AFTER CARE PROGRAM APPLICATION

Child's Full Name ________________________________**Birth Date** _______________

Child's Full Name ________________________________**Birth Date** _______________

Child's Full Name ________________________________**Birth Date** _______________

Home Address ____

City/State/Zip Code ____

School District ____

Program Options:

	Mon.	Tues.	Wed.	Thur.	Fri
3:00pm-6:00pm*	______	______	_____	______	_____

Note:** ***The program begins immediately after school at 3:00pm and concludes promptly at 6:00 pm.
Late fee for children who remain after 6:00pm is $5 per every 15 minutes late rounded up in 15 minute increments.

Parent One ____

Home Address ____

City/State/Zip Code ____

Home Phone ___________________ **Other Phone** _______________________

Parent Two ____

Home Address ____

City/State/Zip Code ____

Home Phone ___________________ **Other Phone** _______________________

Who is financially responsible for program expenses?

____

Is your child currently receiving, or has she or he in the past received, professional help for learning, emotional, or behavioral difficulties □ yes □ no. If yes please attach a statement outlining the difficulties.

Does your child have any allergies?

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In the case of an emergency, we will consult your Emergency Form on file in the school office, unless otherwise indicated below.

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____________________________ ____________________________

Parent Signature **Date**

Please return this completed application to:

Mountain Laurel Waldorf School
P.O. Box 939
New Paltz, NY 12561
Tel. (845) 255-0033 - e-mail: administration@mountainlaurel.org

Mountain Laurel Waldorf School does not discriminate on the basis of race, religion, color, nationality or ethnic origin in its admissions, tuition assistance or educational policies.

For School Use only.

Date application received: ________________

Approved by: _________________