\_ Age \_\_\_\_\_ Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: M / F Race: \_\_\_\_\_

### \*Parent(s) Information:

Mother's Name: \_\_\_\_\_  
(First Name) (Last Name)

Address: \_\_\_\_\_  
(Street & Apt/ PO Box) (City) (State) (Zip)

Phone: ( ) ( ) E-Mail Address \_\_\_\_\_  
(Home) (Cell)

Place of Employment: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Work Address: \_\_\_\_\_  
(Street & Apt/ PO Box) (City) (State) (Zip)

Does Child Live With Mother? Yes No

Father's Name: \_\_\_\_\_  
(First Name) (Last Name)

Address: \_\_\_\_\_  
(Street & Apt/ PO Box) (City) (State) (Zip)

Phone: ( ) ( ) E-Mail Address \_\_\_\_\_  
(Home) (Cell)

Place of Employment: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Work Address: \_\_\_\_\_  
(Street & Apt/ PO Box) (City) (State) (Zip)

Does Child Live With Father? Yes No

Legal Guardian (If different from Parent)

Guardian's Name: \_\_\_\_\_  
(First Name) (Last Name)

Address: \_\_\_\_\_  
(Street & Apt/ PO Box) (City) (State) (Zip)

Phone: ( ) ( ) E-Mail Address \_\_\_\_\_  
(Home) (Cell)

Place of Employment: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Work Address: \_\_\_\_\_  
(Street & Apt/PO Box) (City) (State) (Zip)

Is there any custody or restraining order on person who may attempt to pick up or have contact with your child? (Beyond the Bell must have a copy of signed court order).

Name: \_\_\_\_\_  
(First Name) (Last Name)

Address: \_\_\_\_\_  
(Street & Apt/ PO Box) (City) (State) (Zip)

**Emergency Contact/Pick Up**

Name: _____	Name: _____	Name: _____
Phone: _____	Phone: _____	Phone: _____
Relationship: _____	Relationship: _____	Relationship: _____

(Other than parent/guardian, only those named above will be allowed to pick up child from the program. Must be prepared to show Identification)

**Transportation:**

Please indicate how your child will get home from BTB:

Parent/Guardian Will Pick up \_\_\_\_\_ My child should walk home \_\_\_\_\_ Bus (where available) \_\_\_\_\_

**Health Record (If none, please mark N/A by each):**

Allergies or Restrictions: \_\_\_\_\_

Operations or Illnesses: \_\_\_\_\_

Behavior or Special Disorders: \_\_\_\_\_

Please List any Medications: \_\_\_\_\_

Will BTB be responsible for administering any medication to your child? \_\_\_\_ Yes \_\_\_\_ No

\*If answered Yes, please include your child's care plan or sign below authorizing BTB to obtain your child's care plan at their school or contact your physician to obtain a care plan.

\_\_\_\_\_  
(Parent/Guardian Signature) / /  
Date

Are there any other medical or behavioral issues that BTB staff should be aware of? \_\_\_\_\_

**Health Screenings:**

	<u>Latest Date Completed</u>	
Dental screening or exam	/	/
Vision screening or exam	/	/
Hearing screening	/	/
Lead screening	/	/
Development screening	/	/
Physical	/	/

My child is free of communicable disease and can participate in program activities.  Yes  No  
\*If you answered No, please list your child's health-related restrictions to participate in BTB Programs.

\_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_/\_\_\_\_/\_\_\_\_  
(Date)

**Physician's information**

**Family Doctor/Center -Must Complete**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street/PO Box)  
\_\_\_\_\_  
(City/State/Zip)

Phone: \_\_\_\_\_

**Medical Specialist/Center:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street/PO Box)  
\_\_\_\_\_  
(City/State/Zip)

Phone: \_\_\_\_\_

Type of Specialty \_\_\_\_\_

**Family Dentist.Center -Must Complete**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street/PO Box)  
\_\_\_\_\_  
(City/State/Zip)

Phone: \_\_\_\_\_

**Dental Specialist/Center:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street/PO Box)  
\_\_\_\_\_  
(City/State/Zip)

Phone: \_\_\_\_\_

Type of Specialty \_\_\_\_\_

**Hospital of choice (Check one):**

\_\_\_\_\_ **Mercy Medical Center**  
801 5<sup>th</sup> Street  
Sioux City IA 51101  
(712)279-2010

\_\_\_\_\_ **St Luke's Regional Medical Center**  
2720 Stone Park Blvd  
Sioux City IA 51104  
(712)279-3500

\_\_\_\_\_ **Other:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Phone \_\_\_\_\_

I have attached a copy of my child's immunization records. (Mandatory)  Yes  No  
If you stated, No-please explain \_\_\_\_\_  
\_\_\_\_\_

In the event that I am unreachable and my child requires medical, surgical or dental care, I hereby give permission for BTB staff and the doctor's and dentist's of the clinics listed to administer medical treatment. I also agree to pay all costs and fees in conjunction with these treatments. Every effort will be made to notify parents in case of an emergency. This form will be presented upon admission for treatment.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**Health/Dental Insurance Policy Information:**

Health Insurance Company Name: \_\_\_\_\_

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

(Street/PO Box)

\_\_\_\_\_  
(City/State/Zip)

Group \_\_\_\_\_ Individual \_\_\_\_\_ Medicaid or Title 19 \_\_\_\_\_ Hawk-I \_\_\_\_\_ None \_\_\_\_\_

Policy # \_\_\_\_\_ Primary Insured: \_\_\_\_\_

Dental Insurance Company Name: \_\_\_\_\_

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

(Street/PO Box)

\_\_\_\_\_  
(City/State/Zip)

Group \_\_\_\_\_ Individual \_\_\_\_\_ Medicaid or Title 19 \_\_\_\_\_ Hawk-I \_\_\_\_\_ None \_\_\_\_\_

Policy # \_\_\_\_\_ Primary Insured: \_\_\_\_\_

**Parent/Guardian Permissions – initial & date each permission allowed**

1. I give permission for my child to be photographed for use in BTB promotional materials.

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

2. I give permission for my child to attend scheduled walking and transported field trips.

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

3. I give permission for BTB to obtain my child's grades for the purpose of program evaluation only. I understand these grades will be kept strictly confidential.

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**I need a referral for:**

\_\_\_\_\_ Child Care Attendance Assistance

\_\_\_\_\_ Food Assistance

\_\_\_\_\_ Housing Assistance

\_\_\_\_\_ Medical Assistance

\_\_\_\_\_ Health Insurance

Other (List) \_\_\_\_\_

Please return completed forms along with all necessary documentation to the Beyond the Bell office: PO Box 2129, 3601 Country Club Blvd Sioux City IA 51104. Forms may also be given to the BTB staff at school. If you have additional questions, or need help filling out these forms, please call our office at (712)277-3600.