

HELPING HANDS LEARNING CENTER

Enrollment Application

2026-2027 School Year

Student Information: *(Fill out one form per child)*

Child's Last Name	Child's First Name	MI	Sex	DOB
Grade (2026-2027 year)	Living Arrangements <i>(check one)</i> : <input type="checkbox"/> lives with both parents <input type="checkbox"/> lives with guardians <input type="checkbox"/> lives with mother <input type="checkbox"/> lives with father			
Address			Home Phone	
City	State	Zip	Family Email Address	

Other students in the household enrolling in Helping Hands Learning Center After School Program:

Attendance:

Please put a check next to the day(s) your child will regularly attend and anticipated time of pick up.

Days:	<input type="checkbox"/> Monday	<input type="checkbox"/> Tuesday	<input type="checkbox"/> Wednesday	<input type="checkbox"/> Thursday	<input type="checkbox"/> Friday
Pick up Time:					

Contact Information:

Name & Relationship to Child	Home/Cell Phone:	Email Address Where Reachable While Child is in Care:
Home Address (Street, City, State, Zip)	Does Child Reside at this Location? <input type="checkbox"/> Y <input type="checkbox"/> N	Place of Employment & Work Number
Name & Relationship to Child	Home/Cell Phone:	Email Address Where Reachable While Child is in Care:
Home Address (Street, City, State, Zip)	Does Child Reside at this Location? <input type="checkbox"/> Y <input type="checkbox"/> N	Place of Employment & Work Number

BEST phone number (3pm-5:30pm): _____ BEST way to reach you: Call Text

BEST way to share program information with you: Printed Letters Email Text Other:

Emergency Contact:

Name: _____ Phone Number: _____ Relationship to child: _____

Address: _____

Authorized Pick-ups: List 2 adults who can pick up your child if any (other than the guardians & emergency contacts). (must have a photo ID to show staff upon pick up).

1. Name: _____ Phone Number: _____ Relationship to child: _____
Address: _____

2. Name: _____ Phone Number: _____ Relationship to child: _____
Address: _____

Physician or Medical Facility:

Name: _____ Phone Number: _____ Facility Name: _____
Address: _____

Allergies: _____

I hereby give my consent for emergency medical care or treatment to be used only if I cannot be reached immediately.

About Your Child: Help us identify your student's specific needs, interests & strengths below

What does your child like to do in their free time? (hobbies, organizations they are in, etc.)

List and describe any other concerns or anything else you would like to share to help us when working with your child?

After School Program Fee Schedule:

	1st Child	2nd Child	3rd child
Full Time (2-5 days/wk)	\$6.50/hour	\$6.50/hour	\$6.60/hour
Drop In (week notice)	\$7.50/hour	\$7.50/hour	\$7.50/hour

Drop In Fees: *Child must be pre-registered at helping hands to be a drop in.* Fees accrued for drop in must be paid upon pick up of your child from Helping Hands. Your child will not be able to attend in the future if no payment is received.

Late Fee: \$7.50 per child for every 5 minutes past pick up time.

I have read and understand the Helping Hands Learning Center Parent Handbook.

Parent/Guardian Signature: _____ Date: _____