



LAKEVIEW EXTENDED SCHOOL DAY PROGRAM INC.  
BEFORE & AFTER SCHOOL REGISTRATION FORM  
2023 - 2024

PARENTS / GUARDIANS NAMES \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ PROVINCE \_\_\_\_\_ POSTAL CODE \_\_\_\_\_

PHONE NUMBERS: HOME \_\_\_\_\_ MOTHER'S WORK \_\_\_\_\_

MOM CELL \_\_\_\_\_ FATHER'S WORK \_\_\_\_\_

DAD CELL \_\_\_\_\_ E-MAIL \_\_\_\_\_

CHILDREN'S NAME(S)	GRADE	TEACHER'S NAME	HOSPITALIZATION #	BIRTHDAY

**PLACE A CHECK BESIDE THE DAYS YOU EXPECT YOUR CHILDREN TO ATTEND EACH WEEK**

**PLEASE INDICATE FREQUENCY BY CIRCLING DAILY OR CASUAL**

DAILY OR CASUAL MONDAY AM \_\_\_\_\_ TUESDAY AM \_\_\_\_\_ WEDNESDAY AM \_\_\_\_\_ THURSDAY AM \_\_\_\_\_ FRIDAY AM \_\_\_\_\_

DAILY OR CASUAL MONDAY PM \_\_\_\_\_ TUESDAY PM \_\_\_\_\_ WEDNESDAY PM \_\_\_\_\_ THURSDAY PM \_\_\_\_\_ FRIDAY PM \_\_\_\_\_

**PEOPLE IN WHOSE CUSTODY WE CAN DISMISS YOUR CHILDREN (PLEASE PROVIDE CUSTODY AGREEMENT IF APPLICABLE)**

**DOCTOR'S NAME AND PHONE NUMBER**

**MEDICAL OR OTHER PROBLEMS THAT STAFF SHOULD BE AWARE OF AND CARE NEEDED**

**ALLERGIES (FOOD OR MEDICATION- PLEASE DESCRIBE IN DETAIL)**

**AN EMERGENCY CONTACT PERSON WE CAN CONTACT IF A PARENT CANNOT BE REACHED**

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE NO. \_\_\_\_\_