Warrior Care Registration

Select the care option that your family needs for the **2025-2026** school year. (choose one)
_____Before School_____After School_____Both Before & After School

Family/Parent Names:_____

Email:_____

Address:_____

City/Zip:_____

Phone Number (during the **Warrior Care Program**):_____

In case of emergency, please list additional contacts below to pick up your child(ren) if needed.

Name:_____Phone:_____Relationship:_____

Name:_____Phone:_____Relationship:_____

Name:_____Phone:_____Relationship:_____

Family Physician:_____Phone:_____

Children attending the **Warrior Care Program:**

Name: _____Birthdate:_____Grade:_____

Allergies:_____

Medical Concerns:_____

Name: _____Birthdate:_____Grade:_____

Allergies:_____

Medical Concerns:_____

Name: _____Birthdate:_____Grade:_____

Allergies:_____

Medical Concerns:_____

Name: _____Birthdate:_____Grade:_____

Allergies:_____

Medical Concerns:_____

Yes, I have read and agreed to the **Warrior Care Program** Handbook.

Print Name:_____Signature/Date:_____