



BAYONNE BOARD OF EDUCATION
AFTER SCHOOL CHILD CARE PROGRAM
REGISTRATION 2025-2026

ABBREVIATED SESSION

STUDENT'S NAME: _____	AGE: _____	DATE OF BIRTH _____
HOME ADDRESS: _____	SCHOOL: _____	Grade _____ HR# _____
PARENT #1 NAME: _____	PARENT #2 NAME: _____	
PARENT #1 CELL: _____	PARENT #2 CELL: _____	
PARENT #1 EMAIL: _____	PARENT #2 EMAIL: _____	
PARENT #1 HOME PHONE: _____	PARENT #2 HOME PHONE: _____	
PARENT #1 WORK PHONE: _____	PARENT #2 WORK HONE: _____	
NAME & ADDRESS WORK: _____	NAME & ADDRESS WORK: _____	

EMERGENCY CONTACT INFORMATION

In case of an emergency, it may be necessary to contact parents during BSCC/ASCC hours. Please furnish us with the following information. I will not hold the Bayonne Board of Education personnel responsible in the event of an accident or injury as a result of his/her participation. I understand that in an emergency I will be contacted immediately. If I am not available I hereby designate:

NOTE: EMERGENCY CONTACTS MUST BE SOMEONE OTHER THAN PARENTS!

Name	Relationship to Student	Home Phone	Work Phone	Cell Phone

NAMES OF PERSONS, OTHER THAN PARENTS, TO WHOM STUDENT MAY BE RELEASED:

EMERGENCY MEDICAL RELEASE

If neither of us is available, I hereby authorize the Bayonne Board of Education take whatever measures that are deemed necessary. I also give permission for my child to be given emergency treatment at a local hospital.

PARENT/GUARDIAN SIGNATURE: _____

Doctor's Name & Phone: _____

Medical Insurance Company (if none, state "none"): _____

Policy Number: _____

****If your child has any special needs, allergies, or uses any medications, please list them. Please inform the BSCC/ASCC Teacher.****

ALLERGIES: _____

MEDICATIONS: _____

SPECIAL NEEDS: _____