

DREAM BUILDERS GREATNESS CENTER

AFTER-SCHOOL PROGRAM

2019-20 Application

Student's Name First	Last	Middle Initial:	Grade Entering	Boy/Girl	Date of Birth
1.					
2.					
3.					
Student Address:			City:		Zip:
Mother/Guardian Name:		Work Phone:	Home Phone:	Cell Phone:	
Mother/Guardian Address:			City:		Zip:
Mother/Guardian Email Address:					
Father/Guardian Name:		Work Phone:	Home Phone:	Cell Phone:	
Father/Guardian Address:			City:		Zip:
Father/Guardian Email Address:					

Emergency Contact:	Emergency Phone:	Relationship to Child:
Emergency Contact:	Emergency Phone:	Relationship to Child:

Transportation:

If your child will be picked up from school by Dream Builders Greatness Center, please provide the following information:

1. School child(ren) attends: _____

2. Teacher Name: _____ Room #: _____

RELEASE AUTHORIZATION

I authorize the following Adults (persons over 18 years old) to pick up my child (other than Parent/Guardian):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Waiver/Authorization to Consent to Treatment of Minor

I/We, the undersigned, parent(s) of, _____, waive any claim for injury or loss to said child that may be incurred or sustained as a result of participation and/or use of premises and equipment by said child in connection with Dream Builders Greatness Center After-School Program.

I/We, the undersigned, parent(s) of _____, a minor, do hereby authorize the Dream Builders Greatness Center, its branches, agents, employees, and volunteers as agent(s) for the undersigned to consent to any X-Ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed hospital, whether such diagnosis or treatment is rendered at the office of said hospital.

It is understood that this authorization is given in advance of any specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

This authorization shall remain effective, unless revoked in writing delivered to said agent(s).

Dated (Inclusive): _____ Through: _____

Mother's Signature