

**METHUEN PUBLIC SCHOOLS  
SACC ENROLLMENT FORM**

PROGRAMS NEEDED: A-Before School \_\_\_\_\_ B-After School \_\_\_\_\_ Reg. Fee (\$30.00) Pd: \_\_\_\_\_

Days needed: M \_\_\_\_\_ T \_\_\_\_\_ W \_\_\_\_\_ Th \_\_\_\_\_ F \_\_\_\_\_ Start Date \_\_\_\_\_  
(Minimum of 2 days per week is required)

Name of Child \_\_\_\_\_  
Last First

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

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Cell# \_\_\_\_\_

Mother's Address: \_\_\_\_\_

Company/Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

Father's Name: \_\_\_\_\_ Cell# \_\_\_\_\_

Father's Address: (if different) \_\_\_\_\_

Company/Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

**If I cannot be reached, I authorize the SACC staff to take my child to the nearest hospital and also attempt to contact the physician and emergency persons listed below.**

EMERGENCY CONTACT (1) \_\_\_\_\_ PHONE \_\_\_\_\_

EMERGENCY CONTACT (2) \_\_\_\_\_ PHONE \_\_\_\_\_

CHILD'S PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

Medical Condition/Allergies/Please include any information concerning your child that will assist us in his/her care.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**I give my permission for the following persons (other than parents) to take my child from the program at the end of the day. I understand that such release requires a permission slip from a parent/guardian.**

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

**A \$30.00 (non-refundable) registration fee per child should accompany this form. A separate enrollment form is required for each child.**

**\* I give permission for my child to be photographed. YES \_\_\_\_\_ NO \_\_\_\_\_**

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_