

Aftercare Program



Application

Package Purchased: (Check one please)
 50 Days 100 Days 140 Days
 Full Year Morning Care Only

Child(ren)'s Name(s):

Parent(s) Name(s):

Child's Address:

Street

City

State

Zip Code

Mother's Information

Home Number:

(____)-____-_____

Cell Number:

(____)-____-_____

Work Number:

(____)-____-_____

Father's Information:

Home Number:

(____)-____-_____

Cell Number:

(____)-____-_____

Work Number:

(____)-____-_____

Important Medical Information:

Allergies: _____

Important conditions (asthma, etc.): _____

If you would like to authorize any additional people to pick your child(ren) up please provide us with some of their information below:

Name: _____ Name: _____

Relation to Child: _____ Relation to Child: _____

Phone Number: _____ Phone Number: _____

Name: _____ Name: _____

Relation to Child: _____ Relation to Child: _____

Phone Number: _____ Phone Number: _____

**I understand and agree to the rules, pricing, and late charges involved in the the Aftercare Program as set forth by Horizon Science Academy.

Printed Name: _____ Signature: _____

Date: ____ / ____ / ____