Fax: 501-835-3582
Email: dreamnlr@yahoo.com

AFTERSCHOOL PROGRAM APPLICATION

CHILD INFORMATION		
Child Name:		
Date of birth: Race:	Male ☐ Female ☐	Phone:
Current address:		
City:	State:	ZIP Code:
Current School:	Current Grade:	Special Needs: Yes ☐ No ☐
Is your child currently taking any medication? _____ Yes _____ No Name of Medication?		

PARENT/GUARDIAN INFORMATION		
Parent/Guardian Name:		
Address:		
City:	State:	ZIP Code:
*Email:		Phone:

EMERGENCY CONTACT INFORMATION	
Emergency Contact Name:	
Relationship to Child:	Phone:
Physician Name:	Phone:
Preferred Hospital:	
Allergies:	

PICK-UP AUTHORIZATION	
Name	Phone

CONSENT TO EMERGENCY FIRST AID & TRANSPORTATION

In the event of an emergency, I hereby give permission for my child to be given emergency treatment by a staff member at DREAM. I also give permission for my child to be transported by ambulance to an emergency center for treatment, and agree to hold DREAM and its employees harmless.

Parent Signature:	Date:

CONSENT TO MEDICAL TREATMENT

In the event that I cannot be contacted immediately, medical treatment can be administered to my child in the case of an accident or emergency, as prescribed by a treating physician, and hold DREAM and its employees harmless.

Parent Signature:	Date:

MEDIA RELEASE

With my signature below, I give permission for DREAM to photograph my child for the purpose program advertisement for the DREAM website and program bulletins recruitment, newsletters and media that promote student and program success. _____ Yes _____ No

Parent / Guardian Signature of Agreement

With my signature below, I agree that the information provided on this application is true and correct. I further agree that if information provided is found to be false, DREAM reserves the right to terminate service immediately.

Parent Signature:	Date: