

SALADO INDEPENDENT SCHOOL DISTRICT

2026-2027 STUDENT REGISTRATION FOR AFTER SCHOOL CARE PROGRAM

Child's Name: _____ / ____ / ____
First Middle Last Date of Birth

Grade: _____ Sex: M / F Physical Address: _____
(where child sleeps at night)

Campus Attending: Thomas Arnold Elementary _____ Salado Creek Elementary _____

Mother's Name: _____

Father's Name: _____

Cell Phone Number

Cell Phone Number

Preferred Email for Contact: _____

Others Who May Pick Up My Child:

Name

Relationship

Cell Phone Number

Name

Relationship

Cell Phone Number

Name

Relationship

Cell Phone Number

Name

Relationship

Cell Phone Number

SISD personnel will release your child only to the person(s) listed above. If there are any custody or other legal issues, the parent/guardian must provide legal documentation to the school office prior to the beginning of attendance in the ASC Program.

Additional School-Age Siblings: _____, _____, _____

Please list any
MEDICAL
CONDITIONS we
should be aware of

Please list any FOOD ALLERGIES we should
be aware of

There is not a nurse on duty during the After School Program hours. In case of an emergency, serious illness, or accident involving my child, named above, I understand SISD personnel may arrange transportation for my child to a physician/hospital.

Parent/Guardian Signature

Date

CHILD WILL ATTEND: (____) MONTHLY or (____) ON DROP-IN BASIS

CHILD OF SISD EMPLOYEE: Y / N If yes, which campus: TAE SC MS HS ADMIN

IS STUDENT ELIGIBLE FOR FREE/REDUCED LUNCH PROGRAM: Y / N

Office Use Only: Registration Fee Received: Y / N All Required Registration Documents Received: Y / N

Online\$ _____ Cash \$ _____ Check \$ _____ Check # _____ Date _____ Staff Initials _____

Return to Main Office