



**CAMBRIDGE CHRISTIAN ACADEMY AFTER SCHOOL PROGRAM**

**STUDENT DATA SHEET**

**Child's Name:** \_\_\_\_\_

**Teacher and Grade:** \_\_\_\_\_

**Male:** \_\_\_\_\_ **Female:** \_\_\_\_\_

**Parent or Guardian:** \_\_\_\_\_

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

**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Parent or Guardian:** \_\_\_\_\_

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

**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Child's Schedule:** **Start Date** \_\_\_\_\_ **Which days to attend:** \_\_\_\_\_

**Pick Up Time:** \_\_\_\_\_

**Authorized Pick-Up Person(s):**

**1. Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**2. Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Emergency Pick-Up:**

**1. Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**2. Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Medical Information**

Child's Name: \_\_\_\_\_

Does your child have allergies? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Reaction: \_\_\_\_\_

Is your child allergic to any foods? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Reaction: \_\_\_\_\_

Child's Physician: \_\_\_\_\_

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