



# SY 24-25 After School Program

## STUDENT APPLICATION

**Office Use Only:**

- Date Stamp: \_\_\_\_\_
- Deposit
- Health Forms
- Signature Page

Complete a separate application form for each child that you wish to enroll in the Renaissance Afterschool Program. **Slots are on a FIRST COME, FIRST SERVE BASIS. The** Program Fee is \$200 per month per child. Deposits are not required until your child has been confirmed and staffing is in place. Deposits must be in the form of a money order/voucher. Parents/Guardians are required to reapply for Afterschool every year, spaces are not reserved.

Applications are to be returned to: **The Boston Renaissance Charter Public School**  
 1415 Hyde Park Ave, Hyde Park, MA 02136  
 ATTN: Main Office

**Student Information**

**Full Name** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_ **Age** \_\_\_\_\_ **Gender** \_\_\_\_\_ Male \_\_\_\_\_ Female

**Address:** \_\_\_\_\_ Street Apt# City/State Zip

**Grade as of Sept 1** \_\_\_\_\_ **Teacher** \_\_\_\_\_ **Room #** \_\_\_\_\_ **PPU #** \_\_\_\_\_

Does the student have a sibling enrolling in the Afterschool Program? No \_\_\_\_\_ Yes \_\_\_\_\_

Name \_\_\_\_\_ Grade: \_\_\_\_\_ **A separate application is needed**

Voucher Recipient? No \_\_\_ Yes \_\_\_, Name of Agency: \_\_\_\_\_

\*Attach confirmation form with child's name or active voucher\*

**Parent/Guardian Information – Please add ALL PARENTS AND GUARDIANS allowed to pick up your child from the Afterschool Program.** Unless other arrangements are made, these are the only adults permitted to pick up your child. Minors are not allowed to pick up a child. THIS INFORMATION IS NOT TRANSFERRED TO OTHER DEPARTMENTS.

**Primary Contact:**

Parent/Guardian Name \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Email Address: \_\_\_\_\_

Address: \_\_\_\_\_ Street City/State Zip

Home Phone: \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell# \_\_\_\_\_

**Secondary Contact:**

Parent/Guardian Name \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Lives with Child \_\_\_Yes \_\_\_No

Address: \_\_\_\_\_ Street City/State Zip

Cell# \_\_\_\_\_ Work Phone \_\_\_\_\_

**Additional Names for Pick-Up:**

Name: \_\_\_\_\_ Cell# \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Name: \_\_\_\_\_ Cell# \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Name: \_\_\_\_\_ Cell# \_\_\_\_\_

Relationship to child: \_\_\_\_\_

**Student Medication:**

Does your child have any medical conditions/allergies?  
YES/NO \_\_\_\_\_

Does your child take any medication?  
YES/NO \_\_\_\_\_

**\*We will require a medication form and Individual Health Care form to be completed.**

**\*Any medication the child is prescribed must be turned in before the child can begin the program**

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

*Thank you for your cooperation, let's make this a great year!*