



# Warrior Care Registration

Select the care option that your family needs for the **2026-2027** 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: \_\_\_\_\_