

AfterSchool Planet After-School Registration Form

Office Use Only:

R.A. _____ RCVD _____

C _____ CK _____ # _____ DT _____

Open to Children who are in Pre-K to Kindergarten to 9th Grade
during the month of September 2022

May 2022 – August 2022 (Special Summer Programs: Snacks Included, Field Trips included)

Please complete all information as clear as possible (ONE form per family):



Parent/Guardian's name _____

Address: _____

City: _____

Email Address: _____

Phone: _____

Work/Cell Phone: _____

Emergency Contact: _____

Emergency Phone: _____

Parent Work Information:

Father's Employer's Name: _____

Father's Employer's Phone: _____

Father's Employer's
Address: _____

Mother's Employer's Name: _____

Mother's Employer's Phone: _____

Mother's Employer's
Address: _____

Participating child(ren)'s Name:	Child 1		Child 2		Child 3		Child 4	
	Boy	Girl	Boy	Girl	Boy	Girl	Boy	Girl
Sex: Please circle								
Birthday/ Age	/		/		/		/	
Grade in September:								
Attending School District? Indicate School Name:	<input type="radio"/> Rosemead <input type="radio"/> Temple City <input type="radio"/> Arcadia <input type="radio"/> San Gabriel <input type="radio"/> El Monte	<input type="radio"/> Rosemead <input type="radio"/> Temple City <input type="radio"/> Arcadia <input type="radio"/> San Gabriel <input type="radio"/> El Monte	<input type="radio"/> Rosemead <input type="radio"/> Temple City <input type="radio"/> Arcadia <input type="radio"/> San Gabriel <input type="radio"/> El Monte	<input type="radio"/> Rosemead <input type="radio"/> Temple City <input type="radio"/> Arcadia <input type="radio"/> San Gabriel <input type="radio"/> El Monte	<input type="radio"/> Rosemead <input type="radio"/> Temple City <input type="radio"/> Arcadia <input type="radio"/> San Gabriel <input type="radio"/> El Monte	<input type="radio"/> Rosemead <input type="radio"/> Temple City <input type="radio"/> Arcadia <input type="radio"/> San Gabriel <input type="radio"/> El Monte	<input type="radio"/> Rosemead <input type="radio"/> Temple City <input type="radio"/> Arcadia <input type="radio"/> San Gabriel <input type="radio"/> El Monte	<input type="radio"/> Rosemead <input type="radio"/> Temple City <input type="radio"/> Arcadia <input type="radio"/> San Gabriel <input type="radio"/> El Monte

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English Proficiency	Please circle one: <input type="radio"/> Fluent <input type="radio"/> Good <input type="radio"/> Not Preferred	Please circle one: <input type="radio"/> Fluent <input type="radio"/> Good <input type="radio"/> Not Preferred	Please circle one: <input type="radio"/> Fluent <input type="radio"/> Good <input type="radio"/> Not Preferred	Please circle one: <input type="radio"/> Fluent <input type="radio"/> Good <input type="radio"/> Not Preferred

Rates are based on the current rate chart posted in office. Rates are paid per month.

Registration fees are not refundable Your monthly tuition is for the spot in our program.

Please make all checks payable to "AfterSchool Planet", write your child(ren)'s names at the memo spot.

We have given permission to the following person(s) for the pick up and drop off of our child(ren). These people must provide ID when picking up the children so that we will know who they are.

Name & Contact no. (Person 1)	Name & Contact no. (Person 2)
Name & Contact no. (Person 3)	Name & Contact no. (Person 4)

I give permission to my child to attend Programs at AfterSchool Planet and authorize for EMERGENCY medical treatment.

Should it be necessary for my child to have medical treatment while participating in programs on premises, I hereby give the person in charge permission to act on my behalf to secure hospitalization or medical services deemed necessary and appropriate by the physician. I hereby authorizes the principal or designee, into whose care the student has been entrusted, to consent to any X-ray examination, anesthetic, medical or surgical diagnosis, treatment, and/or hospital care to be rendered to the student upon the advice of any license physician and/or dentist. It is understood that this authorization is given in advance of any required diagnosis, treatment, or hospital care and provides authority and power to the AfterSchool Planet to give specific consent to any and all such diagnosis, treatment, or hospital care which a license physician or dentist may deem necessary. This authorization is given in accordance with Section 49407 of the California Education Code, and shall remain effective until revoked in writing and delivered to the AfterSchool Planet director. I absolve said AfterSchool Planet and its personnel from any and all forms of negligence and wrong treatment incurred in the procurement and process of hospitalization and medical treatment. All cost incurred for paramedic transportation, hospitalization, and any examination, X-ray, or treatment provided in relation to this authorization shall be my sole responsibility as the student's parent/gardian.

HEALTH ALERTS - List any medical condition which restricts physical activity or requires special attention. Include conditions such as asthma and allergies such as peanut and bee stings. If none, please indicate "NONE".

HEALTH INSURANCE - Does the student have health insurance? ___Yes ___No (please list information below)

MEDI-CAL HEALTHY FAMILIES ID NUMBER - _____

PRIVATE HEALTH INSURANCE NAME - _____ **GROUP NO:** _____

NAME OF DOCTOR/MEDICAL OFFICE: _____ **PHONE NO:** _____

MY CHILD IS ALLERGIC TO THE FOLLOWING MEDICATIONS:

MY CHILD CURRENTLY TAKES THE FOLLOWING MEDICATIONS: _____

Client Information - for purpose of data collection, we like to ask the following demographic information, mark all that apply:

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C	_____	CK	_____ # _____ DT _____

Racial Background Information:
Single Categories:

- _____ American Indian / Alaska Native
- _____ Asian
- _____ Black / African American
- _____ Native Hawaiian / Other Pacific Islander
- _____ White, Caucasian

Ethnic Background:

- _____ Not Hispanic / Spanish / Latino
- _____ Mexican / Mexican American / Chicano
- _____ Puerto Rican
- _____ Cuban
- _____ Other Hispanic / Spanish / Latino
- _____ Two or More _____

Housing Demographics Information:
Area Categories:

- | | |
|-------------------|-------------------|
| _____ Arcadia | _____ Pasadena |
| _____ Duarte | _____ El Monte |
| _____ Rosemead | _____ Monrovia |
| _____ Temple City | _____ West Covina |
| _____ San Gabriel | _____ San Marino |
| | _____ Other |

I CERTIFY THAT I HAVE READ AND UNDERSTOOD THIS FORM AND DO HEREBY GIVE MY AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT, AND THAT ALL OF THE INFORMATION I HAVE PROVIDED ON THIS FORM IS TRUE AND CORRECT.

Signed: _____
(Parent or Guardian's Signature)

Date: _____

Please note that if you plan to terminate our service you need to give us two weeks notice prior to the termination date, as stated in handbook. By signing this form it is the same as acknowledging the rules in the handbook. The handbook can be downloaded through our website.