

**Community Education  
Dover-Sherborn Public Schools**

Elizabeth McCoy, Superintendent

Tracey Carlin, Director of Sherborn Extended Day

**SHERBORN EXTENDED DAY REGISTRATION/RE-ENROLLMENT FORM 2024-2025 Grades K- 5**

**\*Please fill out individual forms for each child\* (Please Print Legibly)**

**2:15-6:00PM**

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

Grade in 2024-2025: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Sponsor (Parent/ Guardian):**

**Co-Sponsor (Parent/ Guardian)**

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

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

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

\_\_\_\_\_

\_\_\_\_\_

Home Phone: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Email: \_\_\_\_\_

PRIMARY EMAIL ADDRESS: \_\_\_\_\_

An Emergency contact is someone other than a parent who can be available within 30 minutes to pick up your child in an emergency situation.

**Emergency Contact 1**

**Emergency Contact 2**

Name: \_\_\_\_\_

Name: \_\_\_\_\_

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

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

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

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

Can pick up anytime? Yes / No

Can pick up anytime? Yes / No

(If NO, you must call or send a note EVERY time this person is to pick-up your child)

**Students must be registered for at least 3 days EACH week.**

**Please circle days needed:**

**Monday      Tuesday      Wednesday      Thursday      Friday**

Please use *the tuition worksheet* to determine the monthly tuition for each child and include the worksheet with your registration forms.

**New Families - Please include a \$25.00 non-refundable registration fee plus your June 2025 tuition deposit.**

**PLEASE MAKE CHECKS PAYABLE TO: SHERBORN EXTENDED DAY**  
Completed registration forms should be mailed or given to the Program Director.

Attach a recent photo of your child here

*\*A new photo is required each year*

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Family Doctor**

**Family Dentist**

**Family Hospital**

Name: \_\_\_\_\_

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

Insurance Policy Number: \_\_\_\_\_

**Does your child have allergies? Yes No (circle one)**

**EPIPEN REQUIRED? Yes No [circle one]**

**If yes, you are required to supply Extended Day with an epipen, in its original box, before your child attends our Extended Day Program.**

**Please describe in full** any and all Allergies, Dietary Restrictions, Medical Circumstances (including medications), Learning Issues (including special ed. testing outcomes or IEP accommodations/ modifications) or any other concerns that the Extended Day staff should be made aware of concerning your child.

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How would you assess your child's social skills?

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**WAIVER TO PROVIDE MEDICAL TREATMENT**

In the event of medical situations deemed to be emergencies I/we, the parents of \_\_\_\_\_ grant permission to the Extended Day staff to obtain emergency medical treatment.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_